Impact of Food Beliefs and Practices on Reproductive Health of Women:

A Case Study of Punjabi Village

by

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DEDICATION

I dedicate this effort to my father and my best friend

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Chapter-1
INTRODUCTION

1.1 The Problem

The topic of the present research is "Impact of Food Beliefs and Practices on Reproductive Health of Women: A Case Study of Punjabi Village."

1.2 Statement of the Problem

Human beings the world over share a common need to meet certain fundamental conditions for survival. One of these needs is securing an adequate diet which provides energy and the various nutrients that are necessary for metabolic functions. The phenomenon of female discrimination regarding food intake is found among many cultures. While the status of nutrition in the urban areas has advanced somewhat but it remains critically unaddressed in the rural areas.

> "The problem of malnutrition is widespread particularly severe in South Asian countries." (Carlson and Wardlaw, 1990).

The over all status of female nutrition in third world countries is poor as compare to the developed countries. The issue of malnutrition has serious implications on the health of women. Effects of diet on the reproductive health of a female do not take place in a day. Certainly, it is her life long dietary habits since her birth that make her malnourished during various during various stages of life particularly during her reproductive stage.

> "The girl child is brought up in a continuous process of social discrimination. A girl child from pre-natal stage to adulthood lives through a series of social practices, which germinate, breed and reinforce social discrimination against her." (Naheed, 1993).

Diet is so important that anthropologists who study the food habits of a group of people say that a society's pattern of choosing, obtaining, preparing and serving their characteristic foods has a major influence in shaping their culture.

> "The girl child is discriminated against from the earliest stages of her life, through her childhood and into adulthood. This is often the girl child is the victim of traditional discrimination that leads to her neglect or to a lack of access to health and nutrition decision making and recreational facilities." (SPARC's Discourse, 2005 a).

It is clear that the diet of a girl is given less importance then her body requirements for food remain unmet throughout her life. Female discrimination for food in Pakistani culture is not a new phenomenon.

> "Malnourishment is a serious problem in Pakistan. Infants, young children and women are identified as high-risk groups. Malnutrition affects adult women more then men and it contributes to a vicious cycle of poor growth from generation to generation. Malnutrition in women is the result of inadequate food intake due to poverty." (Tinger, 1998).

The issue of food taboos and various socio-cultural practices surrounding a woman's life since her childhood make her less fortunate not only in access to proper food but also in access to proper health. From early childhood a girl is considered a burden on the family which leads to discrimination in general and in health and nutrition in particular.

> "The girl child is less likely to be breastfed at all or for as long as the boy child and less likely to receive medical attention as early or as often as the boy child, even before they enter adolescence girls are prepared for their future roles as wives and mothers. Girls are denied from proper nutrition and generally get to eat the least, as a result where there is not enough food for every one, she does not get enough to fulfill her requirements and some times has to go hungry and her body remains underdeveloped and prone to illness." (ibid, 2005).

Although discrimination against woman continues through out her life, such discrimination has great implications when she enters her childbearing age. The effects of

her poor dietary habits impair not only her own health but also the health of future generations.

> "The micronutrient survey of 1986 revealed that 35% of the pregnant women and 41% of lactating women took less than 80% of the recommended Daily amount of nutrients. Pregnant mothers inadequate diet, poor prenatal health care, repeated closely spaced pregnancies all contribute to the high prevalence of low birth weight babies between 25 and 30% of infants weight less than 2.5 kg at birth. This poor start in life may than be compounded by inadequate nutrition in the early years. Protein energy malnutrition (PEM) can be chronic problem causing stunting or it can result from acute episodes of food shortage, which can cause wasting." (AIOU, 1998).

The problem of nutrition for adolescent girls and women has become one of the most burning issues in the realm of women's health. Though several studies have been conducted previously by anthropologists and other social scientists on different aspects of women health, the study of cultural habits regarding the dietary habits of women during various stages of life related to the reproductive health of women is not greatly emphasized.

> "Habibullah 1990 in his paper found that it is not significantly realized that girl children are country's most precious resource. Available information on them presents an over view of negative male/female ratio, higher female child mortality, lesser access to food, health and nutrition, recreation and early induction into domestic work, marriage and motherhood."

This study tries to investigate different cultural aspects surrounding the diet of women of reproductive age group. From an anthropological point of view this study will have great implications because it takes into consideration various social and economical aspects regarding food beliefs and practices that have direct or indirect bearing on the reproductive health of women. As qualitative research allows the researcher to probe the perception of society about a particular issue. Thus, beliefs, perceptions and cultural practices regarding food intake of women will be examined in this study.

1.3 Objectives of the Study

The study aims to explore the following.

- Cultural perceptions and practices about preferred and prescribed food of women of reproductive age group ranging from 13-45 years.
- To understand the perceptions and knowledge of women of reproductive age group about their health in general and reproductive health in particular.
- To explore the prevailing cultural practices to understand the impact of nutritional depletion on the reproductive health of women with a focus on adolescent stage of life.

1.4 Review of Literature

Food intake is response to both biological and cultural stimuli. Culture plays a major role not only in differentiating humans from other species but also in determining what human should eat. Religious, Social and economic aspects of the culture further defines the criteria for the desired food.

> "Human societies unlike those of other animals are distinguished by culture, learned patterns of thought and behavior. It includes not only direct observable behaviors such as patterns of diet and social organization but also more subjective ideological components of beliefs and values. As such culture provides a context of meanings to individuals. Both cultural behaviors and beliefs can have important adaptive functions. These are learned during childhood and they are often deeply held and seldom questioned by adults, who pass their "obvious" knowledge and habits to their offspring. In this regard, cultural beliefs and values are largely unconscious factors in the motivation of individual behaviors. Cultural beliefs define "what is normal" and therefore constraints the choice of behaviors available to an individual." (Stoudemire, 1998).

Significance of food in any culture cannot be ignored. Food habits are developed and maintained because they are effective and meaningful with in a particular culture. Thus food plays crucial role in making a family coherent in exhibiting feelings of love, trust, faith and well being of every individual of the family.

> "Food habits are amongst the oldest and most entrenched aspects of many cultures, they exert deep influence on the behavior of people. The cultural

background determines what shall be eaten as well as when and how it shell be eaten. There is of course, considerable variation, and both rational and irrational and beneficial and injurious customs are found in every part of the world. Nevertheless, by and large food habits are based on food availability, economics or symbolism. Included among these influential factors are geography of the land, the agriculture practiced by the people, their economy and market practices and their history and traditions." (Bhatia, 1999).

In every culture, variations are found regarding the definition and classification of food, value of food and rules regarding its preparation and consumption.

> "Anthropologists have pointed out that cultural groups differ markedly in their dietary beliefs and practices. For example, there are wide variations throughout the world in what substances are regarded as "food" and what are not. Food stuffs which are eaten in one society or group are rigorously forbidden in another. There are also variations between cultures as to how food is cultivated, harvested, prepared, served and eaten. Each culture usually has a set of implicit rules which determine who prepares and serves the food- and to whom. Which individuals or groups eat together? Where, and on what occasions, the consumption of food takes place. The order of dishes with in a meal and the actual manner of eating the food. All of these stages in food consumption are closely patterned by culture, and are part of the accepted ways of life of that community. Because of the central role of food in Daily life, especially in social relations, dietary beliefs and practices are notoriously difficult to change, even if they interfere with adequate nutrition." (Helman, 1984 a).

> "Williams and Schlenker (2003 a) are of the view that culture involves not only the more obvious and historical aspects of a person's communal life, that is language, religion, politics, technology, and so on, but also are the little habits of every day living, such as preparing and serving food and caring for children, feeding them, and lulling them to sleep. These many facts of a person's culture are learned gradually as a child grows up in a society. Through a slow process of conscious and unconscious learning. What ever is invented, transmitted, and perpetuated-socially acquired knowledge and habits. We learn as part of our culture these elements become internalized and entrenched."

Meanings of food vary from one region to another. By looking at some standard definition, terms and classification of food one comes to know how the

meanings, symbolic roles and functions of the food vary in a particular area and culture.

> "According to the Dictionary of Food and Nutrition food comprise of the substances, which are taken in by mouth, which maintain life and growth i.e. supply energy and build and replace tissues. (Jewel, 2000) Dietary Patterns deals with total diet, rather than nutrients or individual foods. While the Word *food habits* mean habits of an individual in respect of having food, means what, how, when, where and with which frequency he/she uses different foods." (Kant, 2004).
>
> In general, five types of food classification system can be identified, though in practice several of them usually co-exist with in the same society. They are: (1) definitions of 'food' versus 'non food', (2) 'sacred' versus 'profane' foods, (3) parallel foods classifications, (4) food used as medicine, and medicine as food, and (5) social foods (which signal relationship, status, occupation, gender or group identity). Their clinical significance is that they may severely restrict the types of foodstuffs available to people and that diet may be based on cultural, rather than nutritional criteria." (Helman, 1984 b).
>
> "Diet has multidimensional exposure. Assessing the relationship with overall diet rather than with single nutrients, foods, or food groups has intuitive appeal." (Kant, 2004b). "Human foodways a term which includes as well as food choice, methods of eating preparation, number of meals per days, time of eating and the size of portions eaten, are an integrated part of the coherent cultural pattern in which each custom and practice has a part to play. Food habits come into being and are maintained because they are effective, practical and meaningful behaviors in a particular culture. Food habits are acquired early in life and once established is likely to be long lasting and resistance to change". (Feildhouse 1986). Griffiths and Wallace (1998) found that "food habits are primarily based on food availability, economics, and personal food meanings and beliefs."

Since every society has different criteria for desirable and undesirable food and food taboos through out life regarding age and sex and status of an individual. The phenomenal of nutrition needs to study independently. In the orient particularly in Asia women is considered as a lesser being as compare to male. Discrimination against women in this part of the world in every aspect of life is very obvious from literature. Such

discrimination in access to food makes a woman malnourished during various stages of her life particularly during her child bearing age.

> "Food taboos and beliefs practiced in a society play a special role in what food are to be avoided and how food is to be allocated to different family members. Temporary food avoidance my involve limiting an individual's consumption during the short-term condition, such as with holding food to a sick child. Other temporary avoidances apply to group of individuals during certain period of life cycles. For example pregnant women are called upon to avoid eating too much food for the fear of having a big baby and consequently a hazardous delivery, and infants are not given leafy green vegetables as these are likely to upset their stomachs, other group that are most frequently subject to food beliefs and taboos are women during breast feeding and menstruation wearing children and adolescents going through puberty". (Ali, 1993).

> "ibid (1993) in all societies, particularly in the orient, there are established ways in which different categories of people are expected to have special contact with each other. Food is distributed according to the status of person enjoyed by him rather to the nutritional needs. The head of the family by tradition is entitled to get the best food followed by other senior members of the family. Women and children are generally fed after the male members have eaten. Among the young children boys often enjoy higher priority than girls."

> "Stratton (1997) is of the view that meals in whatever forms are contexts in which important process of socialization, communication and intimation can occur for many families. Meal times are the only occasion in which the whole family is regularly together."

The cultures where hot/cold dichotomy of food is practiced it is closely related to the reproductive cycle of a woman particularly during menstruation, pregnancy, postpartum and lactation that has an impact on the overall health of a woman further more it leads to the causes of malnutrition among women.

> "Foods are often classified into "hot" and "cold." For example, eggs are considered "hot" and their consumption increases during winter months because of their "hot" nature. They are also not given to small children (Fortunately in Pakistan, prejudice against eggs is lessening). Similarly, some foods, in cold weather, are considered beneficial, while the same

taken in summer months are considered dangerous. Such ideas do positive harm to persons belonging to vulnerable groups." (Ali 1993 b).

Cultural food beliefs and taboos practiced in a society greatly contribute in constituting desirable food for a person through out various stages of his/her life. These food beliefs are deeply rooted with in the culture and persist for long. These beliefs and practices vary from one region to another.

> "All societies have traditional beliefs regarding harmful and beneficial foods for women during pregnancy. There are also beliefs regarding the optimal amount of food to be taken during the pregnancy for a successful reproductive outcome. These beliefs may or may not confirm to the modern biomedical notions about the proper types and amount of food needed by pregnant women to safeguard maternal nutrition, adequate growth of fetus and safe delivery. Different food items are believed to be harmful and beneficial in the various Indian communities. Some beliefs are often associated with the concepts of "hot" and "cold" foods. In Indian communities food items perceived as 'hot' are often believed to be harmful for pregnant women and those perceived, as 'cold' believed to be beneficial, although in a few communities effects are believed to vary in different stages of pregnancy and also on physical constitution." (Nag, 1994).

Phenomenon of discrimination against women is not new. Women have fallen prey to various forms of discrimination since ages. Women are continuously struggling to fight for their rights.

> "From very ancient times gender inequalities had been found in every part of the world. Women, particularly, had been victims of this condition and the inequalities are continued even today in this age of marvels in science and technology. Men had always been relegating the women to the background. This suppressive act had subordinated women to men and kept them always docile. Also, this had affected their mental abilities to some extent. Woman was often made to feel that her duty was to yield to the desires of man and beget children from him. Her sexual desires or other aspirations were not cared for him. She was considered an object of enjoyment and a child bearing machine and her duty was to take care of children till they attain maturity."

> "Several studies suggest that the existing higher mortality rate of the girl child in many developing countries are not due to poverty or biological reasons but because of the preference for boys that can lead to discriminatory treatment of girls in terms of food, basic health provisions and even prenatal care this male preference has complex historical roots that vary from culture to culture."

Balanced and nutritious diet is very important for the development of any individual but majority of the people in Pakistan have no awareness about diet and its components. Literature on food and nutrition reveal that even educated people are not aware of their diet and their nutritional requirements at various stages.

> "The nutritional status of an individual refers to the availability of energy and nutrients to the cells of the body requirements. Malnutrition is a result of an imbalance in energy or nutrients at the cellular level, including deficiencies and excesses." (Pelletier, 1998).

> "UNICEF (1998) states in a report that the underlying causes for malnutrition include access to basic health services and healthy environment, household food security as well as maternal and child care. Limited access to health facilities, lack of potable water and poor environmental sanitation are important underlying causes of malnutrition. These conditions directly affect hygiene and health. Inadequate access to water affects hygiene and health. Inadequate access to water affects nutrition indirectly by increasing women's workload, thus reducing indirectly by increasing women's workload, thus reducing time available for child care."

> "The study of underlying causes of malnutrition and death has been simplified by the (United Nations Children's Fund, 1990) which provided the foundation for the International Conference on Nutrition (1992). The causes for malnutrition and death are insufficient household food security, insufficient health services and unhealthy environment, inadequate maternal and child health care." (UNICEF, 1990).

In Pakistan the majority of the female children are discriminated against access to food through out their lives. Malnutrition problem in Pakistan is highest among the developing countries which is indeed very unfortunate and alarming. Nearly all the nutritional surveys of Pakistan reveal alarming nutritional status of females of all ages.

> "National Nutritional Survey 2001 indicates that malnutrition is an outcome of inadequate quality and quantity of dietary intake in human. Malnutrition levels in Pakistan are higher than in the developing countries this includes nutritional deficiencies and disorder of protein energy malnutrition, iron, iodine, vitamin A etc. Malnutrition is one of the major public health problems in Pakistan. Prevalence of malnutrition is an indicator of current health status of the population and is directly or indirectly related to inadequate access to food, education, health care practices, socio-economic status and environmental factors jointly or individually."

> "In Pakistan, per capita Daily calorie intake is estimated at 2715 calories for 1999-2000. The intake of Daily protein per capita is 71.03 grams. The national food intake balance sheet of six major food items including pulses (edible seeds, peas beans etc), sugar, milk, eggs and edible oil, shows an improvement in milk, meat and edible oil over the last year, while it has declined in pulses and sugar." (Economic Survey of Pakistan 1999-2000)

Malnutrition among females not only affects their own health but also the health of future generations. Serious efforts are needed to ease this problem in the better interest of mother and child health in particular and health of the society in general.

> "Maternal malnutrition also affects the infant's nutritional status as well as its survival status, through its effect on breast milk and duration of breastfeeding (Wray, 1978). Pregnant women who receive inadequate nutriments are likely to have underweight babies, and are more likely to get infectious diseases leading to early death. Those who survive but receive inadequate food in their early life are more likely to be exposed to the permanent stunting." (Bender and Smith, 1997).

> "The imbalance of energy and nutrients at the cellular level can arise from inadequate nutrient intake and/or disease, such as diarrhea, measles, malaria and other parasitic infections, which may affect nutrient absorption, transport, storage and utilization. The causes of malnutrition and ill health are the state of household food insecurity, the inadequacy of maternal and childcare, and unhealthy environment (UNICEF, 1990).However, poverty is related to most of the immediate, underlying and basic causes of malnutrition." (Gopalan, 1986. WHO, 1995. Keller, 1991).

Adolescence is a limbo period between childhood and adulthood. This period is very crucial regarding physical and psychological development of a person. Many scholars have defined it differently and marked it as a crucial stage of development.

> "Hanlon (1990 a) Adolescence has been defined as "The process whereby an individual makes the gradual transition from childhood to adulthood." Its beginning is marked by the biochemical and physiological changes of puberty. Its ending are less precise varying between the middle teenage years and the mid twenties .for reasons are not although clear but thought to be related to improved health status generally and nutrition specifically."

Adolescence is period of rapid change and development. During this stage food requirements of a person drastically increase. But in Pakistani context less attention is given towards the food requirements of a girl at this stage resultantly her food requirements remain unmet through out life and her growth is badly effected.

> "Katachdourian, 1977. Schuster, 1980 coated by Newman & Newman (1986) noted that because of the rapid growth that occurs during adolescence, the pre-pubertal years and the time just around the highest spurt are periods when a lack of nutritional resources can have particularly serious consequences, adolescents need a greater caloric intake than younger children or adults, for girls, calories requirements are at height during the years from 12-15 at about the time of menarche. During this period girls requirements about 2400 calories per day to sustain pubertal growth. In addition to meeting caloric requirements the adolescent's diet should include adequate amounts of fluids, protein and calcium."

Available literature on adolescence girls of the Pakistan suggests that besides discrimination towards female, other social and economical factor also contribute towards their dormant status. Today malnutrition is the biggest problem of adolescents of Pakistan and its cause are complex and interconnected to poverty, income and food unavailability.

> "Kurz (1991) is of the view that there is limited information concerning the nutritional status of adolescents. Dietary intake and physical activities patterns are the major components of energy balance. The physical activities of work and play during this age period will vary tremendously. Illness plays less of a role at this time then earlier in life. Growth

> accelerates and then slows during this time period, resulting in significant nutritional needs for growth. The potential to realize many of the opportunities of adolescence (such as continued education and growth) is reduced if girls assume adult roles at an early age, especially if they begin having children during adolescence."

Lack of awareness and proper attention towards girl's health significantly contributes in malnutrition among adolescence that further leads to complex and permanent diseases among adolescents.

> "Neilson (1996) most of the teenagers are unknowingly harming themselves as a consequence of their poor eating habits. In terms of their overall health, adolescence with poor eating habits are retarding their body's growth or damaging their muscle or bone tissues because of the rapid growth in our body during adolescence, large amount of calories is needed to build healthy bones and tissues during peak growing years, a teen age girl needs 2,000-2500 calories."

Where as Pati is of the view that;

> "Different studies on nutrition and health status of adolescent girls point out that the requirement of iron for a person depends on his/her sex, age, diet and genes. It is evident that low iron causes anemia and the breakdown in vital reproductive functions and exposure to different diseases, premature birth, low mental performance and death. The findings of the survey conducted by the Federal Centers for Disease Control and Prevention U.S.A (1988) reveals that nearly eight million young woman are deficient of iron." Pati (2004 a)

In many traditional societies, the preference for boys seems very dominant as they are thought to be the primary breadwinners and providers of security to the family and old age of the parents while females are given secondary place. Female's presence and economical benefit for their parents family is quiet brief in comparison therefore they hold secondary place at home and such discrimination is quiet obvious regarding nutritional priorities of females.

> "The pattern of child rearing and socialization of children in a society generally brings about the difference in sex roles. The stereotype roles, thus developed will lead to differential access to food, clothing, medical facilities, resources, prenatal care etc. among male and female children.

> These differences will continue through out the life of people. Since, most of the societies are favorable towards male sex, females are undergoing untold misery at all stages of their lives. Undoubtedly, it has a direct bearing on the reproductive health of women." (Pati, 2003).

It is reflected in literature that females are less fortunate in getting access to medical facilities because of prevailing discriminatory attitudes in various cultures.

> "United Nations (1995) in a study found that girls in many parts of the world are taken less often to the health centers, have lower rates of immunization and receive less nurturing than their brothers this inferior behavior they receive shows up in higher mortality statistics. A girl's poor health and nutritional status may have consequences that last a lifetime. Iron-deficiency anemia, for example an affiliation resulting from poor eating habits, affects between 75% to 95% of girls fifteen or older in Africa. It is responsible for twenty percent of all maternal diseases."

Foundations of motherhood are laid during adolescent age. A healthy diet and environment during adolescence period lays strong footings for the future role of a girl and not only this health of future generation is also dependent on the diet of a girl.

> "Her nutritional status and food patterns, which have developed over a number of years, and the degree to which she has established and maintained nutritional reserves, are all important factors. Cultural and social influences have shaped beliefs and values of both parents about pregnancy. All of these influences come to bear on any pregnancy."

In real sense, throughout life a woman is providing for the ongoing continuum of life through food that she eats. Each child obviously becomes a part of this continuous process during the pregnancy when the mother's diet directly sustains growth both genetically and culturally.

> "Population Council (1998) a focus on adolescent is crucial because what happens between the ages of ten-nineteen, whether for good or ill shapes how girls and boys live out their lives as women and men not only in the reproductive arena but in the social and economic realm as well."

Some qualitative researches reveal that in many traditional societies girls are not told about the physical and psychological changes of their lives that makes transaction from one stage of life to another real stressful.

> "Narayan, Srinivasa, Pelto, Veerammal (2001) suggested that some studies of Indian women have found that young girls are generally told nothing about menstruation until their first experience of it. The events and the experiences surrounding menarche can be a significant influence on young girl's view of themselves, as well as on their understanding of reproductive health issues, and on appropriate behavior for hygiene management of menstruation."

In Pakistani context children before entering the age of adolescence are not educated regarding their sex and the changes associated with it. Majority of the girls are unprepared for pubertal changes and its management.

> Mumtaz and Rauf (1996 a) Menstruation is the watershed between being a girl child and becoming a woman. Most girls are quite unprepared for this change in their lives. While a few have some idea of the impending event. Socially a silence is maintained about issues related to sexuality. These are not discussed openly, not even among women. With in the household if a girl is menstruating the older women are not supposed to know. If she suffers cramps or pain then also those who are closer to her like a sister or sister in law are informed. Mothers are told if there is no other person near her age group. The pretence of illness is maintained for other members of the household."

Adolescent age coupled with early marriage and child birth increase the nutritional needs of a female. At this stage her previous dietary habits play vital role. National nutritional surveys depict that majority of adolescent mothers are anemic and deficient of many important nutrients.

> "Williams and Schlenker (2003 b) age plays a major role in pregnancy. The teenage mother adds her on immaturity and growth needs to those imposed by pregnancy. At the other end of the reproductive cycle, hazards increase with age. Also, the number of pregnancies (gravida) and the number of viable offspring (parity), as well as the time intervals between them, greatly influence the mother's nutrient reserves, her increased nutritional needs, and the outcome of pregnancy. The mother brings to each pregnancy all of her previous experiences, including her diet and eating habits. Her general health and fitness and her state of nutrition at the time of conception are products of her lifelong dietary habits and her genetic heritage."

> "Maternal factors, which are biological attributes of birth, such as the age of mother at the time of childbirth, birth order and birth interval has significant effects on child survival (Forste, 1994. Rutstein, 1984). A mother's poor health and nutritional status may also have post-natal consequences, like impaired lactation and render her unable to give adequate care to her children." (Rutherford et al., 1989. Gubhaju, 1986).

Nutritional status of mothers specially during adolescent period remains poor and neglected due to immature age and various other social pressures some of them are noted by Pati (2004) in his study that "adolescent mothers in the third world countries severely face deficiency of nutrient food and the consequent reproductive health problems. Women in these countries usually live in families with parents, in-laws, husband and their own children where they found problems in managing their quality as well as the quantity of the food."

> Similarly "Meeks et al. (2003) found that teens are at risk of producing unhealthy babies. A teenage female's body is still developing and maturing. For proper growth, her body needs adequate and balances nutrition. Many teenage females do not have healthful habits. A developing baby relies on the mother-to-be for its nutrition, and whatever the mother-to-be eats, smokes, or drinks get into the bloodstream. Even if the pregnant teenager changes her habits as soon as she knows she is pregnant, her behavior has affected the developing baby from the moment of conception. This means that the baby have been inadequately nourished for six to eight weeks or more. Most pregnant teens delay getting prenatal care. As a result, teen mothers are at risk for having a baby with a low birth weight."

Women in all parts of the world have complex and diverse roles. Not only they have to bear the responsibility of child-rearing, other family member and daily household work but they also look after livestock and agricultural activities of their households. Their responsibilities are huge in comparison to energy intake, health status and leisure time available to them. Acknowledging the importance of women health various global efforts are in progress to improve women's health.

> "ADB and UNICEF (1997) Women's health status is one immediate cause attributed to poor reproductive health, the others being frequent and repeated child bearing, high risk pregnancies at an early age, the health

risk of pregnancy on the whole, and limited access to good health care. Women's health status is characterized by high levels of iron deficiency anemia and poor nutrition. More than 20% of maternal deaths are directly or indirectly related."

"The reproductive role of women is important in determining their health. However, the health needs of women lie beyond their reproductive role and can include illness related to malnutrition, occupational health hazards, overwork, tiredness, family breakdown and violence. These differences stem from socio economic and cultural factors that also determine nutrition, lifestyles and access to health services, and they have led to a gap in preventive and curative services for diseases biologically tied to women health. Social cultural and religious practices and economic factors have a direct impact on women's health." (Malhotra, 2004) similarly some other factors highlighted by (Pati, 2003) in his study is that the reproductive rights of women are closely related with their right to livelihood, right to safety and mobility, right to health care and food security.

Women's responsibilities and work pressures through out life and especially during their reproductive age significantly contribute towards women's malnutrition and poor health. Some studies suggest that the dietary habits of mothers during pregnancy decrease or remain the same to their normal routine before pregnancy.

"Women have multiple roles relating to reproduction, breastfeeding and taking care of their children despite their other socio-economic and health production roles at the household level and its impact on the overall socio-economic development. The incidence of malnutrition among women can be upsetting to all of their roles." (Soomro and Mahmood, 2003).

According to (Thamilarasan, Shankar 2003) Caring for women and educating them is an investment not only in maternal health but also in the health of the community. The vulnerability of mothers, because of the demands on her due to child bearing and child rearing is compounded by social discrimination and cultural practices. Many factors influence maternal health. The genetic constitution, exposure to disease producing organisms imbalanced or inadequate nutrition, low resistance to infection all determine health."

State of the World's Newborn (2001) conducted a baseline survey in all the four provinces of Pakistan it was found that most women either did not

> change their diet during pregnancy or ate less then their normal routine during pregnancy i.e. 78%. "

In order to understand and improve women's health in general and reproductive health in particular it is earnestly important to probe the definition of reproductive health given by World Health Organization (WHO) "Reproductive health is a state of complete physical, mental and social well-being in all matters relating to the reproductive system and to its functions and processes. It implies that people have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this is the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice. Reproductive health care also includes sexual health, the purpose of which is the enhancement of life and personal relations. One can easily infer conclusion of dormant reproductive status of Pakistani females under the light of WHO definition, prevailing situation and available literature. Women's reproductive and nutritional status serious attention.

> "Population Communications international (2001) observed that female reproductive health care behavior is generally indigenous and home spam, unless some complication occurs, children are delivered at home with the assistance of traditional birth Access Attendants or if she is not available, then any other experienced village women. Child delivery is perceived as a natural phenomenon, in which "ALLAH" plays a big role. As in the case of general ailments, only if there is a complication during the birth then the women is rushed to the city or to the near by doctor. During this process, many women die because of lack of medical attention. Similarly, there is no concept of pre or post-natal check-ups, unless there is a complication. Small ailment are overlooked or treated through the home remedies or traditional methods recommended by the TBAs or the village women."

> "Sectoral Policy Document of Development Cooperation (1993) states that developing countries face many challenges in their relentless efforts to improve the quality of life of their people. The role of good reproductive health is increasingly clear, however the reproductive health care is not just family planning, which no doubt is an inseparable part of it, but much more, reproductive health care includes services and provisions which enable people to lead a healthy reproductive life. It covers such aspects as safe motherhood, including prenatal care, opportunities for family

planning, the prevention of sexually transmitted diseases, measuring against HIV/AIDS, treatment of the infertility and gynecological complaints, dealing with the consequences of sexual violence and facilitating safe abortion."

"Hussain (2004) is of the view that women in Pakistan require greater education about reproductive health, particularly about vaginal discharge. Vaginal discharge is one of the most common medical problems among women of reproductive age in Pakistan for which they seek medical advice."

"Daily Times Newspaper (2005) reported that females between 15 and 45 years of age are in their reproductive years. They are suffering from lot of physical and mental problems. The nutritional status of majority of the women in this age group is poor. Anemia and micronutrient deficiencies are common in this age group. These factors plus low literacy level in our society not only has resulted in poor health and nutritional status of the mothers but it has also resulted in high degree of morbidity and mortality in the new born. The percentage of low birth rate babies in Pakistan is still 20-25% which was prevalent 25 years ago as well."

Studies reveal that women are less often taken to the hospitals and some time such negligence bring a greater loss especially to pregnant women and the fetus.

"Javed (2004) reproductive health care system is generally indigenous and home spam, unless some complication occurs, children are delivered at home with the assistance of traditional birth attendants. Access attendance if she is not available then any other experienced woman. Child delivery is perceived as a natural phenomenon, in which "Allah" plays a big role. As in case of general ailments only if there is a complication during the birth then the woman is rushed to the city or to the nearby doctor. During this process many woman die because of lack of medical attention. Similarly there is no concept of pre natal or post natal check ups, unless there is a complication. Small ailments are overlooked or treated through home remedies or traditional methods recommended by the TBAs or village women."

"WHO (1994) found that regular prenatal care is needed to help, detect and manage some pregnancy related complications and to educate women about danger signs, potential complications, and where to seek help Prenatal care beginning early in the first trimester of pregnancy and continuing on a regular basis is important to the health of both mother and

infant. Early prenatal care provides an opportunity to offer preventive care that will benefit the infant as well as the mother such as counseling on hygiene, breastfeeding, nutrition, family planning, tetanus toxic immunization and iron and folate supplementation. Prenatal care helps to prevent complications during pregnancy and labor."

"Mumtaz and Rauf (1996 b) older woman can predict pregnancy from looking at the face and observing physical movements of a woman. In fact they claim to know by looking at the posture, eating habits and expression whether a woman will have a male or a female child. Once pregnant such woman receive a fair amount of advice from elder women of the family and the neighborhood about what to eat, how to sit and are cautioned against lifting heavy things. If there is a serious problem woman goes to the *Dai* or a female doctor. Regular check ups is not a common practice."

"INFO Project (2003) In Asia and in the North East and North Africa nearly 60% of pregnant women receives one or more visits from a skilled provider during their most recent pregnancies and in Pakistan this case is even more adverse where only one forth of the women receive such care."

Studies found that malnutrition of mother dreadfully effects health of the new born baby. The situation becomes adverse with small intervals between pregnancies with out proper medical consultation and proper diet.

The pregnant women who receive inadequate nutriment levels are likely to give birth to underweight babies, who survive but receive inadequate food in their early life are more likely to be exposed to permanent stunting of their physical growth. The physical environment, socio-economic status, diet, parental education and infections determine a child's growth." (Sommerfelt and Stewart, 1994). Another dominant of the maternal factors affecting child survival is birth interval. A short interval has traditionally been viewed as a risk factor for poor pregnancy outcomes, particularly infant mortality in developing countries (Winikoff, 1983).

In the light of literature it can be safely said that serious attention towards female health in terms of both her diet and health is very crucial right from the start of her life. In order to understand problem of malnutrition among females more qualitative researches are need that lay focus on the cultural where such problems exist. Present research is also an attempt in this regard.

"Department of family welfare (1996) reviewed the critical impact of life cycle approach of women in reproductive and child health program. Because women's health is important during all phases of their lives, from childhood to adulthood. Good health is cyclical in nature. In a woman's lifetime, her health status during any phase of life impinges upon the next phase. When she gives birth, she passes on the gift of good health to the next generation. A healthy child grows up into a healthy adolescent. Good health during adolescent years leads to health during reproductive years. The cycle continues into the next generation when a healthy pregnancy ensures a healthy child. After the reproductive years, women face health problems during menopause that also need to be addressed in order to ensure a good quality of life. Health care for elderly women will have a positive impact on the health of future generations."

"Singh and Jain (2004) maternal nutrition is often considered as an important regulator of human fetus growth. It is not only nutrition during pregnancy but also childhood nutrition of the woman that may influence pregnancy outcome."

National Institute of Population studies carried out a study namely Pakistan Demographic and Health survey 1990-91 and it was found that on average Pakistani women breastfeed their children for 20 months and the median duration of amenorrhea following pregnancy is 6.3 months.

"Breastfeeding has numerous bio-demographic, social, and economic effects. It affects the health and nutritional status of both the mother and child. The role of breastfeeding is very important in the post-neonatal period. Energy intake for children less than two years of age is determined more by feeding practices such as the frequency of feeding and the energy-density of the food offered and less by food availability." (Brown and Begin, 1993).

"A set of guidelines for infant feeding in developing countries is recommended by the WHO and UNICEF. The basic recommendations are: initiation of breastfeeding within about one hour of birth. Infants should get only breast milk up to 4-6 months of age. Starting at the age 4-6 months in addition to breast milk, adequate and appropriate supplementary foods should be given. Breastfeeding continue in combination with supplementary foods up to the second birthday or beyond." (WHO/UNICEF, 1994, WHO, 1991).

Not many studies on nutritional status of females of Pakistan are available. Major proportion of available literature is on women reproductive and general health perspective. Although Quantitative studies like nutritional surveys are available but qualitative studies on social aspects associated with malnutrition are not commonly available.

> "National Nutritional Survey 2001-2002 found in the light of the Body Mass Index (BMI) of 12.5% non pregnant and 16% of lactating woman were malnourished i.e. BMI< 18.5, 9.4% mothers were vitamin A deficient, 48.7% women were deficient of iron, 41% were zinc deficient. The dietary habits and nutritional intakes of lactating/ pregnant mothers indicated that both mother and children were consuming less than RDA of essential nutrients."

> "Habibullah (2001) quoted that Pakistan is growing by 2.8% a year according to census survey report 1998. On the bases of these figures she concluded that this has serious implications on the health of country's women who on an average give birth to 6 children each, frequently experience malnutrition during pregnancy and shoulder a heavy burden of manual work. Many marry and begin pregnancies at an early age. Many are illiterate and have no knowledge of maternal health services even when available or accessible. Socio-economic conditions including housing are poor and women also have to content with environmental hazards and harmful traditional practices. Poor nutritional status is an important cause of increase morbidity and mortality not only in mothers but also in neonates and children under five years of age. "

> "The Nation Newspaper (2002) reported that a typical woman, for instance has to cater to the nutritional needs of a baby for some time. It has long been established that nutritional needs soar in pregnancy, and that a breast-feeding mother would do well to increase her milk intake to ensure her bones are not leeched of calcium. But there is more to the issue than the recent developments suggest i.e. The US Department of Agriculture survey of food consumption shows that about half of women over the age of 20 do not get enough of some necessary vitamins and minerals, like calcium, iron, folic acid, and other B vitamins. The magnitude of the problem being this in the US. The figures are bound to be much worse for Pakistan. "

Improving women's nutrition can help nations achieve three of the Millennium Development Goals, which are commonly accepted as a framework for measuring development progress.

> "Ali (1993 c) during pregnancy a woman must be supplied all the proteins, minerals, vitamins and other nutrients for her and the developing fetus. The requirements for most nutrients increase by 30% in the fourth, fifth and sixth months and by about 50% for the seventh, eighth and ninth months. Her energy needs, however, increase only about 10% from the forth month onwards. "

> "According to World Bank Report (1998) Low status of women is also one of the major factors affecting women health apart from poverty, education, inadequate sanitation and water supply. Women in Pakistan are constrained in seeking health care for themselves and their children on account of their restricted mobility. In many rural areas, women are not permitted to leave the house or village and are subject to severe restrictions in their interactions with any males from outside their immediate family and communities."

> "Khalil (2003) states that according to the two surveys conducted in 1993, Anemia is common in women due to frequent childbirths. Lack of iodine is also a problem. The cause of malnutrition in the region includes lack of knowledge about what food to be taken and availability of foods that may be seasonal or gender related. A survey conducted in 1993 by AKHSP and FAO shows that the average age of giving birth is between 14 and 16.3 years. 39.2% of the females give birth between 14 and 16. 74.7% of mothers do not eat any special food during pregnancy and lactation. The major nutritional deficiency diseases are protein energy malnutrition (PEM), Iron deficiency anemia, iodine deficiency disorders (IDDs) and Vitamin A deficiency (VAD)."

Pakistan National Forum on Women's Health (1997) Malnutrition is a serious and widespread problem through out Pakistan. Malnutrition is a result of an adequate intake of calories and protein, low absorption of certain iron, zinc and iodine and lack of knowledge about what constitutes a balance diet. Infections reduce the bio availability of foods consumed and deplete nutrients from body. These factors combine to make malnutrition in Pakistan, one of the primary determinants of maternal mortality and child morbidity and mortality.

"Cox and Canada (1994) the expectant mother should eat a well balanced diet with plenty of fluids. She should consult with her doctor about the adequacy of her diet. Malnutrition can cause physical weakness, stunted growth, rickets (softening of the bones), scurvy (weakness, anemia, bleeding gums), and even mental retardation in the fetus. Poor diet can also cause spontaneous abortions and stillbirths where an infant is born dead. An inadequate diet leaves the mother more prone to illness and complications during pregnancy."

"Population Council (2003) the first pregnancy is rarely associated with antenatal care with the exception of urban areas and it appears that the young cohort is receiving less care for the first births than the older cohort did for their first births. Home births of a first baby are common among all young women, but more so among the younger cohort than the older cohort. The younger cohort was also more likely to have traditional attendants and less likely to have a medical person at her first birth, when compared to the older cohort. Thus the adolescent child bearing appears to taking place in a more risky environment than just five years earlier."

"Payne and Hahn (1999) during a normal pregnancy, approximately 75,000 calories are required to support the development of the fetus and formation of maternal supportive tissues and to fuel the mother's basal metabolic rate."

Afghan (2003) conducted a study on 150 pregnant women visiting for antenatal care at Maternity Child Health center, Pakistan institute of Medical Sciences, Islamabad. For this particular study she divided pregnant women into three categories according to their weight.

1. Less than 8 kg weight gain during pregnancy as below normal
2. Between 8.0-12.0 kg as normal.
3. Above 12 kg as above normal.

She found that the significant number of subjects under the influence of food taboos is found in group one category. That is below normal supports the assumption that food taboos play profound role in nutritional deprivation among pregnant mothers. She further found that 40.7% of the expectant mothers among her study subjects were under weight. She concluded that pregnant mothers were not adequately aware about

importance of nutrition during pregnancy and its impact on their own health and on their future baby.

> "Hanlon (1990 b) is of the view that there are sound reasons for this special attention to pregnant women brings double health benefits: first to her as an adult member of society and second, to the child born of her pregnancy. Other reasons are that pregnancy is a period of particular physical stress during which the women may face unusual risk. Undesirable influences during the prenatal period may jeopardize the health of the mother and the expected infant. Short of facilities, these effects may result in health and economic disadvantages for the women and child and even for the rest of the family .if the mother's health is permanently impaired. The problem seems to be that eating traditionally in most countries has failed to take the male-female differences into account. Milk, for instance, is a traditional health food in Pakistan for men, but there is no custom encouraging consumption of milk in women. The out come is that many women are going without the necessary nutrition."

> "White discharge is significantly related to the level of hygiene. White discharge among adolescence girls and women shows some level of reproductive track infections. It suggests the presence of gynecological morbidity. Patterns of menstrual hygiene that are developed in adolescence are likely to persist into adult life."

> National Nutritional survey 2001-02 findings reveal that 75% of mothers got married between the ages of 15-24 years. In rural areas 10% of mothers got married even before they were fifteen years. The survey further emphasized in accordance with clinical and bio-chemical assessment of micro nutrients i.e. goiter: the prevalence of visible goiter was high among young mothers aged below 20 years of age. 50% of the mothers in the rural areas while, 46.6% in the urban areas were found anemic. It was also observed in the survey that maternal rates of zinc deficiency range from 28.7-52%."

> "Pakistan population has increased from 34 million in 1951 to 142.5 million in mid 2001. Over one third of the population of Pakistan is living in poverty. The impact of population growth on poverty is obvious, this large part of the population is constraint to live in poor housing and sanitation conditions and lack the access to safe drinking water. In particular, income poverty leads to pressure on food consumption and adversely affects caloric intake and increasing malnutrition in poor

families and contributes to high levels of child and maternal morbidity and mortality (Government of Pakistan, 2002). Maternal mortality rate is about 400/100,000 live births." (Sultan, 2004).

Despite growing efforts towards improving the health of women malnutrition among the females of developing and under developing countries of the world still is a big challenge for the international arena.

"In 1998 alone, 46.4% of all females in the population were estimated to be in the reproductive age groups as against 43% in 1981. The high fertility rate in Pakistan is also attributed to social structure, low level of education especially among females, status of women, limited work opportunities for women and urban-rural imbalance in provision of required care and service. Women play a significant role in the health sector, both in their role in reproduction and their role in the household and community services. With the exception of sexually transmitted diseases, the health risk associated with reproduction impact solely on women and children." (Malhotra, 2004).

"Kirk & Rey (2000) are of the view that ability to become pregnant and have a baby is one of the most fundamental aspects of the women lives. A woman becomes pregnant for many reasons: she wants to have a child. She wants to experience pregnancy and childbirth. She believes it will make her a "real" woman. She hopes it will keep her relationship together or make her partner happy. Some women plan to be pregnant. Others get pregnant by accident, still others as a result of being raped. Having a child is profoundly a personal experience, usually with far reaching consequences for the mother's life. The number of infants who die in their first year is an important indicator of infant and maternal health. Infant mortality is commonly a result of low birth weight, poor nutrition and prenatal care."

"According to a WHO report 1997 because of the strong preference for male children in many parts of the world, many girls receive inferior nutrition and health care from birth onwards."

"It is documented in the Economic Survey of Pakistan (2002) that Protein energy and micronutrient malnutrition has a very severe impact on the potential development and productivity of the people. They contribute to a great deal of morbidity and ill health, growth retardation and reduce level of physical and developmental activities. The basic cause of these

deficiencies is the lack of adequate intake through diets. Poverty in many cases is the major basic cause of malnutrition. In Pakistan per capita per day calories intake is estimated at 2306 for 2001-02 and protein intake per capita is 67.0 grams."

"Khalil (2004) Household food security is judged by the nutritional security of the household. Food security effects nutritional security at both the macronutrient and micro nutrient levels and contributes to the higher maternal and child mortality. Nutritional status data is therefore used as an indicator of the food security and insecurity. From the four national nutritional surveys conducted in Pakistan during 1960s, 1977-78, 1987-88 and 2000-01, it is evident that the nutritional status of the population has not improved and the number of the malnourished people mainly children and their mothers have increased due to the increase in population from around 35 million in 1947 to 259 million in 2004."

Kumar et al (1981) is of the view that scientifically, the nutrient needs are more during an illness due to increased metabolic demands in the body. Traditional beliefs regarding food restriction often conflict with modern theories of nutrition and their practical application.

"A poor diet and exposure to repeated illness are two of the major causes of malnutrition in developing countries (Mosley and Chen, 1984).When child survives the neo-natal period, better child nutrition becomes an important part of child health since nutrition during childhood makes a major contribution to child development, growth, and survival, ultimately influencing the human and social capital of a society. The role of breastfeeding is very important in the post-neonatal period." (Jellifie and Jellifie, 1978).

"The Food Guide Pyramid (1996) states that health professionals can use their knowledge and beliefs to reinforce positive dietary practices, such as encouraging the consumption of protein rich soups, for the Yin (condition of "weak blood" in Chinese women) or cow's milk with almonds and saffron for fetal development in Indian women. However cultural beliefs, such as the avoidance of iron supplements to prevent hardening of the fetal bones, may pose special challenges and should be explored with the women and possibly other family members. Dietetic professionals should become familiar with cultural practices and beliefs that may affect the diet intakes of their clients and provide culturally relevant advice."

"Kittler and Sucher (1988) are of the view that many traditional cultures apply a hot-cold classification to foods and believe that some foods or ingredients are to be avoided and other encouraged during pregnancy to prevent imbalances and protect the fetus. Greeenberg (1997) found that age and sex were important predictor variables for diet."

"Ali, Azam and Noor (2003) suggest after conducting a hospital based study that the first and foremost task for medical doctors and other health care givers is to identify the local cultural and traditional practices and beliefs regarding properties of different food items. An understanding of existing food beliefs will help to improve food intake during health and disease by strengthening useful beliefs and discontinuing harmful ones. "

The following quotes from latest National Nutritional Survey 2001-02 reveal nutritional vulnerability and poor health status of women of Pakistan who are in their reproductive ages. Survey also found that females of reproductive age living in urban areas are more nutritionally depleted then the females living in the rural areas.

"The share of quality protein food items was quiet low in the regular diet of the mothers. Only 4% mothers reported eating meal regularly during the week. While 22% of the mothers ate meat twice a week. The consumption of chicken was slightly higher. About 7% mothers took chicken daily and the proportion increase to 10% in the rural areas. About 33 and 35% of the mothers, respectively, consumed chicken meat at least once a weak in rural and urban areas. Daily consumption of milk was reported by 24% of mothers in the rural and urban areas. About 14% of mothers took milk or milk products once a weak. However, 47% did not consume any milk or milk product. The consumption of carrots by mothers was also very low. Only 9% reported taking carrots once or more than once in a week. Almost three-forth of mothers consumed green leafy vegetables once a week and 5% reported consuming them Daily. The frequency of wheat bread usage by mothers was high. 84% mothers ate bread everyday as part of their meal. A smaller proportion 4% however, reported taking bread only once a weak.

Iodized Salt: at national level, 56.4% mother were aware of iodized salt where as in the urban areas this proportion rose to 76.4% while in rural areas it stayed low at 48.3%. 30.9% use of iodized salt was found in urban households where as in rural house holds it was 21.2%. Significant number of the household, especially in the rural area was unaware of the type of salt they were using.

Vitamin A: At national level knowledge of its benefits was only 10.1%. In the rural areas it was7.6% where as in the urban areas 14.7%."

Iron: only 37.3% of the mothers were aware of the benefits of iron supplements. The proportion in rural areas was lower (30.6%) than in urban areas (49.2%) while anemia was wide spread the use of iron supplements by mothers was rather limited. Only 15.7% mothers at national level were currently taking iron supplements. 18.6% urban and 14.1% rural mothers. Use of iron supplements was higher in pregnant then non-pregnant mothers. As regard of the frequency of use of iron supplements most of the mothers were taking them occasionally or when they felt week."

Malnutrition poses a variety of threats to women. It weakens women's ability to survive childbirth, makes them prone to diseases and infections and leaves them with fewer reserves to recover from illness. It also hampers their ability to take care of their families and reproduce healthy babies.

1.5 Field Experiences

As far as good rapport building is concerned, it requires articulated blend of experiences and techniques to get an opportunity to mix up with the people of the locale and obtain data regarding their life affairs. Otherwise it is absolutely difficult to obtain information regarding their behavior, political or economic activities since they are not ready to disclose their identity to the strangers. Even at the first day they hesitate to answer simple questions so, this initial stage of mixing with the people requires making friendship with them in a convincing manner to win their trust.

It was noticed that in many ways the beginning of the fieldwork is the most difficult part of the research. While carrying out the present study many problems occurred during the first few weeks in the field. Off course the first and the foremost problem was building initial impression and rapport with the locals. Initially I was not welcomed by the locals. They feared that I am a government personal from income tax department who is deputed there to inquire about their assets and will later impose tax on them. Some people thought that I was in the village to market a product. In the recent past some women of the village had bitter experiences with marketing personals. These

incidents were quite fresh in their memory. As a result of that I not had to listen to their experiences but also had to clear my position to win their trust.

Interestingly some local people suspected me as a dealer of fake gift scheme of some substandard items i.e. surf (a brand of washing powder), tea and cloths. Local women said that they had wasted a lot of money in this way that's why they suspect every outsider as a cheat.

One of my key informant's presence and reference of the family who helped me in intervening the village proved helpful in gaining trust of the local women. Then these women felt sorry and became more friendly and shared reasons of mistrust on outsiders. One of the women told an interesting story.

> *"Some times back women gang use to come to our village. They made fool of us. I tell you my own experience once these women visited my home and asked me give them 500 rupees promising me that they will convert it into double amount through magic. I was surprised at this but somehow or the other they convinced me, I gave them 500 rupees, they took away my money, cheated me and made me unconscious. I was unable to comprehend all this. When I came back into my senses they were out of the scene with money. See these urban people are very clever."*

With the passage of time I was able to win local women's trust and started enjoying my work independently. Suddenly another wave of mistrust and doubt was observed during the mid of my fieldwork period because of an incidence of an attempt of robbery at the home of one of the influential politician of the village, sadly in this incident one lady of family had severe bullet injuries by the robbers. When I went to that home to pay a customary visit along with few other women of the locale, one woman of present there suspected my involvement behind the incidence therefore she directly said to me in a loud voice.

> *"See what has happened in this village after your presence here, such thing never happened before."*

This comment was odd because it put me in an embarrassing situation in front of a group of women of the same locale. It was a real difficult moment for me but before I respond to her misunderstanding she was corrected by the injured women herself as she was successful in recognizing the one of the robbers. She told her that this incident has nothing to do with me. In this was my position was clear. In addition to injured women's comment, I also clarified that my presence in the village was just for study purpose then the matter is settled.

After wining their trust being a woman I was having liberty to move around their houses and talk to women more frequently. Initially I had problems in interacting with males and getting information from them as the males were not very open to talk and secondly it is considered unlikely to talk with stranger females in the village. Later on when doubts against my presence lessened then they were also helpful in sharing information.

In order to get the useful information, I made cross questioning, and asked the same questions from several persons that gave greater insight to my research problem.

1.6 Research Methodology

Major part of study was covered with anthropological qualitative techniques because it was most suitable for the nature of the study. In addition to qualitative approaches quantitative methods were also used to accumulate socio-demographic characteristics of the community and respondents. Incorporation of quantitative data in qualitative was helpful in deep comprehension and endorsement of the qualitative findings.

Following qualitative and quantitative tools are used for the study.

1.6.1 Participant Observation

Participant observation is the key tool in qualitative research. For the present study this method was instrumental in providing me an entry into the community, establish a rapport with the locals and share and observe their experiences directly

whenever possible. Collection of authentic data about the locale would not have been possible with out using this tool because more reliable data is based on eye witnessing. This technique also enabled me to see, observe and know the same as the member of that society. By adopting this technique I was able to observe the daily routine, practices of the local people and participate in ceremonial functions in which the women of the village were allowed.

1.6.2 Key Informants

Key informant is also one of the core techniques in anthropological research. Key informant being the representative of the locale is very knowledgeable about the past and present events of any society. The things we cannot observe and the events that happened in the past can only be known through key informants. These are people of locality with whom a researcher chooses to have extensive exchange of views and conversations with in order to develop better insight into the local point of view.

After rapport building four key informants were identified as key informants for the present study. These key informants were from different socio-economic backgrounds. A fairly old and experienced woman was taken as key informant for the present study. She belonged to a middle class family of Qureshi caste of the village. She was extremely helpful not only in establishing the rapport with the people of the village but also in sharing useful information about the village, people and settings etc.

One of the Lady Health Workers of the village was taken as a key informant. She was helpful firstly in intervening the community and secondly in providing information about the health status of the women of locale. She was selected as a key informant because she serves in the community and has close interaction with majority of the households in general and women in particular. She shared the existing health practices of the locals, particularly problems of the local women regarding their health, nutrition and the coping mechanisms available to them.

Third key informant was a fifty years old man, lawyer by profession and ex-politician of the village. He provided rich information regarding the history, geographical features and socio-political setup of the village. He was selected as a key informant

because he was greatly respected by the community. He had rich knowledge about various internal and external affairs of the village. He knew every household and the setting very closely.

Lastly a thirty five years old young and educated lady was taken as a key informant. For the last five years she is running a private school in the village up to grade 12. She moved to this village after her marriage. Her husband works abroad. She is working independently. Her in-laws family belongs to one of the few well off families of the village. Being the principal of the school she frequently interacts with almost two hundred students and their parents. She was selected as a key informant because being an educated outsider she was helpful in sharing different level of thoughtful conversation and a different perspective about the village setting. She helped me in interacting with the adolescents girls studying at her school. I resided with this lady during my field work. When ever we both had time then we use to have informal discussions about various issues of the locale.

1.6.3 Socio-Economic and Census Survey

By administrating the socio-economic & census form baseline data regarding family size, sex, age, education, caste, income, profession, and agriculture and livestock of the village population was accumulated. It was helpful to know about the socio demographic and economic status of the locals. This method not only provided quantitative data but also qualitative data. It provided an opportunity of gaining access, knowledge and observing the layout of every household. This technique was useful in providing an opportunity to interact with every household of the village, spend time with them and win their confidence and trust. When the socio-economic census survey of the village was completed the accumulated data was further analyzed with the help of Statistical Package for Social Sciences Software (SPSS). Software was used for organizing, cross tabbing and analyzing different variables.

Socio-economic and census survey reveals that the total number of households in village *Gumti* at the time of present study was 137 comprising a population of 944 persons.

1.6.4 Mapping

Village sketch was drawn to understand the geography and topography of the locality and its surroundings. Identification of important places i.e. schools, mosques, hospitals, shops etc. it contains the location of territorial boundaries, water resources, fields, paths and ceremonial places, building sides and residential areas.

1.6.5 Sampling

For the present study stratified random sampling was done because of great variation in the composition of the population regarding their castes and great variation in number of households under each caste. To achieve a true representative sample this sampling method was used. The target population was women of the reproductive age group falling in the age bracket of 13-45 years age. The upper limit of the respondents was kept up to 45 years of age because reproductive phase for the women normally ends by that time.

Respondents were further divided into two equal groups one group consisted of respondents falling with in the age group of 13-19 and the other group was from the age group of 20-45. The reason for this further division was to closely observe the adolescents age group period. This time period a limbo period in girl's life regarding bodily changes, acquiring different social status and roles furthermore the attitudes and practices developed in this phase of life have great bearing on the future life of a girl and hence determining her health.

1.6.6 In-depth Interviews (IDIs)

In-depth interviews were administered to get better insights and probing of the research problem. For the present study in-depth interviews of thirty six women of reproductive age group (13-45) were conducted. To administer in depth interviews cassette recorder was used with the consent of the respondent as it was very difficult to simultaneously concentrate on asking questions and translating into another language i.e. Urdu, noting down the responses, observing the body language and maintaining a good eye contact with the respondent. Recording method proved very useful in solving such

problems. Note taking was done where the respondents did not consent to record their voice. All the In-depth interviews were conducted in Potohari (dialect of Punjabi language spoken in the area).

At times when the respondent was educated and can understand Urdu still, I preferred to conduct the interview in local language for I was interested in acquiring richness to the primary data and depth in terminology. Above all I realized that the respondents were more comfortable, expressive, and open while speaking their local language and felt me close to them when I spoke and behaved like them. Later transcription of the recorded data was done. It was one of the more laborious works during the entire research process. Recorded interviews in Potohari language were first transcribed in Urdu language and then translated in English. It was time consuming but fruitful exercise.

Two separate guidelines were developed for the in-depth interviews. One for unmarried adolescents (13 to 19 years of age group) and the second guideline for the married women including both married adolescents and women up to the age of 45 years. The interview guide for adolescents was brief as compare to female women. Developing two guide lines were necessary because unmarried girls have different experiences then that of married women. As a matter of fact they had not undergone experiences of marriage, pregnancies, child rearing and the dietary habits during these stages however their present food related practices and reproductive health issues were taken into concentration and perception about certain issues of reproductive roles after marriage were sought rather in an indirect way.

The topics that were included in the guide line for interviews relate to the respondent directly and to the other members of her house and community indirectly. Questions regarding household, rituals, eating practices/patterns at home as well as in other social ceremonies, problems faced during pregnancy, dietary recall and beliefs regarding food during this stage were part of the guidelines.

1.6.7 Focus Groups Discussions

Focus Group Discussion (FGD) technique was applied in order to explore in depth views and experiences of participants. Exploration of the ideas and interpretation what people say about their cultural practices and dietary patterns was sought. Five focus groups were conducted during my field work i.e. initially one focus group was conducted at community level. Both male and female participated in Focus Group Discussion. Firstly this Focus Group Discussion helped in establishing rapport with males and secondly opinion of both genders was sought on issues like health, education, civil amenities and diet of the locals etc. Male and female participants of Community Focus Group Discussion were between 50-60 years of age. Main objective of this focus group was to get broader perception of both genders about different aspects of their lives.

Two Focus Group Discussions were conducted with female adolescence of 13 to 19 years of age. Main purpose of these FGDs was to know about the daily routine, health facilities, perception about adolescent's health, puberty experiences, management of health of hygiene, marital age, educational and dietary trends of females during adolescent's age. These FGDs were very rich and informative in improving and refining the in-depth interviews guidelines for adolescents. Non verbal behavior and interaction of adolescents with their fellows was also observed.

Two FGDs were conducted with women of age 20 to 45 years of age. Topics such as health problems, health facilities, perception about women's health especially about reproductive health issues, daily diet, diet during pregnancy & postpartum period, child's diet, food beliefs, relationship with family were discussed at length. These focus group discussions tremendously helped in understanding research problem and deep probing during my field work.

One FGD was conducted at initial stages of fieldwork which worked in three ways: a) rapport establishment at community level, b) got an idea about local perceptions regarding their dietary habits, c) familiarity with local terminology being used to express different feelings and situations. Main purpose was to get an understanding of general perception the topic. These focus group discussions assisted me to understand the whole

phenomena of food belief and reproductive health of women in that locale through out my fieldwork. With the help of FGDs I gained valuable insight of local terminology, verbal and non verbal behavior of the local people. FGDs provided rich source of understanding to the research problem.

1.6.8 Case Studies

A case study is a detailed representation of ethnographic data to some sequence of events which a researcher selects in order to draw some theoretical conclusions. Keeping in view the importance of this research technique four selective case studies were carried out to get the holistic view of the life of local adolescents and women of reproductive age in a more focused way.

While accumulating data I met four respondents and realized that their experiences were rich for the study purpose therefore an elaborated data about their diet and reproductive health experiences was gathered. Three of the respondents of the case studies were married females with children. They had different sorts of serious and unattended reproductive health complications coupled poverty and malnutrition. By the time of research they were still suffering from such morbidities they had poor dietary habits. While the fourth respondent was an adolescent who was suffering from different gynecological problems. These case studies gave a holistic view about 1ocal perceptions about women from individual, family and community perspective.

1.6.9 Informal Group Discussions

This technique was used during the entire course of research work in order to gain valuable insights from the interactions and discussions conducted with the local persons including both men and women. These informal group discussions were helpful in unprompted emergence of variations in local cultural beliefs and perceptions regarding different social issues in general and dietary practices in particular.

1.6.10 Audio Visual Aid

In order to achieve maximum information by the respondents, both informal discussions and focus group discussions were recorded with the consent of the

respondents. This was helpful in conducting Focus Group Discussions/ group discussions and later transcribing the data.

During the fieldwork photographs were taken with the consent of respondents, which was found very difficult at times because women and especially young girls were reluctant to be photographed due to the strong prevalence of purda and restrictions by the male family members. Towards the end of my stay at the locale some females and their families had no such reservations. This happened because of the trust that they have shown in me. Later photographs also proved as a good resource to the study.

Chapter-2

VILLAGE PROFILE

2.1 The Locale

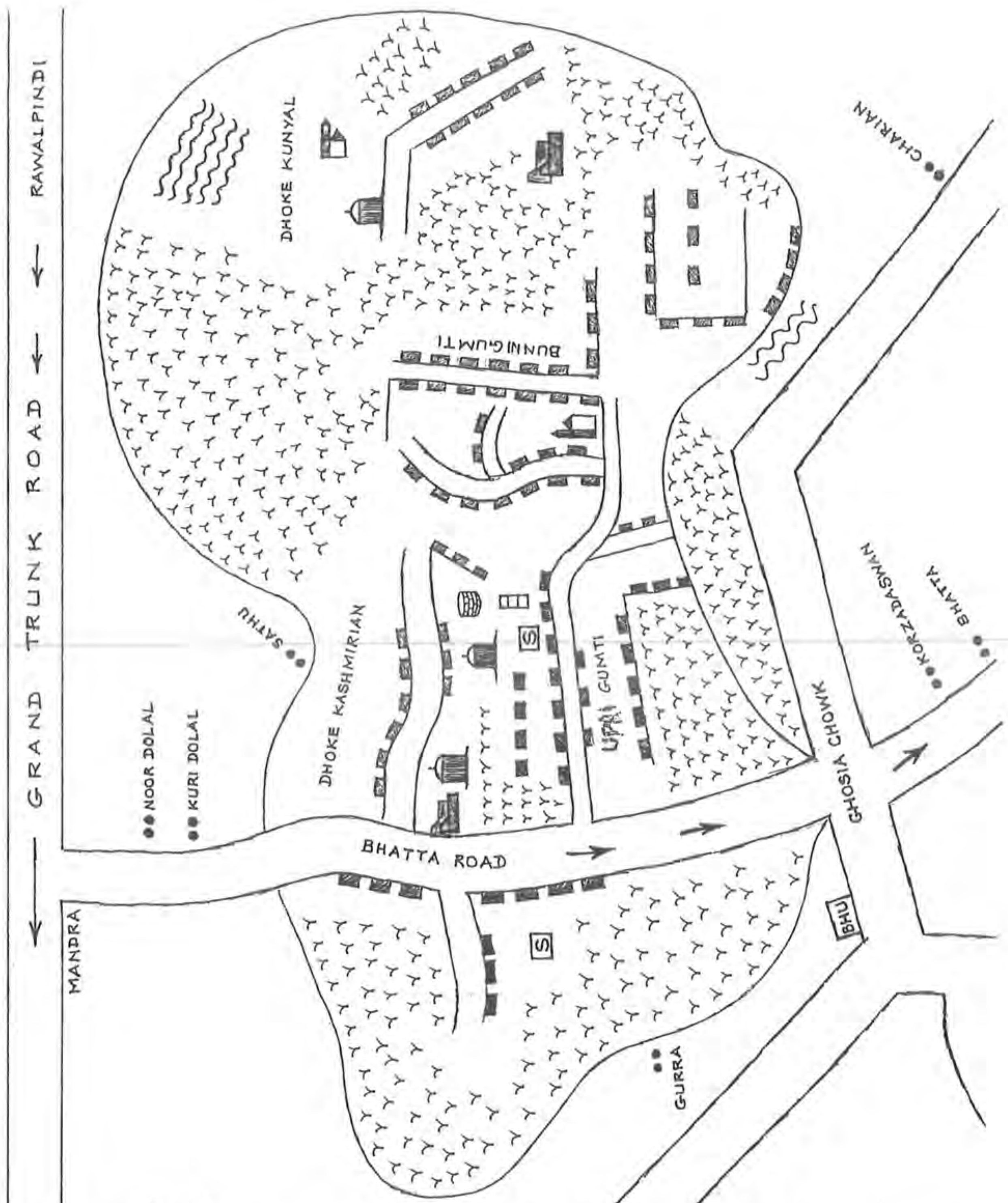
My research locale Gumti falls under the jurisdiction of district Rawalpindi, Tehsil Gujar Khan located in the south of Rawalpindi (sketch-1). While traveling on Grand Trunk Road from Rawalpindi to Lahore, Mandra Town comes at a distance of thirty kilometer. On the left side of Mandra Town a link road called Bhata leads to Gumti which is five kilometers away from Mandra. Bhata Road passes by many villages i.e. Sathu, Jhaag, Gurrah, Chairain, Korzada Sawan and the oldest village of the area called Bhata. The link road itself is associated with the name of the oldest village.

No documented history of Gumti was found. There are a couple of myths about the name of village. According to some locals, village name has some associations with one of the oldest graveyard of the village called Topi Qabristan (Topi graveyard). Some people believe that there were two ancient graves of saints in this graveyard and there was a small dome on these graves. In the native language a dome that is small in size is called "Gumti" whereas large size dome is called "Gumbad". As this dome on the graves was small in size therefore it was called Gumti and the village was named after it. Recently this dome is replaced with a big tomb.

Gumti has five compact settlements "Dhoks" namely Upri Gumti, Bunni Gumti, Dhok Kashmirian, Dhok Kunyal and Ghosia Chowk. According to the revenue record these dhoks fall under different revenue states i.e. Upri Gumti and Bunni Gumti comes under the jurisdiction of Noor Dolal, Dhok Kashmirian falls in Wasla Bangiyal, while Dhok Kunyal comes in Arazi Asnal. Overall Gumti falls under the working boundaries of Police Station Mandra. During the present study construction of highway patrolling police station was underway at Ghosia Chowk.

Out of the five dhoks, four dhoks are situated adjacent to each other while Ghosia Chowk is a distant settlement at a distance of half a kilometer from the main village.(Plate No.1) Qureshies are settled in Upri and Bunni Gumti, Kashmiries are

Sketch 1: Internal layout and surroundings of the village



Legend

School	[S]	Surrounding Villages	••	Grave Yard		Cultivated land	Λ	Barren Land	
Houses	▪	Common well		Shrine		Mosque		Basic Health Unit	BHU

settled in Dhok Kashmirian, Kunyals live in Dhok Kunyal whereas Daniyals are settled at Ghosia Chowk. Different streets demarcate these Dhoks. Majority of the Dhoks are situated on one side of the main link road (see sketch-1).

2.1.1 Surrounding Villages

Many villages surround Gumti. On its left a link road leads to one of the oldest and densely populated village of the area called Chairain village. Chairain is significant in providing vegetable to the neighboring villages including Gumti.

Northeast side of the village is surrounded by jungle (forest) called "Karali" while on the west side there is a stream called Chairain Arain. Locals of the Gumti have their grazing land near this stream. This land usually serves the purpose of animal fodder and wood for the fuel to the locals. Union council Kuri Dolal demarcates village from right side. Other small villages that surround Gumti at the distance of one kilometer are Arrah, Gurrah, Lamiyani Dhok and Buna Mera etc. These villages are vital to the locals of Gumti because their kin are settled in these villages.

According to the locals village Bhata is comparatively more developed and has a relatively higher literacy rate in the area. Being one of the ancient village of the area Bhata is significant in facilitating the surrounding population with educational and health facilities.

2.1.2 Graveyards

In Gumti there are two-graveyards namely Naya Qabrestan (new graveyard) and Purana Qabrestan (old graveyard). Former is located near the link road and the later is located near Dhok Kashmirian. Some of the graves at both the graveyards are known as shrines. Locals and other people of the area visit these shrines. Some of the common reasons for visiting these shrines are; spiritual healing, to make a vow, remedy for certain

diseases and upon completion of the vow etc. Upon completion of a wish people burn lamps at these shrines, distribute sweets, and rice. (Plate No. 2 & 3). For the locals visiting these shrines is a regular activity. As a symbol of respect people visit the Purana Qabrestan barefooted.

2.1.3 The People

Qureshies are the pre-dominant and the oldest inhabitants of Gumti. Qureshies are settled in Upri and Bunni Gumti. Kunyals and Kashmiries are settled in their respective dhoks while Daniyals are settled in Ghosia Chowk.

About 98% of population speaks "Potohari"- a dialect of Punjabi language while 1.8% of people speak Kashmiri. Potohari is an enriched language with a lot of literature, including poetry. An interesting thing is that the females of old age with illiterate status use to quote a variety of poetry time to time according to the situation in any gathering and discussion. Although they cannot read but they have learnt it from their forefathers. Moreover, some of the cases were found who could not attain education, do not know reading or writing and do not have much interaction with outer world, but they do meaningful poetry, in which they express their own life experiences and feelings.

Another variation is worth to mention here is that the people who are educated and having a sound socio economic status are more likely to be conscious to speak Urdu, especially when they are communicating with any stranger. This is interesting to observe that the girls and boys who are getting education want to express their thoughts in Urdu to build a good impression.

The locals get up early in the morning and offer Morning Prayer. Male members of those families who posses livestock use to milk their animals. Females milk the animal in case of absence of males or they may provide assistance to the males. Normally this activity is done before the breakfast. Women prepare breakfast, first it is served to elders and males and then to rest of the family members. Normally women take breakfast after every one has eaten. Young girls assist their mothers in preparing and managing breakfast by cleaning used pots. Some girls lend hand in cleaning the house. School going children

get up little late. They are served with breakfast. After breakfast school going children leave for schools /colleges and men leave for their work places.

Those girls who are not getting education do more work in comparison to other girls of their age. They manage various household chores like preparing meals, cleaning of home, laundering and taking care of the siblings. These girls work solely or in assistance to their mothers. Elderly women have the responsibility of looking after small kids and grazing animals on field.

Most of the time males remain busy in their routine jobs and after coming from job they remain busy in agriculture related activities. Males bring wood for fuel purpose of the household. Young boys help their fathers in agricultural activities and in bringing fodder for livestock. Elderly people of the village remain busy in maintaining social relations. Some elderly males regularly visit their social circle for gossip and smoking Huqah[1] in the evening.

Dress code for males is shalwar Qamiz. Elderly males also keep a large square piece of cloth on their shoulders. The stuff of the dress is cotton or mixed. Sometimes educated males and those who do work in offices wear trousers and shirts during office hours and then change to Shalwar and Qamiz when return home. Females wear Shalwar, Qamiz and Dupatta. Variation was observed regarding stuff, designing and colors for different age groups among females.

During summer elderly women normally wear light color cotton or lawn dress with a dupatta. Dupatta is of different color that does not match with dress. When they pay a visit somewhere then they wear big Chadar (piece of cloth larger in length and width then a dupatta). Middle and old age women use relatively light colors with small prints while young girls use vivid colors and prints. Change of season does not change the basic dress pattern but the stuff is changed for instance in summer thin cloths are used while in winter the thick cloths replace the thin stuff. Woolen shawls become an important part of female as well as males dress. Sweaters are not in common use. There

[1] Traditional way of smoking tobacco

are two private schools in Gumti, the uniforms for girls is white Shalwar Qamiz with dupatta and for boys grey pant with white shirt and a tie. It was observed that when girls reach the age of 6- 8 years they are instructed to cover their heads and bodies with dupatta.

2.1.4 Food Patterns

The eating schedule of villagers is three times a day. Some locals told that one or two generations back people of the village use to have two meals in a day, their forefathers use to start their day with morning lassi (yogurt diluted with water) then breakfast was taken around 10 to 11'o clock and 2nd meal was taken after the sunset or after offering day's last prayer. In this regard, aspect of urbanization can be observed here because now people take three meals in a day.

The reason for this change can be, they are living not very far to the urban life and they are in frequent interaction with urban centers thus patterns are adopted and practiced. In term of timing of food, women start making first meal (breakfast) just after offering their morning prayer. Tea, fresh wheat bread either oily or simple and leftovers are generally included in menu. Second meal is taken in noon around 12 o'clock. Vegetables and pulses are in common use. Meat is not used frequently because majority of the households can not afford to purchase it and secondly meat is not readily available in the village people have to go to the nearby markets to get it. Third and last meal of the day is served after offering "Maghreb" (it is the second last prayer of the day and is offered after sunset). Normally, a leftover from lunch is used in this meal.

In food serving patterns gender difference are visible for all three meals in general and at breakfast and dinner in particular, because males and children are not home at noon due to schooling and job purpose. In morning women of the household prepare breakfast, which is first given to males and elderly, then school going children including both male and female but preference in food is given more to a male child. When the children and husband leave home then in the last women take breakfast.

At lunch time women and little kids are generally at home, after preparing meal they serve to elderly, if they are there, then women and kids at home, take their lunch.

School going children and earning males take lunch whenever they come back. Interesting point here is that, although women usually take their lunch earlier to males but they consider it important to keep separate best quality and quantity of food for males. At dinner, males and elderly are served first. This is not a normal practice that all family members sit together to have their food. Males are served their food on Charpai (bed) whereas children and women usually sit in cooking area on floor and have meal at the end.

Another interesting dimension is serving of food to guests. The type of food and the way of serving indicate their hospitality. They are even curious to know that who served what to their guests and then analysis is being done whether food was respectful or not. For example, if someone prepares chicken, rice and any sweet item in meal for guest then it is considered respectful food while serving routine food like vegetables and pulses might lead to gossip for other neighbors. Food is served in separate place to guests and normally family members do not accompany them.

In social gatherings, like marriage or death ceremony, generally one or two type of dishes are being prepared in sufficient quantity and the whole village is invited there. Incase, any shortage of food happens and if all guests could not be provided same quality and quantity till end then it is perceived very shameful thing for the host. In normal routine they use utensils like mud backed, silver or steel and for cooking purpose silver is being used but guests are served in pots, which are not in routine use rather dinner sets of plastic are used which are considered prestigious. All these food patterns are culturally defined and all of these practices refer to one or other symbols.

2.1.5 Religion

People of the village belong to Sunni sect of Islam. Commonly locals relate and refer every practice and custom in the context of Islam. Although their knowledge about religion lacks because majority of them are unable to read and they just rely what is interpreted in religious addresses but they try be a true Muslim. Elderly people are relatively strict in observing the teachings of Islam and they regularly offer their prayers, one reason can be that in our culture, people start to be regular in prayers and to worship God more consistently in old age.

Each of the five Dhoks of the village has separate mosque. Usually the males offer their daily prayers in the mosque situated at their own Dhok however males from all dhoks of Gumti prefer to offer Jumma prayers in the main Jamia mosque situated in Upri Gumti. Services of a Molvi have been hired for main Jamia mosque of the village. Few years back he migrated from Kashmir and got settled here along with his family. The locals provided home to his family free of cost. He is also given a salary of twenty five hundred rupees per month. His salary is generated by the contribution of each household of Upri and Bunni Gumti. Children of the village are given religions education (both oral and verbal recitation of the Holy Quran) at the Jamia mosque. While at other mosques of the village usually the eldest member perform the duty of Azan (call for prayer).

In the socio-economic census and survey form, religious education was divided in to two categories first is Hifz mean learning of the Holly Quran by heart and other is Nazra, means literacy to recite the Holly Quran. 1.4% of population is Hafiz-e-Quran from the total population while 73.6% has got Nazra education. Recitation of Quran is considered as an important part of life for every Muslim, thus almost all Muslim male and females get this education even if they are uneducated because religious education, especially recitation of Quran, is an independent mode of education which has no relation with formal schooling. The whole distribution tells that almost 100% population who are eligible in terms of age to get this religious education have attained or attaining this education. Furthermore this kind of educational attainment is not comparable with formal education.

The main Jamia mosque is the oldest mosque of the village. To enhance capacity it was recently renovated. Now it is maintained by the mutual contribution and charity by the people of the village. Once in a week some elderly females and children take the responsibility of maintaining purity of the mosque. Normally this is done on Thursday because the next day Jumma (Friday prayer) is to be held. 62 year old women who use to maintain the mosque for the past 10 years, describes this activity as a source of spiritual uplift and satisfaction:

> *"On the day of justice Allah may or may not ask about prayers, but the most important question He will ask would*

be about mosque's cleanliness that's why we all women (old aged) clean our mosques on every Thursday because next day Jumma Prayer is offered at the main mosque in which males of our village and outsiders come for prayer".

2.1.6 Shrines and Saints

The locals are mainly followers of two different schools of thought of Suni sect; one is Naqshbandi while the other is Chishtti. The concept of Piri Muridi (saint and its followership) seems very dominant in the village. People of the village particularly women pay regular visits to darbars (shrines) both within and outside the village. To show utmost respect to the saint called Pir Sahib (in the cultural context addition of word sahib with any male's name reflects respect). Normally when a woman starts talking about Pir/shrines it generates flow of talks around this issue. Women keenly listen to her talk, nodding their heads in affirmative way. Every woman shares the information and her views in the discussion. If some one negates their interpretations and connotations then it is highly disliked. If some thing bad happens to a person then it is strongly associated with deviance from what is commonly believed about Pirs and shrines.

There are five holy places in Gumti that includes two shrines and three ancient graves that are perceived as the graves of pious people. The history of these ancient graves is unknown. People of all ages pay frequent visits to these shrines. Women pay frequent visits at shrines of the village. They believe that doing this result in fulfillment of their desires, spiritual satisfaction and healing of their ailments and worries. Shrines and graves are known for specific kind of satisfaction one can have i.e. women visit Bunni Dhok shrine for the treatment of different body pains and tumor. Women visit these places to perform a ritual called "Gitti marna" (throwing small stones at grave) believing or praying that their prayers will be answered. Some women take a small amount of soil from the grave and rub it against their body to get relief from pain.

Some people tie up small green cloth on the nearby tree making a wish that upon fulfillment of their desire they will untie the cloth. Special offerings are paid at shrines at various occasions like birth of a child, when an animal like buffalo, cow or goat gives

birth to a baby, sweat products are made from the first milk of the animal or ghee is placed at these graves in small earthen pots like saucer, special lamps are also lit by the women. Women also tie a green color piece of cloth on the nearby tree and when their desires are fulfilled then they came to untie that piece of cloth. When desire is fulfilled women again go to the particular place where they made vow and distribute sweet or rice among all the people who are around. And a green color sheet decorated with golden lace is also placed at the grave.

There is a living holy Pir in Gumti. He is a resident of the village and belongs to Qureshi caste. He is quiet young in age. According to the locals he divorced his wife few years back and was jobless, later he adopted this profession. People of the village especially women visit him almost once or twice in a week. On Friday males from the village and outside the village visit Pir for their spiritual uplift and solutions to their physical and social problems. On every visit people give certain amount to this saint and food is cooked and distributed at his place on voluntary basis.

Visiting Pir is the most important activity for majority of people of Gumti. Besides visiting Pir living at Gumti other saints (both living and dead) outside the village are also visited. For such visits people have to travel for few hours. Special vehicles are arranged for these visits. Planning and arrangements regarding the visit is an important issue among the women folk because male usually made these trips alone. Announcements for the visits are made from the mosque's loudspeakers and request for the collection of money is made by the Molvi. Interested people give collection of traveling fair to the Molvi. Then he makes arrangements of the vehicle with the help of some males of the community. This activity usually takes two to three days. Female of all ages pay visits to saints. During the visits few male members who are usually their close kin also accompany them. Most of the time these one day visits are paid but occasionally women stay at saint's place for few days.

In case when the locals are the followers of a saint who is not resident of the village then the saint is invited to the village once or twice in a year. On his arrival special arrangements are made by the contribution of the community for his stay and addresses. Pir comes and listen to the talks and problems of the people. He guides them

for the solution of their problems. He addresses the women as well. Women listen to his address from a covered space. Separate arrangements for female seating are already made. He gives lecture on living a life according to Islamic code of life. People give money to the Pir according to their affordability. Pir resolves conflicts among people. He is also invited on the funerals.

2.2 Civil Amenities

Facilities available to the people of the village serve as an indicator to measure their socio-economic status moreover it also indicates the changing patterns of the locals at societal level.

2.2.1 Water Supply

Initially the locals use to fetch water from the communal wells at different Dhoks. Now some households have wells and borings within their houses. A significant number of households are still dependent on communal wells (Plate no.4). These communal wells are purified twice in a year every year by joint contribution of money and labour. Households who have wells or boring inside their houses are considered relatively well off as compare to others.

2.2.2 Electricity

According to the socio-economic census survey conducted for the present research 93.3% households are equipped with the electricity.

2.2.3 Streets

A broken metalled street leads to the village. Some of the streets are paved by the bricks where as other are mud tracks. Where there are no streets at Ghosia Chowk as all the houses are located alongside the main link road.

2.2.4 Bank

There is no bank in the village and people visit Mandra city to avail this facility.

2.2.5 Markets

There are few small shops in Gumti. These shops are situated at different streets. These shops provide daily use items i.e. cigarettes, sweets, onion and potatoes, pulses, rice etc. Mostly elderly women, males and children go shopping at these shops. Women and young girls are not likely to visit these shops. One of the shops is run by a woman. Young girls who live near her house prefer to go there. These shops also include a video center that is situated near the main link road this shop is a source of entertainment for young males. Elderly inhabitants of the village do not like the presence of the shop in the village. They believe that it is a source of bayhayaie (shame). Moreover their Pir has also forbidden them to be indulging in such activities.

At Ghosia Chowk there is a big market comprising thirty six different shops that include five general items shops, five tailors' shops, five welding shops, three barbers shops, two blacksmiths shop, six cement dealers shops, two fruits and vegetables shops. One hotel, gas filling shop, one medical store, two homeopathic clinics, one chaki (floor mill) etc.

Mandra city is the main nearby market of the vicinity. People go there for bulk shopping and for the things that are not available in the village. Shops include cloth depot, grocery shops, traditional healers and private medical practitioners. Many households of village Gumti buy their monthly audible from Mandra. For women enjoys visiting Mandra. Women are not encouraged to visit the market alone.

2.2.6 Transportation

Majority of the locals travel by public transport. Mandra has the main bus stand that connects these villages including Gumti to other cities. Local transport that plies between Mandra and villages is available up to evening time. Public transport vehicles are quiet few and are insufficient to meet the requirements of people of the surroundings. That is why these public transport vehicles remain over crowded all the time. In case of emergency there are three private cars in the village that are hired on special booking. These vehicles are hired in case sudden illness or at the time of taking pregnant women to the hospital.

2.2.7 Schools

There are two private English medium high schools in the village. Both schools are located in Upri Gumti and are near the main link road. Both the schools have their independent building particularly constructed for the school purpose. In past boys and girls had to peruse their education outside their village. Now Gumti has got two high schools to facilitate education with in the village (Plate no.5). Now private classes up to bachelor level for females are running at one of these two schools. These schools have very short history, prior to this there were no educational facilities at village level. Female staff is working at both schools. The locals of the village prefer and encourage their females in teaching profession and are not encouraged to do office job.

2.2.8 Health Services

Basic Health Unit (BHU) is located in the south of the village at the distance of half a kilometer. This health unit falls outside the geographical boundaries of village Gumti. To seek health facilities outside the village people prefer to go to different Hakeems (traditional healers), homeopaths and allopathic clinics located in Mandra city. In case of emergency or severe problem they go to Gujar Khan Government hospital, Combine Military Hospital (CMH) and Holy Family hospital in Rawalpindi. In the evening a doctor from the (BHU) practices in a private clinic near Ghosia Chowk.

Chapter-3

SOCIO DEMOGRAPHIC COMPOSITION OF THE VILLAGE

The present chapter deals with the socio-demographic features of Gumti. Source of the qualitative data presented here is the socio-economic and census survey conducted by me. There are 137 dwellings in the village where total population 944 individuals are residing.

Table 3.1: Distribution of the Population by Sex

Gender	Frequency	Percentage
Female	456	48. 3
Male	488	51.7
Total	**944**	**100**

Total population of Gumti is 944 out of which females constitutes 48.3% whereas males constitute 51.7% of the total population. Male population is slightly higher then females. The sex composition depicted in the table includes males and females of all age groups. According to socio-economic and census survey data accumulated for the present research average number of persons per household is 7. This is quite close to the national level figure (6.8 per household-1998 census survey).

Figure 3.1 depicts distribution of population divided in five different Dhoks. The majority (70%) of the population is residing in Upri Gumti while rest of the 30% of the population is divided into four Dhoks. Above figure depicts the distribution of population in Gumti. Study sample was drawn from all dhoks according to their population size.

Only 5% of the population is residing at Ghosia Chowk. Majority of the people residing in the Upri and Bunni Gumti are Qureshies by caste, they are believed to be the oldest inhabitant of the area. Only in Upri Gumti small proportion of different "quams" castes are settled i.e. there are few households of barbers and blacksmith families in Upri Gumti where as in other Dhoks people specific caste is living in the form of clusters.

Figure 3.1: Distribution of Population by Dhok

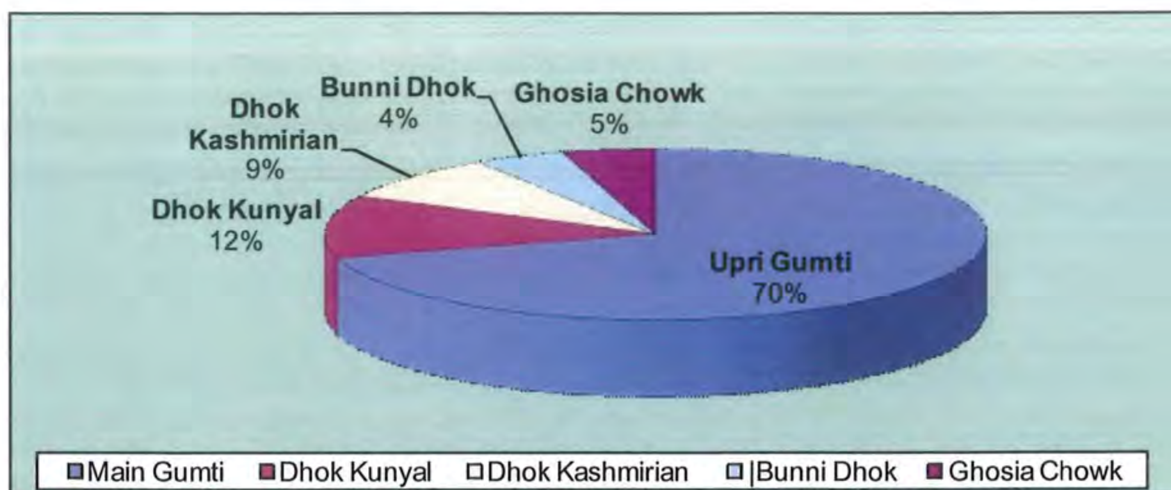


Table 3.2: Age distribution of Population by Sex

Years	Female		Male		Total
	No.	%	No.	%	No.
1-10	107	48.6	113	51.4	220
11-20	111	47.0	125	53.0	236
21-30	73	45.6	87	54.4	160
31-40	51	53.7	44	46.3	95
41- 50	45	58.4	32	41.6	77
51-60	32	45.1	39	54.9	71
61-70	18	37.5	30	62.5	48
Above 70	19	51.4	18	48.6	37
Total	**456**	**48.3**	**488**	**51.7**	**944**

Age and sex are very important variables for the analysis of other types of data and for the evaluation of accuracy of population counts. The definition of age use for the research purpose is age of an individual at last birthday. Data in table 3.2 suggests that majority of the population falls in 1 to 30 years of age constituting 65% of the total

population, while the number of person fallings in the rest of the age groups is decreasing with increase in age. Population above 30 years of age is 34.7%.

The highest proportion of population falls in 11-20 years. Important to mention here is adolescent age group falls in this age group and adolescent comprise of 25% among all age groups. 25% population of adolescents constitute significant portion of population. A visible proportion i.e. 23.3% falls in the age group of 1-10 years age that is slightly less than that the second age category.

Number of male in 1-20 years age group are slightly higher then females of same age group, constituting a sex ratio of 106 males per 100 females while the lowest sex ratio 71.1 is observed in the age group of 41-50. Average age of the population is 27.2 years. Further distributions suggest that 17% of the population falls in 21-30 years age group. 10% is in the age limit of 31-40 years group, 8.2% is in 41-50 age group, 7.5% from 51-60 years of age, while 5.1% belongs to 61-70 age category and just 4% comprises elderly population who are 70^{+}. An obvious sense emerging from this type of distribution is that the dependency ratio is high because about 64.8% population youngest and elderly are dependent on 35% of earning population, which is bearing the burden of youngsters and elderly. Average age coming out of data is 27.2 years.

Gender wise comparison of the data suggests that difference between number of females and males in the total population is quite close however females are slightly higher in number than males.

Another important point is regarding the population falling in the reproductive age group i.e. 47% of the total population it including both males and females. That definition of reproductive age group used here is 15-45 years that is usually used in Pakistani demographic and social surveys at national level.

Table 3.3 reveals that majority of the population i.e. 39% belongs to Qureshi Caste while, Mughals and Dhanyal caste comprises 18%, 17% respectively, Chohan constitute 12% where are Kashmiries are 11% of the total population. Qureshi caste is the prominent caste of the village whereas minor caste is Nai that constitutes only 3% of the total population. Qureshies are not only in numerical strength but are also politically

influential. They hold more land in Gumti. On the other hand barber families don't have their own land and they are least influential. They work as tenants and sharecroppers. After harvesting season people of the village give them certain crop share against their services.

Table 3.3: Distribution of Population by Caste

Sr. No	Name of Caste	Frequency	Percentage
1	Qureshi	368	39
2	Dhanyal	160	17
3	Chohan	113	12
4	Mughal	170	18
5	Kashmiri	104	11
6	Nai	28	3
Total		**943**	**100**

In Gumti it was observed that people of the lower caste hide their true ethic identity in front of the outsiders with whom they have lesser or one time interaction. Nai's don't like to disclose their profession and cast. They introduce themselves as the members of other respected casts of the area. During the fieldwork initially barber families introduced themselves as members of Malik caste one of superior caste in the area. They further told that tailoring is their profession.

These people are landless are attached with landlords as tenants and get share of crop from the landlords. Being close to the urban areas they also generate handsome income from their own profession. Some of their family members including females does tailoring, livestock business and generate income. Qureshies consider themselves superior and respectable than other casts because they are the oldest inhabitants of the area with the passage of time members of the migrating castes bought land from Qureshies and started living here.

Dhanyal constitute 17% of the population they are also settlers. Since generations they are known for rendering religious services to the locals of Gumti. In local language they are called "Miyanay" that means religious educators. This caste is respectable and influential for its teaching and services to the community. Some families of Dhanyal caste are economically very sound because their male members work abroad. Apart from this they also earn money from education profession. Important to mention here is that both the schools of Gumti are run by the two Dhanyal families.

Agriculture is the basic economic activity of the Gumti and more or less every caste is allied with farming but not totally dependent on it. Apart from agriculture there are other sources of earning that are adopted by the locals that include daily wage labor, army, and work in government and private organizations.

Some of the Qureshies are politically active i.e. councilor of the village is from this cast, another influential of the same caste is an advocate who is also helpful for village's internal affairs. Socio economically, some of Qureshies are better off.

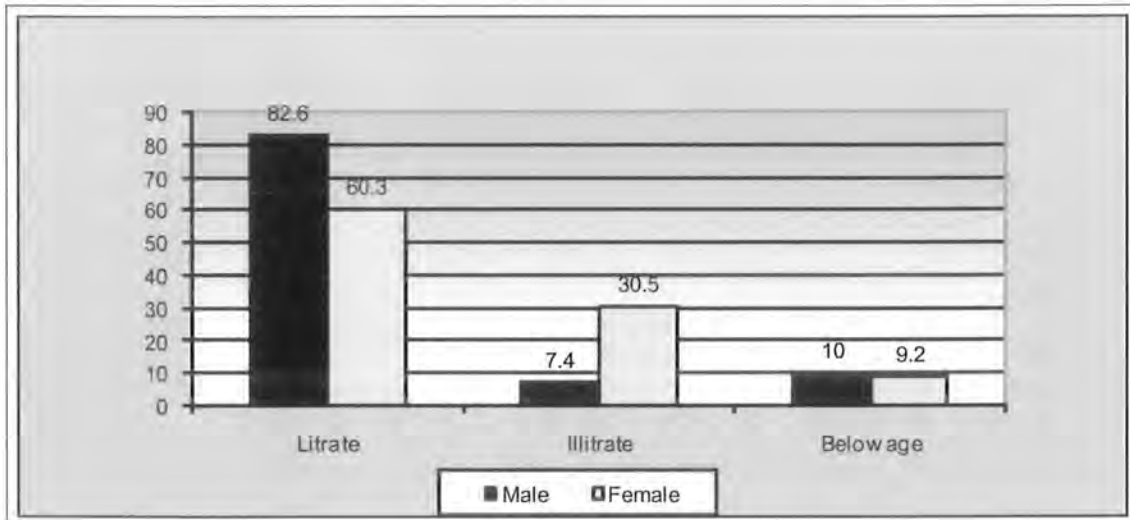
Social organization in the village is based on baradri basis. Settlements in the village are made in the form of baradri clusters. Common disputes are settled first at baradri level with the influential persons who are generally well off, and politically sound. Pir muridi is very dominant in the power structure of the village as people of the village give high regards to their spiritual leaders. They play role important role in the overall lives of the people. People of the village take guidance from their saints in decision making on their important issues.

3.1 Formal and Informal Educational Attainment Status

Figure 3.2 presents the data regarding the status of literacy level by gender. Operational definition for literacy here includes individuals who ever attended school regardless the grades. Data shows that about 72% of the population of the village is literate majority of the males 82.6% are literate as compared to 60.3% females. The reason for low level of literacy for the females is social customs and barriers restricting female mobility. Females get less opportunity outside their home to acquire education. Despite this female illiteracy rate is 30.5% that is four times higher than males i.e. 7.4%.

The ratio of the male and female who are below the age of school enrolments are almost the same i.e. (male 10.0% and female 9.2%). The operational definition for school going age of children was taken as children of 4 years of age.

Figure 3.2: Gender Wise Distribution of Population by Literacy Level



There are two private schools in the village both are providing co-education up to middle level. These schools started functioning few years back, prior to these schools male students had to go to other nearby towns/village for educational purpose. At that time educational facilities and opportunity were very limited for females as compared to the males. Female mobility, gender differences, male preferences and poverty were some of

The factors hindering female's literacy. Now the trend is changing because the girls are getting education after grade ten within their own village. One of the schools is running classes for females up to higher secondary level. Some girls of the village travel to nearby towns for education.

Now mobility restrictions are becoming flexible, which is creating positive change toward female's educations. One of the Qureshi girls is continuing her education after matriculation in Islamabad by living at her uncle's house. While another girl form the same cast is privately preparing for second part of master degree by staying at her

own village. She provides tuition facility to the young children of the community. The girls who are getting education are respected in the village.

Figure 3.3: Gender Wise Level of Educational Attainment

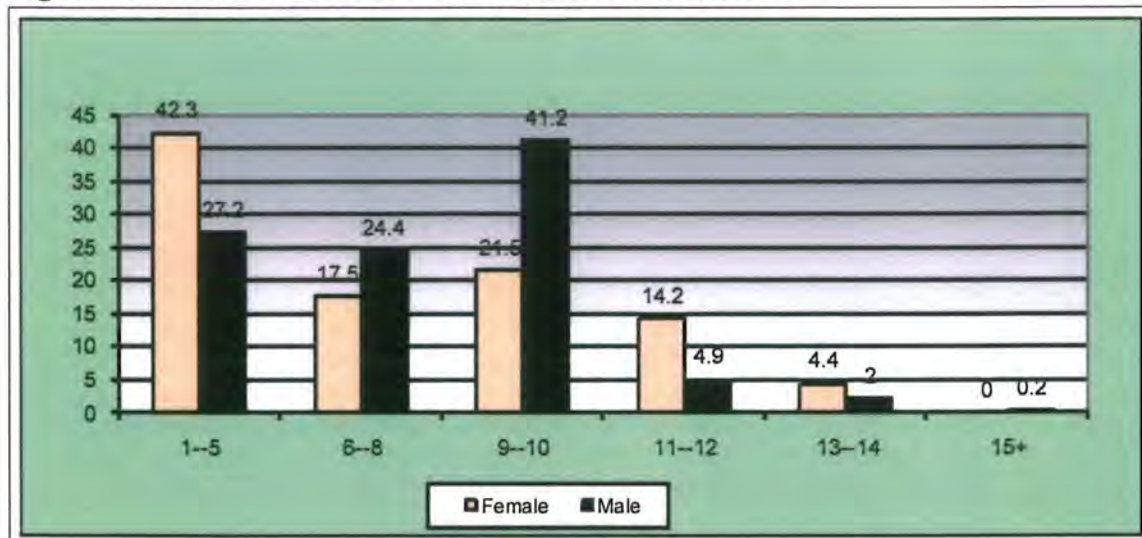


Figure 3.3 presents information on different educational levels for males and females of all ages in a more precise way. Data shows that significant number of females got education up to primary level i.e. 42.3% as compare to 27.2% males. Out of 42.3% majority of the females are unable to continue their education after elementary grades the reason for this is that the rate of school dropout for girls starts from the beginning.

Some times girls get quit from education after one or two years of education because a girl in a village is deemed to be coherent with household cores right form the start and her education is given secondary value. The number of primary literate males is less in comparison i.e. 27.2%. The history of female education in the villages is bleak as compare to males. Main factors for leaving schools for males can be their own lack of interest and financial problems.

Moving towards next grades, data show that the number of females up to middle grades is less than males, only 17.5 females could get education up to middle level while 24.4% males got education up to this level. It was observed that old male of this village are educated to some extent but majority of their female contemporaries had been to school. Educational level of grade 9-10 seems crucial data suggests huge difference

between males and females. At this stage 41.2% males have completed their education up to matriculation while almost half i.e. 21.5% females could do so.

Interestingly, data has shown tilt towards females after matriculation. 14.2% females have either completed 11-12 years of their schooling or they are currently enrolled. The trend of higher education is on the rise among females.

Two to three years ago there was no college facility at village level. Girl's mobility was restricted that resulted in hampering females education. Now with the provision of educational facilities with in the village girls have more access to education. One main reason for decreasing trend of male education after matriculation is joining jobs to become an earning hand to the family. Majority of the males of the village are government employees in army and telecommunication department. They join these departments after metric on low cadres.

Overall higher level of education between males and females is low in numbers compare to previous grades; still females studying higher education are more in numbers than males. About 4.4% of females got education up to bachelor level whereas just 2% males reach this level. There are no educational facilities for graduation level at village level. Some females who reach this level seek education from cities by residing with their relatives in Islamabad, Rawalpindi or Gujar Khan. According to socio-economic census survey data one male and a female of Gumti were privately studying master level education.

Societal change is a constant element of any society, though the pace can vary in different situations. Behavioral change cannot be measured but can be observed on the basis of different indicators that assist to evaluate change occurring in society. In Gumti, this kind of change can be observed on the basis of Education, Cast system and their socio-economic status

There is a change in trends of educational attainment especially with reference to females. Looking 4-5 years back there was no facility available within the village and mobility out side the village for girls was not encouraged. There were two private English medium elementary schools out of which one was run by an educated lady who moved

here in marriage bond from a city and acted as a change agent. After assessing the need of higher school especially for girls both schools were upgraded.

The up gradation of two private schools within the village led to obvious societal changes like the mindset of parents as well as of girls has been changed, now parents are willing to send their girls for higher education and there is competitive atmosphere among girls to study further. These girls are more confident and they are given autonomy at household level to some extent because usually villagers perceive an educated person as more wise person regardless of his/her age. Their life styles are different from their contemporaries who are illiterates that are visible both in their verbal and non verbal communication, dressing, serving of food specially guests, speaking Urdu, use of English words in conversation etc.

They have their own internal community of all educated peers. They are very close to each other regardless of cast and social status. They get more exposure and as a result of that they are against some of their routine practices like women gossiping ideology.

3.2 Marital Status

Table 3.4: Distribution of Population by Marital Status by Sex

Marital Status	Female		Male		Total	
	Number	Percentage	Number	Percentage	Number	Percentage
Single	243	45.8	287	54.2	530	56
Married	190	54.0	162	46.0	352	37.3
Remarried	6	18.2	27	81.8	33	3.4
Divorced	5	71.4	2	28.6	7	0.9
Widow	10	83.3	2	16.7	12	1.3
Separated	2	20.0	8	80.0	10	1.0
Total	**456**	**48.3**	**488**	**51.7**	**944**	**100**

Table 3.4 elaborates marital status of locals. 56% of the population is unmarried while 44% is married. Among unmarried proportion 46% are females while 54% are

males, whereas among 44% of married population there are different status like currently married, remarried, divorced, widowed and separated. People who are once married are 37% of the total population while people who are remarried make 3.4%.

By looking at the numbers, males are four times more likely to remarry than females. In contrast to previous category, out of total 7 cases of divorce (0.9%), 5 are females and just 2 are males. Widow cases are 1.3% with almost equal numbers of males and females, and last category of separated cases is 1% in which 2 are females and 8 are males.

Table.3.5: Distribution of Age at Marriage by Sex

Age	Female		Male		Total	
	Frequency	Percentage	Frequency	Percentage	Frequency	Percentage
12-16	34	16.3	2	1.0	36	8.8
17-21	83	40.0	48	24.1	131	32.2
22-26	63	30.3	59	29.6	122	30.0
27-31	15	7.2	53	26.6	68	16.7
32 +	13	6.3	37	18.6	50	12.3
Total	**208**	**100**	**199**	**100**	**407**	**100**

Data pertaining to age at first marriage of males and females is presented in table 3.5. Data suggests that on average females get married much earlier than males i.e. 16% of females get married by age of 16 years of age while only 1% of males get married by this age. Parents prefer to marry their daughters at early age. Similarly, 40% of females and only 24% of males got married between 17-21 years of age. This age range involves majority of the girls because after 21 or 22 years, it is considered that now girl is late for marriage.

Almost equal proportion (30%) of females as well as males got married between 22-26 years of age group. However, males who got married by 27 years or later are three times higher than females, which indicates that concept of delayed marriages does not

prevail among females. Therefore, it is concluded that female get married much earlier compared to their male counter part.

3.3 Occupations

Table.3.6: Distribution of Population by Skills Attainment

Type	Frequency	Percentage
Formal	80	8.5
Informal	114	12.1
No skill	750	79.4
Total	**944**	**100**

Overall, 20.6% of population has got any sort of skill, which is to be utilized for earning capital while rest of 79.4% does not acquire any skill. It shows that generally there is not much trend of skill acquisition both for males or females. Out of overall skilled population, just 8.5% got training at a formal institution whereas 12% learnt life skills from any informal source.

Majority of those who learnt are working in the telecommunication department or army rendering the services of lineman, technician, driver, plumber etc. and these skills were not learnt before joining the job while very few males joined institutions for short term computer courses.

In informal skill acquisition, skill of driving and mason are most common. Masons learn this skill either from their adults or by getting some sort of training from experienced person, similarly driving was learned by spending some time with drivers. These drivers are involved in local transport, pick and drop business for school collage students. Some of them have their own vehicles and some work for others.

On the female side, there was a vocational school in Gumti that was run by a local girl now she has moved to another village after marriage. Stitching, embroidery, cutting, knitting training was offered at that institute. After the marriage of the instructor the

institution is now close. Local females have great desire to acquire these skills because it adds value to personality of a female in the local setting.

Table 3.7: Distribution of Population by Occupation

Category	Occupation	Frequency	Percentage
Male	Skilled Labour	78	16
	Army Employed	39	8
	Pakistan Telecommunication	44	9
	Government Employ	25	5.2
	Privately Employed	49	10
	Working Abroad	22	4.5
	Shop keepers	20	4.1
	Barber	20	4
	Agriculture related work	36	7.4
	Unemployed	155	31.8
	Total	488	100
Female	Employed	18	4
	Unemployed	438	96
	Total	**456**	**100**

In village setup income generation is generally considered as the domain of males. But a slight analysis explains that this is a general and broad level perception which prevails in society otherwise there are many income generating activities that are exclusively related to females like rearing livestock and poultry selling products related to it. These activities are not counted as primary source of income rather taken as secondary and informal contribution by the females.

According to that data shown in table 3.7, a diversity of occupations is found in the village. Out of total, a major proportion 16% falls under skilled labor category that is engaged in private sort of jobs like masons, drivers, electricians, automobile mechanics etc. These labors either have their own small scale setups or they are employed by

someone. 8% males are currently serving in Pakistan Army and all are in low ranks, 4% are serving in Telecommunication, and 5.2% are government employees

Another large proportion is comprised of those people who are getting pension after retirement, 10% people are privately employed, 4.5% males are working abroad who sent remittances from there, 4.1% are shopkeepers who have their own shops either within the village or out of the village and 4% are barbers.4% of females are working as a teachers and are contributing in economy of their of the households. Finally looking at the agriculture related work, data shows that there are just 7.4% people who are associated with agriculture but the distinction is needs to be made here that this percentage is exclusively linked with agriculture otherwise almost all of the population is associated with it but they are also engaged with formal kinds of jobs.

3.4 Agriculture

Yearly agriculture production of the area is high. The land of the area is arid. Yearly rainfall and climatic conditions are favorable for good agricultural yield. Grazing land is available for livestock. People have got fragmented land holdings. There are some families having large land holdings. The minimum size of land holding is 3-4 canals while its maximum range goes to 128 canals. Majority of the locals posses land holding between these ranges while some posses no land like barbers. This certainly creates imbalance in the social structure.

There are two major crops during a year.

1. Rabi (Winter crops)
2. Kharif (Summer crops)

The major crops of the area are Kanak (Wheat), Makh (Maize) and Mong Phali (groundnut). While Dal (pulses) and sursoon (mustered), Jawar (Barley) are also harvested on a small scale. People are largely dependent on agriculture for their livelihood, household consumption for the whole year and producing chara (fodder) to rear their livestock.

Wheat is cultivated on a large part of the cultivable land. It is the biggest staple crop. People of the village sell wheat after keeping it for the whole year household consumption. Contrary to wheat maize is cultivated on a small area people keep a very little amount of maize production for the household consumption and the rest is sold. Peanut cultivation is also less in the village because villagers think that it requires a lot of labor and time to manage this crop however few households cultivate it on small patches of land.

3.5 Landholding Patterns

In Gumti majority of the people have inherited land. 70% of the land belongs to Qureshi caste. With the passage of the time they sold land to other people i.e. Kashmiries, Chohan, Mughal and Barbers. In village Gumti the pattern of landholdings are;

1. Cultivated Private Land
2. Un cultivated private land

3.5.1 Cultivated Private Land

Individuals own private land most of the time this land is the joint ownership of the family members. Land is divided mostly at the time of the marriage of elder son. The private land is both in the form of cultivated land or uncultivated land. The cultivated land is self cultivated and some times it is cultivated by tenants.

3.5.2 Un Cultivated Private Land

The uncultivated land is used for animal grazing. It also serves as a source of fuel to the people. Grass cutting is not practiced in the area rather uncultivated land is grazed by animals by tenants.

3.6 Kinds of Land

There are different types of land in the village categories according to the production of the land and its attributes are as under.

3.6.1 Lapara

This kind of land is located near the houses. It is very easy to access. This is the most fertile type of land amongst all because people dispose off the animal excretes in it. Every household has a piece of Lapara near its house. This land is best known for quality production. It produces bi annual crops. Mobility of married and elderly women is frequent in the lapara but unmarried girls are not allowed to go in the fields alone, some times when they have to serve meal or tea to their family members who are working at field then they have to take a grown up child or a male along with them. Going alone of a female is culturally disliked in village Gumti. They are permitted to go there because all the neighboring houses are usually the members of the same caste (baradri) and members of close kin for whom the purda restrictions are a bit flexible.

Another big advantage of lapara is easy access to fodder for livestock. Due to its proximity less labour and time of females is consumed to dispose off animal excretes. This land is also used for the extension of the house structure according to the growing needs of the households especially after marriage of elder son one or two rooms are constructed in lapara.

Women play active role in agricultural activities such as growing vegetables, sowing, harvesting and managing crops. While unmarried females are responsible for managing the crops once it is brought to home. Women's service at land continues through out the year. Agricultural work is in addition to routine work of a female. A woman continues working either at home or in field with low energy reserves and without extra diet. While working at field women only consume their routine meals either at field or after returning from field. Such practices make her nutritionally depleted but it has become more like a habit for every female of the village.

3.6.2 Luss

Land next to lapara is called luss it is situated at the distance of one kilometer from main houses. This land is situated little far away from houses. This type of land lies in a slope either it is located near or far. It is deeper than lapara. With the use of fertilizers its production is also good. Bi annual crops are harvested in this type of land.

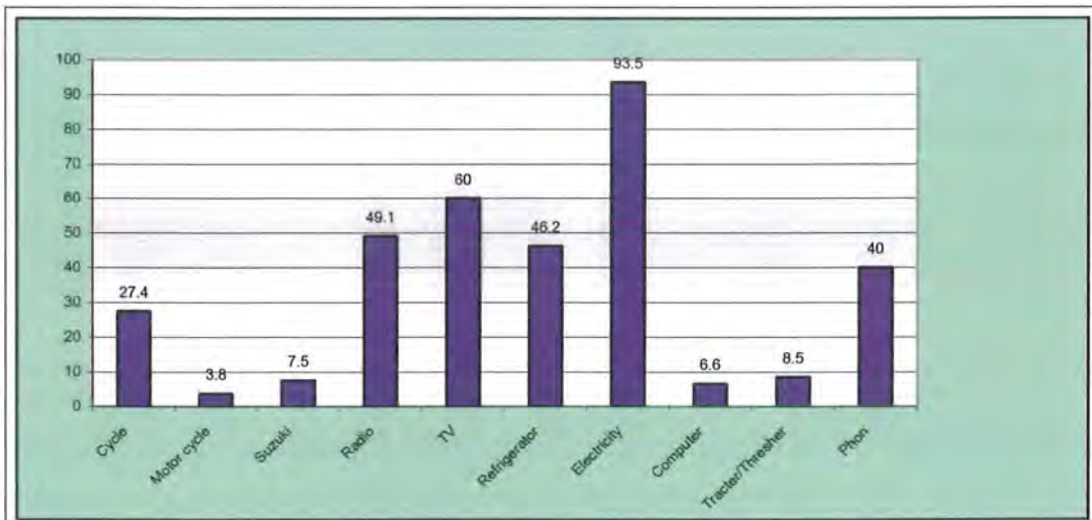
3.6.3 Mera

Mera comes next to luss. Women bring fodder for the animals from Mera. As the land is far the women are not allowed to go there alone. Two or three neighbors patch up to go there or they take one of their kids with them. The production of this land is less as compare to luss and lapara. In a year after the harvesting of wheat that is the main staple crop. Mong phali (Groundnut) and Jawar (barley) is cultivated on it. After the harvesting of these crops the land is kept barren for next five to six months. In the meanwhile the land is prepared for the next year by giving it manure.

3.6.4 Forest

Forest popularly called as "jungle" by the local people is a communal land. The distinctive feature of this kind of land is it has got plenty of trees and bushes that serve the purpose of fuel to the people of Gumti. This land is not suitable for cultivation of crops due to its hard nature. The color of the soil is red. The Jungle area further demarcates the geographical boundaries of the village. It also serves as a source of grazing land for animals. At events like death or a marriage in the village it serves immediate timber needs of the locals.

Figure 3.4 Percentages of Household Assets Owned by Population



The data was collected on the household assets keeping in view that it could provide a picture of socio-economic status of a household to some extent and emerging trends in the community can also be assessed out of it. Figure shows that majority of the households (93.5%) have got electricity. This is the basic facility, which is a source of having many other electrical appliances like TV, radio, motors and refrigerators. 60% of household's posses television, which indicates the trend of increasing media, possession of radio is 49%.

It shows that now TV is most commonly uses than radio. 46.2% households have refrigerator in their houses that are shared by some of their close relatives and neighbors residing near their homes.

Another modern asset is telephone, which is possessed by 40% of households and it includes both land line and mobile connections. Computers are also considered another indication of better socio-economic status. 6.6% households have computers at their houses and these entire household are from well to-do families and young generation is utilizing this facility for educational, learning and entertainment purpose. 8.55% of the households have tractors or threshers and these households belong to some of the economically well off families. Tractors and threshers are hired by the locals during sowing and harvesting season. For that they have to give per hour charges. These households who have their own thresher and tractor earn enough money in harvesting season this is their prime source of earning for the whole year.

For the transportation mode 27.4% household have cycles. Just 3.8% households have motorcycles while Suzuki or car is possessed only by 7.5% of the household. These private vehicles are mostly used as public vehicles. While only four families of Gumti have cars for personal usage. Socio-economic status is another source of change in society. People of the village who are working abroad have changed economic status of their families. Their families especially women are more liberal in terms of decision making, spending money and mobility. There is an example of a lady whose husband is abroad and she is first female who has started driving a car to deal with outside matters.

In some cases males of the villages who went abroad (specially to Saudi Arabia) for working are different in their belief system towards the existing cultural practices related to the religion specially visiting saints, offerings at graves etc. after having being exposed to other cultures many changes are incorporated in their ideology, beliefs and behavior. This creates a difference between theirs and rest of the local's ideology. Another aspect of change is that families with strong socio economic status become reserved and they keep less social contacts with locals as compare to others.

Chapter-4

PUBERTY, ADOLESCENCE AND ADULTHOOD

Threats and Challenges

4.1 Characterizing Adolescence

Today the world is home of the largest generation of 10-19 year old population in history. The first step for deepening our understanding is the concept of adolescence. There is no universal method for doing so, and in Pakistan policies and progress affecting young people are affected by the lack of consistency. UNFPA terms youth as all those people between ages 15-24. Below this age young people are categorized as children. However the Government of Pakistan defines child as up to age 14, although for specific sexual crimes the criteria to determine adulthood is the onset of puberty. UNICEF meanwhile holds that a child is some one between ages 5-19. For international research and statistical purposes, ages 10-19 are used to identify adolescents. Traditionally, the term adolescence has been used to identify the transition from childhood encompassing the interval between puberty and marriage (Menschatal 1998 coated by Khan 2000).

This shows that at various levels these people who are neither child not adults are struggling to get a proper definition. For the present research endeavor adolescence falling in the reproductive age group of 13-19 is taken.

4.2 Background

Childhood is the first stage of individual's life cycle that starts from birth and ends at puberty. In village Gumti the age of childhood for girls is shorter in span as compare to boys. Among Gumti inhabitants the childhood limit is 0-12 years for girls and 0-14 for boys. A girl of six or seven years of age is consider bachi (minor) while attaining the age of ten girl is no more considered a child. She is termed as "lohri bari hoi gaee" meaning that the girl is grown up. Even before the start of menarche a girl is taken as an adult.

In Gumti time period from birth till the age of four years of an individual's life span are known as early infancy in which a child is totally dependent on mother for feed and care. Late infancy starts from five years and ends when the child is of ten years. A child of seven years starts sharing some responsibilities at home by assisting in household work, collecting fuel, attending siblings, bringing items from shops fetching water etc. In particularly a girl child starts participating in household cores from the earlier stages of their lives.

In the village Gumti, Puberty is the end point, when an individual leaves the childhood and enters the adolescence stage. Adolescence is the period of rapid growth that starts with the onset of puberty. In the Gumti adolescent is the second stage of women's life, which comes after childhood. While going through the lifeline in sequential manner, every individual has to touch the age of adolescence which is of short duration. It is a period of transition and transformation when individual change physically from child to an adult.

In this chapter I am going to discuss various aspects of adolescence lives with special emphasis on food beliefs and practices that has great bearing on the health and future roles of adolescence. This age group is critical regarding physical growth and maturity. It's a limbo period for a girl in which she is physiologically prepared for reproducing. The eating habits during this period play a vital role in her growth and future health.

In Gumti the girls who reach puberty are no more considered as a child. It is believed that adolescents are the newcomers into adult world. On average adolescence extends from 11 to 18 years for girls and from 14 to 18 years for boys.

4.3 Beliefs about Adolescence

Most of the respondents defined adolescence in different ways. Though the words changed in various discussions but the theme remained the same. All of them had a belief that the adolescence age starts with the onset of puberty, physical bodily changes and

psychological changes in ones life. Adolescence is referred as Jawani[2] in the local terminology. In Gumti, for girls the age of puberty is generally ten years to fourteen years while for boys it is from 14 to 18 years.

In Gumti the onset of menstruation marks abrupt changes in qusai-adult status in a girl's life. Community believes that adolescence is characterized with bodily changes like growth of hair on male's face, change of voice and height for male. While female start menstruating, undergoes bodily changes and increase in breast size.

4.4 Perception of the Parents about Adolescence

Parents perceive adolescence with the onset of pubertal changes for females even with the age of menarche a girl is given the status of jawan (youth). The duration of adolescence is not specified in the cultural setup of the village. It was observed that parents no more consider their girl as child after menstruation however for males the age limit of adolescence is quiet flexible.

4.5 Adolescent Own Perception Regarding the Recognition of Adolescence Age

Adolescence recognition of this age is not different from community and parent's perceptions. For them adolescence is associated with menses and bodily changes. Interestingly adolescence in a Focus Group Discussion (FGD) associated adolescence with psychological changes and change in the attitude towards life. One of the adolescent respondent in an in depth interview said that,

> *"It is the age when one wish to fulfilling her/his desires by doing fashion, hair cutting and wearing gay color dresses of her choice that gives him/her a satisfaction of looking different from others."*

Another girl in an interview said,

> *"When a person is a kid he/she does not pay attention to him/herself, during adolescence a person comes to*

[2] A person who attains the age of puberty.

> *recognize about him/herself. A person dress up well and does fashion to look different."*

Perception of majority of the adolescent was.

> *"Adolescence age starts with the onset of menstruation."*

4.6 Mobility Restrictions

In Gumti a girl is considered as a child up to the age of seven. Upon reaching this age a girl experience sudden changes regarding her mobility and interaction with others. Her role in household work increases. She is no more allowed to play out side. She is only permitted to visit few neighbors or relatives house that are greatly trusted by her family.

The women in the Gumti have to face strong mobility restriction however mobility restrictions are relaxed in the old age. Adolescence period is extremely critical regarding female mobility. Girls of this age group face increased restrictions, curtailed activities outside their home. Contrary to them males of same age experience greater freedom and exposure to the outer world. Some of the quotes given below reflect their views regarding mobility of girls.

> *"A girl of seven years of age in considered as younger, later on she has to remain at home. She cannot go outside her home and when she attains the age of puberty she is considered as adult."*

> *"Girl of six years of age has to remain in home and she is not allowed to move outside her home."*

> *"These restrictions on girls are due to the environment. If one is right then there is no problem if it is not then the problems emerges. The minors cannot differentiate between what is right and wrong that why girls face restrictions from earlier stages of their life."*

Data reveals that strong cultural practices regarding the seclusion of women starts very early in females life. People of village are much conscious about the observance of *purda* by females at a younger age. It was observed that in the Gumti the age of social

maturity of females starts much earlier as compare their biological attainment of adolescent stage.

The childhood period is attributed with play pleasure, freedom and trust that lay strong footing for healthy development. These features seem relatively less among the girl's lives of village Gumti.

4.7 Gender Differences

In Gumti it is said that man with male child is immortal because male child is considered back bone of one's family. He keeps name of his ancestors and therefore male child is of utmost important to the family. Where as a girl presence in the family is taken as ephemeral therefore she is considered to be brought up to hand over to some one else's family.

Another main reason for desiring male child is economic aspect. Female employment is rigorously practiced in this village just a few females are in teaching profession. Generally male is the sole bread earner of the family. Son is indispensable for the support and assistance to his father. He can fight for to the cause and settle disputes. People with more number of male children are considered strong in Gumti so as they can hold pressure on others.

The status, which is given to a female at the time of birth, is inferior to male child. Son preference is very common not only in Gumti but also in the other areas of the country. When the couple is married their next expectation is to have a male child. People extend their good wishes to the newly married couple by saying that.

"May God give you a male child."

Such cultural practices affect the entire life of a growing girl in Gumti. Since birth a female child fells prey to various differences and discrimination not only in access to healthy food but also in having many other fundamental rights.

4.7.1 Birth Rituals and Celebration

On the birth of a male, gun fires can be heard. 1 to 2 monds (40 to 80 kgs) of sweats are distributed in the village by the well off families and those who are unable to buy sweats distribute small amount of sugar among their relatives, neighbors and to those who come to greet the family.

Generally on a greeting visit on the birth of a male child people and relatives give *Panji* to the child's family. *Panji* includes either money or gift or both. Close relatives usually bring gifts including gold ring, sweats, cloths and money to the new born as *Panji*. *Panji* is reciprocated among the village fellows and relatives at the time of male child in their family. *Panji* indicates a loud expression of happiness and sharing among the locals.

At the occasion of male birth in the family particularly on the birth of first male child importance is given to both child and his mother in terms of food, care and comfort. On the other hand at the birth of female child no such ceremonies are performed. The birth of male child is a moment of utmost joy to the family while female child is considered as a burden on the family. Some times the neighbors come to share the sadness of the family, this situation particularly happen when the family already has two or three girl child and no male child.

It can be safely stated that the desire for having male child is very strong in Gumti and it puts burden on the future reproductive roles of a woman.

4.8 Female Socialization

Socialization is the process of interaction that influences the psychological characteristics of personality. It is a varying learning process according to different socio-cultural set up. The children acquire all those important ideals, beliefs, standard moral and behavior pattern in which they are brought up. Both the family and society plays important role in shaping personality of a person according to the cultural merits and demerits that are governed by the society. Socialization is a long process, which

continues through out the life of an individual. In Gumti socialization is carried out in two different ways.

a. Informal institution of socialization that includes family and friends.

b. Formal institution of socialization that includes school and mass media.

4.9 Family as an Agent of Socialization

In Gumti the time of birth only the child's sex organs distinguish whether it is the male or female but the family later on socializes the child according to its gender. A female is socialized and likewise expected to o show feminine traits. The social environment of the house and parents-child relationship strongly affects the child personality. In Gumti the masculine and feminine behavior is culturally defined. The children are socialized in which is culturally appropriate for their sex. The indoor activities such as cooking, washing, cleaning home, and attending siblings are feminine activities. Since childhood female are socialized in a way that they develop a sense of obedience, women hood responsibility and seclusion.

Gumti is characterized by patriarchal society. Males are considered as superior, powerful and strong therefore they posses accord, high prestige and greater authority in domestic, legal, moral affairs of the family. Generally males have aggressive and volatile nature. In Gumti the criterion for female appreciation and recognition is with the amount of work that she exhibits. The more she works more she becomes populous in the community. One of the respondent in an in depth interview said.

> *"In village importance is given to a girl relating to her work, even if the girl does not have good looking features but she works efficiently, she will be more praised than other girls because of her work. The people will have a count on her labour (household work). If not any other advantage they can get from her they will give preference to her work."*

Majority of the girls are socialized to start hard work at home from very earlier age, so that they can learn the art of doing hard work to live a successful and respectable life in future, and become active domestic wives.

A girl said,

> *"Girl child is liked because of work only."*

4.10 General Eating Patterns

The eating schedule in Gumti is three meals in a day i.e. breakfast, lunch and dinner (see chapter 3). Gender differences and discrimination among female child is visible in all of the three meals. A girl after getting up early in the morning starts performing various household cores in comparison males of her age perform little work in the morning. Mother's differential attitude is observed when they are in the kitchen. She not only gives preference in serving food to male members of the household but also provides them best food both in terms of quality and quantity. When they had eaten enough, the remaining is given to daughter(s). Mothers give priority to husband and son and serve them with eggs, meat, milk and fruit etc. A mother socializes her daughters in the same spirit as a result of that these discriminatory practices pass on to her daughter as well. Girls from early stages of their life are supposed to comply with the existing traditions and practice the same in their life.

One respondent commented that.

> *"When chicken is cooked at our home then the best pieces of the chicken is given to the guest or male members of the household. I, my sisters and our mother eat the left over."*

Majority of the respondents said that beef is cooked at their home only once or twice in a month usually on Thursdays, because small amount of food is given to a needy family in the memory of a deceased person of the family believing that this deed will render reward to the departed soul. Chicken is considered as a prestigious and expensive food. Therefore it is cooked either on special occasions, festival or on the arrival of guests.

Fruit is occasionally consumed by the adolescence and other members of the family. Majority of the adolescent were of the view that fruit is occasionally brought to their home, furthermore its quantity is far less then the requirement of every member of the family. Fruit is first served to adult males and child members rest is consumed by the females. Sometimes guests bring fruit to the family. The concept of hot and cold is also associated with fruits i.e. Orange, Banana, and Watermelon are thought to be cold while Mango, Dates and Sweet melon are thought to be warm.

An adolescent girl requires, but rarely gets 18% of the more iron per kilogram of body weight than male adolescents (Rao *et al*. 2000).

Every girl or women in Gumti has to go through and comply with the existing traditions including food. Where she is socialized and taught to be more submissive and sacrificing through out her life. When this discriminated girl becomes authoritative after marriage in certain aspects she exactly treats her daughter in the same.

4.11 Daily Diet and Life Style of Adolescents

On the bases of observations and data the Daily routine of adolescents can be discussed for two angels.

1. School going adolescents
2. Non school going adolescents

4.11.1 School Going Adolescents

School going adolescents get up early in the morning. Some offer Morning Prayer while others do not. They assist their mothers by performing household chores. Breakfast contains a cup of tea and *paratha* (oily bread or *roti)* plain bread with curry. After breakfast they go to school accompanied by their friends or one of their family members. Mostly these girls are given 2 to 5 rupees to spend on eating during break hour at their school. They spend it on eating sweats or chips. Only one of the respondent mentioned that she takes lunch box to her school.

These girls perform laborious household work followed by a low breakfast before going to school. Some girls have to go to the college that is far from their village. After doing such work the body requirements for energy becomes very high for these growing female child which remains unmet that is crucial because the rate of growth during adolescence is greater. The nutrient needs are greater during this stage of life that remains unmet.

After coming from the school/college, these adolescent girls change dress and have lunch with approximately two chapattis and curry made of vegetable, or *dal* (pulses). After lunch most of the girls have rest for at least two hours. After getting up they usually have a cup of tea then they perform household cores i.e. preparation for night meal, mixing up the flour that is called *"Ata Kondna"* fetching water taking care of siblings and cleaning home and pots etc. They spend little time in doing school assignments at least an hour in the evening. After the dinner they watch television especially the drama at 8 o'clock and then they sleep at 9 o'clock. These adolescent perform less household work as compare to their non school going counter parts. Still they have to face a continuous pressure both in their studies and household work.

The family does not compromise on their household cores because in the village the concept of ideal girl lies with work not with education. Sometimes the mothers verbally sympathies with their daughters regarding studies but they do not let them stop the household work. During whole day these young girl only have three routine meals. That is insufficient to meet their body requirements during this phase of life. The amount of labor by them in a day is much more in comparison to their food intake.

4.11.2 Non School Going Adolescents

Non school going adolescents have greater responsibilities at home regarding household work as compose to their counter parts. They remain busy in doing various household cores cooking meals laundering taking care of the siblings and adults, crops management etc. People of the village appreciate those girls who are active in doing laborious work. Village women in their discussions congratulate the mothers of those girls whose daughters manage their household cores well by saying that.

"Your daughter has become young, she manage home well, now you need not to worry."

In Gumti Adolescent period is the best period regarding training of household work. During crops bowing and harvesting season. The work routine of the adolescent becomes double. They are not involved in working at fields due to the observance of *purda* but their work increase regarding managing the harvested crops at home. Through out the year these non-school going adolescent Along with household work remain busy in agriculture related activities. They get three regular meals and little time for rest during the whole day.

4.12 Dressing

Girls wear three-piece dress consisting of *Qamiz* (shirt), *shalwar* (trouser) and *chilla* or *dupatta* (a large stole). *Qamiz* reaching well below the knees loosely stitched. The *shalwar* (trouser) is full, being gathered at the waist and tapes at the ankles. The *dupatta* consists of two to two and a half yards of cloth.

In Gumti Adolescents usually wear gay colors but during the summers girls wear light colors printed cotton or lawn suits. When they have to go to a function like marriage then they wear colorful embroidery and beads. Stuff, color and designing of the adolescent dress are more attractive in comparison to others in the village. They prefer to wear bright colors like red, orange, green, maroon and blue. During winter season girls wear more silken warm cloths. Warm shawls are preferred instead of light *dupatta*. The change of season does not affect the pattern of the dress only the material and stuff of the cloths gets changed. As there are two schools in Gumti the school going adolescents wear blue and white uniform with white *dupatta* up to class eight after that they wear white uniform with white *dupatta*.

At home these girls have to perform a lot of household work that is why usually their dress remains untidy and some times it is burned in small bits due to wood fire while cooking. They usually change dress once or twice in a week.

An adolescent girl in an interview said that.

> *"Although I wish to change the dress every day but I cannot do so because by doing so I am going to ruin all my cloths while doing different household works."*

In Gumti the girl from infancy wear full dress where as the dressing for boys remains flexible during infancy and early childhood. Boys most of the time remain without shirt or trousers. Cultural restrictions for the chastity of female are strongly associated with infant female child. Mothers are more careful about covering the body of their female child. Other family members remain very particular about covering the female child's body.

4.13 Marriage Pattern

In village Gumti endogamy is strictly practiced except few males who married outside their caste. For female endogamy is strictly practiced and preferred. No choice is given to a female regarding the decision of her marriage. Usually her mother is not consulted in this matter. The issue of a girl's marriage is decided by the male members of the household (usually her father and brothers). Interesting finding from the study regarding the age at marriage for women is that in comparison to the parent generation the age at marriage of a girl has risen over the years. Currently the incident of early marriage is much lowered in the village. Only few girls in the village are married during the adolescent age however it is thought that the ideal age for a girl to be married is below twenties years.

4.14 Puberty

In Gumti the onset of menstruation is the final stage of detaching a girl child from childhood stage. Menstruation marks a strict enforcement of *purda*. The age of menstruation starts at the age of 10 to 11 up to the age of fourteen. Girls are not told about this big physical change of their life earlier in their lives. Experience of menstruation for the first time was noted as the state of psychological trauma for nearly all the respondent of the study. The girls in village Gumti are not mentally prepared for this change.

In an in-depth interview one of the respondents said that.

"I remember that when I experiences menses for the first time in my life. I was totally unaware of it and its practical management. I wept a lot wondering what has happened to me all of the sudden. Out of sheer tension I went to my mother about that then she told me about this and its management before that she never told me any thing about this."

4.15 Practical Management of Menstruation

Regarding the practical management of menses girl use cloth. Generally this cloth is washed, and dried after menses for reuse. This cloth remains unhygienic and dirty as it is not washed and dried properly that may cause different type of infections and allergies in the female body. None of the respondents is using sanitary napkins because of their inability to purchase due mobility and financial restrictions.

50% of the girls said that they used to burn or burry the cloth in/outside their home after using. For this they go along with their mother in the jungle. It was further noted that some practices related to menstruation were worrisome from hygiene point of view that surely have great bearing on the overall health of the female. Like it was observed that girls remain unclean during this period, use unclean cloth for the management. They are forbidden to bath during this stage. Only three girls out of 18 said that take bath more than once during this period. It is believed to have a bad effect on the health of an adolescent girl it causes pain and further disturbs the warm state of the body during menstruation. The patterns of menstrual hygiene developed during the stage of adolescence prevail through out the life of a female.

In Gumti the duration of menstruation is considered as a period of *napaki* (pollution) for a girl that usually lasts for 6 to 7 days. During this period a girl normally does not change dress. It is believed that touching clean things while observing menses makes them things polluted as well. Recitation of the Holy *Quran* is stopped during this period. However no change in the routine amount of household work of adolescence was observed during this period.

Majority of the girls 7 out of 9 in adolescent FGD said that they are suffering from *sufaid pani* (leucorrhea) disease for which they never sought any medical advice. One reason for that is adolescent in the village believed it as highly shameful act to share any information about this disease with the male doctor although female doctors. This high rate of white discharge among the adolescent is an indicator of some degree of reproductive track infections and gynecological upsets. 60% of the respondents said that they were suffering from this disease from 3 to 4 years. When the problem becomes unbearable instead of personally visiting the doctor or *hakeem* they ask their mothers to bring medicine for them. It can be stated that the health of the girl is generally ignored in Gumti during the adolescence stage due to various restrictions. The reproductive health related problems are unreported to the doctors rather temporary home remedies are practiced.

In contrast to female adolescence males of this age group have the freedom and support by the family to consult the doctor for general ailments. Males of this age group can visit the doctor alone. Apparently heath of adolescents female is not good as compare to male of their age group. In Gumti it is believed that if the girl is not producing appreciative work at home it means that her health is not good. In short the household work is used as an indicator to measure the health status of a female.

4.16 Ailments Related to the Reproductive Health of Adolescents

For the adolescents of the village menses is a period of pain and distress. A significant number of females of this age group are suffering from irregular menstruation apart from this adolescence in the village are suffering from various other ailments like abdominal pain, nausea, vomiting, backache, pain in the legs and leucorrhea. The presence of these problems at a very early stage of adolescence in Gumti clearly indicated a sign of unhealthy reproductive health that is further likely to persist throughout their life. It was noted that there is high degree of negligence about seeking medical assistance. Seeking of medical treatment is believed to be associated with shyness or shame (sharam) for girls. Same idea is expressed by one of the adolescence in the focus group that.

> *"If we are suffering from common fever even then we are hesitant to go to the doctor, we feel ashamed."*

A sixteen years old adolescent in an in depth interview said.

> *"Chahay kuch bhi ho jay larkiyan doctor kay pass nahein jatein" meaning that girls in the village do not go to the doctor even the worst might happen to them."*

4.17 Case Study

Tehmina is a fifteen year old adolescent girl studying in class ten. She belongs to barber caste. She has four unmarried brothers and one married sister. Tehmina is youngest of all. Her parents are illiterate however two of her brothers are literate. Tehmina apart from studies provides full assistance to her mother in routine household work. While going to her school she observes *purda* by hiding her face and covering her body with a long scarf like other girls of her age in the village. Her school is at a few steps distance from her house.

Tehmina gets up early in the morning offer her morning prayer then she cleans and maintains the house. She cleans the floor with a moist and heavy piece of cloth. After that she takes breakfast and goes to the school. After coming from the school and having lunch she takes rest for two hours then she again cleans her house with the moist cloth and cleans dirty pots. Some times she prepares dinner as well. After serving the dinner to others she dines at the end then she watches television and does studies for an hour finally her day activities get close at 10 o'clock at night.

Apart from her studies and tough daily routine regarding work at home Tehmina is having reproductive health related problems as she is suffering from irregular menstruation with acute backache and severe white discharge problem for which she hardly sought any medical treatment. Expressing about the gravity of the health problems she commented that.

> *"I am suffering from chronic* Leucorrhea problem *since long it has caused immense pain in my abdomen. Now I have excessive flow of secretion which is not only hard for me to bear but hard to manage as well. See today I have*

worn a new suit but it has become unclean. I always need proper practical management for the disease like one does to mange menstruation flow. For the treatment of this I have never been to any doctor because I feel shy nevertheless I told my mother about this but she took it lightly and said that she will bring medicine for me from the doctor. I know that it is weakening my bones and stamina and it needs proper attention but I cannot do so, I always feel bad about this."

4.18 Treatments

It was observed that generally health of the adolescent girls is ignored by all socio-economic groups in the village. The state of body during menstruation is believed as a cold state. For the treatment of ailments at the start of menses girls rely on home remedies and ethno medicines and foods that are perceived as *garam* (hot).

4.19 Ethno Medical Practices and Home Remedies

4.19.1 Tea

Tea is considered as a remedy for certain ailments. *Kehwa* (black tea) particularly it is thought to be very effective in pain relief at the start of menstruation. Some of the forms of tea that are consumed for various diseases are *podinay ka kehwa* (mint tea) thought to be good for cholera, *long ka kehwa* (clove tea) thought to be good for various oral and stomach allergies and *sawi pati ka kehwa* (green tea).

Sawi patti kawa is green tea that is very effective for menstrual pain. It is prepared by boiling green tea leaves with little amount of sugar added in it. Then the girl is asked to take tea it is helpful in making the body warm and smoothening abdominal pain.

4.19.2 Eggs

Anda (egg) are classified as "hot." It is given to a menstruating girl to make her body warm. Egg is given either in simple boiled form or half fried state mixed with turmeric.

4.19.3 Parsley

Jamain (parsley) is considered best remedy for abdominal pain. Normally it is given to the patient with water. There are two ways of its consumption; one is raw form of Parsley i.e. one table spoon of raw parsley with water while the other is the powdered form of *jamain* that is prepared roosting then grinding it by adding small quantity of sugar. Sugar is added to make its taste sweet. It is given to the girls and women with a glass of water or tea. This dose is given twice or thrice in a day. This ethno medicine is usually available at every house because it is considered equally good for every member of the household to relief abdominal pain.

4.19.4 Honey

*Makhi (*Honey*)* is considered good for various diseases it is particularly given to the menstruating girls so that they can feel less pain. Honey is considered as warm and is specially given to control the temperature of the body.

4.19.5 Allopathic Medicine

Allopathic medicines like Brufen and Disprin are commonly taken for the relief of pain. None of the respondent had ever sought any medical advice associated to menstruating problem.

4.20 Food during Menstruation

In Gumti the concept of *garam/thanda* (hot/cold) classification is closely tied to the reproductive cycle. Imbalances are and must be particularly avoided by menstruating, pregnant and lactating women. Talking here with reference to adolescent of Gumti it is generally perceived that the girl/women is warm during menstruation and must avoid cold foods which cause cramps and irregularities. The state of menstruation is further associated with illness *(bimari)*.

Dichotomy of hot/cold food is very obvious during menstruating period. There are certain foods that are believed to be "hot" and are particularly given to the girls during menstruation. Food that is classified as hot food is tea, egg, and mustered seed. These

foods are specially given during this particular period. While yogurt, water, milk, lemon, turmeric and *Lassi* are believed to be "cold" adolescent girls are withdrawn from cold foods during manses.

Majority of the girls do not consume any form of meat during menstruation because it is forbidden for the fear of having abdominal pain and cramps and secondly it taste and smell is not liked as well. Some of the girls reported no idea of hot and cold restriction during menstruation as well. It was observed that in the daily routine diet of the adolescents the use of milk, protein, and eggs is very little. There are many factors behind it one such factor is poverty.

The socio-economic status of majority of the adolescence is low. Apart from poverty another reason behind it is that eggs and milk is sold for income generation proposes. Every house hold keeps very little amount of these products after selling. Usually less then one kg. Milk is kept at home that is used for making tea. Some times little milk is kept for male members of the family. The consumption of the food in the daily diet of the household in general and adolescent in particular is quite low.

During the month of Ramadan menstruating adolescents remain starving for the whole day. They are afraid of being seen by other while eating therefore they prefer not to consume anything. Even in the absence of male members at home almost no food is consumed. It causes high energy and nutritional depletion amongst the adolescence.

Generally the classification of hot and cold food is observed in the routine diet but during menstruation period it is highly considered. Mothers of the adolescence girls play key role in restricting their daughters to avoid such food.

Chapter-5

RURAL WOMEN: THEIR ANGUISH AND ASPIRATIONS

Health of a nation is dependent on the health of a mother. In order to understand the phenomenon of women health it is important to understand the various aspects of women's health in general and reproductive health in particular. Food beliefs coupled with other cultural practices are one of the key areas that directly affects female health during their entire life in general and reproductive health in particular. This chapter is an attempt to explore such issues at length and it covers two important areas related to women health, first is women routine life activities and perception about their own health. Secondly daily food intake of married, pregnant and lactating women between 20-45 years age group. Dietary habits and routine activities of married woman were observed in general whereas women dietary habits and routine activities of pregnant women were explored particularly.

5.1 Daily Activities of Women

In Gumti a woman has major responsibility regarding management of the household work. She gets up early in the morning and offers morning prayer. She starts her household work even before the prayer. After prayer she manages work related to livestock, cooking, cleaning, milking etc. Women are assisted in household work by their daughters and unmarried sisters' in-law and sometimes mother in-law lends hand in household work. Those women who do not either have daughters or their daughters, are too young to assist them have to manage bulk of work at their own. There are women of agricultural families, landless and poor and rich families. It was observed that women of rich agricultural families do little or not work on field rather labor force is hired from landless communities of the village.

The burden of household work is comparatively low among females of rich families because females of landless communities of the village are hired as domestic laborers. Similarly availability of food is in abundance at rich families because they have high agricultural yield and their purchasing power is also high therefore comparatively

females of these families are less nutritionally depleted. Whereas women of poor and landless families are less fortunate both economically and in getting access to quality food. One thing that was found common among all females despite their caste and economic status was ignoring, sacrificing and forgoing nature of females towards their rights in the interest of their male family members. Particularly this was observed in terms of having food. Females do so firstly to express their love and secondly it is customary to do this.

Women assist male members in their responsibilities related to cultivation, they lend hands in harvesting, work related to agriculture. Basically its male's job but women extend full support in its management both at field and at home. Women take care of harvesting and management of crops (Plate no.6), grazing of animals, bringing fodder and fuel wood. Important to mention here that female work at lapara because it is close to their homes and normally their kin reside around lapara fields therefore female mobility is frequent at these places and purda is not strongly observed (for details see chapter 3, types of land). In the absence of husband she has to manage outdoor activities as well. Some women are involved in income generating activities i.e. selling milk, ghee and poultry products and cottage crafts. A small proportion of women sell dung cakes. This results in getting very little time for her to take rest unlike the women living in urban areas. The life of village women is not only more laborious and tedious but equally stressful.

5.1.1 Women Discussions

Women of Gumti are confined to their houses, they work as house wives. Their modesty is reflected by their *purda* observance. Their only liberty is general discussion and gossip among women folk. Despite limited mobility women have sound knowledge of all sorts of affairs of the village in general and their Dhok in particular. These discussions are generally held at meeting places such as fields, hospitals, wells and various social ceremonies such as marriages, births, funerals, shrines, visiting saints. The main topics which are discussed by women are social affairs, family matters, kin's affairs, politics, livestock and agricultural activities. These discussions serve as a medium of catharsis and pleasure to all of them.

young girls who are getting education discuss matters regarding study and arrangement of various sorts like tuition, transportation and fashion etc. these young girls strictly observe *purda*, and they are effective change agent with enlightened point of view thus they take common affairs more objectively. They play their role in educating their siblings and they also discuss matters with their family members and relatives with somewhat broad perspective.

5.2 Women's Perception of Health

In Gumti health of a woman is given least important in comparison to males and children of the household. Initially women do not consult doctor for ailments and keep on ignoring and lingering disease unless it becomes unbearable to them and they become unable to perform household chores. On the other hand if males have health problems they immediately consult a doctor.

Women of village Gumti perceive that health of a woman and her household chores are reflected in her "chat" its literal meaning is state of being quick and energetic implying that she believes that the work done by her should be nicely done and in quick time. A woman in a FGD said that;

> *"A woman's strength is exhibited through her work, this she does by working effectively and efficiently through out the day without showing any signs of fatigue."*

An unhealthy woman is ignored and criticized for her ailing state because according to set standards for a woman in Gumti she should always remain well and healthy to perform her duties. She should not have ailments like fever because if a woman is suffering from fever then she is unable to perform her duties both at field and at home. Ideal woman should not look pale from her face, as it reflects her general health and well being. Locals believe that health of woman is measured through her working capacity and physical appearance only. A woman who does more work is idealized and praised by all. To keep the image high a woman has to continuously ignore common and some times even serious diseases. More a woman works the more she is appreciated. To reach this standard women ignore their health.

5.3 Community Perception about the Health of a Woman

Community perception regarding health of the woman is not different from women's own perception regarding their own health. Community perceives that a healthy woman should remain fit and engage in work. With work she should set example for others. Another belief is that woman should have pink and white checks and she should neither be too slim nor too fat. A woman said.

> *"Health of a woman is measured either by her face or by her performance at household work. There are no other parameters then these two."*

Another thirty years old woman belonging to a well to Qureshi family said;

> *"In the case of a daughter-in law, her health always looks good to her husband's family nothing matters even if she is suffering from diseases. They believe that they are providing her with the best available to eat and drink."*

Some of the local terms which are used to describe qualities of an ideal woman are the following.

"Akalay wali" literal meaning is wise women implying that woman is active in performing various household chores, works hard and manages household better. Furthermore she provides comfort to her husband and his family members. She takes little or no rest, and knows how to live in difficult circumstances. To win this "title" work becomes her first priority. She has to be vigilant in every field of life. A woman who does not posses these qualities is termed as known as *"Bay akal"* meaning a lazy and unwise woman who does not attend her duties.

Another term is *"Hati Katti"* this term is used in both positive and negative way. In positive sense it describes good health of a woman while in negative sense this term is used in taunting that woman is putting an excuse of bad health, to avoid work. Some times this term refers to a woman who eats enough and workless.

"Taiz Taraz" term is used both ways to describe a 'wise' as well as hard worker. Furthermore, the woman who is skillful and can do easy as well as difficult jobs. Such a woman knows who to deal and reciprocate with others. She lives her life by

understanding the environment around her. In negative sense term *"Taiz Taraz"* refers to clever and deceiving nature of a woman regarding her character or molding the situation in her own interest.

"Susth" refers to lazy nature of female regarding her duties towards her household. *"Kalori"* means ugly implying some one's disliking or jealousy towards a certain person or act.

The above terms and their explanations imply the significance of labour and criteria for setting up merit for an ideal woman in the cultural context of Gumti. In this particular frame these terms it can be said that doing laborious work is one of the basic prerequisite for a woman for seeking appreciation. According to local females generally health of a female seems secondary, ignored and furthermore her diet is understood as a least contributor towards her overall health. Volume of work exhibited by her helps in defining her health status, under this scenario labour becomes top priority for almost every female of the village to get a sustainable image in society. It seems that besides reproduction only and utmost function of a woman is to work all the time. An ideal girl is not supposed to complaint about her health and fatigue. She has to sacrifice her health and diet for cause of work in order to hold a respectable position and high status.

5.4 Beliefs Regarding Food

Inhabitants of Gumti believe that food is something that is a basic necessity for life of any person. Food provides energy to live and carry out everyday jobs. All perceptions that were reflected in in depth interviews (IDIs) carry same idea that food is the basic necessity of life.

Different perceptions regarding food were came up in data. A forty years woman of barber family believes that;

> *"Food should be balanced constituting of goshat (meat), dodh (milk), (mukhan (butter), sagh (leafy vegetables), and desi ghee (pure ghee)* etc."

People believe that food should be simple and less spicy. In a FGD a thirty years old woman said that.

> *"One should eat all kind of pulses, vegetables, pure ghee, meat and salad. In addition to this elderly and children should have a glass of milk daily. To express discriminatory attitude towards married women she further said that only the daughter in law should not have milk because she is not supposed to have it."*

In Gumti woman serves best food to others, and some times she has to sacrifice on her share of food as well. She first serves food to the male members and elderly then her male children and finally her turn along with her daughters comes. When almost all quality food is already taken over by others.

A forty years old woman in an in depth interview said that.

> *"I always keep desi ghee (pure ghee) just for my husband because he does work and he is the bread winner of the household. My children also want to have desi ghee but I hide it from them and seldom give it to them."*

Sacrificing nature of woman continues through out her life in Gumti even during pregnancy she observe more or less the same cultural practices like getting up early in the morning doing regular routine work and sacrificing her food for others.

5.5 Symbolic Roles of Food

Food serves some special purposes i.e. warmth and friendship is expressed through sharing food, giving gifts of food and inviting person to dine. It shows relationships between individuals and groups, such as who will eat together when and what will be served to whom and with whom one has to avoid eating. In every society to offer food is to offer love and affection. In daily life food is first served to male members of the family, remaining is consumed by women (Plate No. 7).

Likewise on the arrival of guests, male guests are served with food first. male guests are made to sit and eat separately in a special room called *baithak* (drawing room) for guests. Close male relatives are also served in this way. Usually male members of the

family accompany male guests while eating. In case of absence of male member of the family elderly female serves food to male guests but she does not eat with male guests. Adolescent and young females are not encouraged to interact with males other then their close family members. Elderly females can interact with males because with the passage of age mobility and interaction restrictions becomes flexible for them and secondly elderly woman in family gains more respect with age as compare to other female of the family. Similarly at different occasions such as marriage, birth or death food is first served to males and then to female guests. Such food consumption patterns may not be interpreted fully as discrimination against women regarding food but such strong cultural practices surely make women less fortunate in having equal quality and quantity of food as compare to male.

According to locals food can be classified as "*tagrri khurak*" means healthy and prestigious food. According to them *tugdri khurak (*healthy food*)* includes chicken, butter, eggs, pure ghee, curd, milk and fruits. This category of food is served to special guests.

5.6 Malnutrition Among Women

Foster and Anderson (1978) define and distinguish "nutrient" and "food". Nutrient is a biochemical concept, a substance capable of nourishing and keeping in good health the organism that consume it. While food is a cultural concept, a statement that in effect says "this substance is suitable for our nourishment" as it is clear from the above definition that food is a cultural phenomenon. People of every society only have food that is culturally sanctioned. Sometimes food carrying ample substantial nutritional value is not deemed as culturally appropriate and is prohibited for person because of prevailing religious taboos, superstitions, and health beliefs. That is why millions of people in third world countries are malnourished or undernourished.

Due to low literacy the locals have little knowledge about importance of food in relation to health as they have inadequate knowhow that which food is nutritionally rich. Generally food has a function to fill stomach. According to them good health depends on quantity rather than on quality of food furthermore sex, age play an important role in

determining quantity of food to be taken. Women and children are fed with less quantity as compare to men because it is believed that their food requirements are less. It is also believed that during sickness a patient needs less food because one can not eat much. Generally locals consume overcooked food that destroys nutritional value of food. There are several reasons for malnutrition among females but the most important are lack of resources, lack of knowledge and cultural barriers.

Majority of the females of the locale belongs to poor socio-economic status. Among them lack of resource is the primary cause of an inadequate food intake that affects their health. poor intake of female is either because of availability or affordability of food. Where as females of rich household are malnourished because of this reason but due to general ignorance towards their health.

Among the locals there is low literacy and lack of awareness towards relationship between food and health and about the nutritional qualities of food that causes deficiency of protein, vitamins and various other nutrients in food. Adequate diet according to them is more dependent on quantity rather than the quality of food. Food is taken only to satisfy hunger. Only few food stuffs, such as milk, eggs, *desi* (pure ghee), meat especially chicken are considered to be healthy not because of their nutritional values but because traditionally they are considered to be superior foods.

Among local women although nutritional problems remain through out their lives but it is more during menstruation, pregnancy and lactation. These are the stages when nutrient demands increases but little attention is paid by the females of the locale at this stage.

A healthy pregnant woman give birth to healthy baby and is capable to satisfy lactation needs of newborn and shows normal recovery after birth. But woman with malnutrition problems produce unhealthy and premature babies. Among females of Gumti data reveals that frequent pregnancies and abortions at short interval and other gynecological disorders are also major causes behind poor health status of women. Malnutrition among infants and children is a result of failure to recognize nutritional requirements of children by their mothers during their early and late infancy. Tendency of

breast feeding among mothers decreased due to repeated pregnancies, abortions and malnutrition. Little variation was observed among rich and educated females. They normal take care of their health and diet. Frequent pregnancies at short intervals drain energy of the mother. Looking after many children results in exhaustion of mother, this leads to lack of interest in preparing weaning food for young children. Females having first pregnancy are treated differently. Attention is paid towards their health both by themselves and other family members. Later large families and limited resources aggravate the situation and parents are usually unable to provide adequate nutrition to children and females.

Social status of women in Gumti village is low as compare to males; they select protein rich items from what is available, leaving less nutritional parts of food to women and children. Secondly, traditions, customs, concept of hot and cold food and taboos associated with food during pregnancy, menstruation, lactation and weaning period creates malnutrition problems among females.

5.7 Woman Dietary Intake during Various Stage of Reproduction

Reproductive role of a woman is very important and critical in determining health status of both the pregnant woman and her fetus. In Gumti a girl has poor nutritional diet during her childhood and adolescence. With this unsound health background a girl gets married preferably by the age of twenty, subsequently she enters into the child bearing stage where she is confronted with additional burden of reproduction with almost the same or less than usual dietary habits. Most common diseases that women of Gumti suffer from were Anemia, Leucorrhea, Backache and variety of infections and deficiencies of various nutrients during and afterwards, some of these diseases cause subsequent complications in childbirth and miscarriage. Majority of these diseases are directly linked with poor and improper intake of food and proper medical care.

5.8 Food Intake during Pregnancy

Majority of the currently pregnant women and women with live births said that their eating trends during pregnancy remained the same as earlier while significant number of mothers said that their diet during pregnancy was decreased because they did

not feel desire to eat. They believed that eating extra food can cause nausea, vomiting and pain in abdomen. Low income is identified as one of the most important factor for poor dietary habits not only for pregnant women but for majority of the people of Gumti apart from this some of the reasons for decreased dietary intake as described by a recently pregnant woman in an in-depth interview are.

> *"A women suffers from stomach burning during pregnancy and her stomach becomes non responsive for the food. Another reason might be child itself."*

Regarding decreases food intake another currently pregnant woman said;

> *"In our village a woman has to do a lot of household work. She gives preference to her work rather than her food while doing so she completely ignores her health or pays little attention to it due to work and poverty."*

Three respondents said that food intake during pregnancy was increased. These three respondents who increased their diet were educated and they knew the importance of healthy food at this stage. For that reason they were conscious about their food intake during pregnancy and afterwards.

A pregnant woman in Gumti has to undergo strict dietary restrictions during pregnancy and postpartum period specially. The classification of food as hot and cold food is strictly followed. Pregnancy is believed as a warm state therefore nearly all food considered as hot are forbidden during pregnancy for the fear of having miscarriage or blood loss. Some of the hot food that are particularly avoided in Gumti during pregnancy are egg, fish, chicken because these foods are thought to be hot that may cause miscarriage, rice are attributed as *Baadi*[3]. Beef is also avoided for the fear of having constipation.

Milk is attributed as good for the health of mother and newborn baby because it is believed that if the mother consumes milk during pregnancy then she will give birth to a

[3] The food that is classified as baadi causes fatness and swelling.

fair complexion child and secondly child will be healthier. Majority of the respondents mentioned slight increase in milk intake during pregnancy subject to affordability. Some of the respondents said that their husbands remain caring about their diet and while coming from duty after a week or a month they bring some fruits. However dietary recall of currently pregnant women showed less than reported consumption of fruit and milk during a month when interviews were conducted. Every pregnant woman desires to take milk during pregnancy it was further found that the women belonging to well off families are in a better position to exercise their desire for food especially milk. Milk as essential intake especially during pregnancy. A woman in an interview said,

> *"Every woman during pregnancy takes milk, however its quantity depends on the purchasing power of the family."*

5.8.1 Case Study

Azra bibi is a 37 years old woman. She got married with his cousin at the age of sixteen. Both her mother and her husband's mother marriage was a *dowathi* (exchange marriage). This unfortunately was not pleasant. Mothers of the couple experienced harsh time with each other. When Azra got married she became a prey to past happenings. Her mother in-law took revenge from her and treated her badly. Azra's husband had careless attitude towards her. In fact she never had good time at her husband's home. She was thrown out of home many times, later her husband remarried as a result Azra permanently left her husband's home without seeking permission from her husband, she was not divorced. At present she is living alone for the past fifteen years along with her three children including her two young daughters and a son.

During entire separation period her husband never attended her or extended any social or economic support to them. Azra lives at her mother's home at initial stages of her separation she wanted to work but her brothers stopped her then she reared a baby buffalo to generate income for her household. When Azra was living with her husband she had a miscarriage followed with gynecological complications for which she never sought any medical treatment till now. As a result of that she is facing irregular menstruation with high bleeding happening more than thrice in a month with Azra tells about her problem.

> *"Due to miscarriage I have some unknown disease inside my body. You see that after conceiving a baby or even after the miscarriage one gets clean after postpartum period but I am still suffering from bleeding since then. What has happened to me inside? I do not know. I have never been to doctor till today I have too much pain but the time is passing like this. I have menstruation more than thrice in a month."*

Azra is severely anemic because she is suffering from gynecological disorders since long. She never got proper treatment for her disease. She feels ashamed to discuss about her disease to a male doctor. Besides poverty and her neglected attitude towards her health. She consumed poor diet during all her pregnancies and afterwards through out her life.

Azra worked hard to educate her children. One of her daughter left after matriculation while the other was doing intermediate from Islamabad. Important to highlight here is that her daughter is first girl of the village who has migrated from village to seek education. She is residing with her maternal uncle. Azra's son is psychiatric patient. She thinks that improper diet and negligence towards her during and after her pregnancy had adversely affected her son's health.

Azra hardly meets financial requirements of her house and expenses of her daughter's study she says.

> *"At present we have insufficient finances to meet our requirements. I hope that time will come when we will have sufficient to eat and wear."*

Regarding diet she said,

> *"I never brought fruit to my home whenever my brothers visit us they bring fruit. I never eat fruit and meat. I try that my share is taken by my children that is sufficient for me because it gives me pleasure."*

Azra along with her adolescent children is struggling not only for a better future and health but also for minimal level of hunger satisfaction that already had great bearing on her own health.

5.9 Care Provided to Pregnant Woman

Nearly all the respondents said that level of care regarding food and assistance in household work from both in laws and parents side was high at the time of their first pregnancy. Only in subsequent years such special treatments were less. Some of the areas where a women is more caring at the time of first pregnancy are avoiding of "*atta kondna*" (mixing flour), "*taki lagana*" (cleaning) floor with wet cloth in a sitting posture, washing clothes, lifting heavy things etc. During pregnancy period they are provided assistance in these chores their mother, mother in law, sisters, sister in laws. After the birth of a child till postpartum period all her household jobs are looked after by these females. Majority of the respondents said that the level of care after pregnancy depends on sex of the child. More importance is given to both mother and her child newborn child if it is a boy. Majority of birth take palace at home and preferably at husbands home. Another reason for less care towards pregnant woman and her child is noted when she has a nuclear household then she has to manage all household work alone.

5.10 Health Seeking Behavior during Pregnancy and Delivery

It was observed that generally pregnancy is recognized by stoppage of menstruation. In Gumti there is almost no concept of seeking antenatal or postnatal care however slight antenatal care was sought by only two respondents. Husband of both these respondents were working abroad. One of the respondents who sought antenatal care already had gynecological problem therefore she had to seek medical assistance in the beginning.

It is believed that antenatal and postnatal care is only needed in case of emergency. Nearly all respondents said that they never sought such care. Secondly it is believed that pregnancy is a divine matter.

5.10.1 Visiting Saints and Shrines

Religious and spiritual treatment is most common practice of all respondents. Locals have a strong believe on shrines and saints *(Pirs)*. Particularly women of the village pay frequent visits to *Mazar* (shrines), *Darbar* and *Pirs* both within and outside the village. Special wishes are made for having a son. Pregnant women request *Pir* to do *Duwa* (pray) for them to have safe pregnancy and boy baby. Special prayers are made by saint for fulfillment of desires of a person. It is believed that a saint is a pious person and is near to God. God will listen what ever he is asking for. *Pir* gives pregnant women special *tawiz* (amulet) to drink and to tie around abdomen which is believed to serve purpose of avoiding miscarriage and evil eye during and after pregnancy. Women give certain amount to *Pir* or at shrine as *Hadiya* (homage). Most of the time sweet dishes i.e. rice pudding and *Halwa* (batter pudding) or *Pullao* (mutton/chicken fried rice) is distributed at shrines before and after fulfillment of the desire.

Spiritual treatment is considered as a source of satisfaction and *sawab* (reward). It gives internal emotional strength to a person. As it is a general practice in Gumti to visit shrines and *Pirs*. Regardless of certain age every one is *Bait (cane)* of a specific *Pir*. These routine cultural practices compel women to have this treatment.

In some cases it was observed that *Abb-e-zamzam* (sacred water from Makkah) is given to women at the time of delivery. It is thought that woman will have less painful labor as a result of sacred water.

A woman in an interview said,

> *"My husband brought a flower and Abb-e-zamzam from Makkah. It was given to me on pre-delivery pains. After that severe pains started and my son was born after an hour."*

5.10.2 Health Services

Generally women of the village seem less concerned towards their health however two types of health services are consulted by women.

1. Hakeem

2. Dai.

5.10.3 Hakeem

Generally treatment of *Hakeem* (traditional healer) is preferred in Gumti. People believe that his treatment is better than allopathic treatment because herbalist treats with herbs that are not only good for health but also have no side effects. During pregnancy antenatal and prenatal health care is not sought by women. *Hakeem* is consulted for different types of diseases during pregnancy most common of them are blood spotting, vomiting, fever, weakness etc.

5.10.4 Dai

In Gumti Traditional Birth Attendant (TBA) is known as Dai. She is usually an old lady who does not have any specific training for conducting deliveries, but she learnt it through experience. Reproductive behavior of woman is governed by indigenous beliefs where pregnancy and delivery are considered as a divine matter. *Dai* holds strong position in rural culture from centuries. In Gumti presence and services of a *Dai* cannot be ignored as majority of the pregnancies are conducted at homes by *Dai*. *Dai* is famous for her experience and wisdom apart from this she is considered as cheapest service provider. In Gumti *Dai* is easy to approach because of her geographical proximity and readily availability. Services of *Dai* from neighboring villages are also sought. In Pakistan an average of 92% of the infants are born under the medical supervision of a *Dai* or some relatives, are usually breastfed for at least one year and probably half of them do not get any supplementary food until age one (NIPS, 1992). Similarly PDHS found that three-fourth of the pregnant women received no antenatal care at all and only 30% saw a medically qualified person. Vast majority of deliveries (85.2%) took place at home and most of them were attended by *Dai*s or TBAs (Mahmood, 1992).

Dai is also consulted at the time of miscarriage. *Dai* treats patients with risky practices that may lead to death of both the mother and new born. In recent past A few women died while giving birth.

Services of *Dai* are sought in village since long however with the passage of time change has been observed in the behavior of people as some of the respondents in their in depth interview expressed their concerns towards the treatment given by *Dai*. Some of the educated respondents said that *Dai* is not well equipped and trained as in most of the cases where women suffered from heavy and prolonged bleedings after miscarriage and child birth she is unable to recognize and treat such problems. Such experiences led women of the village switch to deliveries at hospitals i.e. private Health clinics mostly run by nurses. Some people still prefer *Dai* because of affordability and privacy. *Dai* extends services of massage before and after delivery some women only seek massage services of *Dai*.

5.10.4.1 Case Study

Hajra Bibi a 35 year old married woman. She is mother of four children including three sons and a daughter. Recalling her health experiences she told that after few years of puberty suddenly her menstruation cycle got disturbed and finally stopped consequently she experienced immense hormonal disturbance followed by thick hair growth on her body. Initially she tried to hide this change from other but it did not last too long. After some time news of Hajra turning into a male spread in village.

> *"People of our village are ignorant. I remember that after the spread of this rumor that I turned into a boy, people use to come and see me and I had to face strange looks by every one."*

Hajra's mother was also unable to bear medical expenses of her daughter's disease. Then one of her cousin who works abroad lends money for her treatment. Doctor told her that she had a tumor in her uterus that needs to be immediately removed. Doctor advised her family to get her married before surgery. Then she was left with no other option to marry her cousin whom she did not like. After her marriage and successful operation she got pregnant and gave birth to an abnormal baby girl who survived for two years.

Recalling disease and death experiences of her daughter Hajra told that initially she and her family was unable to recognize that her daughter is suffering from some

serious disease. She was just having continuous fever for some days. Her fever was taken light. She was given home remedies and some visits to saint were paid but it brought no result, with the passage of time her diseases aggravated. Finally she was taken to different doctors but she could not be saved. After her death Hajra gave birth to three normal children and one abnormal male child. He had similar symptoms like her deceased daughter.

Similar behavior was adopted towards his disease as her husband was not able to afford his treatment therefore her child was confronted with improper medical care and negligence (Plate no 8). Despite serious gynecological problems, all her deliveries were conducted at home. Hajra said;

> *"At the birth of my second son I had severe bleeding. When I tried to stand I was unable to do so and even I was unable to recognize any one from a little distance. I got headache and weakness."*

Hajra's husband has recently gone abroad and is working as a laborer, he earns little money. Hajra told that during past four months her husband had send them only ten thousand rupees that is insufficient to meet expenses of the family. Hajra has to invest a large proportion out of this small amount on milk and diet of her youngest son and his treatment. She has to pay tuition fee of her three children and has to meet other household expenses as well. She is of the view that she hardly manages the situation by cutting down food expenses of her three other children. With tears in eyes she expressed.

> *"Believe me when I receive money from my husband after several months then I once bring chicken to my children. Some times it becomes hard for me to buy any vegetable. If my children have proper food then they can become healthy."*

Telling about managing the household she said that she utilizes one month budget in two months to sustain living of her household. She keeps one curry for two days. Despite having such difficult time she some times gives milk to her eldest son, as a mother she thinks that her son is studying and getting weak therefore he needs extra care. Hajra never had any special diet during pregnancy because economic conditions of her

household always remained desolate. She is suffering from irregular menstruation and severe backache. Black circles around her eyes tell story of her health which is continuously ignored.

5.10.5 Medical Treatment

A basic Health Unit (BHU) is present in village but it is not preferred by the people of village particularly by women and young girls even for the treatment of common diseases. The villagers think that services provided at the BHU are not good. Medicines provided to a patient at BHU are spurious and expensive. Similar observations were highlighted by all the women in focus group discussion. A woman of Daniyal family tauntingly said.

> *"In BHU no matter what kind of disease a person is suffering from is given same medicine. The one who has cancer, the one who has hepatitis and the one who is pregnant is given same treatment and medicine. All patients are given same tablets, syrup and a water filled injection."*

Another reason is that there is a male doctor at BHU. Women of Gumti avoid seeking medical treatment from male doctors. Although few Lady Health Workers (LHW) are also working at the hospital but they are not generally trusted by people of the village as in Gumti because of poor health facilities available at BHU. LHWs are thought to provide services during polio vaccine scheme only. The other observation behind mistrust towards Lady Health Worker was their careless attitude towards their duties. It was noticed that they rarely visit community. Most of the time LHWs makes visits for different health campaigns.

In some case it was observed that though the pregnant women were willing to go to delivery at a hospital or a private clinic but they were restricted by their mothers in-law and husbands for many obvious reasons. They believe that services provided at BHU and private clinics are not trust worthy. Secondly the family does not except and allow her to be treated or examined by a male doctor. A woman in an in depth interview said,

"BHU has got insufficient facilities to conduct deliveries. The delivery room has got no heating facility. Once my sister in-law went there for delivery I forcefully tried to bring her back to home but she refused by saying that she was unable to move. She had a bad experience of giving birth to a baby at BHU as her child died the same night due to indifferent attitude of BHU staff. Contrary to my sister in law's experience my children are born by the assistance of Dai at home therefore they are healthy."

5.10.6 Nurses

A few years back all deliveries were conducted at home by *Dai*. In recent years a change towards seeking medical treatment has emerged. Resent history reveals that some women of locale consulted nearby Nurses for delivery. Out side Gumti there are four private clinics run by the LHV and Nurses. These Nurses established their own clinics either after serving some time in gynecological departments in hospitals or after assisting some female gynecologist for some time. None of them hold professional degree for extending such type of services. Lady Doctor is available at Gujar Khan Hospital. This hospital is far from Gumti. The reason for shift from *Dai* to nurses in some cases is described by a Kunyal woman as.

"Until recent past all the deliveries took place at home but now women go to the private clinics because some woman died while giving birth at home that has made other women scared therefore they go to private clinics."

Those pregnant women who prefer private clinics have to bear heavy expense i.e. clinic & health provider charges, medicine, food and transport expenses of both the patient and attendants. A poor family cannot afford these expenses therefore home deliveries are preferred.

At household level no advance planning is made to foresee future problems at the time of delivery. Decision of taking a woman to the hospital for delivery is usually made by husband of the pregnant woman. In case of his absence his family particularly the male members take decision that is conditioned to consent of her husband.

Neighbors were mentioned as a prime source of help and assistance at the time of delivery. Neighborhood women usually gather at pregnant woman's home at the time of delivery to extend support i.e. they provide assistance in household work, massage pregnant woman while male help in calling *Dai*, or arrange vehicle in case of institutional delivery.

Important to highlight here is that vehicle cannot reach every household of the village and secondly condition of the link road to the hospital is in terrible condition resulting delay in reaching the hospital.

5.11 Food Intake of the Mother during Postpartum Period

Hot food is preferred during postpartum period. Because it is believed that hot food is good for mothers to regain their energies. Most common hot foods that are given to women during postpartum period are *panjiri.* It is made by combining various dry fruits and ethno medicines like almonds, pistachio, '*sonf*' (Aniseed), sundh (dry ginger), koya (condensed milk) and *khushak* maiwa (dry fruits). All ingredients are classified as hot food. Women after giving birth consume panjiri for 15-40 days.

These foods are considered rich and effective in restoring and regaining health of the mother therefore they are consumed in plenty during postpartum period.

For the initial three days after child birth *Halwa* is considered as best food for mother because it is considered as a light, hot food and easy to digest. Some women reported that in initial days after their delivery they only consumed *Halwa*. Generally *Halwa* is regularly consumed by mothers during postpartum period. Solid foods i.e. *Roti* home made bread or food items comprising bread i.e. *Churi* (made by mixing home made bread, pure ghee and sugar) is avoided by mothers during the initial days because it is considered as heavy and hardly digestive food and second fear is that it may cause bad effect on both mother and child's health.

In majority of the cases women mentioned that before every pregnancy 2 to 5 Kg of pure ghee is purchased in advance depending upon the budget of the household that is to be consumed during the postpartum period. It was observed that woman do not solely

consume this special food that are particularly meant for her eating. A woman in an interview expressed that.

> *"It does not matter if husband or family of the woman shares in eating ghee or panjiri. Normally other members of the household do not eat special food made for her but she herself share it mostly with her husband and in some cases her children too."*

A woman said,

> *"Ghee is a must after delivery. Every one regardless of being poor or rich purchases three–four kg of desi ghee for pregnant woman which she consumed during Chilla (postpartum period)."*

Food classified as cold are milk, lassi, rice and sour fruits therefore forbidden during postpartum period. These foods are perceived to have harmful effects on health of new born and mother. Women are advice to drink boil water as normal water may led to increase mother's tummy afterwards. Some mothers consume Luke warm water during postpartum period. It was observed in majority of the cases that woman raise poultry during pregnancy to yield meat and eggs for postpartum period.

Mothers and daughter were considered as a great source of help to a woman in postpartum period. They provide assistance in various household cores.

At the birth of male child mother is served with best food. Special care is taken regarding food served to her while on the birth of female child less attention is given by her family members. Food discrimination at the birth of female child was quiet obvious in many cases.

5.12 Food Intake of the New Born

Ghutti is the first ever food that is given to new born. It is perceived as best food for the new born. *Ghutti* is made by cooking jamain (parsley), *sonf* (aniseed) and sugar in *desi ghee* (pure ghee) after filtration and cooling prepared fluid is given to the newborn so that the new born can easily suck it. No food except *Ghutti* and boiled water is given

to newborn for at least three days after the birth. After three days Mother's milk is given to the newborn. It is perceived that initial dosage of colostrums of mother is not good for the newborn as believed as sour.

A woman in an interview said that.

> *"I started feeding my children after three days of delivery and first bath of newborn. I never breast fed my newly born children during first three days. In these days child was fed with boiled water and Ghutti."*

It is believed that the one who gives '*Ghutti*' to new born transfers his/her personality's trait to the baby. Sometimes village '*Molvi*' is requested to perform this task.

Health of a new born baby is generally poor according to the observations of local women generally at the time of birth majority of the newborns in village are weak and in poor health. A woman said in a FGD.

> *"In* Gumti *a child at the time of birth is very weak then mother of the child takes good care of the children then the baby gradually becomes healthy."*

Daily diet is one such area where discrimination against female is quiet obvious since birth male child is given preference over her in terms of food and care. Majority of the respondents said that they breast feed their male child longer then female child. Abrupt weaning of a child is starts at age of five months by giving child loaf of bread or bone etc. Child weeping is associated with sign of hunger by the child.

A child is carefully fed up to the age of one and a half year, later on child starts eating with adults. With the passage of time and age female child is socialized to eat after male members of the household. She remains less fortunate regarding food as she is always on sacrificing side. Mothers always give preference to male child and their husbands. In a focus group a twenty-eight years old woman said,

> *"I am unable to take care of my daughter's health even if I wanted to do so because my mother in law says that male*

child should be given preference and must be given every thing to eat. It should not be given to a girl? She is not going to live in this house for long. My girl is very weak if she says that she is not feeling well or having pain in the abdomen then I ask her not to eat meal with curry rather I give her some milk. Once my mother in law saw me doing this then she got angry at me. When my son came back to home she said to him that your mother takes work from you and gives milk to your sister not you. She asked him to pretend that he is having pain in the abdomen like his sister so that he is given milk."

5.13 Health Seeking Behavior during Postpartum Period

All the respondents except a few believed that there is no need to seek any health service during postpartum period. The health services should be sought in case of severe problem or complication. It is further believed that women and children should remain inside home unless it becomes very necessary to move outside home for the fear of avoiding evil spirits and change in temperature. For both mother and child sudden changes in temperature are not thought to be good for their health. During postpartum period mother and child are not allowed to sleep alone for the fear of felling prey to the evil sprits. To avoid evil spirits iron things such as knife or rod is placed below the pillow of the mother.

5.13.1 Treatment of *Dai*

The only care that is provided to a mother after delivery is massage by *Dai* at least during initial ten days of postpartum period. It was found that there is no trend of having massage on birth of a female child. *Dai* usually charges five hundred rupees for ten days massage. In case of male birth she is given a silk suit and sweets along with money.

5.13.1.1 Case Study

Farzana is a 40 years old woman with nine children and three miscarriages. Last time she had a miscarriage 10 years back before the birth of two of her youngest kids. At that time she suffered from excessive bleeding for three months because of her miscarriage. She could not timely manage to seek medical treatment and *sufai* (procedure

of dilatation and curettage (DNC)). When she was about to die due to over bleeding then she was taken to Gujar Khan Hospital where she was undergone DNC. She had a narrow escape from death since then Farzana is unwell. Her body is swollen. She is suffering from both leucorrhea and arthritis. She told that she never sought any medical treatment for her diseases expect taking medicine from few *Hakeems* (traditional healers) but every thing proved ineffective. She is still surviving with all her health problems believing that,

> *"Every one has to die one day."*

The reason Farzana told about miscarriage was due to *pachama* (obsession by evil spirit or a woman who lose her died before delivery or after delivery) Having seen by a woman who had miscarriage or who's child is born died after birth is believe to have strong effect on other women and young girls which can cause the same to happen with them. This effect is very strong at the time of first bath of mother. It is believed that after the bath the first thing that she sees begets effect of *pachama*.

She told that when she was going outside her home she saw a women whose child died just after birth. To cut effect of *pachama* she made few trips to *Pirs* and drank *tawiz* (amulet) by mixing in water. As a result of that she got better.

Farzana had nine children (five daughters and three sons) and three miscarriages but her diet remained the same as other member of her household. She said,

> *"I ate what ever was available. If I got nothing to eat even then it did not matter to me. I remember during pregnancies I ate the same like other family members."*

She never went for any antenatal care or postnatal care and all her deliveries were conducted by *Dai* (TBA).

Chapter-6

SUMMARY AND CONCLUSIONS

The present research was aimed to study the impact of food beliefs and practices on the reproductive life women of a typical girl/woman of village Gumti falling in the age bracket of 13 to 45 years. The present study was specially focused to highlight various dimensions of adolescent's lives because this age group is very critical and crucial regarding growth (both physical and mental), development and preparation for the future roles.

Dietary habits and various cultural practices once developed during this stage are likely to persist throughout the life of a woman. Health in general and food intake of a girl/woman in particular is the most neglected side. Malnutrition is a serious health problem in Gumti. Infants, young children and women are identifies as high risk group. Rural populations are especially prone to malnourishment and malnutrition because they are more likely to be poor (Tinger, 1998).

Major objectives of the study were to understand the perceptions of women of reproductive age group about their health in general and reproductive health in particular. The study explored the reproductive health problems of adolescents of 13 to 19 years age group. Overall the study explored the existing dietary trends and their effect on the health of a girl/woman of reproductive age group.

Birth of a male child is a moment of great joy to the family while the birth of a female is a moment of sorrow. Since birth a child has to face discrimination in almost every aspect of life and she is given a status of "lesser being" because her stay is viewed as temporary while male child is considered as a permanent support to the family. Male child is valued by the family because he is the "bread winner." These differences are quiet obvious regarding the preference given to male child regarding quality and quantity of food through out life.

A girl is consider as a child up to the age of seven even after that age a girl has to remain at home she is not allowed to move outside her home alone and she has to always cover her body with *dupatta* (a long piece of cloth). Girls from early childhood start participating in the household cores in contrast male children of the same age group enjoy more freedom. With the onset of menstruation a girl is given a status of an adult with more strict observance of *purda* and restrictions on mobility.

Girls are not prior told about the future puberty changes particularly about menstruation study found that first observance of menstruation is a phase of mental stress of majority of the girls as they are not mentally prepared for this change. Further more girls/women remain unhygienic during menstruation. They use old cloth for the practical management of menstruation that cloth is not properly washed and dried and it is reused that increase many gynecological problems like various type of infections, allergies. Leucorrhea was found a common disease among majority of adolescent girls and women.

Adolescent girls do not seek any medical advice for the treatment of disease because it is believed as a shameful act to tell doctor about such diseases. Young girls are only taken to the doctor in case of extreme emergency only. Although adolescent girl suffer from my gynecological problems like irregular menstruation, leucorrhea various type of body pains and even having fever remains unreported to the doctor. The presence of such diseases at the early stage of adolescent clearly indicates the signs and start of poor reproductive health that are likely to persist in the future life of adolescents. For the treatment of general diseases preferred mode of treatment is ethno medicine for adolescents. In contrast to female adolescents males of this age group have the freedom and support from the family to consult the doctor for general ailments. Male of this age can easily visit the doctor alone.

It was found that male and female are considered two separate spheres in Gumti, in all fields of life similarly they are differentiate while having food. The eating schedule in Gumti is three meals in a day i.e. breakfast, lunch and dinner. Gender differences and discrimination among female child is quiet visible for all the three meals. Mother's differential attitude is observed when she is in the kitchen. She not only gives preference in serving to male members of the household usually her husband and sons. She feels it

her duty to provide the best of the food in both quality and quantity. When they had eaten enough, the remaining is eaten by her along with her daughters.

Mothers give priority to husband and son and serve them with eggs, meat, milk and fruit etc. this discrimination caused by mother passes on to daughter from the early stages of her life so that she can amicably handle her future roles and comply with the existing traditions. Mother socializes her daughter in the same spirit.

In the light of the weekly and monthly recall of the diet of the respondents the data reveals that intake of protein and other important vitamins and minerals is quiet low in the daily diet of the adolescents/women. Fruit is occasionally consumed by majority of the respondents. Fruit is brought home twice or thrice in a month only. Again it is little in amount in comparison to the need of every member of the family. Fruit is served to the male and child members first after that if the remaining is left for the females.

Study found that when this discriminated girl becomes authoritative after marriage in certain aspects of her life she exactly treats her daughter in the same manner and she is socialized like wise in this way this is a true tradition which is carried out in Gumti from family to family and generation to generation.

It was found in the study that the status of an adolescent girl/woman health is measured by the amount of work she displays. More she works more she will be idealized by the community. Girls are socialized to take active part in household work from early childhood to live a successful life in future.

In Gumti the concept of *garam/thanda* (hot/cold) classification is closely tied to the various stages of reproductive cycle. A girl has poor nutritional diet during her childhood and adolescence and after that when she enters the child bearing stage after marriage she is confronted with additional burden of reproduction with the almost the same or less than usual dietary habits. Most common diseases a women face during pregnancy are Anemia, Leucorrhea, Backache and variety of infections and chronic deficiencies of various nutrients that are responsible for subsequent complications in childbirth and miscarriage. Majority of these diseases are directly linked with poor and improper intake of food and proper medical care.

Study found that the food intake of majority of the currently pregnant women and the women with live births either remained the same or decreased. They did not want to eat any thing most of the time because of vomiting, nausea and pain in the abdomen. Poverty is identified one of the factor for the poor dietary habits not only for the pregnant women but for the majority of the people of Gumti.

Some cultural practices have very negative effect on the health of both mother and the new born i.e. not feeding the breast milk in the first three days considering it bad for the health of newborn. Mobility restrictions for mother during postpartum period.

Medical mode of treatment was reported as the last resort as the people of the village are not satisfied with the medical services provided to them. Majority of the deliveries are conducted by *Dai* (traditional birth attendant). Degree of mistrust on the services provided at the Basic Health Unit is alarming as the indigenous people are avoiding it hence the medical institutions are not preferred by them. Sale of spurious patent medicine and fake treatment of diseases are perceived to be the major causes. Study found that the reproductive health status of women of village is dismal because of their economic backwardness and lack of trust on modern services available in the village. Women prefer treatment from *Hakeems* (traditional healer), *Dai* (traditional birth attendant) and nurses and seek satisfaction from the spiritual healing of a *Pir* (saint) medical treatment is the last resort. LHW role is perceived as vaccination agent only.

6.1 Recommendations

In the light of this research work following recommendations can be made to apprehend the attention of concerning authorities in making any policy for the improvement of health of the adolescents and woman.

- From evidence available there are compelling reasons for the local government institutions and relevant Community Base Organizations (CBOs) to jointly undertake initiative to forester social, economic and cultural cohesion in the communities in order to ensure their fundamental rights.

- While the status of women nutrition in the cities has advanced somewhat in the urban communities with particular reference to nutritional intake. This sector remains critically unaddressed in rural communities.

- Rural women suffer from lack of appropriate food quality as well as food security evidence reveals that rural women not only lack appropriate food security but also lack of empowerment.

- In view of the lack of proper education about nutrition it is important to undertake the following steps to facilitate their advancement. Measures should be taken to ensure that appropriate framework should be formulated primarily for nutritional intake and food security of women. In order to ensure that adolescence and childbearing age group should be protected from rigors of pregnancies.

- Measures should be taken to provide better nutrition and education to women along with imparting training on equal access of women to livelihood and nutritional efficacy.

- In order to achieve a general educational environment in which health needs and education pertaining to proper food intake and nutritional diet for women it is important that flexible awareness program should be launched. These methods should be developed on the base of the data available on the subject through the present research.

- With in the framework of making food security a vital and sustainable program measures be taken by involving local rural women in any nutritional development polices.

- Poverty in rural areas hinder the affective participation of rural women not only in their health and educational services but also in decision making activities that lead to destabilizing the process of community development at the grass root level. Such issues should be addressed at every stage.

- To make rural women participate in decision making it is crucial to build their capacity so that they can undertake responsibilities that are important for the rural development agenda.

- To make the modern health services including Mother and Child Health (MCH) more acceptable. It should be reoriented in accordance with the cultural cognition of the people of the rural areas with in the broader framework of modern medicine. Lady health worker role should be made more effective by providing her further trainings to win the trust and confidence of the intended beneficiaries.

- To address the traditional belief system a new system needs to be designed to cater the health requirements of the people of village in general and women in particular. This new system should be participatory one where the local people, their traditional healers and their ethno medicine be involved to increase the efficiency in the health sector.

- In the light of this research it is important nay significant that any formulation of strategies designed to alleviate the problems of rural women and adolescents have to base on a holistic and comprehensive paradigm of implementing tools. All the areas explored in the present work not only cry out for itself but are critically integrated with all policies and programs directed for the welfare, education, social and economic uplift and rehabilitation of women in the rural communities such as Gumti and other surrounding villages.

GLOSSARY

1.	Allah	Name of God
2.	Ameer	Rich
3.	Aklay wali	A woman who is wise
4.	Anda	Egg
5.	Andi gawandi	Neighbours
6.	Aulad	Decedents
7.	Azan	Muslim call for prayer
8.	Bacha	Minor boy/male child
9.	Bachi	Minor girl/ female child
10.	Butky	Ancestors
11.	Baji	Elder sister
12.	Barri	Land
13.	Bay	Old lady/ old term use to call mother
14.	Bay akal	Unwise woman
15.	Bay aulad	Childless
16.	Bimar	Ill/ word is also used to refer to a pregnant or menstruating girl/woman
17.	Bladri	A group of people from whom sentiments of a frontal kind are expected
18.	Cha	Tea with milk
19.	Chaliyan	Postpartum period
20.	Cheela	Head scarf
21.	Chilm	Clay pot used for smoking tobacco

22.	Chula	Fire place
23.	Dai	Traditional birth attendant
24.	Dair	Husband younger brother
25.	Dadapotri	Father's brother daughter
26.	Dadapotra	Father's brother son
27.	Dalain	Pulses
28.	Dhok	A geographically identified village section
29.	Dowathi	Exchange marriage
30.	Eid	Muslim festival celebrated twice in a year
31.	Garam	Warm/hot
32.	Gharib	Poor
33.	Ghee	Purified butter
34.	Ghutti	First food given to the new born
35.	Hakeem	Traditional healer
36.	Handi	Curry
37.	Hati katti	Healthy woman
38.	Kawa	Tea without milk
39.	Izzat	Honor
40.	Jaith	Husband elder brother
41.	Jamai	Son in law
42.	Jamain	Parsley
43.	Jamatra	Son in law
44.	Jharu	Proom
45.	Jawan	Grown up

46.	Kami	A person from inferior caste
47.	Kanak	Wheat
48.	Kaprey kharab hona	experiencing menstruation
49.	Katvi	Pot for cooking curry
50.	Lohar	Blacksmith
51.	Mahwari	Menses
52.	Makh	Maize
53.	Makhi	Honey
54.	Mardana kamzori	Male impotency
55.	Masi	Mother's sister
56.	Mseet	Mosque
57.	Mazar	Shrine
58.	Molvi	Spiritual leader
59.	Nai	Barber
60.	Namashay	Time after sunset
61.	Naqab	Veiling of face with long piece of cloth
62.	Nazar	Evil eye
63.	Nouh	Daughter in law
64.	Pait	Abdomen
65.	Paishi	Afternoon
66.	Paniya	Sister's husband
67.	Panjidar	People involved in reciprocity of gifts at marriage birth, death, illness etc.
68.	Papa	Elder brother
69.	Patti	Tea

70.	Ptwari	A government official who keeps land register, geologies and statistics
72.	Payn	Sister
73.	Perjai	Sister in law
74.	Phal	Fruit
75.	Pir	Saint
76.	Poutra	Son's son
77.	Poutri	Son's daughter
78.	Podna	Mint
79.	Purda	Veil
80.	Putar	Son
81.	Qabristan	Graveyard
82.	Rishtydar	Relatives
83.	Roti	A pancake of wheat/bread
84.	Sawa	Green color
85.	Sawab	Any act to please God for the sake of having reward on the day of judgment
86.	Shalwar	Trouser
87.	Sufaid pani	Leucorrhea
88.	Taiz taraz	Clever woman
89.	Thanda	Cold/cold
90.	Taviz	Amulet
91.	Teeh	Daughter
92.	Qabeela	Tribe
93.	Zanana bimari	Gynecological morbidity

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Annex No.1

In Depth Interview Guideline of Adolescents

1. With whom you are very close at home?
2. What is the reason for closeness?
3. Up to what age a girl is considered as child in your village?
4. What are the attributes for a girl in your village to be taken as young/adult?
    - Symbolic resemblance to elder females?
    - Changes in the attitude
5. Who is given more important at your home?
6. At what age a girl of your village starts covering her head with the Dupatta?
7. At what age you started covering your head?
    - Cover head fully all the time
    - Partially cover head
    - Cover head when outside home
    - Fluctuations
8. Who advise you to keep the dupatta? What happens on violations?
9. What type of dupatta do you wear when you are at home & out side your home?
10. While working at home can you keep the dupatta around your neck?
11. Are you allowed to wear half sleeves shirt in/outside your home?
12. If not, then why not?
13. Do you have a passion for education?
14. Up to what level you intend to study?

- Have you ever studied in co-education? If not then what was the reason for that?

15. Who accompanies you while going to school?
16. Is there any advantage of studying? If you would have been illiterate then, how it may have affected your life?
17. If your mother would have been educated then would her life be different from her present life?
18. Generally on what matters your parents guide you?

    - On what matters do they stop
    - Who stops reasons?

19. What are the restrictions on you by your parents on your mobility outside your home?
20. Are you allowed to talk with males?
21. What household chores you perform in a day?
22. Do you assist your mother in work?
23. Can you easily share your personal problems/feelings/concerns with your mother?
24. What was your age of menstruation?
25. Did you had any prior knowledge about menstruation and physical changes before you experienced yourself?
26. If yes then who told you?
27. How was your first experience of menstruation?

    - Place

- Response
- Management of menstruation cycle

28. What do you do when you have menstrual problem?
    - Consult Doctor
    - Use home remedies/ethno medicine
    - Others (specify)
29. What household chores you perform during menstruation?
30. What is the duration and flow of your menstrual cycle?
    - Heavy flow
    - Low flow
    - During that period how many times you take bath?
31. What food do you take during menstruation?
    - Routine food
    - Fluctuations (specify)
    - Hot/cold food issues
32. Does your mother stops you from eating certain food due to its hot/cold effect during menstruation?
    - Restricted from doing certain kind of work during menstruation
33. 35. While experiencing menstruation during the month of Ramadan do you take breakfast and lunch? Or you eat with others in the evening?
34. How do you take care of your personal hygiene?
    - During menstruation
    - Extra hair growth
35. What is your perception about food?

36. How much food do you consume in a normal day?

37. In what quantity do you consume these items in your meals in your daily, weekly and monthly diet?

- Fruits
- Mea
- Milk
- Eggs
- Butter

38. What is the pattern of eating food at your home?

- Who eats first
- Eat jointly

39. What about use of listed food item at your home on daily, monthly basis?

- Fruits
- Meat
- Milk
- Eggs
- Butter

40. At present do you have any health Problem?

41. Have you ever gone to the doctor for any disease?

- Why?
- When?

42. Do you have Leucorrhea?

- If yes then what treatment you sought?
- Why did you prefer this treatment why not the other one?

43. Does your mother have any health problem?

44. What is done when some one gets sick at your home?

- Home remedies
- Consultation to health physician

45. Who gets worried at home when you get sick?

46. What that person does for you?

Annex No.2

In Depth Interview Guideline
(Women of 20-45 Years of Age)

1. What household work you do in a day?
2. Does any one assist you in your routine work?
3. How many times you take meals in a day?
4. Who prepares meals at your home?
5. Who decides what to be cooked in a day?
6. Can you name which food was cooked at you home during last week?
7. Had any guest came to your home in past few days? Week/Month?
8. If yes, then what was cooked for the guest?
9. Do you normally eat the same type of food that you consumed during the past week?
10. How many times in a day food is cooked at your home?
11. How much milk your household members consume in a day?
12. If you sell milk then how much do you keep for your household needs?
13. How this milk is consumed?
14. In a day how many times tea is made at your home?
    - Timings
    - Kind of tea
15. Which oil is used for cooking at your home?

16. Which salt do you use?

17. Which fruit were brought to your home in last week/month? (Specify quantity)

18. Who brought fruits?

    - Guest(s)?
    - Family Member?

19. Who consumed fruits?

20. Is similar quantity of fruits is often consumed by your family?

21. What are your household's own agricultural/poultry productions?

    - Crops
    - Livestock/Poultry
    - Milk/Ghee/Butter

22. Which consumable items you have to purchase from market?

23. How much meat is consumed by your family members during the past week?

    - How many times meat was cooked in past week?
    - Type of meat/quantity?

24. During the past week did any guest(s) paid a visit to your home?

25. What was served to the guest(s)?

26. Usually who in your family is severed first while eating?

    - Why?
    - Eating pattern

27. Does your economic condition fulfill your household requirements?

28. Does your husband take care of you? How?

29. How is your in-laws behavior with you?

30. At present are you suffering from any disease? If yes then specify?

31. Are any of your household members suffering from any disease at the moment?

32. If yes then specify disease and its duration?

33. What health assistance was sought for his/her treatment?

- Home remedies (specify)
- Allopathic treatment
- Homeopathic treatment
- Traditional healers
- Saints

34. At what stage health practitioners are consulted?

35. Who among the above mentioned list in question no 32 is consulted first?

36. When your child has minor disease, how do you treat him/her?

37. Which diseases are taken light and which are not?

38. For what kind of your personal ailment you become worried and which are taken light?

39. Have you ever suffered from any gynecological problem? (specify)

40. What was done to cure the disease?

41. At present are you suffering from any gynecological disease?

- Details
- Treatments, why this treatment? Not other?
- Religious/spiritual healers.

Food during Pregnancy

42. What is your perception about food?

43. What is your perception about ideal food for a woman?

44. When and where your first child was born?

45. When were you pregnant last time?

46. How is your menstruation cycle?

47. Who was more caring to you during pregnancy? How did he/she took care of you?

48. Do you think that there was a difference in care towards you when you were pregnant for the first time and later?

49. If yes, then what was the difference?

50. What was the reason for that?

51. What was your eating pattern during first pregnancy?

    - Age at first pregnancy?
    - Total number of pregnancies/abortions?

52. During your pregnancy was there any difference between your and your's family's diet?

53. During pregnancy period was there any fluctuation in your dietary habits?

    - Food likings
    - Food disliking

54. What were the reasons for liking or disliking certain food?

55. Who advised you during pregnancy which food should be avoided? Why?

56. Were you ever advised by the doctor about your diet during pregnancy?

57. During pregnancy specify the quantity of consumption of these food items?

- Milk
- Ghee
- Eggs
- Fruits
- Any other thing to enhance energy

58. How far is the doctor from your residence?

- How did you reach there?
- Time required reaching there?
- Who bears your medical expense?

59. During pregnancy did you used ethno-medicine?

- Which ethno-medicines?
- If your child was delivered at the hospital then how took you to the hospital?
- How you reached hospital?
- Transport facilities
- If child was at home then who conducted your delivery?

60. At what place do the women of the village give birth?

- Home
- Midwife
- Hospital

61. When did you start your routine household work after the delivery?

- Which work was done at start?
- What was avoided? Why?

62. During postpartum period who helped you? How?

63. What was the reaction of you family members at your child's birth?

64. What time after the birth of your baby he/she was introduced to first food?

- Food (specify)
- Colostrums
- Ghutti?

65. What was your food during postpartum period? Any special food?

66. Were there any hot/cold food issues during delivery and postpartum period?

67. Did you receive proper antenatal case?

68. How long did you breast fed your child?

- Was your milk sufficient for child's need?

69. Which foods were consumed and avoided by you during breast feeding? Why?

70. At what age did you introduced first solid food to your child?

- Food quantity and duration (specify)

71. At what age child starts eating the same food as other members of the house do?

72. Up-to what age the child is fed with?

- Mother attention?
- Other home member's attention?
- Male/female child discrimination regarding food?

73. In what age do you think that diet of the child should be very good? Why?

74. Have you ever heard about family planning?

75. Do you use any methods of family planning?

76. If yes, then which method and after how many children? Why?

- Criticism you faced for using family planning method?

Annex No.3

Focus Group Discussion Guide Line

Adolescents

1. What kind of health facilities is available for adolescent/women in village?
2. Do the young girls go to the health centers?
3. What kind of health problems adolescent suffer in *Gumti*?
4. What sort of treatment is sought for such diseases?
    - Reasons for preference for a certain mode of treatment
5. What are the perceptions about the adolescent's health?
    - Perceptions regarding healthy/weak girl
    - Care by the family towards adolescent health
6. What kind of educational facilities is available in *Gumti*?
    - Trend towards female education
    - Optimal level of education for adolescents
    - Problems faced in education
7. What is the Daily routine of an adolescent girl in *Gumti*?
8. What are the dietary habits of an adolescent girl in *Gumti*?
    - Perceptions about ideal food/ideal food
    - Daily diet
    - Consumption of meat, fruits at home if not then why not?
9. In village up to what age any person specially a girl is considered as a child?
    - Kind of restriction faced by a girl with growing age

- Restriction faced during adolescent age

10. How puberty is recognized in the village?

12. Do the adolescent are prior informed about the future changes in their life?

13. What is the age of menstruation of a girl in *Gumti*

    - Knowledge about menstruation
    - Experience of first menstruation and preparedness
    - Food during menstruation
    - Treatment sought during menstruation

14. What is the age of marriage for a girl in village?

Annex No.4

Focus Group Discussion Guide Line of Women

1. What kind of health facilities is available for a woman in village?
2. Do the women in your village visit health centers?
3. What kind of health problems women suffer in village?
4. What sort of treatment is sought for such problems?
    - Reasons for preference for a certain mode of treatment
5. What are the perceptions about the women's health in the village?
    - Perceptions regarding healthy/weak woman
6. What is the Daily routine of a woman in *Gumti*?
7. What are the dietary habits of woman/girl in *Gumti*?
    - Perceptions about food/ideal food
    - Daily diet
    - Consumption of meat, fruits at home
    - If low consumption then reasons
8. What is the age of marriage for a girl in village?
    - Endogamy
9. Do husbands take care of their wives in the village?
    - Care by the family
    - In laws
    - Children
10. What type of problems a woman has to face in village?

11. What kind of gynecological problems women suffer from in the village?

12. What is the normal diet of a woman in village?

    - Food during pregnancy
    - Food during postpartum period
    - Food during lactation

13. Where does majority of the deliveries take place?

    - Reasons for this mode

Annex No.5

Focus Group Discussion Guide Line of Community

1. Generally how health is perceived in village?
2. Does women health is given importance in your village?
    - How?
    - When?
3. What kind of a girl is considered healthy in your village?
    - Attributes of a healthy woman in your village?
4. Which woman is considered weak in your village?
    - Criteria for measuring health of a woman?
5. What kind of health facilities is available for adolescent/women in village?
6. What importance is given to the health of adolescents in your village?
    - What is done?
7. What is the age of marriage for a male and a female for marriage?
    - Endogamy
8. What kind of restrictions women of the village has to face?
9. What is the daily routine of a village woman?
    - Work
    - Food
10. What are the things that are produced by people own land/household and what are the things that you need to get from the market?
    - Pulses

- livestock
- Crops
- Poultry
- Consumption and selling trends of these products

11. What is the diet of a person in village?
12. Does mothers' breast feed their infants? If not then why?
13. At what age a young infant is introduced to semi solid/solid food?
    - List of things
    - Age of introduction
    - Timings
14. What is the diet of child of 1-5 years age in your village?
15. What do you think that food has any effect on the health of a person?

Annex No.6

Plates of the Village

Plate No. 1: View of the Village

Plate No. 2: Offering at Graves by the Locals

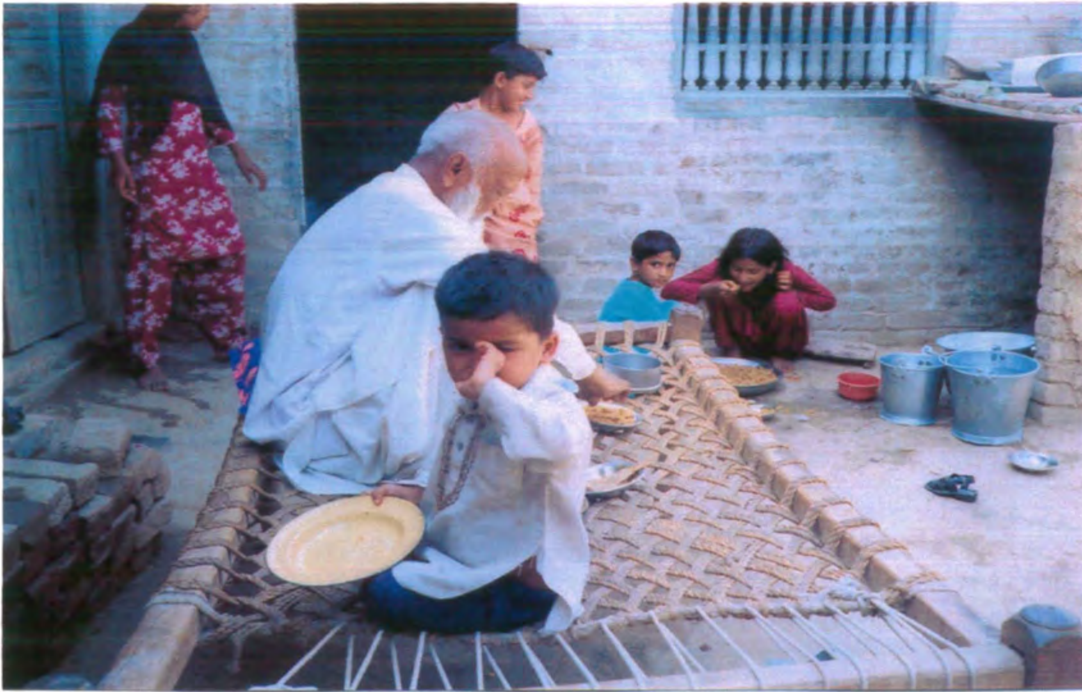
Plate No. 3: Women Visiting Holy Graves

Plate No. 4: Females at Communal Well

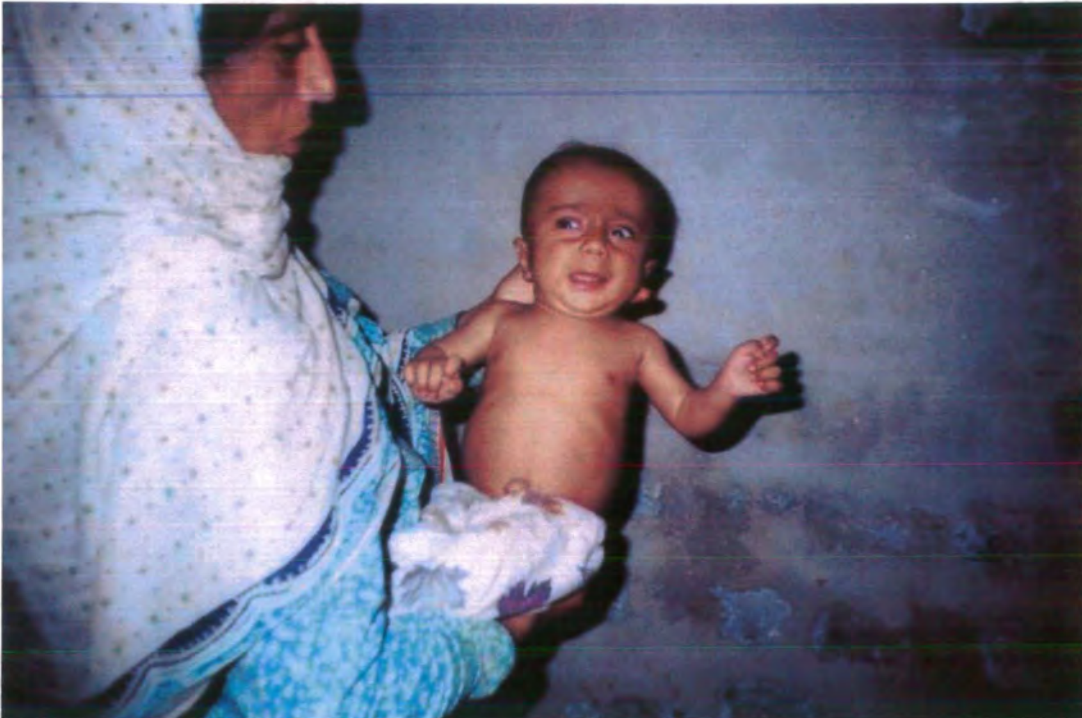
Plate No. 5: Adolescents at School

Plate No. 6: Women and Children at Work in Field

Plate No. 7: Food Eating of a Family



No. 8: Malnourished Mother and her Child



Socio-Economic and Census Survey Form

Sr. No: ______________

ame: ____________________ Dhoke: ______________ Date: ____ ____ 2005 (dd mm yy)

S. No	Name	Age	Gender		Relation With HH	Caste							Religious Sects				Remarks
			F	M		Qu	Mg	Ka	Jo	Ni	Ch	Ot	AH	AT	WH	OT	
1																	
2																	
3																	
4																	
5																	
6																	
7																	
8																	
9																	
10																	
11																	
12																	
13																	
14																	
15																	

S. No	Literacy		Formal Educational Levels						Other Types of Education And Skills Acquired					Marital Status						Remarks
	LIT	ILL	1 - 5	6 - 8	9 - 10	11 - 12	12 - 14	14 +	Religious		VE	Skills acquired		S	M	D	W	SP	RM	
									Nz	Hz		Informal	Formal							
1																				
2																				
3																				
4																				
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				

S. No	Age at Marriage		Married Since When		Current Pregnancy Status		Child Died		Occupation	Income			Total Annual Income	Remarks
	C	P	C	P	Not Pregnant	Month of pregnancy	M	F		D a	M n	A n		
1														
2														
3														
4														
5														
6														
7														
8														
9														
10														
11														
12														
13														
14														
15														

Information at Household Level

1. What is the main language spoken in your household	Urdu ... 1 Punjabi ... 2 Pothohari/ pahari ... 3 Pushto ... 4 Others **[Specify]** ... 5	6. What are the following parts of (living) rooms of your dwelling primarily made of?	
2. What is the status of the dwelling you live in – do you own it or do you rent it?	Own dwelling... 1 Rented dwelling... 2 Others **[Specify]**... 3	a. Roof	Cemented/ Concrete ... 1 Mixed ... 2 Katcha ... 3 T- iron guarder... 4 Tin/ metal... 5 Others **[Specify]** ... 7
3. How many (living) rooms are there in your dwelling? (Apart from bathroom, kitchen and rooms for livestock)	________________	b. Floor	Cemented ... 1 Mixed ... 2 Katcha ... 3 Bricks... 4 Others **[Specify]** ... 7
4. What kind of kitchen do you have in your dwelling?	Separate room for cooking ... 1 Cook in main room of dwelling... 2 Use open space for cooking ... 3 Others **[Specify]** ... 4	c. Walls	Cemented ... 1 Mixed ... 2 Katcha ... 3 Stone Wall ... 4 Others **[Specify]** ... 7
5. What type of toilet facility does your dwelling have?	Use open space outside the dwelling ... 1 Latrine (pour or flush) ... 2 Closed pit (soak pit) ... 3 Others **[Specify]** ... 4	7. Does your household own any agricultural land/ Plot?	Yes... 1 No... 2
		8. What size of land does your household own?	Non-Agriculture Agriculture/ Livestock

9. Is your house equipped with any of these amenities?	
a) Electricity	Yes.........1 No....................2
b) Piped natural gas	Yes.........1 No....................2
c) LPG gas cylinder	Yes.........1 No....................2
d) Piped water (Govt. Supply)	Yes.........1 No....................2
e) Telephone	Yes.........1 No....................2
10. Does your household own livestock?	Yes.........1 No....................2
11. Which livestock does your HH have? Write the number of each livestock.	a) Poultry b) Goat/ sheep c) Cow d) Buffalo e) Oxen f) Camel g) Mules/ Donkeys h) Others **[Specify]**
12. What are the Crops at your field?	______________________ ______________________

13. Does your household have these items?	
a. Cycle	Yes.........1 No....................2
b. Motor Cycle	Yes.........1 No....................2
c. Car/ van	Yes.........1 No....................2
d. Radio	Yes.........1 No....................2
e. TV	Yes.........1 No....................2
f. Dish/ Cable	Yes.........1 No....................2
g. VCR	Yes.........1 No....................2
h. Refrigerator	Yes.........1 No....................2
i. Computer	Yes.........1 No....................2