Decision-making processes for female reproductive health in cultural context (A Case Study of Potowar Area)

By

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DECLARATION

I hereby declare that this thesis is the result of my individual research and that it has not been submitted concurrently to any other university or any other degree.

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My motivation for this research came from the realization that much needs to be understood and done about female reproductive health in Potowar region, in particular and Pakistan, in general.

Nabila Zaka

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LIST OF ABBREVIATIONS

BHU	Basic Health Unit
BMR	Basal Metabolic Rate
CMH	Combined Military Hospital
CPR	Contraceptive Prevalence Rate
DHQ	District Head Quarter
DMPs	Decision Making Processes
HIV/AIDS	Human Immuno-deficiency Virus / Acquired Immune Deficiency Syndrome
HSB	Health Seeking Behaviour
HP	Health problem
IUCD	Intra Uterine Contraceptive Device
LAM	Lactation Amenorrhoea Method
LHV	Lady Health Visitor
LHW	Lady Health Worker
MH	Military Hospital
MINI	McGill Illness Narrative Interview
MMR	Maternal Mortality Ratio
MNCH	Maternal Newborn Child Health
MSM	Men having Sex with Men
NIPS	National Institute of Population Studies
PAHO	Pan American Health Organization
PDHS	Pakistan Demographic Health Survey
PIH	Pregnancy Induced Hypertension
POF	Pakistan Ordnance Factory
RGH	Rawalpindi General Hospital
SMAM	Singulate Mean Age of Marriage
STD	Sexually Transmitted Disease
STIs	Sexually Transmitted Infections
TBA	Traditional Birth Attendants
TMG	Therapeutic Management Group
THQ	Tehsil Head Quarter Hospital
WHO	World Health Organization

Abstract

This thesis intends to understand the cultural beliefs, attitudes, traditions and practices in a rural setting of Pakistan that drive the decision-making processes around female reproductive health.The study was conducted in village Jaffer of district Attock in the province of Punjab, Pakistan. Cultural interpretive and critical theories are used to map the decion-making processes. Participant observations, in-depth interviews, oral histories of illness experience and patient-provider interactions are documented to inform this thesis.

The pluralistic healer environment provides an easy geographic access to a wide variety of reproductive health practitioners including *dais, hakeems, pir*, shrines, chemists, public and private doctors and health facilities. Centuries old influence of Buddhism, Hinduism and Islam and traditional medical systems have influenced the perceptions and practices of local women about the common reproductive health problems. Kinship bonds and '*birdari*'-dictates bind women to the cultural and social ideals of honour, chastity, docility and high fertility. Endogamy has facilitated marriages within the same village and strong bonds and interaction exist among the married women and their natal kin. Eighty two percent of women visit their natal house either at daily, weekly or fortnightly intervals.

The study elaborates upon the variables of female status and autonomy in a typical Potowar village. Nearly half of the women were illiterate and mostly married before reaching twenties. Marriage decisions due to their importance in one's life were surveyed. Among the ever-married women interviewed, 32% of women exercised choice for selecting their spouse. Ninety percent women report their inclusion in household decision-making though 38% also witnessed opposition to their decision at some point of time. One fourth of all ever-married women themselves could make a decision for seeking health care when sick. A large proportion (46%) depends upon the decision by their husband; 10% by their sons, 10% by the joint family and another 8% by the mother-in-law to decide getting external help for health care. Only 36% ever-married women can

go to the health centre without seeking special permission. Mother-in-law, sister-in-law, daughters and a woman's husband take care of household affairs in her absence. Ten percent respondents reported that no support is available. Thus it is observed that more social support is accessible to enable a woman to seek outside care in joint and extended households but the same living arrangements lessen female autonomy on the other hand by the need to comply with the joint and harmonious decisions by a larger family. Women attain status in the village by marriage, by bearing sons and by entering menopause.

Female identity formation and the ideals in the rural Muslim society of the village depict symbolic values of various reproductive illnesses which have strong implications for care seeking patterns. The uterus is considered the '*jaan*' (life) of a female individual as it ensures her biological identity and prowess of fertility; the private parts are the reservoirs of a woman's and family's shame and hence to be concealed togther with the ailments which have to be borne in silence; the concepts of '*paaki and pleeti*' (purity and pollution) give rise to taboos related to menstrual blood and the vaginal discharge. As a woman reaches menopause she also achieves the long lasting '*paaki*' (purity) unmarred by monthly cycles and child bearing. This purity and relaxation in mobility and '*purdah*' (veil) restrictions give her an elevated status.

Traditions, rituals and religion knit a web of meaning in a woman's life. Being a '*zanani*' (female) in the village only gathers status by virtue of being '*halalan*' (chaste); '*suhgan*' (currently married) and being able to produce an offspring. Motherhood and total obedience to one's husband including related concept of 'self annihilation/self-sacrifice' is glorified. Women make an effort to uphold these ideals of female virtue even during sickness. Chastity, docility and stoicism lower a woman's chances of being an active partner in matters related to her sexual health and her negotiation power.

Health is understood as the ability to be able to fulfill one's domestic and sexual roles ' *poora kar sakna*' (ability to deliver). Illness recognition comes with inability to perform one's routine tasks or by physical variability in body. Seeking care is linked with the

perceived cause of an illness. Local belief systems hold illness as a sign of Divine wrath; a predestined event or a result of an evil eye, magic or *'be-ihtiaati'* (carelessness that results in imbalance of hot and cold humours in the body). Reproductive illnesses are classified as pertaining either to vagina, uterus or breasts and include variations in libido. Uterine illnesses comprise the largest category including menstrual problems, issues of infertility, pregnancy and child birth related complications, *'naaf girna'* (tipping), tumours and prolapse. Efforts to regain 'health' or curing an illness include household remedies, indigenous use of certain herbs, vaginal tampons and manipulations by *dais,* prayers at shrines and use of amulets and *'dam'* (breath). Modern medical care is occasionally sought from the Lady Health Worker, Lady Health Visitor and doctors.

The decision-making processes are linked with the local concepts of menstruation, sexuality and menopause. The advice by *'dais'* (traditional birth attendants) dominate the practices and care-seeking for conditions related to pregnancy, child birth and puerperium. The narratives of women demonstrate their struggle to seek reproductive health care for managing their fertility and infertility issues. Children are valued to fulfill one's maternal aspirations and procreative ability, to gain the status of responsible adulthood, continuity of the lineage, old age support of parents and means of going to heaven in the afterlife. A higher than actual desired fertility is aimed to guard against high child loss. The motives of fertility regulation include completion of desired family size, the high financial cost of rearing, aspirations to stay free of responsibility, avoiding division of property, fear of having young orphans if children are born in later age, and avoiding embarrassment of simultaneous child bearing among two generations of women.

The study concludes that reproductive health decision-making among females is a product of the cultural ideals of the female body, sexuality and extrinsic factors. Positive status change is gained by life transitions of menarche, marriage, fertility and menopause. Care is sought only if the illness causes a hindrance in performance of a woman's gender roles that vary with the stage of her life cycle. The locus of control by self and choice of providers is positively associated. Traditional and faith healers enhance the feeling of

control and empowerment. Modern health care providers and their therapeutic regimens, on the other hand, allow little patient participation in illness management. The conformity between cultural values of patient and provider determines patient satisfaction. Culture is more determining in framing decision-making than the availability of services and economic cost; the study shows continuity of traditional norms even if awareness is present and modern health services are accessible.

CHAPTER 1

INTRODUCTION

1.1 The Background

Women bear and rear the next generation. Mothers are thus symbolized as the cradle of civilization. In almost all cultures, human reproduction is the basis for the continuation of a lineage, society and culture. Man and woman both have sexual and reproductive roles and functions as individuals and as couples playing their part to form a family which is the basic unit of any society and culture. Both are gifted with reproductive organs and capacity and both are susceptible to associated illnesses. Women, however, due to their biological role, face a disproportionately higher share of reproductive burden and associated health problems.

Female reproductive health is a concern world-wide and especially in developing countries like Pakistan where a woman dies every forty minutes due to causes related to pregnancy and child birth and an estimated another forty develop life-long disabilities or suffer illness in the process[1]. Apart from the specific pregnancy and childbirth events in one's life; women face health issues related to adolescence, menarche, breast conditions including cancer, reproductive tract infections, genital mutilation and cancers and menopause related problems. Female reproductive health is not only a product of anatomical construction, functions and pathology but also an outcome of cultural beliefs[2], traditional practices[3], gender[4] roles and power relations[5] within a household and society.

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[1] Pakistan Country Population Assessment, 2006, Ministry of Population Welfare and UNFPA

[2] Hahn, R.A. and Kleinman, A.M.(1983). "Belief as Pathogen, Belief as medicine: "Vodoo death" and the Placebo Phenomenon in Anthropological Perspective". Medical Anthropology Quarterly.14 (3):16-19

[3] Hahn, R.A.(1995). Sickness and healing: An anthropological perspective. New Haven, Connecticut: Yale University Press.

[4] http:www//:WHO Gender.mht accessed on 5-05-2009

[5] Cox Robert W. and Jacobson H.K. (1977). "Decision-making" Int. Soc.Sci. Journal. XXIX (1): 115-134

1.2 Concepts of Reproductive Health and Decision-making

Biological reproduction is the production of human beings; it is a necessary condition for the perpetuation of the society.

> *"The power of reproduction, to express sexuality and to create life, has never been considered a solitary event. Rather, it has been a pivotal social force binding individuals, families and communities together" (Anderson, Barbara A. 2005:2)*[6]

A perceived change in one's reproductive health and illness status invokes a personal or community response determined by cultural factors. As this thesis intends to study decision-making processes for female reproductive health in cultural context, it is important to develop a common understanding of the terminologies of 'reproductive health' and 'decision-making processes' to begin the discourse.

1.2.1 Reproductive Health

Reproductive health, in simple terms, embraces all individual states of well-being or other-wise, in matters pertaining to biological sex, human sexuality, gender roles, and processes involved in procreation.

1.2.1.1 WHO Definition of Reproductive Health

World Health Organization (1994)[7] defines reproductive health as a state of physical, mental, and social well-being in all matters relating to the reproductive system at all stages of life. Reproductive health implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so. Implicit in this are the rights of men and women to be informed and to have access to safe, effective, affordable, and acceptable methods of family planning of their choice, and the right to appropriate health-care services that enable women to safely go through pregnancy and childbirth.

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[6] Anderson, Barbara A. (2005). Reproductive Health: Women and Men's Shared Responsibility. London: Jones and Bartlett Publishers International.

[7] http.www//RH Resources <rh_resources.htm> International Conference on Population and Development (1994). Report of the International Conference on Population and Development (CA/CONF 171.3) Cairo Egypt: United Nations Printing Office.

Reproductive health care is thus in essence the constellation of methods, techniques, and services that contribute to reproductive health and well-being by preventing and solving specific health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted infections. This definition is therefore, broader than fertility and childbirth alone and implies a holistic approach to a health system and a social structure that makes choices available to all women not only to seek health care but to protect themselves against all forms of violence (Artlette et al. 2006: 3)[8]. Sexual health is an integral part of reproductive health and includes the capacity to enjoy and control sexual and reproductive behaviour in accordance with the social and personal ethics of a society (WHO, 2006)[9]. The reproductive goals thus can only be attained by upholding the universal ethical principles of human rights, individual freedom, and dignity, as a vital responsibility of the health system. Gender equity and empowerment of women needs to be addressed as many of the female reproductive health problems arise from the persistent gender inequalities including women's relative lack of power and influence in both public and private spheres. (WHO, 2007)[10]

1.2.1.2 Anthropological Definitions of Reproductive Health

Anthropological discourse separates the definition of reproductive health from the clinical setting and places it within the domain of human experience.

> *"...reproductive health within medical anthropology encompasses people's emic perspectives on all matters related to sexuality and reproductive processes and functions."*
> *(Andrea Whittaker, 2004:280)* [11]

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[8] Artlette, C. W., Thomas W. M., et al. (2006). Reproductive Health: the Missing Millennium Development Goal. Washington: The International bank for Reconstruction and Development/ The World Bank.

[9] WHO (2006) Accelerating Progress towards the Attainment of International Reproductive Health Goals. A Framework for Implementing the WHO Global Reproductive Health Strategy. WHO/RHR/06.3. Geneva: WHO Press.

[10] WHO (2007) The WHO Strategic Approach to Strengthen Sexual and reproductive Health Policies and programmes(WHO/RHR/07.7) Geneva: WHO Press.

[11] Whittaker, A. (2004). "Reproductive Health" pp.280-292 in Carol R.E. and Melvin Embers (Eds.) Encyclopedia of Medial Anthropology: health and illness in the world cultures. NewYork : Springer

Carol H. Browner and Carolyn F. Sargent (1996)[12] have elaborated the different dimensions of female reproductive health:

> *"...human reproduction is never an entirely a biological affair, all societies shape their members' reproductive behaviour. This cultural patternining of reproduction includes the beliefs and practices surrounding menstruation; proscriptions on the circumstances under which pregnancy may occur and who may legitimately reproduce; the prenatal and postpartum practices that mother-to-be and their significant others observe; the management of labour, the circumstances under which interventions occur, and the form such interventions may take; and comparative study of the significance of the menopause.*(ibid:219)

In a broader sense, reproduction refers to the activities and relationships involved in the perpetuation of social and cultural systems. Marxism uses the term 'reproduction' to describe the progressive continuity of production itself, that is, the perpetual processes of production-circulation-consumption-production that account for the ability of social systems to sustain over time (Harris and Young 1981: 114)[13]. The term also refers to the relationships and activities involved in feeding, socializing, and otherwise sustaining the members of a society who carry out its productive activities (Edholm et.al 1977)[14]. Feminist scholars have broadened the concept of reproduction to include the entire set of social relationships associated with the maintenance of a society's political and ideological structures and the sustenance of its non-producing members (Beneria and Roldon 1987)[15] and (Gailey 1987)[16].

Thus reproductive health from anthropological perspective has diverse and distinct dimensions that are interrelated and determined culturally and socially. It includes society's structural and symbolic principles and its paradigms of maternity, that shape

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[12] Carol H. Browner and Carolyn F. Sargent .1996. "Anthropology and Studies of Human Reproduction" (pp: 219 – 232) in Handbook of Medical Anthropology. Contemporary Theory and Method. Revised edition Edited by Carolyn F.Sargent and Thomas M. Johnson. Westport: Greenwood Press

[13] Harris,O. and Young,K.(1981).Engendered Structures: Some Problems in the Analysis of Reproduction In The Anthropology of Pre-Capitalist Societies, ed. J.S. Kahn and J.R. Llobera. London: Macmillan.

[14] Edholm, F., Harris, O., and Young, K .(1977). "Conceptualising Women". Critique of Anthropology, 3 (9-10): 101-130

[15] Beneria, L. and Roldan, M. (1987). The Crossroads of Class and Gender. London: University of Chicago Press Ltd.

[16] Gailey, C. W.(1987).Kinship to Kingship: gender hierarchy and state formation in the Tongan Islands. Austin: University of Texas Press.

maternal roles, childbirth, and related reproductive activities and that link culturally constituted notions of femininity and maternal behaviour.

1.2.2 Decision-making

Decision-making is the cognitive process leading to the selection of a course of action among alternatives[17]. Every decision-making process produces a final choice. It can be an action or an opinion. It begins when we need to do something but we do not know what. In other words, decision-making is a process of selecting from several choices, products or ideas and taking action. In Medical Anthropology, the decision-making for health care, is considered a dynamic process where recognition of symptoms, is the first step. Ember and Ember (2004)[18] posit that symptoms are not always grouped together in the same way cross-culturally. They are evaluated on the basis of how dangerous to life they are suspected to be, the degree to which they interfere with life functions; the visibility and frequency of the same symptoms in others, and the way this compares with their visibility and frequency in the ill individual. The cultural context of decision- making is important as

> *"...in recurring decision situations where alternative courses of possible action exist, members of a group come to shared understanding, a common set of standards concerning how choices are made (Goodenough, 1963, pp.265-270.Quinn, 1978; Young and Garro, 1994). Cognitive ethnographic studies of medical decision-making seek to understand what people do when faced with illness, how this knowledge is applied in evaluating illness and the process whereby decisions about treatment are made."(ibid: 17)*

Decision-making is a reasoning process which can be rational or irrational, and can be based on explicit assumptions or tacit assumptions. Decision-making is also said to be a psychological construct. This means that although we can never "see" a decision, we can only infer from observable behaviour that a decision has been made. Therefore, we conclude that a psychological event that we call "decision-making" has occurred. It is a

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[17] James, G. M.(1994). A Primer On Decision-Making: How Decisions Happen. NewYork. Free Press.
[18] Carol, R.E. and Melvin, E. (eds.) (2004). Encyclopedia of Medical Anthropology: Health and Illness In The World Cultures. NewYork : Springer

construction that imputes commitment to action. That is, based on observable actions, we assume that people have made a commitment to affect the action.[19]

To understand how the cognitive process of decision-making process develops and interplays with construction of illness and healing, we have to delve deeper into understanding of the human mind and its development. Mario E. Martinez (2001)[20] uses theories of co-emergence of thoughts, emotions and language to understand the process of cognition and decision-making. In the process of knowing, bio-information is selected, stored, and retrieved as contextual fields of inseparable cognitive, biological and cultural parameters. Nervous, endocrine and immune pathways together create a contextual relevance. Thus health and illness are neither exclusively biological nor totally mental.

> *"Linear knowledge can not exist without context and we can not evolve without knowledge, entropy which is defined as a progressive complexity of mind, body and cultural parameters that seek contextual relevance (meaning) in a field of constant oscillation between stability and chaos. Thus, to know is to recognize contextual irrelevance. Homo sapiens evolved from the simplistic Darwinian survival instincts toward the pursuit of meaning when consciousness co-emerged as observer of our journey and the judge of our actions. Behaviour could no longer occur without justification."(ibid: 413)*

Since, few decisions involve only two people, most decisions are made by a group. Hammond, Mc Clelland and Mumpower (1980)[21] studied a wide variety of disciplines that endeavour to evaluate human judgment and decision-making and eloquently describe the inherent dilemmas in the process,

> *"Such, then, is the basic polarity of cognition, which we may expect to continue as long as we fall short of omniscience. On one side, irresponsible but secure common sense; on the other, responsible but insecure critical cognition."* (ibid: 4)

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[19] Janis, I.L., Mann,L. (1977). Decisionmaking: A Psychological Analysis of Conflict, Choice and Commitment. NewYork: Free Press.

[20] Maritenz, M.E.(2001). "The Process of Knowing : A Biocognitive Epistemology – The Journal of Mind and Behaviour, 23(4): 407-426

[21] Hammond, K. R., G. H. McClelland, J. Mumpower. (1980). Human Judgment and Decision Making. New York: Praeger.

Melberg (1996)[22] has quoted Gaenslen who regards culture as a composition of assumptions about human nature, causality, the possible, the desirable, the appropriate, the nature of physical environment, and the relationship of human beings to their fellows. Beliefs and values are the main determinants of actions, which in turn create aggregate behavioral patterns in society. There is a positive correlation between collectivist attitudes and high interpersonal orientations. The smaller the conceptual distance between cultural variables and what one wishes to explain by them, the more compelling a cultural explanation is likely to be.

1.2.3 General Classification of Decisions

Levin et al. (1998)[23], classify decisions as those made under conditions of certainty; those made under conditions of uncertainty where insufficient knowledge does not permit the assignment of probabilities to the different choices and; those made under conditions of risk where available information does not support a definite positive probability value.

Decisions define the boundaries of our experience. These decisions are commitments to what is accepted as self versus non-self and the relationship to the other. The models and theories[24] used to increase our comprehension of the decision-making process are 'mathematical'(seldom applicable to real human situations) where two plus two makes four i.e. all options are known with possible outcomes and decision-makers are rationale in their choices to select the choice that maximizes value of the desired outcome and 'subjective expected theory' that proposes that the ultimate goal of all human actions is to seek happiness and avoid pain. In this model, 'subjective utility' means the prospects are based on an individual's values rather than on objective criteria and 'subjective probability' means the prospects are based on an individual's estimates of likelihood rather than mathematical equations.

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[22] Melberg, H. O. (1996). Culture and decision making: a review of an article by F. Gaenslen, http://wwww.geocities.com/hmelberg/papers/960904

[23] Irwin, P. L., Jasper, J. D.,Wendy, S. F. (1998). "Choosing Versus Rejecting Options At Different Stages Of Decision Making" Journal of Behavioural Decision Making.11(3): 193-210

[24] James, G. M.(1994). A Primer On Decision-Making : How Decisions Happen. NewYork: Free Press.

1.2.4 Decision-making Processes (DMPs)

Decision-making processes (DMPs) are defined as social situations in which decisions for action or inaction are made. Power relations are an essential part of DMPs and can be identified while investigating DMPs.

> *"Decision making processes are arenas in which power relations, social networks and gender relations are manifested and therefore identifiable"* (Katzan 1999: 16) [25]

The analysis of decision-making is one way of studying power relations. Decisions of course, do not reveal power directly. What they may show directly is influence, or the way in which power is translated into action. The relative power of contending forces, is an inference that can be drawn from a careful observation of the working of influence.

> *"Decisions can change power relations either by changing the resources available to the actors or by changing the procedures through which they interact so as to give some actors a more advantageous position than others. The study of decision-making is, accordingly, a study of the dynamics of power relations: and it seeks to understand how the decision process may tend to sustain or to change that structure". (Cox and Jacobson 1977:16)* [26]

Thus, individuals are driven by their beliefs, attitude and culture in their decisions around reproductive health care and any action is determined by a sub-conscious or conscious evaluation of different options available and their perceived outcomes. The benefits of the action, risks in the action, and alternatives to the prospective action including doing nothing at all are assessed and compared to develop a final decision[27] .

Decision making processes can also be understood in terms of 'health behaviour' as posited by Gochman (1988)[28] to include,

> *"..those personal attributes such as beliefs, expectations, motives, values, perceptions, and other cognitive elements; personality characteristics, including affective and emotional states and traits; and overt behaviour patterns,*

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[25] Katzan, J. T. (1999).'Decision making processes and power relations at the household and village level in the Union Council of Gali Jageer Tehsil Fateh Jang' HSA Press : Public Health Monograph Series No.1

[26] Cox, R.W. and Jacobson, H.K. (1977) "Decision-making" Int. Soc. Sci. Journal. XXIX(l): 115-134

[27] James, G. M.(1994). A Primer On Decision-Making : How Decisions Happen. NewYork:Free Press.

[28] Gochman, D. S. (1988). Health Behaviour: Emerging Research perspectives. NewYork: Plenum Publishing Corporation.

actions and habits that relate to health maintenance, to health restoration and to health improvement. (ibid : 169)

It is, perhaps, pertinent to note that the cost of making no decision at all itself is a factor, and that the benefit of making some decision, even a random choice, can be beneficial in the longer term. Thus, the reversibility of an action may be a good way to judge whether or not an action or process is beneficial. The more general types of decisions involved in reproductive health care, are to label personal change in condition as a health or illness; to employ self-help to find a cure for an illness; to seek or not to seek external care and to identify the suitable provider.

"Illness behaviours include- but are not limited to- responses to bodily signs and symptoms; seeking opinions and advice from persons who are believed to have health expertise, whether they are officially recognized by larger society (health care professonals or not, folk practitioners, lay therapists); seeking opinions and advice from relatives, friends, neighbours, colleagues; as well as doing nothing but waiting to see whether the unusual signs or symptoms go away." (Gochman 1988: 5)

1.3 The Problem

Processes involved in decision-making for female reproductive health need to be understood at their core. Knowledge levels do not directly correlate with health service utilization. Attitudes form the middle link and these are a product of a culture in which individuals grow up (are socialized into) and operate. The process of decision-making is circular and not linear as the previous experience modifies the cognitive process. One becomes conscious of problem or action; recognizes the problem and its definition; analyzes potential alternatives and consequences; selects the solution; implements the decision and feedback of the consequences, is fed into subsequent decisions of similar nature[29].

Decision-making processes for female reproductive health are a complex phenomenon. Risks of ill health and death rise with each pregnancy and child birth. There is an almost

[29] Maritenz, M.E.(2001). "The Process of Knowing: A Biocognitive Epistemology " The Journal of Mind and Behaviour. 23(4): 407-426

total economic dependence on men and social reliance on elderly females for health care seeking. Strict moral codes determine their sexuality and mobility. Thus, tracing the pathways and processes of decision-making is important. There is a need to understand prevalent attitudes and beliefs and how these affect the healer choice.

> *"Reproductive health problems are rooted in a bio-medical dimension yet their origins often lie in human behaviours..." Oona Campbell et al (1999: 1)*[30].

Processes involved in decision-making for reproductive health need to be recognized in the cultural contexts. The prevalent beliefs, values and attitudes require an in-depth understanding to analyze construct of health and sickness, in general and reproductive health and sickness, in particular. Traditional practices for healing call for an exploration in the domain of female reproductive health. The role of 'self' versus 'the significant others' should also be unraveled. Local concepts of reproductive health and illness, gender roles and provider efficacy, are cross-cutting themes that necessitate a closer examination.

1.3.1 Statement of the Problem

Reproductive health is often associated with the biological and physiological aspects of human race procreation and perpetuation processes including menstruation, coitus, conception, gestation, pregnancy, parturition, infertility, abortion, and menopause. This subject has been studied in the context of gender dimensions[31], reproductive and human rights[32,33,34,35], care seeking behaviours[36,37], influence of male involvement[38,39] and

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[30] Campbell,O., Cleland,J., et al.(1999). Social Science Methods for Research on Reproductive Health (WHO/RHR/HRP/SOC/99.1). Geneva: WHO

[31] Lesley,D. (2001). "Sex, gender, and health: the need for a new approach" British Medical Journal.323:1061-1063.

[32] Cook, R.J., Dickson, B.M., Fathullah,M.F. (2003). Reproductive Health and Human Rights: Integrating medicine, ethics, and law. Oxford : Oxford University Press.

[33] Petchesky, R.P. and Judd, K. (eds). (1998). Negotiating Reproductive Rights: Women's Perspectives Across Countries and Cultures. London/NewYork : Zed Books.

[34] Germain, A. (2004). "Reproductive health and Human rights. The Lancet. 363(9402): 65-66.

[35] Freedman, L. P. and Stephen, L. I.(1993)."Human Rights and Reproductive Choice" Studies in Family Planning; 24(1):18-30.

[36] Nanda, P. (2002). "Gender Dimensions of User Fees: Implications for Women's Utilization of Health Care". Reproductive Health Matters. 10(20):127-134

burden of disease[40]. However, all these dimensions at their core relate to decision-making processes at the individual, family and community levels.

Despite the increased focus on medical and epidemiological aspects of women's health, psychological and behavioural factors and their inter-relationships with biomedical factors are usually not given sufficient attention. Women are a heterogeneous group which may vary with ethnicity, race, parental background, marital status, education, income, occupation and geographical location. Barriers to obtaining services, styles of coping, or bases for well being, therefore, may vary among different socio-economic groups. Petchesky (1984)[41] has asserted that

> *"....these... physiological processes are not invariant but rather are experienced through cultural filters. Biological reproduction is inevitably a social activity, determined by changing material conditions and social relations". (Petchesky 1984:8).*

Apart from the socio-economic determinants, culture is an important but often ignored variable influencing the decision-making processes. From anthropological perspective, decision-making is a product of culture and involves complex processes instead of simple choices made on cost-benefit basis.

Culture is created by humans in process of creating society, polity, religion and arts. Belief is a product of human imagination; it lays the foundation of art and religion and thus, plays a central role in the creation of a socio-cultural reality. This understanding of the reality is common among the members of a society and creates a general outlook towards experiences of illness and health.

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[37] Stephenson, R. and Tsui, A. O. (2003). "Contextual Influence on reproductive Health Service Use in Utter Pradesh, India". Studies in Family Planning. 33(4): 309-320

[38] Green, C. P. and Cohen, S. I, et al. (1995). Male Involvement in Reproductive Health, including Family Planning and Sexual Health. newYork: United Nations Population Fund [UNFPA], 1995.vi.104 p. (Technical Report.28).

[39] Hoga, L. A. K. (2001). "Adult male Involvement in Reproductive Health : An Ethnographic Study in Community of Sao Paulo City, Brazil. Journal of Trans Cultural Nursing. 12(2):107-114

[40] Lopez, A.D.and Murray, Christopher C. (1998). "The Global Burden of Disease, 1990-2020." Nature Medicine.
4 : 1241-1243.

[41] Petchesky, R.P. (1984). Abortion and Woman's Choice: the state, sexuality, and reproductive freedom. New York: Longman (Longman Series in Feminist Theory).

The analysis of decision-making is also one way of studying power relations. Power determines the influence and its translation into action.

> *"The relative power of contending forces is an inference that can be drawn from a careful observation of the workings of influence. Decisions can change power relations either by changing the resources available to the actors or by changing the procedures through which they interact so as to give some actors a more advantageous position than others. The study of decision-making is, accordingly, a study of the dynamics of power relations and it seeks to understand how the decision process may tend to sustain or to change that structure". (Cox and Jacobson 1977: 116)* [42].

The different aspects meriting a special focus in the area of female reproductive health decision-making, are, determining the individual or collective nature of a decision; the process of negotiation to seek or not to seek care; the previous experience of the significant others and how the education levels of the couple and family patterns impact the selection process amongst the available choices. Some significant decisions made in the context of reproductive health are opting for a married life, balancing sexual fulfilment desires of both partners, determining the number of children and specifically 'sons' a couple would want, the choice of provider for seeking pregnancy and maternity care and for any gynaecological problems, the use or non-use of contraceptives and deciding the limits of acceptable economic and social costs of the healing options in case of illness.

The religious and non-religious values, quality of spousal communication, type of family, balance of power in the family, social status of the individual woman and the structural factors, all play a decisive role in decision-making for female reproductive health.

1.3.2 The Study Objectives

The specific objectives of the research study were to understand common reproductive health issues for females in the area as perceived by them; identify cultural determinants of female health seeking behaviours; develop a greater understanding of beliefs and attitudes around sexuality, puberty, fertility and gender roles and their influence on

[42] Cox, R. W. and Jacobson, H.K. (1977). "Decision-making" Int. Soc.Sci. Journal. XXIX (1): 115-134

health; study pathways of decision-making from recognition of symptoms to care seeking and understand the choice of providers in a medically pluralistic environment.

1. 4 The Hypothesis

The hypothesis tested during the field work was

> "The cultural beliefs and values regarding female reproductive health guide the decision-making processes involving the selection of the treatment/healing source".

1.4.1 Operationalization of the Hypothesis: Variables and Indicators

In this hypothesis "cultural beliefs and value system for female reproductive health" is the independent variable, which is indicated by symbolic portrayal of a woman in the village's social set-up, religion, ritual and folklore, including beliefs about reproductive health and illness, traditional healing practices and availability of different provider options.

On the other hand, "decision-making processes" are dependent variables which are indicated by female autonomy patterns in matters relating to her education, marriage, perceived status of health, number of children desired, use of contraceptives and the choice of providers for various illnesses. A woman's age, educational status and socio-economic background may influence the dependant variables and are thus studied.

1.5 Locale of the Study

The study was conducted in village Jaffer of Tehsil Fateh Jang, District Attock, located in Potowar area, in the Northern part of the Punjab Province of Pakistan. As this was a qualitative study which aimed to get a detailed and in-depth, but at the same time holistic view of the situation, it was decided to concentrate on one village population only. The selection of the village required socio-economic similarities with other rural areas of Pakistan and a truly pluralistic environment of reproductive health care providers.

The village Jaffer was, therefore, chosen because of its typical rural agrarian status which resembles most of the Potowar. The other reason was my personal familiarity with

the place and the knowledge that it had a public health facility, presence of two Lady Health Workers(LHWs), local Traditional Birth Attendants (TBAs) called *'dais'*, a popular shrine; a slight remoteness from the nearest urban centre and a comparatively homogeneous population.

The presence of a Basic Health Unit (BHU) in the village provides easy access to modern health care and referral is possible to higher level of care, available in hospitals of Fateh Jang, Attock, Taxila and Rawalpindi. This gave an opportunity for comparative analysis of traditional and modern health care systems on decision-making processes and determination of choices.

1.6 Methodology

The fieldwork of the present study commenced from February, 2007 and continued till the end of December, 2008. To ensure accuracy in the collection and presentation of the field data, triangulation of methods and anthropological techniques, was employed. Both quantitative and qualitative data were collected, compiled and analysed.
The following research methods were used:

1.6.1 Rapport Establishment

Formal meetings with the Department of Health officials in Attock and Fateh Jang were held for official consent of the study to involve the facility and the health care providers deputed at the Basic Health Unit (BHU), Jaffer. When I initiated my field work, there was no doctor appointed at the health facility; however, a male Medical Officer joined in later half of 2007. Rapport- building visits were initially conducted to meet female health care providers at the Basic Health Unit. None of them were resident of the village. They identified a Lady Health Worker (LHW) as my key informant to initiate mapping the local population and households. Meetings were held with the Village Councillor, one of the local *'dai'* and the biggest landlord. It was found that the village population belonged either to *Mughal* or *Awan* families. The doctor who was also incharge of the Basic Health

Unit was very sceptical in the beginning about the selection criteria of the village, evident from his remarks,

> *" Aakhir Jaffer par tehqeeq karnay ki kia shaan-e-nazool hay?"*
> [After all, what was the (divine) revelation for doing a research on Jaffer?]

Upon my explanation, he was not convinced but assured me of any possible help. The Lady Health Worker introduced me to the village women as her guest and told them that I was writing a book on female diseases. This really facilitated my acceptance in the community.

1.6.2. Participant Observation

The basic anthropological technique was employed of taking active participation in the daily activities of the locals. This made possible not only gathering first hand information but also an understanding about the norms, values, realities, illnesses and coping strategies of the native women. I lived in the village and actively participated in marriage ceremonies, funerals, condolence visits, child births at home and accompanied women in their visits to the health facility, the shrines and to the *'baithak'* (sitting room) of the *'Pir sahib'* (saint). The strategy of participant observation also facilitated the process of data collection, reduced the risk of reactivity and helped in formulating sensible questions and understanding the meaning of my observations. Where possible, patient-provider interactions have been recorded and reproduced in this study, to give a direct account of the dealings.

1.6.3 Meetings with Key Informants

Certain informants proved to be an important source of information on the key issues of female reproductive health in the village. I gained tremendous insight into the prevalent practices and the relevant vocabulary. Detailed discussions were held with the Lady

Health Visitor (LHV) -the female functionary at the BHU; the local *'dais'*, *'Pir sahib'*, village elders (both male and female); female doctors at the public hospitals, a *'hakeem'* (practitioner of *'Unani Tibb'* or Greek medicine) and a homeopath in Fateh Jang. The information obtained was cross-checked from other villagers.

1.6.4 Census Survey

A sample of one hundred households was included in the census survey conducted in the initial phase of the study. Information about the socio-economic conditions of the village was hence, collected including basic information of households (family type, residential pattern, household possessions, education levels etc.). The household has been defined here as a people eating from the same hearth and having a common purse.

1.6.5 Semi-structured In-depth Interviews

Quantitative and qualitative information was obtained from a selected sample of fifty married women to provide important statistical data and used to determine individual and family level variables and possible determinants on the process of decision-making. Female interviewees with present or recent history of reproductive health illness were screened for in-depth interviews. It was evident from pre-testing of the quantitative questionnaire that those with no significant reproductive illness could not provide any in-depth information. Additional quantitative data were derived from the local health facility and Lady Health Worker's records.

Household interviews focused on individual and household variables on type of family, decision-making patterns in the family, perceived reproductive health problems, attitudes towards menstruation, marriage, sexuality, fertility, health care seeking patterns in pregnancies and child births, family planning, choice of providers and any experience of a recent reproductive health illness.

The women with recent experience of reproductive health illness were then approached for detailed semi-structured interviews. Some of the interviews took more than one sitting depending upon their convenience and availability.

1.6.5.1 Sampling Procedure for Semi-structured In-depth Interviews

Initially, a purposive sample on the basis of economic status of the households (household income), was envisaged to draw a representative sample of respondents in each *'biradari'*. However, at the stage of pre-testing of the questionnaire, it was clear that respondent selection needed to be done on the basis of a recent history of reproductive illness to draw sufficient details about the decision-making processes involved. Hence, the methodology was revised to identify ever-married women by a purposive sampling to include those who were identified by local providers/ women to have a significant illness experience in the recent past. It was found out that the respondents identified, thus, were proportionally representative of the two *'biradaries'* living in the same village. The questionnaire was not attempted with the un-married girls or women due to the nature of questions on sexuality and sensitivity around such queries. Un-married adolescent girls were included in group interviews with an abbreviated interview guide.

1.6.6 Oral History Method and Illness Narratives

The study relied heavily on the qualitative methods and use of oral histories to depict reproductive illnesses and decision-making processes involved in the care seeking. The oral histories were presented in the form of women's own narratives and were illustrative of an individual's struggle to find meaning and cure for her illness. These were used to understand the cultural context within which decision-making takes place and to gain an in-depth understanding of contextual factors affecting female reproductive health and care seeking behavior.

McGill Illness Narrative Interview (MINI)[43] was adapted for the semi-structured qualitative interview protocol. This protocol has been designed to elicit illness narratives in health research and comprises of three portions:

[43] Groleau, D. , Laurence,K., Young A. (2006). "The Mc Gill Illness Narrative Interview (MINI) : An Interview Schedule to Elicit Meanings and Modes of Reasoning Related to Illness Experience." Transcultural Psychiatry, 43 (4): 697-717.

1. A basic temporal narrative of symptom and illness experience, organized in terms of the contiguity of events.
2. Salient proto-types related to current health problems based on previous experience of the interviewee, family members or friends and mass media or the popular representation.
3. Any explanatory models including labels, causal attributes, expectations for treatment, course and outcome.

The pathways to care, were asked by requesting participants to describe the nature of their own routes into care, to identify a number of common themes related to their struggles with correctly identifying the early stages of illness, becoming motivated to seek help, and actually accessing the health care.

1.6.7 Group Discussions

Semi-structured group interviews were conducted with adolescent girls, married women and married men.

1.6.8 Photography and Records

Some still photographs of important sites were taken. Photography served to preserve the real outlook of the local setup. The annual birth and death record of the village maintained by the Lady Health Worker was also consulted to extract the required information.

1.6.9 Daily Diary and Field Notes

Diary and field notes were maintained on daily basis to store and maintain the collected information.

1.6.10 The Data Analysis

Qualitative analysis took place during and after the field work. Observations within the community were cross-checked with key informants, in order to explore village patterns and among others, to develop criteria for selection of the respondents for in-depth interviews. After field work, the data were compiled and analyzed. During field work, systematic protocols of the semi-structured and in-depth interviews were written immediately and re-checked to complete any missing information.

1.7 Justification and Significance of the Study

The topic has been explored for individual female reproductive health issues e.g. pregnancy care, family planning and abortion but a holistic view is required considering the complete life cycle from birth to death. The cultural factors are mostly discussed in epidemiological research but usually without details of their origin.

Therefore, the topic has been focused on individual female medical issues such as pregnancy and ante-natal care, child birth, menopause, family planning and abortion. The later two areas have been more researched than the others. However, no attempt has been made previously to see the decision-making processes around a reproductive ill health in an individual's life cycle approach. The factors that facilitate the use of different health care services, and the barriers or constraints to use those choices needed a close examination and analysis.

It is pertinent to note that the dynamics of decision-making in the area of reproductive health have not been clearly understood earlier, in the context of rural Pakistan in general, and Potowar, in particular. This study was thus aimed to shed more light on the underlying belief systems, attitudes and practices regarding the female reproductive health.

1.8 Expected Contribution of the Study

The decision-making processes for female reproductive health has been studied in this thesis comprehensively, including socio-cultural determinants, pathways, social capital

and economic factors to contribute to the existing academic anthropological knowledge on female reproductive health.

An anthropological preview of female reproductive health processes will also benefit the society in general, by highlighting gender and intra-household relations, as well as social networks, and informal sector activities that are not covered by conventional statistical methods. Qualitative research reveals the unexpected and furthermore empowers the women as their voices are heard.

1.9 Overview of Global and National Situations of Female Reproductive Health

The scale and magnitude of the issue is enormous as,

"Women are half of the world's population and mothers of the other half" A Mexican quote

In this section, a global perspective of the issue is presented and then the focus is narrowed down on Pakistan to document the specific and important challenges at the country level.

1.9.1 Global Situation

According to WHO(2004)[44], each year, some eight million of the estimated 210 million women who become pregnant, suffer life threatening complications related to pregnancy, many experiencing long term morbidities and disabilities. In 2000, an estimated 529,000 women died during pregnancy and child birth from largely preventable causes. Globally, the maternal mortality ratio has not changed substantially over the past decade. Regional inequities are extreme, with 99% of the maternal deaths occurring in developing countries. The life time risk of death from maternal causes in Sub-Saharan Africa is 1 in 16 and in South Asia 1 in 58, compared with 1 in 4000 in industrialized countries. Factors commonly associated with these deaths are the absence of skilled health personnel during

[44] WHO (2004). Reproductive Health Strategy. Department of Reproductive Health and Research. Geneva: WHO

child birth, lack of services able to provide emergency obstetric care and deal with complications of unsafe abortion and ineffective referral systems. Contraceptive use has substantially increased in many developing countries and its use is approaching the level in developed countries. Yet surveys indicate that in developing countries and in countries in transition, more than 120 million couples have an unmet need for safe and effective contraception despite their expressed desire to avoid or to space future pregnancies. About 80 million women every year have unintended or unwanted pregnancies, some of which occur through contraceptive failure, as no contraceptive method is 100% effective. Unsafe abortions kill an estimated 68,000 women every year, representing 13% of all pregnancy related deaths. In addition, they are associated with a considerable morbidity; for instance, studies indicate that at least one in five women who have unsafe abortion suffers a reproductive tract infection as a result- some of these infections are serious, leading to infertility. Some 60-80 million couples worldwide suffer from infertility and consequent involuntary childlessness, often as a result of fallopian tube blockage caused by an untreated or inadequately treated sexually transmitted infection. Sexually transmitted infections including HIV, constitute 340 million new cases each year, half of them among young people aged 15-24 years. The proportion of new cases with HIV and AIDS is higher among women than in men. Five million new HIV infections occur each year. Together, these aspects of reproductive and sexual ill health accounts for 20% of the global burden of disease for women and some 14% for men.

Table 1: Worldwide Estimates of Reproductive Events/Reproductive Ill-Health

Category	Numbers per year (in millions)
Acts of sexual intercourse	43,800
Couples with unmet family planning need	120
Induced abortions	45-60
Unsafe abortions	21
Pregnancies	150
Complicated pregnancies	30
Maternal deaths	0.585
Peri-natal deaths	0.7
Low birth weight infants	23
New cases of STDs	250
New cases of HIV	1
Women with female genital mutilation	85-114
Infertile couples	60-80

Source: WHO 1994[45]

[45] WHO (1994). *Reproductive health activities in WHO.* Geneva, World Health Organization, 1994 (Unpublished document No. HRP/PCC(7)/1994/6a).

Table 1, depict the magnitude of reproductive events and global burden of dethas and diseases associated with it.

Maternal Mortality is an important indicator of reproductive health and women's status in a society. Iqbal Shah and Lalay (2007)[46] have summarized the global data around maternal mortality, which shows that in 2005, an estimated 536,000 women died of complications of pregnancy, child bearing or unsafe abortion. This represents a 7% decrease since 1990 in the estimated number of world-wide maternal deaths.

Studies show that some developing countries including Egypt, Honduras, Malaysia, Sri Lanka and Thailand have dramatically reduced maternal mortality since 1987 (Wendy J Graham et al.)[47]. There is no longer any disagreement that good nutrition and effective treatment during pregnancy for chronic conditions such as anaemia, diabetes, HIV, TB and malaria; delivery with a skilled birth attendant; and access to timely emergency obstetric care, when required, are the best ways to avoid unnecessary deaths and morbidity in women and newborns.

> *" While socio-economic inequity largely determines which groups of women run the greatest risk when they become pregnant, gender inequity helps make it acceptable to dismiss maternal mortality and morbidity as too rare, too complicated, too stubbornly unchanging and hard to measure for serious attention and investment."*
> *(Freedman 2007: 219)*[48]

The bottom line, though is that reducing maternal mortality is about valuing women. The situation of 536,000 women dying in 2005 alone, needlessly, often in agony, remains.

> *"The women dying are in their prime of life: they are crucial to society and the economy; they sustain the next generation; they make up more than half the workforce..... Continuing high levels of mortality in mothers and babies is a global collective failure."*
> *(Graham et al. 2007:211)*[49]

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[46] Iqbal, H. S. and Lale, S. (2007). " Maternal Mortality and Maternity Care from 1990 to 2005: Uneven but Important Gains" Reproductive Health Matters.15(30): 17-27

[47] Graham, W.G., Achadi, E.L. et al. (2007) "Round Table: Is Pregnancy getting safer for women?" Reproductive Health Matters 15(30):211-213

[48] Freedman, L. P. (2007). Health System Strengthening: New Potential for Public Health and Human Rights Collaboration" Reproductive Health Matters. 15(30):219-220

[49] Graham WJ, Achadi E L, et al. (2007). "Is Pregnancy Getting Safer for Women?" Reproductive Health Matters. 15(30):211-213

1.9.2 National Situation

Maternal Mortality Ratio (MMR) is 276 per 100,000 live births, in Pakistan[50]. This means the life time risk of maternal death for a Pakistani woman is one in 89. This high maternal mortality is mostly attributed to a high fertility rate, low skilled birth attendance rate, illiteracy, malnutrition and insufficient access to emergency obstetric care services. Hemorrhage, eclampsia and sepsis are the main direct causes of maternal deaths. The poor quality of available emergency obstetric care services results in 8% of all maternal deaths attributed to iatrogenic causes.

Table 2: Causes of Maternal Deaths in Pakistan

Cause	Percentage
Postpartum haemorrhage	27.2
Puerperal Sepsis	13.7
Hypertensive related	10.4
Iatrogenic	8.1
Obstetric embolism	6
Abortion related	5.6
Ante-partum Haemorrhage	5.5
Other In-direct	5.7

Source: Pakistan Demographic and Health Survey (2006-07)

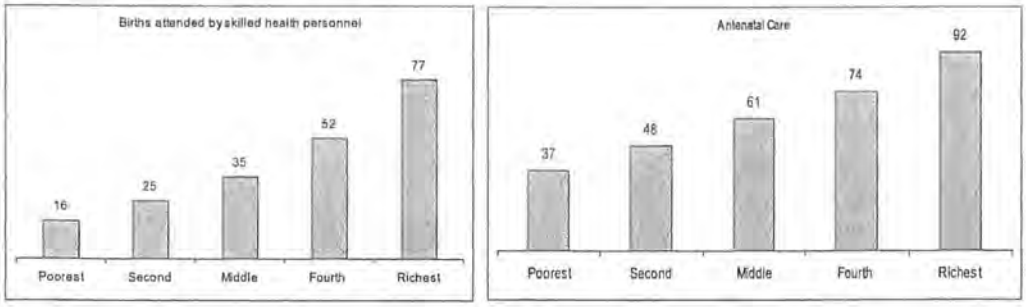
The use of skilled attendant at delivery is 39% higher in urban areas with greater reliance on the private sector. Out of the total 34% institutional deliveries, 27% are conducted in private sector institutions. This trend is largely supply-driven as maternity homes and clinics are concentrated in the urban areas. Thus 66% of babies are born at home in the hands of traditional birth attendants or senior female family members. Inequities are marked on the basis of socio-economic status. It is also seen for women reporting at least one ante-natal care visit in their last pregnancy and skilled attendance at delivery.

The Contraception Prevalence Rate (CPR) is 30% with only a 22% use of a modern method for family planning. The unmet need for family planning (32%) and failure rate

[50] Pakistan Demographic Health Survey, 2006-07, National Institute of Population, Studies, Islamabad, Pakistan.

of traditional methods lead to a high percentage of births being termed unwanted. A high rate of clandestine abortions (290,000 per year) is also observed. This contributes to reproductive morbidity and complications. Appropriate health care services for post abortion complications are highly inadequate in terms of availability, accessibility and quality. Functional family planning services are limited in the public health facilities. The health sector needs boosting of its internal technical capacity to plan and manage family planning and other reproductive health services. Family planning for optimal birth spacing is one of the most effective and cheapest interventions available to improve maternal, newborn and child health; but it has received minimal investment in the National Maternal Newborn and Child Health Programme. Lack of optimal birth spacing practices contributes to poor maternal nutritional status, high maternal anaemia, higher risk of death due to haemorrhage and a high incidence of low birth weight and foetal loss. Forty percent of all maternal deaths are due to haemorrhage (ante-partum and post partum).

Figure 1: Inequities Due to Socio-economic Status (PDHS 2006-07)



Demand for key MNCH services, is low due to poor awareness levels about the need for a specific service e.g. 50% of all women who did not have any antenatal care visit expressed 'no need' as the reason (see Table 3). Similarly, knowledge about danger signs among mothers, newborns and children and birth preparedness, is very minimal.

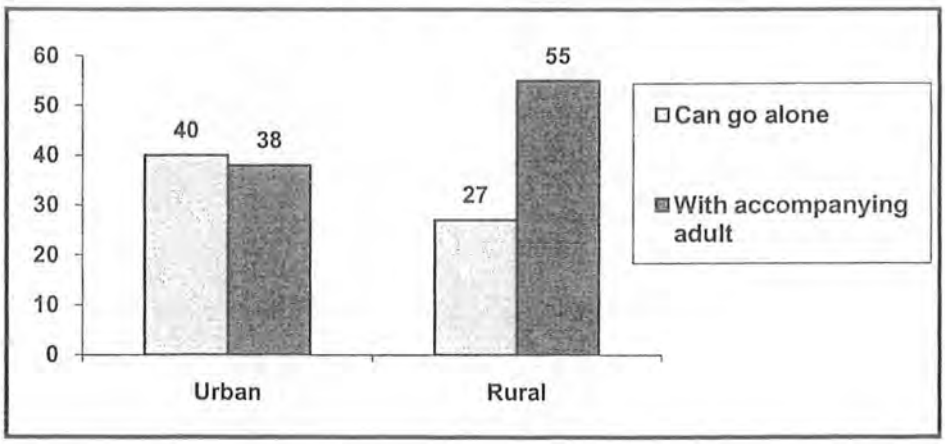
Table 3: Reasons for Not Seeking Ante Natal Care

Reason	Percentage
Healthy/ no problem	55.8%
Could not afford	22.7%
Health facility too far	11%
No reason	4%
No transport	1%
Poor service	1%
Did not know where to go	1%
Others	2%

Source: Pakistan Demographic and Health Survey (2006-07)

The mobility restrictions and tradition of *Purdah* or veil has severe implications for women's health care seeking in Pakistan[51]. In rural areas only 27% ever-married women reported that they can go alone to a health centre, while another 55% required an accompanying adult usually a male.

Figure 2: Female Mobility (RH and FP Survey NIPS: 2003)



[51] Status of Women, Reproductive Health and Family Planning Survey. (2007). National Institute of Population Studies, Islamabad, Pakistan.

Nutrition related disorders compound the health issues of the population with about 30% children either underweight or stunted and half of the women having iron deficiency anaemia[52]. According to the National Nutrition survey[53], about 13 percent of non-pregnant and 16 percent pregnant women are reported to be malnourished (BMI < 18.5). About 45 percent mothers were reported as iron deficient.

Other areas of concern in women's health are the relatively less explored and neglected areas of reproductive tract infections, cancers, sexually transmitted infections and domestic violence and mental illnesses. Available evidence confirms that these represent serious concerns for women's well being and that there are scarce services to address them.

Pakistan currently has the largest group of adolescents in its history with nearly 30 million individuals between the ages of ten and nineteen[54]. Though adolescence is most often associated with physical changes accompanying puberty, the transformation in social roles, expectations, activities and responsibilities that occur as individuals move from childhood to adulthood distinguish this as a formative time with significant consequences for individuals, families, communities, and the country[55]. Adolescent marriage, particularly among girls, is still common in Pakistan. However the age of marriage has been rising in the past few decades. The Singulate Mean Age of Marriage (SMAM) has increased from 16.7 in the 1960s to 22 years in 1998 for girls. For boys the current SMAM is 26.5 and has leaped from 23.3 in 1961 (Pakistan Census Survey, 1998)[56].

In Pakistan, infertility is usually held to be the wife's problem, since the possibility that her husband may be infertile is rarely considered even though scientific research shows that nearly 30% of infertility is due to male causes. National data on infertility is not

[52] Annual report of DG Health, GoP, 2006, 2007.
[53] National Nutrition Survey 2001-02, Ministry of Health, Government of Pakistan.
[54] Pakistan Country Specific Strategic Analysis for MDG 4 and 5. (2009). UNICEF and Ministry of Health, Pakistan.
[55] Durrant, V. L. (2000). Adolescent Girls and Boys in Pakistan. Islamabad: Population Council .
[56] Population and Housing census of Pakistan. Population Census Organization Statistics Division, Federal Bureau of Statistics, Government of Pakistan, July 1998.

available. Small-scale studies estimate that prevalence of primary infertility is 3.4% and secondary infertility 18.4%. Secondary infertility is associated with unsafe abortion and reproductive tract infections, particularly Sexually Transmitted Infections (STIs)[57].

Although currently Pakistan has very low levels of HIV infection, the country is considered to be at high potential risk for a number of reasons. Among these are widespread cultural denial of behaviours that spread HIV (and STIs in general); low literacy rates and a poor educational environment; pervasive poverty; gender issues; and a young population (63% being under 25 years). Fikree reports a 12.3% prevalence of reproductive tract infections in the general community and 25% in commercial sex workers.[58] In particular, there are large concentrations, in the major cities, of individuals with behaviours that make them extremely vulnerable to rapid spread of HIV and of classical STIs such as chlamydia, syphilis and gonorrhoea. These individuals include male and female commercial sex workers, men who have (unprotected) sex with men (MSM), *'hijras'* or transvestites, injecting drug users and highly mobile occupational groups, such as truckers[59].

In Pakistan, abortion is illegal unless it is performed to save the life of a pregnant woman. If a woman wishes to terminate an unwanted pregnancy, she usually turns to an unskilled provider who performs the procedures, mostly under unhygienic conditions. Complications arising from unsafe induced abortions are a significant cause of maternal deaths all over the world. In the Pakistan Country Paper submitted to the *Fourth World Conference on Women, 1995*, the government estimated that around 15% of maternal deaths could be related to abortions.

Many grounds are cited for dealing with unwanted pregnancies, including too many children, incorrect or inconsistent contraception and rape. The typical profile of women

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[57] Bhatti, L.I, Fikree, F.F., Khan, A. (1990). "The Quest of Infertile Women in Squatter Settlements of Karachi, Pakistan: A Qualitative Study." Social Science and Medicine. 49 (5) : 637-649

[58] Fikree, F. (2000). Reproductive Health in Pakistan: what do we know? A paper presented at the Conference on Pakistan's Population Issues in the 21st Century in Karachi, October 2000.

[59] National Study of Reproductive Tract Infections and Sexually Transmitted Infections, a proposed research strategy and study design prepared by the National AIDS Control Programme, MOH, Government of Pakistan (Sept.2002).

seeking abortion is that of a married woman with a minimum of three children, of whom at least two are boys. Thus, induced abortion is often used for limiting family size, and such women opt for illegal induced abortion with the concurrence of their husbands.

Unfortunately, in Pakistan, information on cancer prevalence and risk factors is patchy and unreliable. The only study on the incidence of cancer was conducted in Karachi South District[60], which found greater rates among women than men. Among women, breast cancer was the commonest, followed by cancer of the oral cavity and ovarian cancer. A study[61] has noted that the population of Pakistan has the highest rate of breast cancer amongst the Asian population (excluding Jews in Israel) and one of the highest rates of ovarian cancer worldwide. The majority of the patients presented at a relatively advanced stage; the reason for not contacting a medical care provider included poor socio-economic status and illiteracy. Associated co-morbid conditions were a major cause of delay in cancer treatment. A majority of patients did not receive adequate treatment. All these factors contributed to poor cure rates among cancer patients in Pakistan.

1.10 Medical Anthropological Theories

To understand decision-making processes for female reproductive health in their cultural context, one needs first to understand concepts of health and illness. In all communities, illness is a phenomenon considered threatening to the individual, his/her group and society as a whole. All societies have, therefore, developed coping mechanisms of which medicine and magic are the most important. The experience of disease and death is one of uncertainty and powerlessness in the face of nature and the supernatural. The inability to predict the onset of ill-health and the doubtful results of many medical interventions are the main sources of uncertainty in human life, in order to overcome which every society establishes its own action systems specifically designed to relieve not only pain and suffering but also anxiety and tensions. Surgical, physical and pharmaceutical remedies are only a part of these coping mechanisms. Societies create and maintain, a rather,

[60] Bhurgri, Y., Bhurgri, A, et al. (2000). "Cancer Incidence in Karachi Pakistan : First Results from Karachi Registry. Int. J Cancer. 85 : 325-329

[61] Leide, A., Malik, I.A., et al. (2002)."Contribution of BRCA1 and BRCA2 Mutations to Breast and Ovarian cancer in Pakistan. American Journal of Human Genetics. 71 : 595-606.

specific philosophy of disease and death which may be interpreted as basic and as an important element in the attempt to deal with uncertainties in human life. That is why elaborate concepts of disease, are part of philosophy of life and death.

Medical anthropology has tried to unravel the concepts of illness and disease in human societies. Russel A. (2008)[62] defined medical anthropology as the study of factors that contribute to illness and disease and human responses to illness and disease. Inherent in its approach are characteristics of inter-disciplinarity and holism, being non-judgemental, dis-aggregative and highlighting cultural perspective. It has local and global interests, focuses on individuals but also on populations, groups and societies. It adopts methodological pluralism with innovation and sensitivity; the discipline is comparative in nature and research is inclusive of the study of language, symbols and rituals including those which are 'diffuse', 'muted' and non-formalized knowledge.

The common anthropological theories used to study illness and healing have been broadly classified as:

1. **Ethno-medical Approaches Dealing with Studies of Traditional Medicines**

   Ethno-medicine is a comparative study of native or indigenous system of medicine. It focuses on the etiology of disease, the role of practitioners in health care and the types of treatment administered. It is also a comparative study of how different cultures view disease and how they treat or prevent it, with a focus on medical beliefs and indigenous medical practices. This approach explores the relationship between disease, social behaviour, and human adaptation in terms of man's unique capacities for symbolization and culture. Fabrega (1975)[63] advocated examination of problems in light of their roots and sources, human organization, properties of diseases, the effects and meanings of disease and the practice of medicine in a given culture.

2. **Medical Ecological Theory**

   This theory focuses on ecological determinants of disease and suffering and considers both the natural environment and social environments in which an illness occurs and is treated. It thus accounts for system-based variables and human adaptation. This

[62] Russel, A. Durham University Department of Anthropology. Workshop on Medical Anthropology in UK. 16-20th November, 2008.

[63] Fabrega, H. J.(1975). "The Need for an Ethnomedical Science" Science. 189 (4207): 969-975

theory was formulated by Alexander Alland (1970), and is based on the concept of *adaptation*, defined as behavioral or biological changes at either the individual or group level that support survival in a given environment. Thus, health is seen as a measure of environmental adaptation. A central premise of the medical ecological orientation is that a social group's level of health reflects the nature and quality of the relationships within the group, with neighboring groups, and with the plants, animals and other features of the habitat as asserted by Ann McElroy and Patricia Townsend (2003)[64]. This approach is criticized by B. Good (1994)[65] who states that the focus on culture is thus lost and any cultural analysis can only focus on its adaptive efficacy to the natural or human environment. This approach does not allow for the symbolic construction of the world, the self, the illness and the human reality of suffering and coping with an illness.

3. Cultural Interpretive Theory:

This approach was introduced by Arthur Kleinman[66] and focuses on semantic determinants of disease and suffering, culture, interpretations of symptoms and illness and social construction. This approach regards disease not as an entity but as an explanatory model. From the cultural perspective, disease is experienced through a set of interpretative activities which give it meaning. This meaning may be similar among the healers and patients or dissimilar. The disease is thus a concept constructed by culture[67].

These concepts can be defined as patterns of ideas concerning the causes, manifestations, definitions and value implications of events considered, in a given cultural context, to belong to the realm of disease into the social system.

> *Concepts of disease are every day social elements and not esoteric expert ideologies to maintain the value system or*

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[64] McElroy, A. and Townsend, P. (2003). Medical Anthropology in Ecological Perspective. California : Westview Press.

[65] Byron, J.G. (1994). Medicine, Rationality, and Experience : An Anthropological Perspective. Cambridge: Cambridge University Press.

[66] Kleinman, A. and Kleinman, J. (1991). Suffering and Its professional Transformation: Toward an Ethnography of Interpersonal Experience. Culture, Medicine and Psychiatry. 15: 275-301

[67] Geertz, C. (1983). Blurred Genres: The Refiguration of Social Thought. (pp.19-35) In Geertz, Local Knowledge: Further Essays in Interpretive Anthropology. New York: Basic Books.

> *exercise power over the ignorant. What is defined as disease and how it is interpreted is part of the notion of human nature and generally of cognitive order systems rooted in the mastering and acquisitions of nature. (Pflanz and Keupp, 1977 :386)*[68]

Planz and Keupp 1997, state that concepts of disease in most cultures have five distinguishable features i.e. the general delineation of disease as distinct from other events (including its definition and interpretations); manifestations of disease - the organization of signs and symptoms into distinct disease patterns; general and specific classification of disease; cause of disease and moral and other value implications of diseases.

Applying this model to reproductive health, we need to understand the local concepts of illness, its perceived causes and its moral and value implications. Berkanovic E. 1972 [69] has tracked the academic progress in this area. First Rosenstock et al.[70] devised a conceptual framework based on patient perceptions. As perception is selective, Zola[71] suggested several triggers which impel the symptomatic to seek treatment determined by the expectations which are made of the person with symptoms. He recommends the integration of these approaches in the study of illness behavior.

Arthur Kleinman (1988)[72] states,

> *"When I use the word illness in the book, I shall mean something fundamentally different from what I mean when I write disease. By invoking the term illness, I mean to conjure up the innately human experience of symptoms and suffering. Illness refers to how the sick person and the members of the family or wider social network perceive, live with , and respond to the symptoms and disability. Illness is the lived experience of monitoring bodily processes such as respiratory wheezes, abdominal cramps, stuffed sinuses, or painful joints. Illness involves the appraisal of those processes as expectable, serious, or requiring treatment. The illness experience includes categorizing and explaining, in common-sense ways accessible to all lay persons in the social group, the forms of distress caused by those patho-physiological processes." (ibid: 3-4)*

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[68] Pflanz, M. and Keupp, H. (1977). "A sociological perspective on concepts of disease" Int. Soc. Sci. J. XXIX(3)-386-472

[69] Berkanovic, E. (1972). "Lay Conceptions of the Sick Role." Social Force. 51: 53-64

[70] Rosenstock, I.M., Strecher, V.J. et al. (1988). "Social Learning Theory and Health Belief Model". Health Education and Behaviour. 15(2): 175-183

[71] Zola, I.K. (1966). "Culture and Symptoms—An Analysis of Patient's presenting Complaints" American Sociological Review. 31 (95): 615-630

[72] Kleinman, A. (1988).The Illness Narratives: Suffering, Healing and the Human Condition. New York: Basic Books

Michael J.W.(1978)[73] quotes Duncan (1959) who has distinguished four major interdependent variables constituting an ecosystem. These are population, organization, environment and technology - any of which may constitute the major dependent variable for certain purposes. Operant conditioning, strictly speaking, is the conditioning of operant. An operant of any behaviour can be strengthened or weakened by the contingent events which follow the behaviour. The behaviour may be referred to as a response and its strength may be indicated by several dimensions including its frequency (rate), duration and intensity. An event which increases the subsequent strength of the response which produces it is called a reinforcer, and any event which decreases subsequent response strength, is called a punisher. It is important to realize that the reinforcing or punishing properties do not lie in the stimulus event which follows the response, but in its effects on subsequent response strength. Changes in response strength (operant conditioning, learning), are indicated by comparisons between subsequent response strength and initial operant level, i.e., the strength of the response prior to any known conditioning. The decrease in response strength following termination of contingent reinforcement is called extinction.

> *"Perhaps one of the most important similarities of the two approaches is that both are behaviouristic. This of course, is consistent with the view that change is extremely determined, Thus, both ignore cognitive and other internal states of individuals and collectives of preference to condition and behaviours which can be observed and recorded with relative ease and without great danger of interpreter bias. In this regard both appear to have chosen an approach for its potential heuristic utility rather than for its uniquely human flavour. The focus is not on the people themselves, but on the behaviours or activities they emit. Thus, both have been criticized by their respective parent disciplines as being "dehumanizing" in regard to their basic subject matter." (ibid: 315)*

This theory has been criticized for inadequate attention to the power structures and power dynamics in a society and the means by which the asymmetrical power relations and social dominance of certain groups, is maintained. Singer et al. (1988)[74] have stressed that while symptoms are grounded in the social and cultural realities of individual

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[73] Michael, J.W. (1978). "On the Relation Between Human Ecology and Behavioural Social Psychology" Social Forces. 52: 313-352

[74] Singer, M., Davidson, L. ,Gerdes, G. (1988). Culture, critical theory and reproductive illness behaviour in Haiti. Medical Anthropology Quarterly. 2: 370-85

patients; social and cultural realities are grounded in particular political-economic and historical contexts. Lash and Urry (1994)[75] put forth the idea of reflexive communities. This reflects the particular ways of behaving, thinking and reaching decisions of individuals or groups, which in turn reflect the social construction of their position in wider society at a particular place and time. Acts within the reflexive communities do not rely solely on the processing of information or the construction and acquisition of knowledge. They reflect something far more complex, emotional, social and practical. Harvey (1996)[76] stressed that we look at the way people perceive roles and experience risk.

4. Critical Medical Anthropology Approach

This approach focuses on political and economic determinants of disease and suffering, power resistance, global system-based and ethics and rights. It emphasizes "*understanding the specific structure of social relationships that give rise to and empower particular cultural constructions*" (Baer etal. 2003:34) [77]. Singer (1996)[78] stated that the study of the ecological perspective or nature alone is not sufficient without the study of hierarchical social structure and the changing political economy of human society. Baer et al. (2003) asserted that,

> *".....disease and its treatment occur within the context of the capitalist world system (Wallerstein 1979) rooted in the work of Marx, Engels and C. Wright Mills 1959. Power differences shape social processes (Navarro 1976, Krause (1977), Doyl (1979), Waitzkin (1983) and Foucalt (1975) and the dominant ideological and social patterns in medical care are intimately related to hegemonic ideologies and patterns outside of biomedicine". (ibid:33)*

Critical Medical Anthropology tries to answer such queries as '*Who has the power? How and in what form this power is delegated? How is the power expressed in social relations of the various groups and actors that comprise the health care system? And what are the*

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[75] Lash, S., Urry, J.(1994). Economies of signs and space. London : Sage Publications

[76] Harvey, D.(1996). Justice, nature and geography of difference. Oxford: BlackWell Publishers

[77] Hans, A., Singer, B.M. et al. (2003). Medical Anthropology and The World System. 2nd Edition. West Port : Green Wood Publishing Group. Inc.

[78] Mcelroy,A. and Townsend,P. 1996. Medical Anthropology in Ecological Perspective. California: Westview Press.

principal contradictions and associated arenas of struggle and resistance that affect the character and functioning of the medical system and people's experience of it?'

Baer and Singer (2003: 39)[79] have divided the enquiry into macro-social, intermediate, micro-social and individual levels. At the macro-social level of analysis are the capitalist world system, corporate and state sectors and plural medical systems including cosmopolitan medicine and heterodox/ethno/religious medical systems; at the intermediate levels are health institutions and their policy making, administration by health system and interactions among health personnel; at micro-social levels the social and bio-psychological relations are studied by physician-patient interaction or healer patient interaction; and at individual level are the patient's personal support networks, the patient's experimental response to illness and human psychobiological system.

The gender framework of Critical Medical Anthropology theory has been used to analyze these power structures.

> *"Reproduction and health of mothers and infants cannot be understood separately from the gendered distribution of resources and the division of labour in any society." (ibid:24)*

In other anthropological inquiries of similar nature, Janzen[80] has presented a concept of 'Therapeutic Management Group'. His findings suggest that the whole process of health seeking and decision making is an act of consent seeking, bargaining and negotiating, in which all members of 'Therapeutic Management Group' are involved, and not only the person who has the power to make the final decision. The composition of this group depends on the specific problem at hand. Power relations, social networks and gender relations all interplay to determine the dynamics of this therapeutic management group. Katzan (1999)[81] applied this model to study decision-making processes and power relations in Union Council Gali Jageer of Tehsil Fateh Jang, for child health issues. She

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[79] Baer, H. A., Singer, M., Susser, (2003). Medical Anthropology and The World System. 2nd Edition. WestPort : GreenWood Publishing Group. Inc.

[80] Janzen, J.M. (1978). The Quest for Therapy in Lower Zaire. Berkley: University of California Press.

[81] Katzan, J. T. (1999). 'Decision Making Processes and Power Relations at the Household and Village Level in the Union Council of Gali Jageer Tehsil Fateh Jang' HSA Press : Public Health Monograph Series No.1

studied the relationship of the actors and the factors involved in the process of household decision-making when a child was sick and required treatment. The actors were defined as the social organization of the Punjabi village, i.e., its territorial and kinship units and the health care delivery system. The factors included gender relations, female mobility and social networks that influence decision-making and determine power relations in social and health related situations. She found that at the village level, socially and economically dominant groups, such as specific quom/biradaris (clan/patrilineage), and individuals have disproportionate power and influence in decision-making situations like dispute settlement, the management of welfare organizations, and also in cases of therapy seeking. She observed that in poor, *'kammi'* (village professionals), and in outsider households, the tendency to have controls and restrictions regarding female mobility is stronger than in the middle and rich '*zamindar*' households. With regard to health seeking, women may move and decide inside the village when they or their children are ill, but they have to be accompanied outside the village. The distribution of decision-making power in cases where financial resources and female mobility are at stake are very much the same in health related situations as in everyday life; decision-making power is restricted to men and/or elder women. She labels this pattern as typical of patriarchal societies in which it is perpetuated and culturally legitimsed by the concepts of '*izzat*' (honour) and *'purdah'* (veil). She concludes that women of reproductive age, in particular girls and young mothers, mostly do not have the ultimate decision making power either for themselves or their children.

A study dealing with maternal deaths in a hospital in Karachi, Pakistan, found that

> *"a combination of economic, social and cultural factors played a more significant role in these deaths than medical causes." (Jaferey 1993)*[82]

The study of decision-making derives from many, multidisciplinary approaches. As the present study focuses on "*the cultural context*", the 'Cultural Interpretive Theory' is applied; though an effort has also been made to register issues of power dynamics as illustrated by the Critical Anthropological Theory approach.

Another complementary approach used is 'structuralism'. French anthropologist Claude Levi-Struass[83] pioneered structuralism which concentrates upon culture as a system of

[82] Jaferey, S.N., Korejo, R. (1993). "Mothers Brought Dead: An Enquiry into Causes of Delay". Social Science and Medicine. 36: 371-2

ideas rather only on social structure. It focus upon cognition systems, kinship structure, art, mythology, ritual and ceremony, among others. Related to structuralism is the approach of symbolic anthropology. The emphasis here is upon the culture as a system of symbols, and the task of the anthropologists is to decipher the system in terms of its meanings. This approach has been applied to the examination of religious systems and ritual as well as to kinship, politics, and economics, e.g. Americans think of kinship as a connection through blood in contrast with relations through marriage or in-laws. Another anthropological approach concerned with systems of ideas is ethno-science that investigates systems of cultural classification in different cultures such as the classification of plants, of animals, of colours, of social classes, of sex and gender roles, and of diseases. It is in relation to the classification of gender roles and diseases that we are more interested in the structural approach.The structural approach argues that gender is socially constructed as part of a system of stratification. Instead of focusing on traits that are acquired by individuals, attention is directed outwards,

> *"to the social structures that shape experience and meaning that give people and location in the social world, and that define and allocate economic and social rewards". (Hess and Feree 1987: 11)*[84]

Gender roles are not neutral ways of meeting society's needs but serve to benefit some at the expense of others. Feminist Scholarship, in particular, has resulted in rethinking the family. The activities of family members, their relationship with one another, the distribution of power and resources, the socialization that produces gender specific behaviours, and the interaction of family members, exhibit forms of social organization in which men are dominant over women. Gender stratification, male dominance and female subordination are not constants. They vary from society to society. Gender equality is constructed through women's and men's different work and family activities (Gerslel and Gross, 1993)[85]. Women's reproductive roles and their responsibilities for domestic labour, limit their association with the resources that are highly valued: property, power and prestige. The domestic division of labour, can limit women's mobility, access to

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[83] Strauss, C. L., Jacobson, C. (1963). Structural Anthropology. New York: Basic Books.
[84] Hess, B. B., and Feree, M.(Eds.) (1987).Analyzing gender : A handbook of Social Science Research. Newbury Park:Sage Publications.
[85] Gerslel, N. and Gross H. (1993). Commuter Marriage : A study of Work and Family In Karen Kayser (Ed.) When Love Dies : The Process of Marital Disaffection. New York: The Guilford Press.

health care (availability of time costs: social, opportunity, and fees). Families encompass emotional ties but the unequal division of labour inside and outside the family generates tension, conflict, and change. It is useful to examine religion, politics and occupation patterns to understand gender roles. The customs, beliefs, attitudes and behaviours that discriminate against women are reinforced by organised religion. The working status of women confers social status or deprives them of it according to cultural norms. Participation in public sphere activities and politics is thus also affected, commonly observed as gender gap in voting.

1.11 Theoretical Framework of the Study

In this thesis, a Cultural Interpretive Theory approach to medical anthropology is used to study the decision-making processes for female reproductive health. It also intends to articulate an interpretive approach that is informed by critical theory and the role of the political economy (e.g. class relations) in shaping the formative activities through which illness is constituted and needs to be looked into. Any study of decision-making cannot be complete without applying a 'structuralist' perspective to the meaning of illness and its categories and 'materialist' approach[86] useful to situate decisions in a cultural and economic context, to know how reproductive health issues affect infrastructure: modes of production and modes of reproduction, to find how female reproduction health is embedded in the reality of the domestic economy and to explore justifications, beliefs and value systems governing understanding of illness relating to reproductive health, its manifestations, its course and individual gain and loss.

The life cycle model of reproductive health is used to understand the issues surrounding a woman from birth till death, to record the variations at each life stage and to document the continuities.

The reproductive life cycle, taking a cursory view, may be thought to begin with sexual development at puberty and continuing throughout life for men and ending with the menopause for women (as depicted in Figure 3). In fact, it encompasses sex differentials since birth and inter-linkages between events at younger ages and consequences at later ages.

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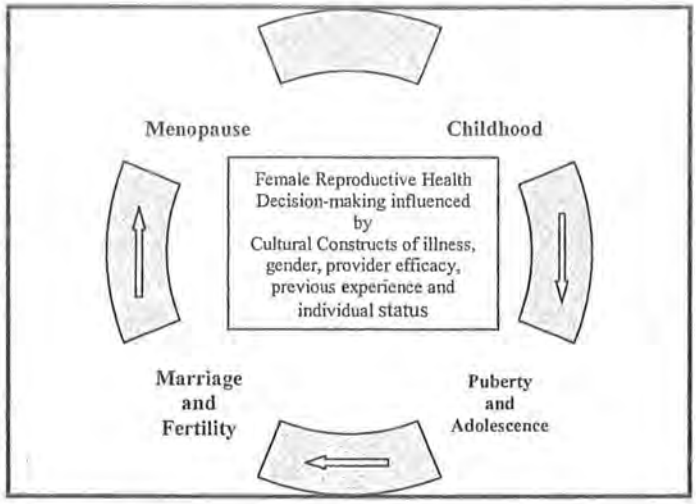
[86] Marvin, H., Johnson,A., Johnson,A. (2001). Cultural Materialism. Oxford: Alta Mira Press.

Figure 3: Life Cycle of Reproductive Health and Decision-making Processes within Cultural Context



For example, lack of paternal love and educational opportunities at a young age result in lower self-esteem and lower self-confidence leading to lower capacity for decision-making for oneself. Taking the same argument forward, Campbell et al. (1999)[87] state,

> *"Gender discrimination in the intra-household allocation of food may lead to stunted and anaemic adolescent girls. In later life, these women may experience obstructed labour due to narrow pelvises, increased infections or contraceptive contraindications due to anaemia"(ibid:8)*

In addition to focusing on the whole life span of a woman in the village, the present study also documents the decision-making processes for an individual illness and the different variables that affect this process.

Figure 4 presents the conceptual framework of the study. The female body symbolizes sexuality, nuptiality, fecundity and family honour and is at the centre of whole process. A reproductive illness is marked by certain symptoms which are articulated by cultural construction to give it a meaning and a name. Recognition is facilitated by significant others who either are more knowledgeable or more experienced than the individual woman suffering from the illness.

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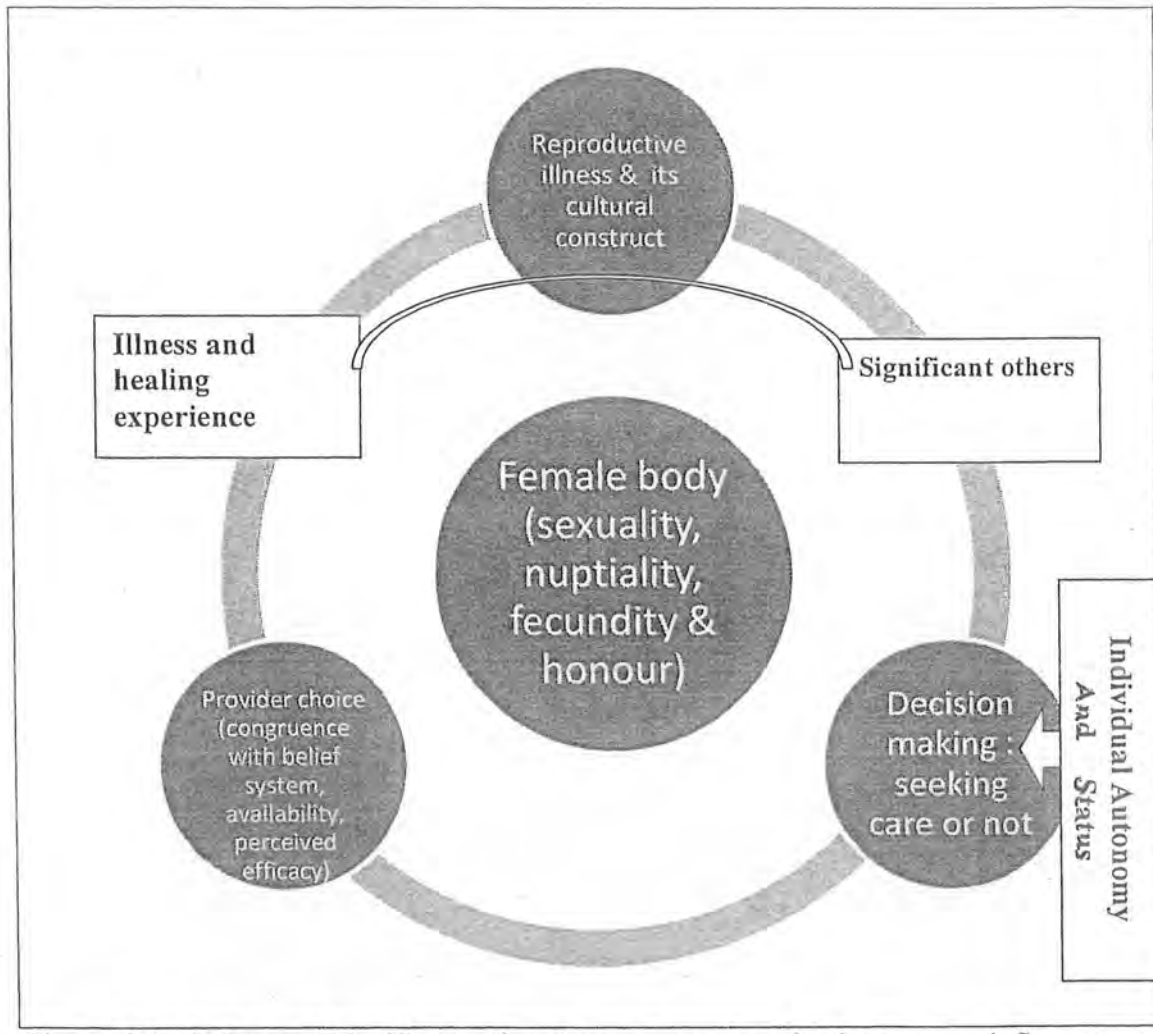
[87] Campbell, O., Cleland, J., et al. (1999). Social Science Methods for Research on Reproductive Health (WHO/RHR/HRP/SOC/99.1). Geneva: WHO.

Figure 4: Diagrammatic Representation of the Theoretical Framework Used in the Study



The sociological term "significant others" mean persons who have great influence on one's behaviour. The act of decision-making is influenced by the individual autonomy and status that gives her the agency to act for herself. Female status and autonomy is gained and lost by certain actions and provide a woman with power to negotiate with the significant others. If a decision is made to seek care out of the family bounds, a suitable provider has to be chosen. This choice is affected by many perceived characteristics of the providers. Perceived provider efficacy, cultural congruence, cost and previous experience affects decision-making on reproductive health (to seek or not to seek care and provider choice). Health care may be sought from multiple providers simultaneously or one at a time. Each individual illness and healer experience is informed by the

previous experience by oneself or others and thus the cultural construction of illness and health is formed and maintained.

The framework also intends to understand the cultural expectations and beliefs around female sexuality, nuptiality and fecundity and how these influence the decision-making processes for female reproductive health.The cultural construction of illness, determines the attitudes and belief systems that influence decisions to seek or not to seek care and are at the core of causal attribution of different illnesses.

Constructs of illness, gender, provider efficacy, previous experience and individual's status in the family are cross-cutting themes in such decisions. Decision-making processes for female reproductive health are thus reviewed in the cultural context of the belief system around female identity and indigenous concepts of reproductive health and illness.

The situation of female status and authority is encompassed together with experiences of individual women in the process of health care seeking. The study framework helps to map out decision-making processes that are illustrated by oral histories of women suffering from specific reproductive illnesses and how significant others and provider interactions framed their choices. Kleinman's Cross-cultural model of the "Health Care System"[88] and "patients and healers" analysis[89] were used in this study to articulate the symbolic and behavioural contexts in which individuals seek to get resources for their treatment.

[88] Kleinman, A. (1978). "Concepts and A Model for The Comparision of Medical Systems as Cultural Systems" Social Science and Medicine, 12(2B): 85-95

[89] Kleinman, A.(1980). Patients and Healers in the Context of Culture. Berkeley, Los Angeles and California : University of California Press.

CHAPTER 2

LITERATURE REVIEW

Studies on illness and healing go as far back as the history of anthropology itself. Academic interest in reproductive health issues emerged later. Anthropological perspectives in reproduction can be traced back to the work of Mary Wollstonecraft (1792)[90] and Lewis Henry Morgan (1983)[91] who documented rules of kinship and marriage in different societies in relation to means of subsistence. Karl Marx and Friedrich Engels (1967)[92] used Morgan's research to connect women's subordination to the development of capitalism. Later Olive Schreiner (1911)[93] and Alexandra Kollantai (1971)[94] informed that women's subjugation is not universal and delineated women's right to 'work' and 'love' in South Africa and Russia respectively. In early twentieth century, Margaret Mead[95] documented the flexibility of human sexual behaviour and the malleable definitions of masculinity and femininity. Elsie Clews Parsons (1906)[96] and Ruth Landes(1947)[97] critically explored the role of men and women and rethought gender and reproduction. Rubin (1975)[98] contested this approach and argued that rules for the reproduction of a society, were generally analyzed without attention to the controversial issues of power and autonomy between men and women. Changing expectations of maleness and femaleness are put forth by Rapp Reiter (1975)[99] and Lamphere et

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[90] Wollstonecraft, M., Brody, M. (1792). A Vindication of the Rights of Woman. London: Penguin Books.
[91] Lewis, H. M. (1987). The Invention of Kinship. Berkeley: University of California Press.
[92] Marx, K. and Engels, F. (eds.) (1967). Capital: A Critique of Political Economy. New York: International Publishers.
[93] Schreiner, O. (1911). Woman and Labour. Toronto: General Publishing Company.
[94] Kollantai, A. (1971). Communism and the Family. London: Pluto Press.
[95] Mead, M. (1928).Coming of Age in Samoa. NewYork :William Morrow and Company.
[96] Parsons, E.C. (1906). The Family. NewYork : G.P. Putnam's sons.
[97] Landes, R.(1947). The City of Women. NewYork: Macmillan Company.
[98] Rubin, G. 1975. The Traffic in Women: Notes on the Political Economy of Sex In RR Reiter (ed.) Toward and Anthropology of Women. NewYork: Monthly Review.
[99] Reiter, R. R. (1975). Introduction in *Toward an Anthropology of Women*. R.R. Reiter, ed. Pp.11-19. New York: Monthly Review Press.

al.(1997)[100]. Christian Gailey (1998)[101] and Behar (1996)[102] stressed that feminist methods in anthropology require recognition of the researcher's own position, an understanding of the social construction of gender, and a commitment to work for the empowerment of women.

In this chapter, the anthropological discourse on decision-making in cultural context is reviewed. The different themes of reproductive health decision-making covered in the existing literature, are mapped. The influence of culture on female reproductive health, is discussed, including beliefs about causation and values associated with illness and life transitions of puberty, menstruation, pregnancy and childbirth and menopause. Paradigms of maternity, sexuality, gender, provider preferences and female autonomy are reviewed. This is followed by a presentation of theoretical and conceptual frameworks and methodologies used by anthropologists to study decision-making processes for health, in general and female reproductive health, in particular.

2.1 Anthropology and Female Reproductive Health Decision-making

Anthropological discourses historically have explored concepts of illness, health and healers; however, there are a limited number of studies on aspects of reproductive health decision- making. Sargent and Johnson (1996)[103] affirm the scant anthropological contribution to the study of reproductive decision-making.

Among the few studies available, a significant contribution is by Nardi (1983)[104]. She analysed reproductive decision-making in Western Samoa and has articulated how the

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[100] Lamphere, L. , Rogo`ne H., Zavella,P. (1997). Situated Lives : Gender and Culture in Every day Life. London: Routledge.

[101] Gailey, C. (1980). Putting Down Sisters and Wives: Tongan Women and Colonization. In Women and Colonization: Anthropological perspectives. M. Etienne and E. Leacock, eds. Pp.294-322. New York: Praeger.

[102] Behar, R. (1995). Rage and Redemption: Reading the Life Story of a Mexican Marketing Woman. InTedlock, D.& B. Mannheim (eds.) *The Dialogic Emergence of Culture*, Urbana and Chicago: University of Illinois Press, p.148-178.

[103] Sargent, F.C. and Johnson, T.M. (eds.)(1996). Handbook of Medical Anthropology. Contemporary Theory and Method. Westport : Greenwood Press.

[104] Nardi, B. (1983). "Goals in reproductive decision making". American Ethnologist 3: 697–714.

value of child labor, old age security, husband's approval, and the intrinsic desirability of children influence women's fertility decision-making behaviour.

In other instances, specific decisions in reproductive health have been studied such as selection of birthing method and adoption of family planning. McClain (1985)[105] found that women in California, who chose the trials of labour instead of elective C-section, based their decisions on their previous child birth experiences and their expectations concerning the two types of delivery. Cornwall (2007)[106] explored questions of choice and contingency in having and bringing up children through a series of case studies. Drawing on ethnographic research in south western Nigeria, she argued that reproductive outcomes may be less a result of consciously pursued "reproductive strategies" than of other choices, and are subject to the influence of other individuals, and also of caprice and circumstance. One needs to understand the contingencies with which women and men contend as they seek to manage the circumstances in which they find themselves.

Decisions made by individuals may just rely on habits rather than representing an effort to make a rational choice, as documented by Lindbladth and Lyttkens (2002)[107]. They contended that traditional economic rational-actor model may be relatively less applicable to those with limited resources. The research found that people in lower social positions are more inclined to rely on their habits and are accordingly, less likely to change their behaviour. These differences are reinforced as not only the disposition to maintain habits but also the tendency to consider the habitual as something good, seems to be strengthened in lower social positions. They have defined habits as non-reflective, repetitive behaviour and found three aspects to emerge from sixteen thematically structured interviews, such as the association between habits and preferences, habits as a source of utility, and the relationship between habits and norms.

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[105] McClain, C.S. (1985). "Why Women Choose Trial Of Labour Or Repeat Caesarian Section" The Journal of Family Practice. 21(3): 210-6

[106] Cornwall, A. (2007). "Taking Chances, Making Choices : The Tactical Dimensions of Reproductive Strategies in South Western Nigeria" Medical Anthropology 26(3): 229-254

[107] Lindbladth E and Lyttkens C. (2002) " Habit versus choice : the process of decision making in health related behaviour" Social Science and Medicine. 55(3): 451-465

In addition to the above, Richard et al. (2001)[108] highlighted the importance of moral values and social virtues in the process of health-care decision-making; Paul Farmer (2005)[109] endorsed an emphasis on power dynamics and Hyder et al. (2007)[110] linked decisions for using a health centre with barriers to access such as mobility restrictions on young women, distrust of the health system on the part of the mother-in-law, and a family desire to preserve health traditions. Perrone et al. (1989)[111] collected experiences of women healers of the American Indian, Hispanic, and main stream American cultures as care givers; emphasizing the importance of stories and oral traditions which guide women to take important decisions,

> *" Women stories have not been told. And without stories there is no articulation of experience. Without stories a woman is lost when she comes to make the important decisions of her life. She does not learn to value her struggles, to celebrate her strengths, to comprehend her pain. Without stories she can not understand herself.....She is closed in silence.... If women's stories are not told, the depth of women's souls will not be known.... Stories give shape to lives. As people grow up, reach plateaus, or face crises, they often turn to stories to show them how to take the next step." (Perrone et al. 1989: 208)*

Finkler Kaja (1997)[112] recommended addressing the issue of women's morbidity by attending to theoretical issues about the nature of sickness, and to the interaction between sickness, gender and society. An anthropological analysis of women's health adds new dimensions to an epidemiological and biomedical grasp of women's morbidity. The anthropological gaze requires close scrutiny of individual women's lives from their perspective and the nuances of meaning they each give to their disorder within an ethnographically appraised context of personal experience. A comprehension of these meanings must also be buttressed by an analysis of women's position in society, the ideologies that sustain it, and by probing into male-female relationships. She proposed

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[108] Eckersley,R., Dixon,J. and Matheson, R. (2001). The Social Origins of Health and Well-being Cambridge, Madrid, Cape Town: Cambridge University Press

[109] Farmer, P. (2005). Pathologies of Power: Health, Human Rights, and the New War on The Poor. Berkeley and Los Angeles: University of California Press, Ltd.

[110] Hyder, A.A., Noor, Z. and Tsui, E. (2007). "Intimate partner violence among Afghan Women living in refugee camps in Pakistan" Social Science and Medicine. 64(7): 1536-1547

[111] Perrone, B., Henrietta, H., and Kruegar, V. (1989). Medicine Women, Curanderas, and Women Doctors. Oklahoma: University of Oklahoma Press.

[112] Finkler, K. (1997). "Gender, Domestic Violence and Sickness in Mexico" Social Science and Medicine 45(8):1147-1160 Elselvier Science Ltd.

that women's disorders are embedded in large measure in their social relations, especially with their mates, and quotes Freud (1990)[113] who recognized that for women, marriage was a conflicting institution .)

2.2 Making a Choice for a Childbirth Care Giver

Extensive ethnographic literature exists on the choice of child birth attendant. Sargent (1947)[114] presented an analysis of health seeking behaviour when multiple health care alternatives exist in the framework of the larger issues of cultural context, social change, and diffusion of innovations, and from the perspectives of disciplines including anthropology, sociology and communications among others.

Sargent's (1989)[115] study of obstetrical decision-making in rural Benin describes how Bariba women's diverse objectives and goals, most of which are non-medical in nature, lead them to make particular obstetrical choices. She found that Bariba hospital users demonstrate the continuing relevance of indigenous beliefs as well as the necessity for modification of such beliefs in a changing cultural context;

> *".... the relationship between cultural belief and behaviour, is mediated by a complex set of individual goals and priorities, or agendas. The agendas of importance in this medical domain of decision making include :*
>
> 1. *Proverbial Virtues, such as honour, courage, and stoicism : these concepts are exemplified in Bariba concern for appropriate behaviour by both men and women when confronted with ordeals including warfare, hunting, initiation or child birth. Ideally, the true Bariba faces pain and danger with endurance and impassivity and would prefer death to shame.*
> 2. *Relgious Factors, here primarily involving concern for witchcraft control:.....*
> 3. *Status Aspirations, in particular the goal of attaining elite status by joining the higher echelons of the government civil service or achieving prominence in Commerce.....urban Bariba aspire to be categorized as civilized.*

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[113] Sigmund, F. (1990). Beyond the Pleasure Principle. New York: W. W. Norton and Co. Inc

[114] Sargent, C. F. (1947).The Cultural Context of Therapeutic Choice. Obstetrical Care Decisions Among the Bariba of Benin. Dordrecht : Holland/Boston: USA. London :England D. Reidel Publishing Company

[115] Sargent, C. F. (1989. Maternity, Medicine and Power. Berkeley, Los Angeles and London: University of California Press.

4. *Medical Concerns, or the search of competent care: this priority appears influenced historically by the marked success of cosmopolitan medicine in eradicating epidemic diseases,..." (Sargent 1989:3)*

She suggested that both cultural dimensions of medical decision-making and extrinsic or structural factors constraining such decisions, interplay in the realm of reproduction.

Goforth's (1988)[116] research on women's choice of birth attendants in a Yucatec Maya community, demonstrated that access to economic resources, was the best predictor of pregnant women's decision to use traditional or biomedical obstetrical practitioners.

Robert Anderson (1996)[117] explored some of the recent anthropological research on optional reproductive strategies and found that cross-culturally, low technology childbirth techniques are often associated with much better outcomes. Modern medicine has turned child-birth into a factory like process in which the body acts as a machine and women are disempowered.

Maria Zadoroznyi (2001)[118] has also examined how women choose their birthing caregivers. Her study of the birthing narratives of fifty women has revealed that they acted as both consumers and patients in the medicalised encounters around their births. Behaviour that Zadoroznyi identified as consumers included: choice of the appropriate maternity services; choice of practitioners; and "shopping around" for birth-care. She noted that consumerism is not the only phenomenon — women were patients too, identifying trust and talking time as critical to their experience, but the consumption aspect was an important one. Zadoroznyi found that women were more 'activist' in their second and subsequent birth experiences than their first; and that class played a significant role in how women exercised 'choice' in birth service delivery. She has

[116] Goforth, L. (1988). Household Structure and Birth Attendant Choice in a Yucatec Maya Community. Doctoral Thesis. Los Angeles: Univ. of California.
[117] Anderson, R. (1996). Magic, Science and Health: The Aims and Achievements of Medical Anthropology. Fort Worth,TX: Harcourt Brace College Publishers.
[118] Maria Zadoroznyi (2001). "Birth and the 'Reflexive Consumer': Trust, Risk and Medical Dominance in Obstetric encounters", Journal of Sociology 37(2): 117-139.

suggested that this development represents (another) small but significant challenge to medical dominance.

2.2.1 Traditional Birth Attendants (TBAs) or *'Dais'*

Janet Chawla (1994)[119] has highlighted the practice of a local *'dai'* as a gynocentric model of female procreative power in the realm of the birthing experience in a generally misogynist Indian tradition. The *'dai'* is seen as the low caste person ritually contaminated through her handling of the dangerous and polluting effluvia of birth- a 'glorified sweeper' on the one hand, and seen as a 'sub-standard obstetrician" in the modern medical system. Chawla sees the *'dai'* as a practitioner of a holistic medicine, combining physical techniques for the management of parturition with ritual gestures that assist the birthing process in more subtle ways - by acting on the unconscious mind of the parturient women and affirming the positive aspects of women's power to bring forth new life. Thus, she is a ritual practitioner deploying a repertoire of symbolic actions that are exclusive to the community of women, associated with the magico-religious tools of an agrarian society; invoking the protection of a holistic and iconic goddess; whose realm is both life and death, fertility and disease.

2.2.2 Vesting of Authoritative Knowledge

Sargent (1996)[120] explored the linkages between the distribution of knowledge about birth and the use of technology; the valuation of biomedical and alternative 'ways of knowing' about birth; the production of authoritative knowledge through interaction; and the relationship between authoritative knowledge and social status. In the Maya low technology, collaborative birthing system in Mexico, the midwife and other adult women share knowledge about birth. In contrast, Spanish-speaking women undergoing caesarean

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[119] Chawla, J. (1994). Child–bearing and Culture : Women Centered Revisioning of the Traditional Midwife: The *'dai'* as a Ritual Practitioner. New Delhi: Indian Social Institute.

[120] Sargent, C.F. and Bascope, G. (1996) "Ways of Knowing about Birth in Three Cultures" Medical Anthropology Quarterly. 10(20: 213-236.

delivery in a high technology public hospital in Texas are, due to their limited English, only minimally able to interact with hospital staff. While they acknowledge the authoritative position of biomedical personnel and value technology, they protest their inability to communicate during their hospitalization. While use of technology is infrequent in the Jamaican case, authoritative knowledge remains vested in biomedicine. Amara and Carol (1996)[121] state that

> *"..... in all regions of the world, there is never one single system of authoritative knowledge, but several. In any particular frame of observation the dominant system either better explains the experienced world to the actor, or is associated with a strong power base.... Systems coexist with varying degrees of cooperation and conflict. People seeking help often move from one to another, and practitioners borrow techniques from each other. Indeed, they are even urged to borrow, as in traditional birth attendant training programs, and synergistic medical systems evolve." (ibid:271)*

They found that the knowledge of traditional birth attendants about birth and health is not overtly shared with men, and thus, their secret skills help to underpin the relatively high social status women have in the area. Women were not subsumed under a single male religious hierarchy as is common in the 'great' religions and childbirth and much healing also takes place in this feminine–religious domain; it is literally 'women's business'. Traditional legitimacy develops through time as qualities of merit, valor, and holiness become associated with a corporate group, or as a descent line of a famous midwife and the junior kinswomen, she has trained. Indeed, all the wisdom associated with ancestral time is of this nature, and un-coerced obedience arises from personal loyalty to those recognized as the heirs and bearers of that legitimacy. Davis and Davis (1996)[122] have explained the distortion caused by western medicine to the mother-baby dyad. They state,

> *"The history of Western Obstetrics is the history of technologies of separation. We've separated milk from breasts, mothers from babies,*

[121] Jambai, A. and MacCormack, C. (1996). " Maternal Health, War, and Religious Tradition: Authoritative Knowledge in Pujehun District, Sierra Leone" Medical Anthropology Quarterly 10(2): 270-286

[122] Davis, F.R. and Davis, E. (1996). "Intuition as Authoritative Knowledge in Midwifery and Homebirth" Medical Anthropology Quarterly 10(2): 237-269

fetuses from pregnancies, sexuality from procreation, pregnancy from motherhood. And finally we're left with the image of fetus as a free-floating being alone, analogous to man in space, with the umbilical cord tethering the placental ship, and the mother reduced to the empty space that surrounds it."(ibid:237)

2.3 Making a Healer Choice for General Health Needs

Colson (1971)[123] posited that the use of modern, as opposed to indigenous sources of therapy, would correspond to the supposed origin of the disease. A disorder of natural origin would be in the domain of the modern therapist, whereas for disorders of supernatural origin, the client would seek traditional health care. This is also confirmed by Ryan (1998)[124] who provided a systematic analysis of sequential data of the lay person's behavior in choosing amongst a variety of options in a pluralistic environment. It was found that the villagers considered seven health actions, including delaying initial treatment, using various home remedies or pharmaceuticals, going to a government clinic or a Catholic hospital, and consulting a private nurse or a traditional healer. The treatment sequences suggested customarily delaying treatment as a tactic in the decision-making process. Home based remedies were used earlier before seeking treatment from outside the compound. Traditional healers were used as a conduit to other outside options. Three basic tenets were followed: firstly uncertainty was minimized by identifying illness types that require particular health actions and by delaying action; secondly the cost of care is minimized by first resorting to less expensive and easy to obtain remedies; and thirdly a variety of treatments is tried in the hope of finding at least one treatment that helps stop the illness.

Patient – provider interactions also exhibit power and control hierarchy between them. Haug and Lavin (1981)[125] state that a power-authority differential is characteristic of

[123] Colson, Anthony. (1971). "the Differential Use of medical resources in developing Countries", Journal of Health and Social behaviour. 12: 226-237

[124] Ryan, G.W. (1998). "What do sequential behavioural patterns suggest about the medical decision making process? : Modelling home case management of acute illnesses in a rural Cameroonian village" Social Science and Medicine 46(2): 209-225

[125] Haug, M.R. and Lavin, B. (1981). "Practitioner or Patient- Who's incharge? Journal of Health and Social Behaviour 22: 212-229

most encounters between lay persons and professionals. Professionals have greater power and authority by virtue of their training, knowledge and skill. In exchange for their services to community and society, professionals are accorded a preferred and special status, which reinforces and augments their power and authority.

Gerson (1976)[126] has viewed illness and the physician –patient encounter in terms of a political process involving conflict between the patient's needs and the physicians who control the work, as well as allocation of scarce resources. Ermann's (1976)[127] analysis is of the shift from decision-making by independent health care professionals who are presumed to be controlled by their clients, towards decisions made by physicians who are employees of hospitals.

2.4 Provider Choice: Congruence with Belief System, Availability and Perceived Efficacy

Sargent (1982)[128] used a multi-faceted model to study therapeutic choice for child birth among the Bariba women of Benin. She suggests that the characteristics of the client, the service therapist and the condition interact in affecting the resulting choice. A set of salient factors, including values and beliefs exists and may change, varying with the situation (e.g. with residence of mother or rank order of the child). The client may be viewed as weighing such factors in terms of the relative monetary and non-monetary costs. Certain combinations of factors, carry different degrees of risk, uncertainty and belief.

A necessary condition of the study of decision making is of provider choice, including the differential influence of individuals based on gender, age and the status attributes. Analysis follows consideration of rewards and costs involved in different choices. Two factors are emphasized: Homophily and Heterophily. Homophily is defined as 'the degree

[126] Gerson, E.M. (1976). The Social Character of Illness. Deviance or Politics. Social Science and Medicine. 10: 219-224

[127] M. D.Ermann, M. D. (1976). "The Social Control of Organizations in the Health care Area". The Milbank Memorial Fund Quarterly, Health and Society. 54(2): 167-183.

[128] Sargent, C.F. (1982). The Cultural Context of Therapeutic Choice. Obstetrical Care Decisions among the Bariba of Benin. London: Reidel Publishing Company.

to which pairs of individuals who interact are similar in certain attributes such as beliefs, values, education , social status and the like. Heterophily refers to the 'degree to which pairs of individuals who interact are different in certain attributes (Roger and Shoemaker 1971)[129].

Hall et al. (1981)[130] has explained this concept as 'reciprocity in the medical encounter'. They found lack of fulfillment of the role expectations held by the rural clients for the nurse midwives. Similarly, attributes such as beliefs, values, past experiences with health care practice, influence prospective clients in their selection among health care alternatives. The explanation of medical encounter is analysed on functional and socio-emotional domains for a provider. In the functional or task domain, questions asking by the provider, information giving, counseling, managing treatment, referral, competence scores and concordance on problem identification and treatment are evaluated. In socio-emotional domain, explicit communication of affective content, conveyed affect (warmth, anxiety, empathy, dominance); interpreted effect and interpersonal attitudes are considered important. Kleinman (1978)[131] has described the above phenomenon as following statement,

> *"patient-doctor interactions are transactions between explanatory models, transactions often involving major discrepancies in cognitive content as well as therapeutic values, expectations and goals (ibid: 254)*

Wenonah Lyon (1991)[132], in her article "Competing Doctors, Unequal Patients: Stratified Medicines in Lahore", discusses 'pluralistic medical models' in Lahore's Green Town. In this stratified system of medicines, the author tells us, a small number of wealthy patients visit a small number of foreign-trained physicians; the larger middle class use the large number of qualified MBBS doctors. The great mass of patients utilise the services of the

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[129] Rogers, E.M. and Shoemaker, F.F. (1971). Communication of Innovations: a cross-cultural approach. NewYork: Free Press.
[130] Hall, J.A., Roter, D.L. and Rand, C.S. (1981). Communication of affect between patient and physician. Journal of Health and Social Behaviour. 22: 18-30.
[131] Kleinman, A. (1978). "Concepts and a model for the comparison of medical systems as cultural systems." Social Science and Medicine.12(2B): 85-95
[132] Wenonah, L. (1991). "Competing doctors, Unequal patients: Stratified Medicine in Lahore" in Economy and Culture in Pakistan.Migramts and Cities in a Muslim Society(eds) Hastings Donnan and Pnina Werbner. London: Macmillan.

largest numbers of allopathic practitioners, both qualified and quacks. The highly specialised elite doctors give treatments to the rich elites, and the large poor masses use the services of common doctors.

2.4.1 Stereo-typing of the Providers

Bogart et al. (2004)[133] examined the patients' stereotypes about healthcare providers in the decision process, specifically examining the association of stereotypes to health care satisfaction and help-seeking among a low income clinic sample; the relationship of stereotypes to satisfaction and adherence to treatment; and the association of stereotypes to satisfaction and help seeking. Their findings indicate that individuals, who held more negative stereotypes about physicians, sought care less often when sick, were less satisfied with the care that they did obtain, and were less likely to adhere to physician recommendations for treatment.

Another dimension of patients' expectations from healers, also need to be considered. Informed decision-making by a client or patient is one of the criteria for the quality provision of health services. However, if the prevailing medical culture is paternalistic, patients may be conditioned to expect their doctors to take the responsibility for making decisions[134].

Anthropologists have also demonstrated that treatment regimes adhered to only if they are consistent with the individual's socio-cultural construction of reality (Chrisman and Kleinman 1983)[135].

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[133] Bogart L., Bird S., Walt L.,Delahanty, D. and Figler,J. (2004). "Association of stereotypes about physicians to health care satisfaction, help seeking behaviour, and adherence to treatment" Social Science and Medicine. 58(6) : 1049- 1058

[134] O'Donnel,M., Monz,B. and Hunskaar,S. (2007). "General preferences for involvement in treatment decision making among European women with urinary incontinence" Social Science and Medicine. 64(9): 1914-1924

[135] Chrisman, N.J. and Kleinman, A. (1983). Popular Healthcare, Social Networks, and Cultural Meanings. NewYork: The Free Press.

2.5 Factors Affecting the Use of Modern Medical Services

Ippolytos Kalofonos and Lawrence A, Palinkas (1999)[136] identified three major items underlying the lack of prenatal care: lack of trust in formal versus informal institutions, wanted versus unwanted pregnancies, and the importance of the social network among the homeless and underserved residents of San Diego.

Jensen and Stewart (2003)[137] found that the staffing level of nearby health facilities is a determinant of the probability that the health facility is utilized.

Cecilia Coale Van Hollen (2003)[138] has asserted that even child birth is affected by globalization and quotes the example of India, where the trend is away from home births, assisted by midwives, toward hospital births with increasing reliance on new technologies. Others like Slobin (1998)[139] quoting George[140], have suggested that doctor and machine mediated 'seeing' demotes bodily experience to a secondary order of significance. It appears that relinquishing one's own personal power, is a pre-requisite for obtaining the gifts of modern medicine.

Chawla and Ellis (2000)[141] observed increased utilization after improving efficiency at public facilities such as availability of drugs, training of health personnel in the use of standard diagnosis and treatment protocols, strengthening management capacity and improving managerial and supervisory capacity even with introduction of user charges.

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[136] Kalofonos,I. and Palinkas, L.A. (1999). "Barriers to Prenatal Care for Mexican and Mexican American Women" Journal of Gender; Culture and Health 4 (2): 135-152

[137] Jensen, E. R. and Stewart J. F. (2003). " Health Facility Characteristics and the Decision to Seek Care" The Journal of Development Studies 40(1):79-100

[138] Hollen, V. and Coale, C. (2003). Birth on the Threshold : Childbirth and Modernity in South India . Berkeley and Los Angeles : University of California Press

[139] Slobin, K.(1998). "Repairing Broken Rules: care seeking narratives for menstrual problems in Rural Mali. Medical Anthropology Quarterly12(3): 363-83

[140] Legal and Ethical Issues for Health Care professionals /George D. pozgar; legal review, Nina M. Santucci: medical review, John W. Pinnela. 2nd Edition (2009) London, Sadbury and Mississauga: Jones and Bartlett Publishers International.

[141] Chawla, M. and Ellis, R. (2000). "The Impact Of Financing And Quality Changes On Healthcare Demand In Niger" Health Policy and Planning15(1): 76-84

Ndyomugyenyi et.al. (1998)[142] found that health seeking behaviour was influenced by several factors, including the perceived high cost of antenatal care services, of conducting delivery and treatment, and perceived inadequacy of services provided by formal health system. Inadequacy of formal health services, was perceived by users to be partly due to understaffing and irregular supplies of essential drugs.

2. 6 Beliefs as Underlying Factors

There is a focus on belief and behaviour to emphasize the cultural context in understanding the individual health care decisions (Erika Brady, 2001)[143]. Anthropological studies have explored the effects of "cultural complexes" such as religion, philosophy, and linguistics. Leon and Byron (1978)[144] and Kleinman (1980)[145] have also contributed in this regard. Young (1981)[146], explored medical choices in a Mexican village and writes,

> *"The best way of explaining the observable pattern of illness treatment choices characterizing a community is to discover , in as direct way as possible , the ideational basis of these choices in the minds of the community members." (Young 1981:5)*

Young denies the determinative role of belief. He concluded that, although numerous previous studies argued that the underutilization of modern medicine was due to traditional beliefs concerning illness, his data showed that the residents of Pichataro retained such beliefs, but this had minimal impact on the treatment choice. Extrinsic factors such as inaccessibility and exclusion provided the primary explanation for observed medical choice.

> *"The best way of explaining the observable pattern of illness treatment choices characterizing a community is to discover, in as direct way as*

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[142] Ndyomugyenyi, R. , Neema, S. and Magnussen, P.(1998). " The use of formal and informal services for antenatal care and malaria treatment in rural Ugnada" Health Policy and Planning 13(1): 94-102

[143] Brady, E. (ed.) (2001). Healing logics : Culture and Medicine in Modern Health Belief Sysytems. Los Angeles : Utah State University Press

[144]Kleinman, A., Eisenberg, L. and God, B. (1978). "Culture, Illness and Care. Lessons from Anthropological and Cross Cultural Research." Annals of Internal Medicine 88(2) : 251-258

[145]Kleinman, A. (1980). Patients and Healers in the Context of Culture. Berkeley , Los Angeles, London: University of California Press.

[146] James, Y. (1981). Medical Choices in a Mexican Village. New Brunswick, New Jersey: Reuters University Press.

possible, the ideational basis of these choices in the minds of the community members." (Young 1981: 5)

Mc Phail and Campbell (2001)[147] explored the societal, normative and cultural constructs in which individual level phenomena such as knowledge, attitudes and behavior are negotiated or constructed. They explored the inter-relationships of individuals containing social systems, cultural norms and system constraints; and understood that the resulting behavior was a product of these inter-relationships rather than something intrinsic to the individual.

The work of Welsh (1983)[148] explicitly treated the role of belief in an understanding of medical practices extending River's dictum that medical practices *"are logical consequences of ....beliefs"* (1924, quoted in Welsh 1983:32). In an analysis of medical belief and practices among the Ningerum of Papua New Guinea, he demonstrated that use of hospital services does not necessarily imply a change in belief system. Although indigenous and cosmopolitan medical practices derive from differing conceptual frameworks, goals and strategies remain constant from the patient's perspective, regardless of the type of care solicited. He argues that,

"we should first seek explanations of all treatment choices in the same indigenous illness beliefs- whether treatment chosen have their origins in indigenous or introduced medical traditions" (ibid:18)

2.6.1 Beliefs about Causation of Illness

Decisions for seeking care for particular illness are, to a great extent, shaped by an individual's belief about the disease causation. One widely held belief, in many parts of the world, is about the evil eye inducing illness and hence, the appropriate healing

[147] Mac Phail, C., Campbell, C. (2001).'I think condoms are good but, aai, I hate those thins': condom use among adolescents and young people in Southeren African Township. Social Science and Medicine 52: 1613-27

[148] Welsch, R. L. (1983). "Traditional Medicine and Western Medical Options among the Ningerum of Papua new Guinea". In L. Romanucci-Ross, D- Merman, and L. Tancredi, (eds.)The Anthropology of Medicine. NewYork : Praeger.

strategy should be the one that nullifies its effect. Lawrence[149] explains the concept of the evil eye,

> *"Belief in the evil eye assumes that the desirous stare of an individual thought to be motivated by envy can bring illness or misfortune to the object of person envied the feature characterizing both the evil eye and the menstrual taboo is belief in the powerful influence of the fixed gaze. Whatever harm is thought to be communicated is transmitted through the eyes. The folk theory underlying the belief is based on the notion that staring, or even paying a compliment, implies desire. Unsatisfied want or frustrated desire are thought to lead to envy, jealousy, and ill feelings." (ibid:130-131)*

Alison (2005)[150]examines the supernatural beliefs of *najar* (evil eye) and *bhut* (ghost) and their roles in illness causation in Gujarati families in Britain today. This study indicates that *'najar'* and *'bhut'* continue to be a concern of women in most Gujarati families in Britain today and across all socio-economic groups, not confined to those on the 'bread-line', as have been previously suggested. These beliefs align themselves with *Hindu* ideas of the soul and reincarnation: powerful forces residing outside the body.

There is a wide variation in beliefs of disease causation across the globe. Payer 1996[151] illustrates in her comparative review of medical practice in the United States and European countries, how the etiology of a migraine is vascular in the U.S., hepatic in France and gastrointestinal in Britain. Additionally, while hypotension is a predictor of longevity in the U.S., it is considered pathological in Germany and called *Herzinsuffizenz* (cardiac insufficiency).

Beliefs also vary among different societies about the prognosis of an illness. Crandon-Malamud, (1997)[152] provided an example of how blood deficiency (anemia) is viewed in Bolivian sub-culture of Aymara Indians. The Western trained physicians attribute anemia to deficiency in the oxygen carrying capacity of haemoglobin and consider it as a

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[149] Lawrence, D. L. (1988). "Menstrual Politics. Women and Pigs in Rural Portugal" (pp.117-136) in Blood Magic. The Anthropology of Menstruation. Los Angeles: The Regents of University of California.
[150] Alison, M. S. (2005). " Najar or Bhut – Evil eye or ghost affliction : Gujrati views about illness causation" Anthropology and Medicine 12 (1): 61-73
[151] Payer, L.(1996). Medicine and Culture. NewYork : H. Holt and Co.
[152] Crandon-Malamud, L. (1997). Phantoms and Physicians : Social Change Through Medical Pluralism in L.Ramanucci- Ross, D.Moerman, and R.Tancredi (eds.), *The Anthropology of Medicine*(pp.31-53). London: Bergin and Gravy

relatively mild condition with good outcomes of treatment. However, the local Aymara shaman (yatiri) would name the disease "*limpu*" with fatal outcomes caused by the spirit of a stillborn who, having died without baptism, is denied entrance to heaven and has to consume to death, the body of the afflicted in order to continue to exist on earth.

Audrey Prost (2006)[153] has focused on the incidence of humoural wind (rlung) disorders among Tibetan exiles in India. He investigated the reasons behind the emergence of rlung as a significant problem among Tibetan exiles, and tried to unpack some of the local meanings of this 'epidemic'. Previous studies have generally described 'rlung' disorders as symptomatic of political and moral concerns, highlighting the connections that Tibetans make between physical, moral and psychological states in the context of Buddhist practice and everyday life. He aimed to further nuance these findings by showing that, while Tibetan exiles include complex causes linked to morality and psychosocial wellbeing in their explanations of 'rlung' disorders, they also 'cut' into this explanatory network in strategic ways, sometimes bypassing religious or psychosocial interpretations of illness altogether. Drawing on this analysis, he has warned researchers against literal readings of general religious precepts when analysing people's everyday negotiations of illness and wellbeing: the attribution of causation is always strategic, and religious observance should never be assumed to be uniform, or taken as a given.

Pelto and Pelto (1997)[154] argue that the concept of 'individual knowledge', utilized by public health professionals, is best regarded as 'cultural belief' in anthropology. They related the development of a decision-making approach to the understanding and analysis of health care behavior.

The study by Mary and Isaac (2006)[155] has showed that mothers classify childhood illnesses into four main categories: (1) not serious: coughs, colds, diarrhoea; (2) serious

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[153] Prost, A. (2006). "Causation as Strategy: Interpreting Humours among Tibetan Refugees" Anthropology and Medicine 13(2) : 119-130

[154] Pelto, P.J. and Pelto, G.H. (1997). " Studying Knowledge, Culture, and Behaviour in Applied Medical Anthropology" Medical Anthropology Quarterly 11(2): 147-163

[155] Nyamongo, M.A. and Nyamongo, I.K. (2006). "Health Seeking Behaviour of Mothers of Under-Five-Year-Old Children in the Slum Communities of Nairobi, Kenya" Anthropology and Medicine 13(1): 25-40

but not life-threatening: malaria; (3) sudden and serious: pneumonia; and (4) chronic and therefore not requiring immediate action : malnutrition, tuberculosis, chronic coughs. This classification is reflected in the actions taken and time taken to act. Shops were used as the first source of healthcare, and when the care moved out of the home, private health facilities were used more compared to public health facilities, while even fewer mothers consulted traditional healers.

The study by Nyamanga et al. (2006)[156]showed that there were significant parallels between human and livestock illnesses regarding terminology, perceptions of pathogenesis and treatment seeking practices. Even practitioners and their medications were often the same. The rationale behind pathogenesis in both cases, was usually that illnesses resulted from some form of inhibition of flow through blockage or clogging of the various 'channels' in the body. Treatment aimed at decongesting or unblocking these channels so as to create openness that would guarantee normal flows and restore health. The study concludes that the domain of animal illness be taken more into account in human medical anthropological studies and vice versa. It further argues the case for considering these similarities when planning and implementing health care services.

Whitley et al. 2006[157] investigated health beliefs of West Indian immigrants in Montreal with somatic, emotional, or medically unexplained symptoms. The overall aim was to elicit and explore illness narratives, explanatory models, symptom-attribution and help-seeking in the community. A sample of West Indian immigrants ascribed their symptoms to post-migratory experience and particularly highlighted the importance of chronic overwork since migration and irregular patterns of daily living. Many had worked long hours, including overtime and moonlighting. Participants related their irregular patterns of daily living to disturbances of bodily functions (e.g., sleeping, eating) as well as to social functions (e.g., family life). These themes reflected elements of ethno-physiological beliefs common in the West Indies, as well as North American illness

[156] Nyamanga, P.A., Suda, C. et al. (2006). "Similarities between Human and Livestock Illnesses among Luo in Western Kenya" Anthropology and Medicine 13(1):13-24

[157] Whitley, R., Kirmayer, L.J., et al. (2006). "Public Pressure, Private Protest: Illness Narratives of West Indian Immigrants in Montreal with Medically Unexplained Symptoms" Anthropology and Medicine 13(3): 193-205

models. Attributing medically unexplained symptoms to overwork and irregularity in personal and social realms, may be a socially acceptable way of critiquing perceived injustices in participants' work, social and interpersonal situations for this marginalized population.

Ecks (2004)[158] explored self-care beliefs in relation to Ayurvedic interpretations of digestion in Kolkata (formerly Calcutta, India). It is held that attentive care of the self, and especially for the stomach, can set a person free from dependencies. Self-care is connected to self-control and a parallel between bodily sovereignty and cultural/political sovereignty, is drawn. 'Modern' people are seen as unable to live up to the ethics of self-care due to 'lack of self-control' which is one of the main reasons for continuing dependency in all spheres of life.

2.7 Self-Control and Decision-making

The aspects of self control, self esteem and self interest are important to map an individual's ability to make decisions and can be considered the determinants of 'autonomy'.

A qualitative exploratory study by Gupte et al. (1997)[159] was conducted in rural Maharashtra to understand the issue of abortion and the factors that affect this process in the overall context of women's lives. Four important landmarks in a woman's life were used as indicators to assess women's role in decision making namely: women's role if any in choosing a spouse, contraception and the first pregnancy, place of delivery and children's education. The paper highlights the fact that the process of decision making involves not only the couple in question, but the larger family, also. Multiple factors intervene during the decision making phase, making the process dynamic and situation specific. The ethical and practical dilemmas that men and women go through during the

[158] Ecks, S. (2004) "Bodily sovereignty as political sovereignty: 'self-care" in Kolkata, India Anthropology and Medicine 11 (1) : 75-89

[159] Gupte, M., Bandewar, S. and Pisal, H. (1997). "Abortion Needs of Women in India: A case Study of Rural Maharashtra" Reproductive Health Matters. 5(9): 77-86

process are also ignored. The findings make out a strong case for encouraging a dialogue between the couple through counseling services before and after the abortion, providing health education related to safe, effective, reversible and user controlled contraceptives, reaching safe abortion services to women as closed to the village as possible and increasing women's decision making capacity in all areas of life, including those related to reproduction and sexuality.

In Pakistan's context, a higher external locus of control (dependence on others) and lower self-esteem is found among adolescent girls than boys[160]. It is also found that a father's discriminatory attitude adversely affects a girl's self-esteem more than the mother's attitude[161]. In a study on marital adjustment and the prevalence of depression, it was found that working women had higher self interest, better marital adjustment and less depression as compared to the non-working women. The later group also showed higher introspective self-blame and avoidance as compared to working women[162]. Thus economic empowerment of a woman is seen to improve her self-control over her life and her decisions. Similar effect is seen as dowry (the single most important kind of a material possession for a married woman in a society where property inheritance is often denied to daughters) is documented to have a positive correlation with marital adjustment[163]. A common decision taken by women in Pakistan is in the selection of food. Food purchase decisions among women are affected by cost, quality, preferences of peers, husbands and children, mass media messages, parents and convenience of food.[164] The status of women and health care utilization patterns have been found to be strongly linked (NIPS 2007)[165]. The study reports that 68% of ever-married women in the national sample have no education and 95% of women do not own any property. 42% women

[160] Naz, A. (2003). Relationship Between Locus of Control and Self Esteem Among Adolescents- M.Phil thesis National Institute of Psychology QAU, Islamabad

[161] Ashraf, M. (2003). Parents' Discriminatory Attitude Toward Women And Its Relationship With The Self-Esteem of Their Children- M.Phil dissertation, National Institute of Psychology, QAU, Islamabad.

[162] Sarwar, A. (1994). Marital Adjustment And Depression Among Working And Non-Working Women M.Phil thesis National Institute of Psychology QAU, Islamabad

[163] Satti, S. T. (2002). Impact of Dowry On Marital Adjustment Among Couples- M. Sc. thesis National Institute of Psychology QAU, Islamabad

[164] Nazir, B. (2001). Factors Affecting the Food Purchase: Decision of Women- M.Phil dissertation, National Institute of Psychology, QAU, Islamabad.

[165] Status of Women, Reproductive Health and Family Planning Survey, National Institute of Population Studies, Islamabad, 2007.

showed interest in availing credit schemes to establish their own enterprise. Women only command great respect and high status in their familial roles, i.e. management of household and family affairs. Sixty five percent women said that their in-laws and husbands listen to them and believe in them. In 47% of households in Punjab, a woman decides what to cook and in 69% handles the money in household affairs. Sixty four percent of all marriages are between first and second cousins. Fifteen percent of women were working for money (mostly employed in production, agriculture and self-employed). 7% reported being able to keep all the money they earned and 22% reported giving all the money to husbands. Only 27% of rural women were allowed to go alone to the health centre, 30% to the market, 48% to neighbourhood, 33% to a friend's place and only 14% to the city or another village. Thus, 27% of rural women use a doctor for antenatal care (highest coverage in the age group 35 plus) and 81% delivered at home. 26% women had experienced some medical problem during their last pregnancy.

2.8 Economic and Contextual Factors

The materialist school in medical anthropology focuses on political economy in relation to health concerns and focuses on macro-level forces such as economic and organizational factors affecting the structure and capacity of the medical care system itself (Pearce 1980[166]; Jules 1981[167]). Kundstadter 1975[168] had also suggested that decision-making process may be more strongly influenced by factors of cost, geographic proximity, and perceptions of rates of cure than by cognitive factors. Foster and Anderson (1978)[169] argue that,

> *"the decision to use new practice is a pragmatic one, made without reference to indigenous theory or need to reconcile conceptual contradictions" (Foster and Anderson 1978:19)*

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[166] Pearce, Tola Olu (1980). "Political and Economic Changes in Nigeria and the Organization of Medical Care" Social Science and Medicine 14 (B): 91-98

[167] Jules-Rosette, Benneta (1981). "Faith Healers and Folk Healers : The Symbolism and Practice of Indigenous Therapy in Urban Africa" Religion (11): 127- 149

[168] Kundstadter, Peter (1975). "Do Cultural Differences make Any Difference? Choice points in Medical Systems Available in North Western Thailand" In Arthur Kleinman et al. Eds. Medicine in Chinese Cultures. Washington D.C. : Fogarty International Centre for Advanced Study in Health Sciences.

[169] Foster, G. M., and Anderson, B.G.(1978) Medical Anthropology. New York , San Francisco : John Wiley and Sons.

Yoder (1981)[170] suggests that studies concerning how medical knowledge is explored in diagnosis and in seeking treatment *"exaggerate the importance of 'belief' and underlying explanatory theories in underlying behaviour related to illness."* He further declares that the management of illness can be better understood through a diachronic analysis of disease episodes, including both *"an examination of behaviour related to disease and illness and analysis of the conceptual categories which give meaning to the experience of illness"* (Yoder 1981 :244).

2.9 Cultural and Structural Factors

The later studies on decision-making have tried to encompass both the cultural and structural factors. Foster (1984)[171] has noted that the complexity of factors determining health care choices should not be underestimated. He states,

> *"Factors of exclusion and inaccessibility as well as cultural factors impinge on health care decisions". (Foster 1984: 21)*

Collier and Yanagisako (1987)[172] endorsed the above approach to seek an interpretation of health care decisions through an understanding of the articulation between 'belief and behaviour', as well as consideration of larger societal constraints. They argue that while political and economic forces may set the parameters within which individuals make decisions, it is none the less necessary to detail the process by which selections are made from among the available alternatives. Rather than seeking to substantiate the primacy of either material or ideological determinants, they argue that ideas and actions are aspects of a single dialectical process,

> *"we conceptualize the inter-related, but not necessarily consistent, meanings of social events and relationships are both shaping and being shaped by practice". (Collier and Yanagisako,1987: 42)*

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[170] Yoder, P. Stanley.1981. "Knowledge of Illness and Medicine among Cokwe of Zaire". In John Janzen and Gwyn Prins, eds. Causality and Classification in African Medicine and Health, *Social Science and Medicine, Special issue* 15 B(3) :237-246

[171] Foster, George M.184 "Anthropological Research Perspectives on Health Problems in Developing Countries" *Social Science and Medicine* 18 (10): 847-857

[172] Collier, Jane Fishburne, and Sylvia Junko Yanagisako, eds.1987. Gender and Kinship. Essays towards a Unified Analysis. Stanford : Stanford University Press

The same ideas were propagated by Phyllis (1986)[173]

> *"Science is predictable and reliable; human behaviour is not. Reactions to the conditions and circumstances surrounding health problems are dependant upon many social, economic and cultural variables. Emotions, feelings, and deeply held values influence one's reactions to health problems and to the treatment prescribed for these problems" (Phyllis 1986 : ix)*

David et al.(1999)[174], have argued that psychological culture influences health through a relationship between cultural discrepancies, physical health and subjective well-being by affecting coping strategies, emotion and mood states. A semiotic framework for analyzing therapeutic systems with a correspondence between conceptual categories and behaviour, was emphasized. This idea was also put forth by Staiano,

> *"All ... cultural systems.... take cognizance of the signs which indicate disease or illness and they have 'medical' theories or ideologies which both provide aetiology and allow prognostication .... such signs prescribe therapies, that is, they function as signals within a given cultural context, producing desirable and expected 'action'. (Staiano 1981:328)[175] "*

Welsch (1983)[176] explicitly treats the role of belief in an understanding of medical practice by extending Rivers's dictum that medical practices

> *"are logical consequence of .... beliefs"* (1924, quoted in Wesch 1983:32).

In an analysis of medical belief and practices among the Ningerum of Papua, New Guinea, he demonstrated that use of hospital services does not necessarily imply a change in belief system. Although indigenous and cosmopolitan medical practices derive from

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[173]Stern Phyllis Noerager (1986) Women, Health , and Culture. Washington : Hemisphere Publishing Corporation.

[174] David Matsumoto, Natalia Kouznetsova, Rebecca ray, Charlotte Ratzlaff, Michael Biehl and Jacques Raroque (1999) "Psychological Culture, Physical Health and Subjective Well being" *Journal of Gender, Culture and Health*;4 (1): 1-18

[175] Staiano, K.V.(1981). "Alternative Therapeutic Systems in Belize :A semiotic Framework in John Janzen and Gwyn Prins, eds. Causality and Classification in African Medicine and Health, Social Science and Medicine, Special issue 15 B(3) :328.

[176] Welsch, R. L. (1983). "Traditional Medicine and Western Medical Options among the Ningerum of Papua New Guinea". In L. Romanucci-Ross, D. Moerman, and L. Tancredi, eds. The Anthropology of Medicine. New York : Praeger.

differing conceptual frameworks, goals and strategies remain constant from the patient's perspective, regardless of type of care solicited. He argues that,

> *"we should first seek explanations of all treatment choices in the same indigenous illness beliefs – whether the treatment chosen have their origins in indigenous or introduced medical traditions"*
> *(Welsch, 1983:18)*

John Janzen and Gwyn Prins (1981)[177] in their work published in the same year quote Staino's[178] work on "Alternative Therapeutic Systems in Belize",

> *"All ... cultural systems.... Take cognizance of signs which indicate disease or illness and they have 'medical' theories or ideologies which both provide aetiology and allow prognostication.... Such signs prescribe therapies, that is , they function as signals within a given cultural context, producing desirable and expected 'action'.*
> (Stiano as quoted by Janzen and Prins :18)

Bhatia and Cleland (2001)[179] studied health care seeking and expenditure by young Indian mothers and found that out of 911 completed illness episodes, no action was taken in 16% of cases, self-medication was taken in 26% and a practitioner was consulted in the remaining 58%. The proportion of cases in which a practitioner was consulted was highest for pregnancy/family planning (85%) and infective/parasitic diseases (71%) including fevers and diarrhea. An appreciable proportion (30%) of genito-urinary problems was completely ignored. Resort to self-medication was high in episodes classified under the categories of nervous and sense organs(unrelated headache, inflammation of eye and ear etc.), connective tissues (unrelated body ache, musculo-skeletal), and of circulatory and respiratory problems. In 72% of severe episodes, a practitioner was consulted, compared to 50% of episodes considered to be mild or moderate.

While political and economic forces may set the parameters within which individuals make decisions, it is nonetheless, necessary to detail the process by which selections are made from among the available alternatives.

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[177] Janzen, J. and Prins, G. (eds.) (1981). Causality and Classification in African Medicine and Health , Social Science and Medicine, Special Issue 15 (B)

[178] Staiano, K. V. (1981) "Alternative Therapeutic Systems in Belize : A semiotic Framework in John Janzen and Gwyn Prins (1981) eds. Causality and Classification in African Medicine and Health , Social Science and Medicine , Special Issue 15 (B) :328

[179] Bhatia J. and Cleland J. (2001) "Healthcare Seeking And Expenditure by Young Indian Mothers in The Public and Private Sectors" Health Policy and Planning16 (1): 55-61

2.10 Paradigms of Maternity

Construction of mother-hood can help us understand the cultural context of reproductive health decisions. Sargent and Johnson (1996: 222-223)[180] quote the following works around the world that substantiate this hypothesis.

> *"1. Successful performance of female role in pre-industrial societies is inexorably tied to a woman's reproductive behaviour and the pregnancy is equated to fruition and becoming more beautiful (Kitzinger 1978 : 36) . This linkage is more pronounced in societies where women's worth is measured by the number of children or more accurately the number of sons she bears as for example in Middle east, the woman is*
> *"...raised for marriage and procreation, (she) acquires her own social status only by fecundity....The young woman (is inevitably) .....taken to be responsible for the sterility of the couple,[and] will do everything to change her state: pilgrimages, magic practices.... And so forth. If she does not succeed, she will only have a diminished status" (Vieille 1978: 456-57)*
>
> *2. An African woman feels truly fulfilled after becoming a mother(Paulme 1960: 140); In Japan , child bearing is considered an important function of a woman reflected in the aphorism, " A woman is a borrowed womb" (Bernstein and Kidd 1982 :101-112)*
>
> *3. In Jamaica, the "childless woman is an object of pity, contempt or derision" (Clarke 1957:95) and in Egypt considered "useless" (Morsy 1982 : 150). Societies glorify fertility, childbearing, and maternal role. Agrarian societies have more pronatalist pressures but even in industrial societies, "people make their 'voluntary' reproductive choices in an institutional context that severely constrains them not to choose non-marriage, not to choose childlessness, not to choose only one child" (Blake 1974 : 30). But some societies value women more as sexual beings than their reproductive potential".*

Oakley Ann (1993)[181] states,

> *"Having babies and trying not to have babies makes women sicker than men in terms of use of hospital and other medical services."* (ibid:12)

The self-less maternal attitude is also expected when a woman is a sick and is in need of a treatment. She comments,

> *"It is indeed , a paradox that, although women's lives are all about providing health for others, as users of formal health-care services,*

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[180] Sargent, C. F. and Johnson, T.M. (eds.) (1996). Handbook of Medical Anthropology. Contemporary Theory and Method. Revised edition.Westport : Greenwood Press.

[181] Oakley, A. (1993). Essays on Women, Medicine and Health. Edinburgh: Edinburgh University Press.

custom decrees that they be no more than patient- patients. ...It is hard to feel in control of one's body and one's destiny during sixteen trips to the hospital antenatal clinic for the ritual laying-on of hands by a succession of different doctors, none of them especially trained in the art of talking to the face beyond the abdomens, or in the science of knowing about the interaction between mind and body, the connection between peace of mind and a competent cervix, or between emotional confidence and a coordinated uterus."(Oakley A.1993: 13)

Beverly (1996)[182] has documented that patterns of nursing are elaborated by women's recognition of the power of foetuses and young children to control fertility, a power that affirms the concomitant role of nursing mothers as being agents of culture who nurture and wean cultural novices.

2.11 Religion and Rituals

Deelay (2004)[183] presented review of anthropology and cognitive science that proposes social, cognitive, and neural mechanisms which convert culturally transmitted ideas into beliefs, discussed in relation to Geertz's (1966)[184]classic definition of religion as a cultural system. Literal and analogical uses of language, and a capacity for mentalizing thought, allow the creation of systems of symbols that vary between groups, contributing to the systematic group-level differences that we refer to as 'culture'. A combination of social referencing, mentalizing, and emotion perception, enables enculturation to occur by attention to stable, repetitive conjunctions of meanings and emotions in the social environment, promoting the formation of cognitive-affective schemata. In addition to informal enculturation in routine social interaction, cultural systems such as religions organize and protect transmission of valued knowledge. Religious rituals are culturally invented symbolic displays that transmit conceptions of the world and imbue them with emotional and motivational significance. Two kinds of ritual are distinguished: high frequency, low arousal rituals belonging to a 'doctrinal' religious mode, and low frequency, high arousal rituals belonging to an 'imagistic' religious mode (Whitehouse

[182] Beverly, E. A. and Whittemore, R. D.(1996). "Mandinka Mothers and Nurslings : Power and reproduction" Medical Anthroplogy Quarterly 10(1) : 45-62 . American Anthropological Association.
[183] Deelay, P.Q. (2004). "The religious brain" Anthropology and Medicine 11(3): 245 – 267
[184] Clifford, G. (1966). Religion as a Cultural System" In Anthropological Approaches to the Study of Religion. Banton Michael Ed. (pp.1-46) London: Routledge.

2000)[185]. 'Doctrinal' rituals allow the extraction of semantic memories and associated emotions through repeated participation and exposure. 'Imagistic' rituals are particularly, associated with intense emotion, episodic memory formation, and the formation of social ties.

Religious rituals, especially imagistic rituals, employ two major strategies to convey conceptions of the world and invest them with a heightened sense of reality and emotion: (1) a 'sensory' route evokes salient thought and experience by orchestrating multiple reinforcing social-emotional signals and other stimuli, engaging attention, emotion, and arousal; (2) a 'semantic' route uses enigmatic verbal and non-verbal symbols to engage an analogical/right hemispheric processing strategy to make sense of what is authoritatively presented as real but incompletely understood. Both routes are hypothesized to activate the mesolimbic dopamine system amongst other components of cognitive-affective processing, so that the 'moods and motivations' evoked by the ritual performance seem 'uniquely realistic'. These social, cognitive, and neural processes constitute ways in which religious ideas are turned into convictions.

Figueroa L.R. etal. (2006)[186] quote respondents' point of view on religion's role in the healing process,

> *".....felt religion was just a pacifier. It was something to fall back upon.Something to explain the unexplainable. Something to pacify a troubled soul. After talking to another individual about the concept of placebos, I guess I am not really sure if spirituality is a placebo to us. If it's something to explain the explainable. If it's something that makes us feel better and pacifies us in times of trouble because that's what we put our minds to believe..... prayer gives us serenity. I feel calm. A lot of times we are stressed and that causes the healing process to be incomplete. But when we pray, we get confidence and we know that we do have help from the higher source. Then we get serenity. Therefore the stress level goes down which helps the healing process." (Figueroa et al.: 86)*

[185] WhiteHouse, H. (2000). Arguments and icons: Divergent modes of religiosity. Oxford: Oxford University Press.

[186] Figuero, L.R., Davis, B., et al. (2006). "The Influence of Spirituality on Health Care Seeking Behaviours Among African Americans" ABNF Journal:17 (2): 82-8.

2.12 Menstruation

Menstruation and related illnesses are a part of the reproductive health package and it is important to see how women perceive this phenomenon and how it affects their beliefs and decision-making for health care. Menstruation is a fertile area of anthropological research. Apart from similarities of puberty changes and menarche, physical and emotional problems related to it vary from culture to culture e.g. Mead (1961)[187] found out that it is unusual for a young woman in Samoa to complain of menstrual problems. Taboos against menstruation as polluting and dangerous do exist e.g. Samoa women avoided making breadfruit pudding and '*kawa*' during menstruation.

Shostak (1983)[188] found that South African people, the Kupeg did not experience Pre-Menstrual Syndrome or mood changes related to it. Strenuous exercises can result in amenorrhea and infertility (Lancaster 1989).[189]Anthropological interest has emphasised the meaning (symbolism) attached to menstruation but ignored the biological and bodily aspects of this process. A wide use of herbs to regulate menstruation has been documented by Browner (1985) [190].

2.13 Menopause

As menstruation is important for a woman to understand her womanhood and to measure the ups and downs in her health, menopause is also a significant landmark in one's life. Davis (1997)[191] has presented ethnographic data from a longitudinal, interpretive study of women's changing social and cultural constructions of menopause indicating that three major changes have taken place in the way women conceptualize female, reproductive

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[187] Mead, M. (1961).Cooperation and Competition Among Primitive Peoples. Boston: Beacon Press.
[188] Shostak, M. (1983). Nisa: The Life and Words of a Kupeg Woman. New York: Vintage Books.
[189] Lancaster, J.B., King, B. J. (1989). "An Evolutionary Perspective on Menopause" (pp.7-16) in Virginia Kerns, Judith K. Brown (Eds) In Her Prime: New Views of Middle-Aged Women. Second Edition. University of Illinois Press.
[190] Browner, C.H. (1985)."Plants Used for reproductive Health in Oxaca, Mexico" Economic Botany, 39(4):482-504
[191] Davis, D. L. (1997) "Blood and Nerves Revisited : Menopause and the Privatization of the Body in a Newfoundland Post Industrial Fishery" Medical Anthropology Quarterly 119(1): 3-20 American Anthropological Association.

life-cycle events and processes. First, folk idioms of nerves and blood that once linked soma, psyche, place and tradition, are now trivialized and have been superseded by biomedical models of menopause. Second, physicians, television, magazines, and school teachers have replaced the community's middle-aged women and the mutual communication of shared experience as major sources of information and advice on reproduction and aging. Third, women's bodies have become privatized, and bodily metaphors that once linked women in a complex individual and collective assessments of shared, highly valued traditions and mutual judgement of moral character, have lost their dominance in village life.

> *"Women's knowledge about menopause was based in lived experience. It was embedded in and conditioned by the day to day dynamics of social interaction. Knowledge of the body came from observations of behaviour, through oral transmission of shared experience, and an intimate, long term knowledge of each other." (ibid:20)*

The existing research on factors influencing decision-making at different stages of life cycle of a woman have been reviewed. The next section, explores the decision-making from the concept of gender.

2.14 Applying Gender Lens

Gender has been defined as,

> *" the social construction given to the biological difference between men and women. Gender involves deconstructing the explanations about women and men's behaviour and characteristics described as "femininity" and "masculinity". Contrary to popular opinion, gender does not mean women or feminism, but refers instead to the power relations between men and women which result from social definitions of femininity and masculinity."(PAHO, 2009)*[192]

Applying gender perspective to the female decision-making process can help in recognition of the impact of gender on women's health status and determinants and gender based hurdles in access to health services and resources as asserted by Doyal L. (2001)[193] and Benhadid[194] F. (n.d.).

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[192] Gender Equity in Health. Fact sheet. Women Health and Development Program, Pan American Health Organization(PAHO). Areaal Office of WHO. 2009.
[193] Doyal, L. (2001). Sex, Gender And Health: The Need For A New Approach. BMJ. 323: 1061-1063

Olujic Maria B. (1998)[195] emphasizes that the concepts of sexuality and gender relations, are important to understand in order to know the underlying causes and forms of gender based violence in peacetime and during wars. Control of women by men and protection of their sexuality is a convenient means of justifying the domination of women by men; and the dynamics of male protection of female honor is embedded in the complex traditional cultures.

> *".... the center of the patriarchal regime is the extended family, called adurga, a corporate family unit under which all holdings – for example , property, livestock, and land –are held communally by the patrilineage....). Zadruga ideology has persisted for centuries and is the crux of Yugoslavian cultural ideologies. ...Women marry into their husband's families and are thus outside of the core social unit. They are valued as sex objects, mothers and workers....). This pattern is familiar to much of the Mediterranean; women represent the code of honor of the family and the code of shame via the blood revenge for non-family member's transgressions, which along with a male – dominated strict hierarchy, provide many behavioral norms and unity ....The honor/shame dichotomy is evident in the highly guarded aspects of women's virginity, chastity, marital virtue, and especially fertility. For women, honor and shame are the basis of morality and underpin the three tiered hierarchy of statuses: husband, family, and village."* (ibid: 33-34)

2.15 Stigma

It is also important to study the effect of a disease/illness causing social embarrassment and the effect of stigma on care seeking decisions. Stigma exerts its core effects by threatening the loss or diminution of what is most at stake, or by actually diminishing or destroying that lived value.

Yang etal.(2007)[196] have utilized the Chinese example of "face" to illustrate stigma as having dimensions that are moral-somatic (where values are linked to physical experiences) and moral-emotional (values are linked to emotional states).

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[194] Benhadid, Faiza. n.d. Gender and Human Rights Context. Presentation at Inter-Agency Workshop for Arab Area. UNFPA.

[195] Olujic, M. B. (1998). "Embodiment Of Terror : Gendered Violence In Peacetime And Wartime In Croatia And Bosnia – Herzegovina" Medical Anthropoloy Quarterly 12(1): 31- 50. American Anthropological Association.

[196] Yang, L.H., Kleinman,A., et al. (2007). "Culture and Stigma : Adding moral experience to stigma theory" Social Science and Medicine 64(7): 1524-1535

Corey and Goodman (2006)[197] state that the lower reporting rates of depression in China are due to stigma and a greater acceptance of distress, differences in representation of mind-body connections, use of neurasthenia as a concept, and (until recently) lack of detection and identification of cases. Sex differences in rates are greatest around the age of 18-55 years, the years of potential childbearing for women.

2.16 Theoretical and Conceptual Frameworks

Decision-making derives multi-disciplinary models to study its various dimensions. The different models referred to in literature are presented here.

2.16.1 Cognitive and Cultural Model of Decision-making

Angel R. and Thoits P. (1987)[198] presented a theoretical framework for understanding the impact of culture on the processes of symptom recognition, labelling, and help-seeking and consequently, on large scale epidemiological studies involving different ethnic groups. They hypothesize the existence of learned cognitive structures, through which bodily experiences are filtered, that influence the interpretation of deviations from culturally-defined physical and mental health norms. A model of illness labelling the influence of culture was proposed by them. The process by which individuals (a) notice physical or emotional changes, (b) label and evaluate them as psychological or physical, serious or trivial and (c) decide upon a course of action, can be conceived as occurring in stages.

[197] Keyes, C. L.M. and Goodman, S.H. (eds.) (2006). Women and Depression. A Handbook for the Social, Behavioral, and Biomedical Sciences. Cambidge: Cambridge University

[198] Angel,R. and Thoits, P. (1987). "The Impact of Culture on the cognitive Structure of Illness" Culture, Medicine, Psychiatry. 11(4): 465-494

Table 4: The Impacts of Culture on the Cognitive Processes

Event	Cognitive Processes	Cultural Influences
Initial Occurance: Objective Physiological or Affective Change		
1.Attend to or Ignore the Change	**First Order Categorization** Normal Vs. Abnormal	a. Socialization of attention to internal states (sensitization) b. Prevalence of state in one's reference group
2.Interpretation and evaluation of the Change	**Second Order Categorization** a. Symptoms or not b. Physical Vs. Psychological (Preliminary diagnosis) c. Seriousness (Chronicity, Cause, Responsibility, Prognosis)	a. Prevalence b. Social desirability c. Beliefs and knowledge d. Advice from significant others
3. Acting on Symptoms	_____	Cultural and structural barriers to treatment Seeking
4.Re-labelling and Re-evaluation	**Altered Second Order Categorizations**	Contact with experts and experience with the illness

Source: Angel and Thoits, 1987: 474

According to this framework, attending to physiological sensations, is the first step and culturally and sub-culturally specific socialization may influence an individual's attention to or monitoring of bodily states. They elaborate,

> *".... attention to physical and emotional changes is influenced by cultural socialization, and the prevalence of those changes in one's reference group influence first-order attributions of normality or abnormality. The subtle effects of culture at this pre-symptom stage are largely overlooked in the medical sociological literature."* (ibid: 477)

The labelling and evaluating symptoms, is the second step in decision-making process, which is situated in a cultural and social context that determines which *"constellations of behaviours or physical changes are seen as abnormal and indicative of illness, either by the person experiencing the changes him or herself, or by the family." (ibid: 477)* Individuals often seek the advice of others in evaluating their conditions. Inputs from others are likely to reinforce cultural conceptions and evaluations of the individual's symptoms, since family and friends generally share the same culture. The third step is seeking help, and the response to disorder depends upon the prior evaluations made concerning nature, severity, chronicity, cause, contagiousness, personal responsibility, prognosis, futility and so on. Socio-cultural barriers such as communication problems and discordant belief systems as well as structural barriers to medical care decrease their

utilization. Other cultural factors include use of folk practitioners and home remedies, fatalism, residential mobility, and language problems.

The fourth step is re-labelling and re-evaluation. Contact with medical or mental health professionals, further influences the individual's interpretation and evaluation of his or her health. Medical experts transform patient's presenting symptoms into specific diagnosis and provide relevant information regarding cause, seriousness, chronicity, and prognosis. It is important to note that professional labelling and evaluation is fed back into the cultural system when the individual communicates the outcome to others. Interpersonal processes may not only bring the individual into treatment, but transmit scientific concepts and information from that treatment back into the social network. Thus culture influences every stage of the illness labelling and help-seeking process, from the perception and interpretation of symptoms, to the options one faces in responding to deviations from health through its impact on the development of health related cognitive categorizations.

2.16.2 Determinants and Behavioral Models of Decision-making

Determinants of health have been defined and efforts have been made to establish relationships with decision to seek health care, e.g. Anderson (1995)[199] has grouped factors influencing health care utilization into three main categories: population characteristics, health care systems and the external environment. Robert Anderson (1996)[200] has presented Behavioural model of healthcare utilization and defined the influencing factors as given in Table 5.

Table 5: Determinants of Health Care Utilization

Pre-disposing features	Age, sex, family size, education, employment
Enabling features	Income, insurance, residence
Need features	Perceived health status, symptom of illness, disability days.

[199] Andersen, R.M. (1995). Revisiting the behavioural model and access to medical care: does it matter? Journal of Health and Social Behaviour 36: 1-10

[200] Anderson, R. A. (1996). Magic, Science and Health : The Aims and Achievements of Medical Anthropology. Fort Worth: Harcourt Brace College Publications.

Kaslet et al.(1966)[201] have focused on individual's health behaviour and adoption of the sick role and Zola (1973)[202] has introduced the 'triggers'(symptoms/situtations) that induce an individual's decision to seek care. Sara Mackian et al. (2004) [203] advocate examination of Health Seeking Behaviour (HSB) from a social and cultural perspective.

> *".....HSB literature does not adequately address the nature of how people reach the decisions they do in the context of their 'daily, socially and culturally embedded lives, or the complexity of health care systems."* (ibid: 144)

They point out that the decision-making for health is not intrinsic to an individual and needs to be studied in context of supportive networks, social capital, and engagement patterns with particular health services. The social and cultural dynamics should be understood in context of indigenous health beliefs, though this dynamism is not readily acknowledged by medical professionals who feel their patients' beliefs are irrational, backward and stagnant. They have sub-grouped determinants into three spheres of influence such as informal, infra-structure and formal, as shown in Table 6.

Table 6: A Framework of Determinants of Health-seeking Behaviour

Determinant	Empirical measure	Examples	Sphere
Cultural	Status of women	Elements of patriarchy	'Cultural propriety'
Social	Age and sex		
Socio-economic	Household Resources	Education level Maternal occupation Marital status Economic status	**Informal**
Economic	Costs of care	Treatment Travel Time	Physical **Infrastructure**
	Type and severity of Illness		
Geographical	Distance and physical access		
Organizational	Perceived quality	Standard of drugs Standard of equipment Competence of staff Attitudes of staff Interpersonal process	Technical Staffing Interpersonal **Formal**

Source: Sara etal. 2004:139

[201] Kasl, S.V., Cobb, S.(1966) . Health Behaviour, Illness Behaviour and Sick Role Behaviour. Archives of Environmental Health 12: 246-66

[202] Zola, I.K. (1966). "Culture and Symptoms—An Analysis of Patient's presenting Complaints" American Sociological Review. 31(95): 615-630

[203] Mackian, S., Bedri, N. and Hermione, L. (2004). "Up The Garden Path And Over The Edge: Where Might Health-Seeking Behaviour Take Us?" Health Policy and Planning19(3): 137-146

The informal domain comprises of cultural variables, the infrastructure is related to the access issues such as economic cost, time lost and the distance traveled to visit a provider and the formal domain comprises of organization and quality of available medical services.

Ensor and Cooper (2004)[204] tried to describe decision-making for health in perspective of barriers not only on supply side but put forth a case for looking at the demand side as well.

This model highlights taking into account the specific factors such as information about health care choices/providers, education, indirect consumer costs (distance/opportunity) and household preferences (control on household resources). Other influencing factors are community and cultural preferences such as attitudes and norms, reluctance to seek health care for women outside home, restrictions of *purdah* (veil) and dislike of male providers for female examination. It is important to determine, who makes decisions within a household and price and availability of substitute health products and services.

Figure 5: Supply and Demand Barriers to Utilization of Health Care

Supply		Demand
-Official price -Input prices (staff, capital, equipment, buildings) -Knowledge of technology of treatments -Management efficiency	⟷	- Price(official, unofficial charge, travel cost, lost work) -Quality -Income -Social, household, cultural characteristics -Knowledge of health care available -Education

Source: Ensor Tim and Cooper S. 2004: 71

Hochabaum (1958)[205]; Becker et al. (1977)[206] and Sheeran and Abraham (1996)[207] have proposed 'health belief models' portraying individuals as a social economic decision-

[204] Ensor, T., Cooper, S. (2004). Overcoming barriers to health service access: influencing the demand side. Health Policy and Planning 19(2): 69-79

[205] Hochabaum, G. (1958). Public Participation In Medical Screening Programs: A Socio-Psychological Study. Washington D.C. : Government Printing Office.

[206] Becker, M.H., Maiman, L.A., et al. (1977). The Health Belief Model and prediction of dietary compliance : a field experiment. Journal of Health and Social Behaviour 18: 348-66

makers. Conner and Norman (1996)[208] provided a social cognition model to predict possible behavior patterns depending on a mixture of demographic, social, emotional and cognitive factors, perceived symptoms, access to care and personality. On the other hand, Ahmed et al. (2000)[209] presented health seeking behavior as a *'sequence of remedial actions'* taken to rectify *'perceived ill health'*. Wallstan (1992)[210] offered multi-dimensional measures model based on health locus of control and linked individual control over health care to health promotion behaviours.

2.16.3 Combination of Process and Determinants Model

Household decision-making on child health care as a process involving four hierarchical steps and determined by factors at three levels, has been studied by Subhash Pokhrel and Rainer Sauerborn (2004)[211] in Nepal. The model encapsulates the process as well as determinants at each stage. The authors argue that quantitative studies on health care utilization often overlook the importance of capturing the 'path way' of household decision-making processes. They offer a four step construct which maps out a hierarchical scale of household decision-making regarding child health care. The construct begins with the perception of illness, moves on to choice of care and provider, and finally ends with health care expenditure. The variation between different choices within the same decision episode has been well captured. For example, all perceived illness does not end up in treatment, nor is equal treatment predictable between different groups having the same need. Secondly, the same background characteristic which explains variation in one choice, may not explain the variation in another choices in the decision process.

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[207] Sheeran, P., Abraham, C. (1996). The Health Belief Model. (pp.23-61)In Conner M, Norman P(eds) Predicting Health Behaviours : Research And Practice With Social Cognition Models. Buckingham: Open University Press

[208] Conner M, Norman P (eds). (1996). The Role Of Social Cognition In Health Behaviours. In: Connerm, Nrman P(Eds) Predicting Health Behaviours : Research And Practice With Social Cognition Models. Buckingham : Open University Press.

[209] Ahmed, S., Adams, A., et al. (2000).Gender, Socio-Economic Development and Health Seeking Behaviour In Bangladesh. Social Science and Medicine 51: 361-71

[210] Wallston, K.A. (1992). Hocus-Pocus, The Focus Isn't Strictly On Locus: Rotter's Social Learning Theory Modified For Health. Cognitive Therapy and Research 16: 183-99

[211] Pokhrel, S. and Sauerborn, R. (2004). Household Decision Making on Child Health Care in Developing Countries : The Case of Nepal. Health Policy and Planning 19(4): 218-233

2.16.4. Models of Power Relations

The study of decision-making is a study of the dynamics of power relations and it seeks to understand how the decision process may tend to sustain or to change that structure (Cox and Jacobson 1977)[212]. The analysis of decision-making is one way of studying power relations. Decisions of course, do not reveal power directly. What they may show directly is influence, or the way in which power is translated into action. The relative power of contending forces, is an inference that can be drawn from a careful observation of the workings of influence. Decisions can change power relations either by changing the resources available to the actors or by changing the procedures through which they interact so as to give some actors a more advantageous position than others.

J.M. Janzen(1978)[213] in a monograph entitled 'The Quest for Therapy in Lower Zaire' has presented a concept of 'Therapy Management Group'- a group of people involved in the process of health seeking, i.e. social unit that is managing the therapy in case of illness. One element in this process is decision-making. According to his analysis in Lower Zaire, individuals hardly ever make decisions alone, it involves the individual, relatives, near friends and so forth. The wider popular setting includes the villagers, elders, former clients suffering from the same problem and health practitioners from both folk (spiritual healer, bone setter) and professional sector (allopathic doctor, etc.).

Katzens, J.(1999)[214] has focused on actors and factors in decision-making process and the role of power relations amongst the actors. Her findings have illustrated that the patterns for the allocation of decision-making power, where financial resources and female mobility are at stake, are very much the same whether in every day life or in health related situations. This pattern is particular for patriarchal societies in general, where men have dominance over women and the access of women to power grows with age and number of sons. In the special case of Punjabi society, this pattern is perpetuated

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[212] Cox, R. W. and Jacobson, H.K. (1977). "Decision-making" Int. Soc. Sci. Journal. XXIX(l):115-134

[213] Janzen, J.M. (1978). The Quest for Therapy in Lower Zaire. Berkley: University of California Press.

[214] Katzan, J. T. (1999). Decision Making Processes and Power Relations at The Household and Village Level In The Union Council of Gali Jageer Tehsil Fateh Jang. HSA Press: Public Health Monograph Series No.1

and culturally legtimised by two main concepts, '*izzat*' (honour) and '*purdah*'(veil). The whole process of health seeking and decision-making is more an act of consent seeking, bargaining and negotiation.

2.16.5 Pathways Model

Barbara Starfield (2007)[215] has asserted that elucidation of pathways is necessary to devise appropriate interventions. The concept of a pathway studies the influence on health of individual and community level factors (income, education, social networks, behaviour, stress, medical care received). Starfield considers inclusion of societal phenomenon more useful to address the recent equity concerns in the distribution of health in populations and sub-populations.

With this overview of existing concepts and knowledge about reproductive health decision-making, a conceptual framework for this study is devised (see section 1.11) to focus more on cultural context and its influence on women's choices for reproductive health care seeking.

The next chapter focuses on the geographical and historical setting of Village Jaffer, the research site for this thesis.

[215] Starfield, B. (2007). "Pathways of Influence on Equity in Health" Social Science and Medicine. 64(7): 1355-1362

CHAPTER 3

THE VILLAGE PROFILE

Decision-making processes can be best understood in the context of area where women of Village Jaffer, specifically and women of Potowar in general, are born, raised, married, give birth to their children, live the trials of reproductive burden and illnesses and experience the old age. Terrain, climate, economic conditions, cultural norms, values, religion, kinship structures, patterns of marriage, dietary practices and physical access to safe drinking water and sanitation facilities; all impact the reproductive health and determine the choices for seeking care for an illness.

> *"...politics, economics, historical experiences, and cultural orientations intersect in influencing social logic and social action" (Weiss Anita M. 1991:1)*[216]

The current study focuses on village Jaffer, Tehsil Fateh Jang, District Attock situated in Potowar - a plateau area of 500 square miles comprising of districts Islamabad, Rawalpindi, Attock, Jehlum and Chakwal. This chapter presents the physical layout of the village, its demography, history and economy. The cultural institutions, health services and profile of the healers are discussed to provide a background and perspective of the study.

3.1 Area and Location

The village Jaffer in Tehsil Fateh Jang, District Attock was chosen to narrow down the focus for the detailed examination of the rural life style and the realities of the local women in the Potowar area in Punjab province of Pakistan.

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[216] Weiss, A. M. (1991). Culture, Class, and Development in Pakistan. The Emergence of an Industrial Bourgeoisie in Punjab. Oxford: Westview Press

3.1.1 The Potowar Area

The origin of Potowar's name is speculated to be historically derived from words *Putho har* – garland of flowers; upper portion of a four legged animal associated with upper area of the sub-continent; *Bhattiwar* – land of Bhatti tribe; a Sanskrit word, *Prshthawar*: 'Prshtha' meaning back of Indus river and 'war' meaning area[217].

Potowar area is a sub-oval table of land situated between the two rivers, Indus to its north and northwest, and Jhelum to its east and southeast. Its north is squeezed between Murree-Abbotabad and Margalla hills. Its south is bordered by Salt range[218]. Major oil fields of Pakistan lie in Potowar Plateau, which were first discovered at Khaur in 1915, Dhulian in 1935 and Tut in 1968. The oil fields are connected by pipeline to the refinery at Rawalpindi.

It is a place of great historic significance and truly a melting pot of cultures. The earliest relics of the Stone Age period have been found with a probable antiquity of about 500,000 years when Soan culture originated. Around 3000 BC, small village communities developed in the Potowar area and began to take the first steps towards the formation of society. This period was followed by the more urbane Indus Valley (or Harappan) civilisation which flourished on the banks of River Indus between the twenty-third to eighteenth centuries BC[219]. The Indus Valley Civilization disappeared abruptly around 1700 BC. It has been conjectured that a cataclysmic earthquake might have been the cause, or, alternately, the drying up of the River Ghagger-Hakra[220]. Soon thereafter, Indo-European speaking tribes from the Central Asia or the southern Russian Steppes poured into the region.[221] These *Aryans* settled in the "*Sapta Sindhu*" area, extending

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[217] Ibid.

[218] Mohammad, S. (1994). Paleolithic Cultures of Potwar with Special reference to Lower Paleolothic. Ph. D. Thesis submitted to Department of Archaeology, Shah Abdul Latif University, Khairpur, Sindh, Pakistan.

[219] http://pakistaniat.com/category/travel-tourism/Published by S.A.J. Shirazi July 31st, 2006 in History, Travel and Tourism

[220] Puri, V.M.K., Verma, B.C. (1998). "Glaciological and Geological Source of Vedic Saraswati in the Himalayas. Itihas Darpan IV(2): 7-36

[221] Gupta, S.P. (1999). in Pande,G.C. (ed.) : The Dawn of Indian Civilization, D.P. Chattophadhyaya(ed.): History of Science, Phiolosophy and Culture in Indian Civilization, I (1), New Delhi : centre for Studies in Civilizations.

from the River Kabul in the north to the Sarasvati and Upper Ganges-Yamuna Doab in the south."[222] It was in this region that the hymns of the *'Rigveda'* were composed and the foundations of Hinduism laid. Mainstream scholarship places the Vedic culture lasting from the early second millennium BC to the middle of the first millennium BC, and the end of this period was marked by linguistic, cultural and political changes[223]. The city of Taxila, in the present Rawalpindi district, became important in Hinduism (and later in Buddhism). The great Indian epic Mahabharata was, according to a tradition, first recited at Taxila at the great snake sacrifice of King Janamejaya, one of the heroes of the story.[224]

The interaction between Hellenistic Greece and Buddhism, started when Alexander the Great conquered Asia Minor, the Achaemenid Empire and the lands of present-day Pakistan in 334 BC, defeating Porus at the Battle of the Hydaspes (near modern-day Jhelum) and conquering much of the Punjab region[225]. The interaction between South Asia and Central Asia continued for centuries afterwards, generating intense cultural exchange and trade. This included arrival of people from the Central Asian nations such as the Turks, Mongols and Mughals. This period also proved to be a significant turning point in the history of South Asia with the '*Qalandars*' (wandering *Sufi* saints) from Central Asia, Persia and Middle East preaching a mystical form of Islam that appealed to the Buddhist and Hindu populations with their concepts of equality, justice, spirituality, and secularism. The Mughals who were the descendants of Persianized Central Asian Turks (with significant Mongol admixture) set up their empire for another two centuries after invasion of Babur. The strategic importance of Potowar was recognised by Emperor Akbar the Great, the grandson of Babar, who in 1581 built his famous Attock Fort complex here. The Mughal empire was taken over by the British Crown till its independence later in 1947 in to two separate states of Pakistan and India.

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[222] Kenoyer, J. M.(1998). The Ancient Cities of the Indus Valley Civilization. Oxford University Press.
[223] Plutarchus, Mestrius, Bernadotte Perrin (trans.) (1919). Plutarch's Lives. London: William Heinemann, Ch. LX. ISBN 0674991109. Retrieved on 2008-01-09.
[224] History in Chronological Order. Government of Pakistan. Retrieved on 2008-01-09.
[225] Jaffrelot, Christophe (2004). A history of Pakistan and its origins. London : Anthem Press.

3.1.2 District Attock

District Attock located in the Potowar area, was created in 1904 by the merger of Tehsil Talagang from the District Jehlum and Tehsils Pindigheb, Fatehjang and Attock from District of British Empire. Its original name was District Campbellpure after Sir Campbell who founded the city of Campbellpure to the southeast of Attock Town[226]. The name of the district was changed to Attock in 1985. The district has an area of 6,857 kilometers, a population of 1,274,935 with 20.45% in urban areas[227] with a population density of 186 people living per square kilometer. Main languages spoken are Punjabi, Hindko, Urdu and Pushto. Awans, Milars and Khattars are major tribes of District Attock.

Potowar area, in general, and District Attock in particular, have been the route of many invaders. Alexander the Great of Macedonia passed through and, so did the first Mughal, Emperor Babur, and the various Afghan Sultans before him. However, Attock appears in history also as the birth place of famous mathematician Panini (520 BC- 460 BC)[228]. Panini was born in Shalatula, a town near Attock, on the bank of river Indus. He was a Sanskrit grammarian who gave a comprehensive and scientific theory of phonetics, phonology, and morphology. A treatise called Astadhyayi (or Astaka) is Panini's major work. In this work, Panini distinguishes between the language of sacred texts and the usual language of communication. Panini gave formal production rules and definitions to describe Sanskrit grammar.The next significant mention of this area, is by the first Mughal Emperor Babur, confirming Attock and Potowar area to be home of the Gakhar clan in Baburnama;

> *"Sultan Sarang was now of age, and finding that he could not oust his cousin (Hati Khan) by force of arms, he procured his death by poison and assumed the chiefship in 1525. He and his brother made their submission to Babur, and Adam Khan, with a Gakhar force, attended him to Delhi, and for this the Potowar country was confirmed to them by the Emperor" (as quoted in Rawalpindi Gazetteer 1894)*[229]

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[226] The Pakistan Gazetteer. New Delhi, 2007, 7 Volumes.

[227] Population Census, 1998; Government of Pakistan.

[228] O'Connor, J. J., Edmund F.R. (2000) "Panini". *Mac Tutor History of Mathematics Archive.*

[229] Rawalpindi Gazetteer, 1894, Government of British India, New Delhi.

3.1.3 Tehsil Fateh Jang

Fateh Jang (Fatehjang / Fatehjung / Fatehgarh / Fatehgunj / Fatehganj)[230] is one of the tehsils (sub-districts) of District Attock, in addition to Hazro, Hassan Abdal, Jand, Pindi Gheb and Attock. It is located nearly 25 miles southwest of Islamabad on Rawalpindi-Kohat road. Four roads originate from Fateh Jang which link this town with cities of Kohat, Attock, Rawalpindi/Islamabad and Khaur. Since 1922, a railway line runs from Rawalpindi to FatehJang to Gaggan to Jand and Kohat.

Fateh Jang has almost all amenities including a government run Tehsil Head Quarter Hospital, many private clinics and hospitals, pharmacies and hakeem and homeopath shops. It has a police station, many public and private schools and separate intermediate colleges for boys and girls. A cattle market is held here on every Thursday. Fateh Jang is famous for its bulls, ground nuts, brick kiln industry and clay pottery. People are fond of cockfight, quail fight and dog fights. Like Bannu, Kohat, Chakwal and Mianwali towns, in the *bazaars* (markets) of Fateh Jang, one can find *chukor* or *quails* hanging in cages on every second shop or one can see people fondly taming the quails for the next fight.

Annual horse and cattle show or September *Mela* (fair) is organized where people of the area gather to enjoy horse races, hunting dog races and other local sports in addition to parading and trading of fine quality animals. Farmers from the village Jaffer look forward to this '*mela*' (fair) for getting new animal breeds and introduced to some new seed varieties. The other attraction is '*kanjariaan da dance*' (performance of dancing girls). The '*mela*' (fair) is also one occasion where one day of the week is reserved exclusively for women. With the increasing trend of *'purdah'* (veil) and avoiding any fun in the name of religion, women from the village seldom go there. Only girls and minors go who are accompanying their fathers and brothers to enjoy the rides and get new toys. Men of the area also use *'mela'* as an opportunity to settle scores with an old enemy and commit planned killings as a result of long family feuds.

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[230] Tehsils and Union Councils in the District Attock, National Reconstruction Bureau. Government of Pakistan. 2006.

Such events and traditions in Fateh Jang are also quoted in Michael Palin's travels from pole to pole (Himalaya Day-4)[231]. He narrates the hosting experience at Prince Malik's place in Fateh Jang.

> *" (we are having lunch, he says)The honey is of my land. It is very good. Have some more.' He pushes a bottle of Côtes du Rhône towards me. It's full of honey, not wine.....In the afternoon, despite the great heat, he insists that we visit the fort in Fatehjang. This is where the local jerga, or council of elders, meets. Recently they dealt with a vendetta that had gone on so long between two families that 13 had been killed on both sides. At the jerga they agreed that there would be no more killings, and, having forsworn further violence on the Holy Koran, the feud was declared to be at an end, with none of the murderers facing trial. Prince Malik shrugs.'That is the way it works in the country. He insists that, if we are really interested in the rural life, we must come along as his guests to a bull-race in nearby Taxila tomorrow. Of course we can't say no. He wouldn't let us."*

3.1.4 The Village Jaffer

Village Jaffer, the locale of the study, is situated in Union Council Ajjuwala of Tehsil Fateh Jang which is also the nearest town centre. It is located on the right hand side of the road leading towards Kohat and Pindigheb and is about 20 kilometres from Fateh Jang and 42 kilometers from Islamabad. A track of the railway line separates the muddy village road from the metalled road. About two furlongs from the main Fateh Jang–Kohat road, starts the village settlement with streets winding and steeping high to reach the small mountains which form the backdrop of the village.

There are many small hamlets around the main village. The village itself is divided into Jaffer *'sharqi'*(eastern) and Jaffer *'gharbi'*(western). These two portions are referred to as *ara garaan (eastern portion)* and *para garaan(western portion)*. The village derives its name from the 'Pir Jaffer' shrine that is located in *para-garaan*. Most of the public amenities are available in the town centre of Fateh Jang and people commute through several private vehicles running on this route.

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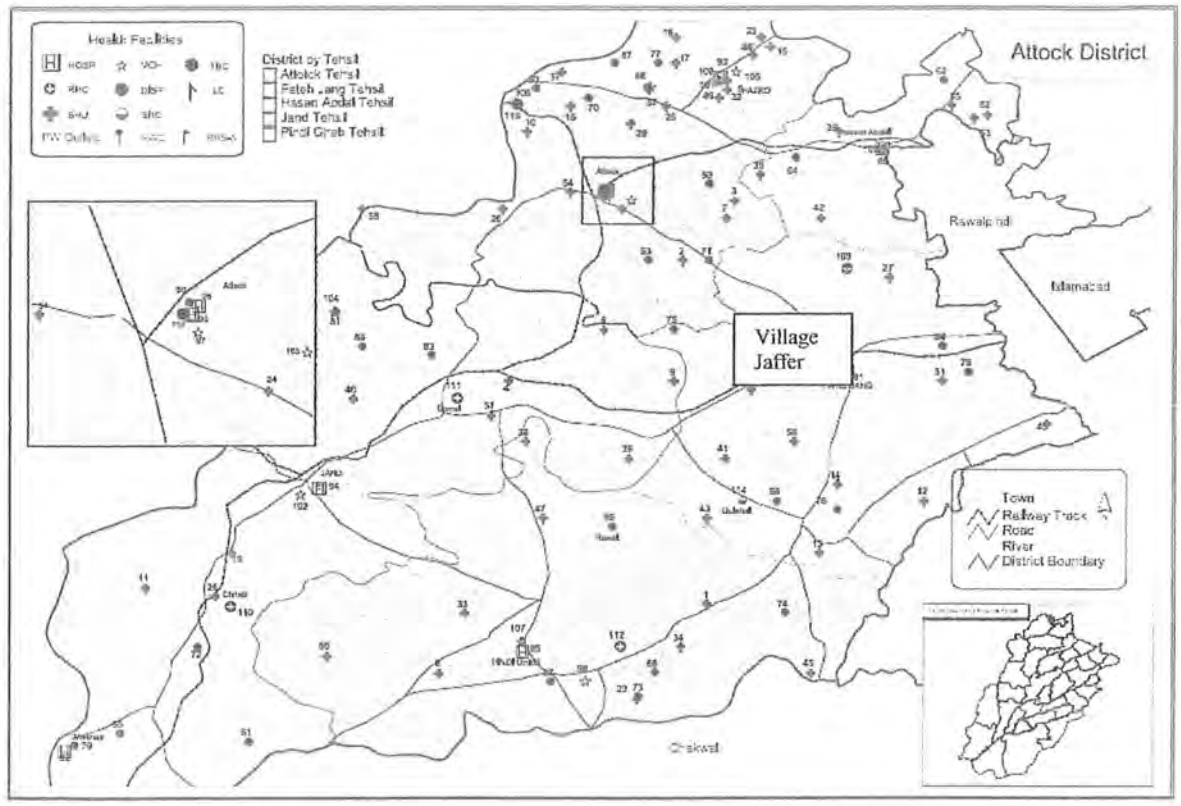
[231] Michael Palin. Pole to Pole with Michael accessed at http://www.palinstravels.co.uk/static-12 accessed on 04 April, 2009.

Figure 6: Map of District Attock, Punjab Province, Pakistan Showing Village Jaffer in Tehsil Fateh Jang



3.1.5 The Shrines of Pir Jaffer and the Others

Locals say that a pious man by name of Jaffer lived here and once dacoits who came to the village for looting, were turned blind by his prayers. This led to all calling him *Pir Jaffer* (Saint Jaffer). There is no '*gaddi*' (a hereditary descendence of shrine's caretaker). A small committee looks after the tomb and the annual '*urs*' (anniversary of the saint when the shrine is decorated and celebrations are carried out). Women praying at the shrine, take voluntary turns to do brooming and mopping the area. Some say there is no one in the grave. The tomb was erected a few years back.Another shrine is said to possess the spiritual power of alleviating tooth ache and people pray there for their affliction. On

each Thursday, one can see clay lamps lit on the shrines for a fulfilled *mannat* (a wish/prayer that has been granted).

3.1.6 Historical Background

According to the oral traditions, the history of the village dates back to 200 years ago – 1800s, as evident from dates inscribed on the tomb stones of the old graveyard. There is no written record but many interesting versions exist as explanation for the arrival and settling of *Mughals* in this area. The story of the village starts with *Mughal* prisoners who were thrown here and worked as slaves, mostly of Khattars. As is narrated,

> *"This area was like a kalapani where prisoners were disposed off."* [232]

It is not clear whether those prisoners had their families along with them or not. The only sign of their presence is obtained from the old graveyard and the style of tombstones and the year markings. Another saying is that they were fugitives from *Mughal* army who had tried to overthrow the king and were declared traitors. There are some *mussallis* (folk singers) in Kot Fateh Khan who confirm the tales of *Mughals* and history of this area. Their version is:

> *"Those who came here had taken refuge here- they must be fugitives and they must have been weaker than the other group that is why they had to run in the first place. There is no doubt that the old graveyard is of Mughal prisoners. They may have been traitors – after all elders can give the throne to only one successor, every one can not have it."*

The elders in the village narrate that the hillocks in the backdrop of village settlement, were once all covered with thick forest. When the railway track was built, the earlier settlers- the prisoners but now slaves of Khattars used to cut the woods on the mountains which were then supplied to the British cantonments elsewhere.

The village Jaffer has a fascinating history of its *Mughal* population. Initially there were only ten house holds belonging to two *Mughal* families: *Bhagan wali* and *Rahwan wali*. *Bhagan wali* family had more resources and got educated, whereas, the other got weaker

[232] Personal communication with an eighty five year old man from the village

with the passage of time. In addition to Jaffer, four other nearby villages also have a predominant *Mughal* population.

There is also a common reference to four brothers who inhabited the village first and their progeny grew to the present village population of *Mughals*. These brothers were Agral, Ajral, Abdal and Jajjal. The village mohallas were named after these brothers.

A tale goes that the Mughals were very fond of horses and their grooming. One of their ancestor, Agral trained a wild horse of a British officer who as a token of appreciation gave the whole village in name of the family. Another tradition goes that one of the ancestors fought a legal battle with Khattars and acclaimed the land, they were cultivating.

According to the villagers, there were only a few native Sikh families who left at the time of partition of India. Some Urdu and Punjabi speaking families got claim of the Sikh property but sold it off and never lived in the village long enough.

3.2. Topography and Land Terrain

Jaffer is a typical village of Potowar Plateau. In geology and earth sciences, a plateau, also called a high plateau or tableland, is an area of highland, usually consisting of relatively flat terrain[233]. Potowar plateau is undulating, multi-colored, picturesque and geographically an ill-defined area. Sakesar is the highest peak in this region. The area is arid and the terrain is mainly hilly, covered with scrub forest, and levelled plains inter-spaced with dry rocky patches[234].

The village area where houses are built is a steady slope with small mountains at the back drop and the ground level becoming lower and flatter as one moves towards the main road and the

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[233] http://www.scienceclarified.com/landforms/Ocean-Basins to Volcanoes/Plateau. html.accessed on 04 April, 2009.

[234] Potwar Plateau. (2009). In *Encyclopedia Britannica*. Retrieved April 03, 2009, from Encyclopedia Britannica
Online: http://www.britannica.com/EBchecked/topic/472944/Potwar-Plateau

agricultural fields. The village thus, has a natural water drainage under gravity.

The village land is a true picture of plateau and a common saying about Potowar sums up its characteristics:

"Zameen hamwaar nahin; Mausam da aitbar nahin;
Darakht phaldar nahin; Aurat wafadar nahin"

[The land is not plain; The weather is not predictable
The trees do not bear fruit; The woman is not faithful]

3.2.1 Water Sources

Potowar has rivers Haro, Swaan/Soan, Sil and Indus passing through it. The lakes of Uchali, Khabeki, Jhallar (Ramsar site) and Kallar Kahar are big water reservoirs in the area.

Village Jaffer however, does not have a stream or lake in its vicinity. The agricultural land is rain fed or underground water is pulled up with the help of Persian wheels and electricity run tube wells. The average annual rainfall in the district Attock is 783 mm.

Previously, the village had three wells for drinking water and household consumption in between *Ara garaan* and *Para garaan* (two portions of the village). However, after installation of hand pumps or electric motor pumps, these wells are no more in use. One fifth of the households, still do not have a hand pump in their houses and fill water from facilities at the houses of neighbours and relatives. Carrying water to one's house, is the responsibility of the women- mostly the young ones. Instead of water pitchers, now water is carried in plastic containers, water coolers or buckets.

Two natural water ponds exist in the middle of the village where cattle are taken for drinking water and bathing purposes.

3.2.2 Flora and Fauna

The natural vegetation in Potowar includes Kau, sanantha shrub and acacia trees which are profound. Low rain fall, extensive deforestation, coal mining and oil and gas exploration, have severely affected the natural flora in Potowar. The chief crops

cultivated by farmers include wheat, barley, sorghum, and legumes; onions, melons, and tobacco.

The diverse wildlife includes urial, chinkara, chukor, hare, porcupine, mongoose, wild boar and yellow-throated martin which have been affected by frequent hunting.

3.2.3 Climate

District Attock and village Jaffer have a typical northern Pakistani climate with very hot summers and very cold winters. It is mostly humid in the months of July and August. The presence of electricity in all households ensures fans work in summers, though the very long periods of electric load shedding (8-10 hours a day) makes life difficult.

3.2.4 Agriculture

Agriculture holds the key to survival for people living in Jaffer. People are either landowners or tenants. 84% of the village households possess land, though majority has 5 kanals or less to till. As a primary or secondary source of income for each household, land and its harvest is critical for the economy of Jaffer. The land is arable and *barani* (rain-fed). The produce depends upon the rainfall and its timing. Two crops are cultivated annually i.e. *Rabi* (spring) and *kharif* (autumn). Wheat, maize and fodder are the major crops. The wheat harvest, a busy time of the year generally falls in the months of April and May. Not only are the men folk busy with cutting, thrashing and storing in '*boris*' (jute bags) but women also actively participate in cutting and managing continuous supply of food an drinks to all those working in the fields. Jaffer is known for its produce of melons which are plentiful in the month of May. In addition, vegetables like spinach, mustard, cauliflowers, turnips and pumpkins are grown.

Women also participate in weeding and picking up vegetables from the field, drying the harvest in the sun before storage and sorting husks and grains by sifting in a *chaaj* (a flat tray made of straw with three sides turned up).

3.2.5 Livestock

Common livestock kept in Jaffer includes buffaloes, bulls, goats, donkeys and poultry. Women are primarily responsible for taking care of the domesticated animals and selling their produce.

3.3 Demographic Characteristics of the Area

According to the Population Census Report (1998)[235] of District Attock, on average 117 people inhabit one square kilometre of land. Tehsil Fateh Jang has an estimated population of 114,849.

The census survey carried out as part of this research in the village Jaffer presents the following findings:

Table 7: Demogrphic Characteristics of the Village

Village Jaffer	Population	Male	Female
Ara garaan	1418	728	690
Para garaan	593	316	277
Total	2011	1044	967

Source: Census Survey

The age composition of the population shows a significant percentage of women of child bearing age (15-49 years).

Table 8: The Age Composition of the Female Population of the Village

Age group	Percentage of the population
0-15 years	37%
16-49 years	46%
50 years and above	17%
Total	100

Source: Census Survey

[235] National Population Census of Pakistan, 1981, Pakistan Census Commission.

The physical characteristics of people in village Jaffer are like those of other Punjabi villagers

> *" The typical Punjabi was tall, spare but muscular, broad shouldered, with full dark eyes and an ample beard. The hair was invariably black, but the complexion varied from a deep lime-brown to wheat colored."*
> *(G.S. Chabra n.d.: 21)* [236]

The men and women in Jaffer generally, have a wheatish complexion. According to one of the elders (which is also a noticebale fact),

> *"Aap aasani say mughal aur doosary logoun mein pehchaan kar saktay hein. Mughal logoun kay sar baray hein aur naak apni khari aur seedhi naak say pehchanay jatay hein. Agar thora ghour karein to hamaray naak aagay say gol hein jabkay Khattar logoun ki naak aagay say muri hoti hay"*
>
> [You can easily distinguish a Mughal from a Non-Mughal and a Mughal from a Khattar. Mughals have distinctively large heads and slightly broad necks as compared to non-Mughals. Mughals also have an upright nose with a round tip which is distinguishable from Khattars who also have thin nose but slightly hooked tip.]

3.4. The Language and the Dress Pattern

The dialect spoken in the village is a mix of Punjabi and Hindko unlike remaining Potowar and Fateh Jang where Potowari is spoken predominantly. The educated people can also speak Urdu- the national language. Punjabi is a very old language and has been related to Sansikrit, Pali, Prakrit and Upbharnash in Ashok period (273-32 B.C.) and Multani under Muslim Period (711-1857)[237]. Hindko also has its roots in Parakrit. The Punjabi language has a rich oral tradition. The Great Sufi poetry in Punjabi is still sung and heard with great love. The spoken Punjabi of Muslims and Sikhs of the sub-continent is alike except that the former is written in the Persian script and the latter is in Gurumukhi (the script of Sanskrit and Hindi).

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[236] Chabra, G.S. n.d. Social and economic History of The Punjab. 1849-1901. Jallunder: S. Nagin and Co.
[237] statpak.gov.pk- *Population by Mother Tongue* accessed on 03 April, 2009 at http://www.absoluteastronomy.com/topics/Demographics_of_Pakistan

Prakash (1968)[238]presents a vivid account of the Punjabi language,

> "Punjabi is a quaint language, slow, indelicate and lusty.....Punjabi excels in love and abuse. Its abuse is of the genealogical kind which can trace one's family history in the most revealing and incestuous terms... vivid in quarrel, Punjabi can equally convey its vigour in love, whether in ballads, the improvisation of the peasant in the field or the women quarreling in the muhallas (neighbourhoods), its purple passages are those tinged with the facts of life. They are earthy and direct" (Prakash Tandon, 1968:71)

Traditional dress for both men and women, consists of *shalwar kameez* (loose pants and tunic). Men commonly, wear '*pag*' (turban) on their heads while outdoors, whereas women cover their heads with their *'dupatta'* (diaphanous veil) in the home, and wear a '*chadar'* (loose veil which drapes over the body) when they go out. Women tie their hair in a plait that loosely hangs at the back. Tying hair in a '*joora*' (bun) is mocked at considering it a sign exclusively of Sikhs. While Islam enjoins a woman to cover her hair and "body ornaments", women here customarily cover their face with the veil as well, so they can not be recognized. A woman rarely goes alone, so that her virtue can not be questioned. If a woman happens to come into contact with a male outside of her close circle of kin, she observes "eye-purdah", looking down and away to avoid eye contact.

The size of the *chadar* is taken as a sign of travel distance. *Choti* (small) *chadar* (covering the head and upper body) is worn when going around in the village while the *Bari* (large) *chadar* (covering the head and the body until the heels and also covering the face except for the eyes with a portion of *chadar* resting on the nose bridge) is worn when going out of the village to town or other cities. A slightly thinner *dupatta* is worn at home covering the head and upper torso which is conveniently used to wipe one's own wet hands, a child's face and to dust a guest's chair. While washing one's face and for *wudu* (ablution), it is gathered together and tied at the back of head like a hair band. While saying prayers the dupatta is secured by putting its head portion covering the forehead and going behind the ears. At times when one gets a headache it is fastened tight around the head.

---

[238] Tandon, Prakash (1968). Punjabi Century: 1857-1947. Berkeley: University of California Press.

Unmarried girls and married women all wear coloured "*choorian*" (glass bangles). Gold jewellery is only worn in ears (rings or pendants) and nose (a star or circular designed pin for older women and a wired ring for younger girls) in daily life. There are only single pricks in ears or nose even among the older ladies. For festive occasions like marriage, women wear their other gold ornaments including necklaces, bracelets, finger rings and a *teeka* (head wear).

3.5. Religion

All the residents of Jaffer are Sunni Muslims, mostly practicing five time prayers daily. Fasting is observed in the month of Ramadan[239]. Jaffer has two mosques, one newly built on the road side and the other, old one in between the houses in the upper alley. The knowledge about religion and spirituality is increasingly sought by all.

> *"Illiterate people have been religious minded from the very beginning but it is now that even the educated ones are turning to religion. People have donated 500 canals for building a mosque to the maulvi sahib."*
> [240]

The syeds running the older mosque, also give *taweez* (amulets) and *dhagay* (threads) and practice *hikmat* (treatment of ailments according to Unani system of medicines).

The ups and downs of the hard life, are endured by the prevalent spirituality and the inculcated habit of counting one's blessings and being thankful to one's Creator. The Muslim population here as in the rest of Punjab, still shows evidence of historical influence from Sikhism practiced in the area before, as reflected in a passage from folk story of Heer Ranjha[241]

> *"Awal-akhir naam allah da lena: duja dos Muhammad Miran;*
> *Tija naun mata pita da lena, unha da chunga dudh sariran;*
> *Chautha naun an pani da lena; jis khave man banhe dhiran;*
> *Panjman naun Dharti mata da lena; jis par kadam takiman;*
> *Chhewan naun Khwaja Pir da lena, Jhal pilave thande niran;*
> *Satwan nauan Guru Gorakhnaath da lena, patal puje bhojan;*
> *Athwan naun lalanwale da lena, bande bande de tabaq janjiran."*

---

[239] Tenth month in Islamic lunar calendar when fasting is obligatory.
[240] Person communication with an elderly man in the village
[241] The legends of Punjab by RC Temple- Introduction by Kartar Singh Duggal. Rupa and Company. Vol.2 P.606; accessed on http://www.the-south-asian.com/july-Aug 2006/Bhera-part1-1.htm

[Firstly, I take the name of God; secondly, of the Great Muhammad, the friend (of God);
Thirdly, I take the name of father and mother on whose milk my body throve;
Fourthly, I take the name of bread and water, from eating which my heart is gladdened;
Fifthly, I take the name of Mother Earth on whom I place my feet;
Sixthly, I take the name of Khwaja (Pir), the saint, that gives me cold water to drink;
Seventhly, I take the name of Guru Gorakhnath whom I worship with a platter of milk and rice;
Eightly, I take the name of Lalanwali that breaketh the bonds and the chains of captives]

3.6 Dietary Beliefs, Habits and Practices

Prevalent poverty among the usual households, seldom allow them to have any thing except *roti*. To ease swallowing of the *roti* pieces, people usually have *chai* (tea) or *lassi* (yogurt drink) with it.

A thick wheat *roti* (bread) is the staple diet, eaten with *daal* (lentils), *saag* (spinach and mustard), and *sabzi* (vegetables). As a measure of hospitality, the guests are offered butter with *roti* and curry. A thick butter slab placed on the *roti* itself is referred to as *"loni"* (literal meaning: spread).

Pulao (saltish rice cooked in meat broth), *zarda* (sweet orange coloured rice dish with raisins and nuts) and *gosht* (meat)/ *murghi* (chicken) dishes are cooked occasionally on Eid festivals, upon arrival of the guests, marriage or funeral parties or during other festivities. Most houses have *tandoors* (earthen ovens) buried in their courtyards, usually located towards a corner, where, firewood and other kitchen accessories are close by. To economise on firewood and find an opportunity for socializing, women usually take turns to burn *tandoor*. The older generation of women are nostalgic about the good old times when they could be together at the well for fetching water or used to sit jointly at nights for *charkha katna* (spinning cotton wool into thread). The adolescent girls get together for sewing and embroidery classes at one of the houses with an experienced lady.

Good food has been scarce and having a stomach full, is held responsible for one's fanciful wishes and desires as Waris Shah[242] depicts in verses 16 and 80.

> *"Karein akaran kha kay dudh chawal, aeh ruj kay khan dian mastian nein*
> *Makkhan, khand, parothay kha miaan maheen charh day Rab day aasray tay*
>
> [One is stubborn after he is spoiled by eating milk and rice to his fill
> Eat butter, sugar and fried bread-leave the cattle in God's surveillance]

Households with buffaloes and goats, do have an easy access to *doodh* (milk), *dahi* (yogurt), *makhan* (butter) and *lassi*(yogurt drink). To earn cash, most households are selling milk to the village vendors who collect it and sell to nearby urban areas of Rawalpindi and Islamabad. Their own consumption of milk and its products remains usually very low.

Many households have kept poultry and eggs and meat obtained is the most common source of animal proteins, though, on an occasional basis, in Jaffer. The earning male members get an egg in their breakfast and the most meat/chicken pieces in the curry. The elder male members are second in priority followed by male children. The members of the household are served food in the same order of priority as well. In case of a guest in the house, he/she gets priority above all others. Women do get special treatment for their diet during pregnancy and *chalees din* (forty days of puerperium), when they are offered more animal proteins and *desi ghee* (butter oil).

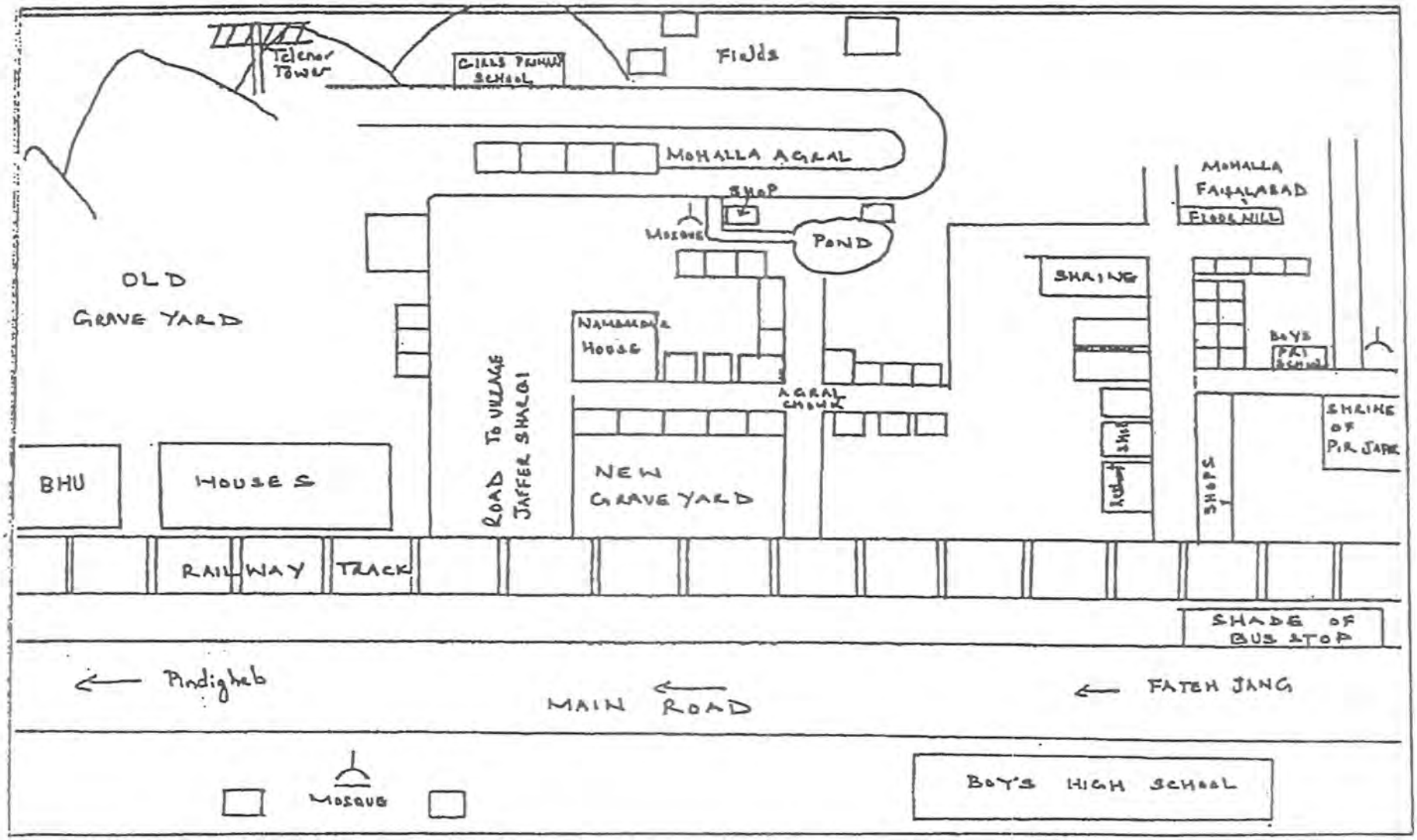
3.7. Settlement Pattern

Village Jaffer has most houses built along the sides of two lanes that connect to the main village road. The Mughal families are predominant in the village. All the ten Awan families have houses built in a row in the upper lane.

New houses are being built in the plots carved out of agricultural fields adjacent to the old village houses, growing outwards towards the main road. Some of the houses are also

[242] Waris Shah. 1766. Heer Waris Shah accessed on http://www.the-south-Asian.com.July-Aug2006/Bhera-Part1.htm on 06-06-2008

Figure 7:Map of The Village



built on the opposite side of the main road in the ancestral land away from the main village.

A usual house has a small door opening in the alley and leading to the courtyard which may be *kacha* (mud plastered) or *pacca* (cemented/brick laid) according to the economic status of the household. The living rooms are usually built in a line facing the entrance door and opening in the courtyard. Each room has usually one small window except in the houses of more well off families where large rooms have two or three windows. The ceilings have iron beams and the brick work is not painted. Rooms have shelves in the walls to keep things. Almirahs are rare and exist only in rich households. Usually a shelf high up, close to the ceiling is built to keep the utensils/crockery which is used at special occasions when guests are around. These shelves have cloth spreads with embroidered designs mostly cross stitch or machine made and a crochet lace to adorn their edges. Similar spreads are also seen to cover the top of boxes for bedding and suitcases. The pillow cases and cushions have similar embroideries. Most of the embroidered decoration cloths belong to dowry of the women of the household. When a new bride comes in, the couple usually settles in a newly built room and the girl keeps most of her dowry things there. The remaining rooms will have similar but older versions of spreads belonging to older sisters-in-law or mother-in-law. A side room is kept to keep the beddings and serve as a store room for keeping boxes and suitcases and grains etc. The rooms have another set of doors also usually linking all the rooms internally, so one can move between the rooms without going out into the cold in winters or in the sun in hot summers.

The rooms are usually built on an elevated level higher than the court yard with an open '*beramda*' (corridor). A portion of ceiling and floor, extends into this corridor. This place is utilized to spread *charpoys* (wooden cots) in case of rain and to keep household possessions like chairs, a small table for the guests, a sheet spread on a table or floor to iron the clothes and children's school bags and toys etc.

The kitchen is usually built in the courtyard in one of the corners of the house, with a small cemented floor just under the hand pump and sewerage to drain water used for

washing utensils and cooking pots. The same place is used for keeping the buckets for washing clothes. A place to bathe is usually close by near the hand pump. The newly constructed portions or houses are being built with motor pumps, overhead tanks and piped water supply net work to kitchen and bathroom.

The only toilet is usually built in the opposite corner to the location of the kitchen and water is usually placed in a bucket there.

The courtyard is the busiest portion and the actual place of activity, of the house. Mostly households keep their cattle and poultry in a portion of the courtyard. A cloth line is usually seen running across the court yards to hang clothes for drying. The *charpoys* (wooden cots) are laid in the court yard to sit in the sun in winters and to sleep in summers in the open.

Tandoor (clay oven) and *Chullah* (stove place) are present in all households. Some of the houses have a room dedicated for kitchen area , while others have a shed only. Women do the cooking mostly, sitting on a small short legged wooden stool with woven seat called*" peerhi"* or a bigger one with a back called *"peerha"*. Jaffer does not have any natural gas supply. Mostly, wood and dung cakes are used to make fire. In times of rain when wood becomes moist and difficult to burn, most households keep oil stoves which are burnt by use of kerosine oil.

3.8 Family Structure

Patriarchal, patrilineal and patrilocal, the family in Jaffer, virtually revolves around its males, although the females are responsible for the internal tasks of the household such as food preparation and child rearing etc. Generally, there are three types of families in the village, nuclear, joint and extended. In nuclear families, a couple lives with their unmarried children; in joint families, couples live with their married and unmarried sons and daughters; and in extended families the grand parents, parents and their children all live together.

Table 9: Distribution of Households by Family Type

S.No.	Type of Family	Number of Households
1.	Nuclear	147
2.	Joint	114
3.	Extended	28
	Total	289

Source: Census Survey

3.9 Traditional Kinship Patterns

Village social life revolves around family and kin. Even among members of the most well-to-do, family retains its overarching significance. The family is the basis of social organization, providing its members with both identity and protection. Rarely, does an individual live apart from relatives; even male urban migrants usually live with relatives or friends of kin. Children live with their parents until marriage, and sons often stay with their parents after marriage, forming a joint family.

The household is the primary kinship unit. In its ideal, or extended, form, it includes a married couple, their sons, their sons' wives and children, and unmarried offsprings. Sons may establish separate households upon their father's death. Whether or not an extended household endures depends on the preferences of the individuals involved. Quarrels and divisiveness, particularly among the women (mother-in-law and daughters-in-law), can lead to the premature dissolution of a joint household.

Descent is reckoned patrilineally, so only those related through male ancestors are considered relatives. The '*biradari*' (the patrilineage and affinal kin) plays a significant role in social relations. Its members neither hold movable property in common nor share earnings, but the honor or shame of individual members affects the general standing of the '*biradari*' within the community. A common proverb expresses this view:

"*One does not share the bread, but one shares the shame.*"

Members of a *'biradari'* are co-residents of same area or the village. However, land fragmentation and tendency of out-migration over time, have led to the dispersal of many members of the *'biradari'* among various villages and cities. Patrilineal kin continue to maintain ties with their natal village and enjoy the legal right of *'Haq-e-Shufaa'* (first refusal) in any land sale. Members of a *'biradari'* also celebrate the major life events together. Patrilineal kin are expected to contribute food and to help with taking care of guests in the ceremonies accompanying birth, marriage, death, and major religious holidays. The *'biradari'* has traditionally served as a combined mutual aid society and welfare agency, arranging loans to members, assisting in finding employment, and contributing to the dowries of poorer families etc.

There is always a considerable pressure for patrilineal kin to maintain good relations with one another. *'Biradari'* members who had a quarrel, will try to resolve their differences before major social occasions so that the patrilineage can present a united front to the village. People with sons and daughters of marriageable age, keenly feel the necessity to maintain good relations because a person whose family is at odds with his or her *'biradari'*, is considered a poor marriage prospect.

Although descent is reckoned patrilineally, women maintain relations with their natal families throughout life. The degree of involvement with maternal kin varies with residential status of mother and daughter living in the same or different villages. The tie between brother and sister is typically strong and affectionate; a woman looks to her brothers for support in case of divorce or widowhood early in her marriage. In the village Jaffer, families maintain considerable contact with maternal kin. Children, even though they are members of their father's patrilineage, are indulged by their mother's kin and have strong bonds with their maternal uncles and aunts.

3.10 Terminology for Cousins by Descent

There are separate words for paternal and maternal cousins in the local language e.g. paternal uncle's son is *'Dadpotra'*; paternal aunt's son is *'Phupaira'*; maternal uncles's son is *'Malaira'*; maternal aunt's son: is *'Masaira'* and so forth.

The above listing is also the priority sequencing for marriage settling in the same order. A paternal side preferred with uncle's son getting preferred on aunt's son. However, the availability of the respective sibling's issue of suitable age, is also a determining factor. If a brother and a sister in one family can be married to a set of brother and sister in another family that arrangement would be preferred called *"watta satta"* (exchange marriage).

3.11 Marriage Patterns

Marriages are mostly endogamous, preferably within one's own *'biradari'* and mostly with first cousins. Endogamy is preferred to preserve purity of one's generation's blood.

> *"Humara rivaj nahin kay hum khandan say bahir shaadi karein, is tarah hamara khoon saaf raha"*
>
> [We do not have the custom of arranging marriage outside the family, thus our blood remained clean]

Among all the marriages in the village, only two were found exogamous; in one case a *Mughal* man marrying a *Khattar* woman due to a friendship between two army service men and the other, a man remarrying for want of children and unable to find a second wife within his own relatives as nobody wanted to give one's own family girl as a co-wife.

While Muslim men are allowed in Quran to have more than one wife (with the provision that they treat them equally), most families here are monogamous. There is a significant trend of serial monogamy rather than keeping more than one wife together. In cases when a man married more than once, the first wife usually left after some time seeking divorce.

Social constraints against polygamy stem from the system of arranged marriages, which regard every marriage as an alliance between families and not simply a union of individuals. The practice of *watta-satta* (exchange of two siblings a brother and a sister in marriage with siblings both from the other family) is also common. This acts as a

deterrent against wife abuse, divorce or re-marriage. Economic factors are also an important consideration not only for the number of wives a man may have, but also the number of progeny which will result from multiple marriages. Early marriages are also common in the village.

3.12 Divorce

Seeking to end a marriage contract is permissible for both the partners in Islam. The village people think that the divorce trends have increased with the passage of time. The reasons for divorce differ for most of the cases but usually, it is dislike of the spouse chosen by the parents, failure to conceive children, major disagreements between the partners or simply to get rid of financial responsibilities. For example, once a man divorced his sick wife instead of getting her admitted in hospital. The wife was pregnant with her first child and required a caesarian section. The divorce was done on the insistence of husband's family who said, *"why spend so much on her?"*

Men also re-marry if the first wife does not have children. Mostly, the first wife seeks a divorce and prefers to live with her parents rather than being subjected to the life of discrimination and neglect by her husband.

Annulment of marriage also occurs if the wife is not considered loyal to her husband in matters of family feuds. The village women narrate the story of one couple where, the man came home and asked his wife to give him food. She said she was going on a wedding and asked him to prepare something for himself. He got furious and announced,

" mein nahin chahta key tum hamarey dushmanoon ki
shadi par jayo aur mujhey kaho key khana khud bana lena.
Is waja sey mein tum ko talaq dey raha hoon"

[I do not want that you attend the wedding of our enemies
and tell me to cook myself the food. So, I am divorcing
you because of this reason.]

There have also been instances where, one man liked another man's wife and asked him to divorce her, so he can marry her. This has happened only where the two men had hierarchically different positions in the village.

3.13 Major Ethnic Groups

The tribes, clans and castes that inhabit Potowar, are the *Awans, Rajputs, Mehr, Kahuts, Mughals, Gujars, Gondals, Arains and Sheikhs*[243]. However, in Village Jaffer, only two ethnic groups are living i.e. *Mughals and Awans.*

3.13.1 Mughals

This is predominantly a village of *Mughals* who are the also the landowners, here. There are some other villages of *Mughals* as well in the same Union Council of Ajjuwal. The *Mughals* are proud of their ancestors and acknowledge that their status is deteriorating with time.

> *"We have a nambardar family who was always strong but now they have developed ills (aiby ho gaye hain). They are becoming poorer now and were never so down the scale as now. Agral had more pomp and show (dabdaba) earlier, now they are on decline".*
> (Quote from a man from Agral family)

Like any other Punjabi village, the village population is divided into two man socio-economic and professional groups, the *zamindars* (landowners) and the *kammis* (tenants or skilled craftsmen). These two groups have a hierarchical relationship similar to caste. The *zamindars* claim higher status and are normally in the majority and *kammis* are ascribed lower social status and normally represent a minority. Unlike the caste system in India, however, no religious connotation is attached to this classification. The seypi-system in which the handicraft group is dependant on the farmers is still prevalent in most parts of Punjab (Eglar 1960 and Chaudhry, 1999)[244]. Traditionally, this hierarchy was also manifested economically; *zamindars* were better off than *kammis*. But this

[243] Leading Tribes of Punjab and their Origins : Publisher : ANSInet, Asian Network for Scientific Information.
[244] As quoted in Katzan, J. (1999). Decision making Parocesses and Power Relations in Gali Jageer : HAS Monograph Series 1.

economic gap is in the process of disappearing. With the growth of industry, more and more *kammis* took the opportunity to work in factories and the like, thereby earning regular incomes and often becoming richer than the *zamindars*.

> *"The land of zamindars , in successive generations is being divided in to fractions, rendering them poor. "This process of social mobility and change challanges the traditional value system, which is linked to the hierarchical relationship between zamindars and kammis. This process of social mobility and change challenges the traditional value system which is linked to the hierarchical relationship between zamindars and kammis.* (Chaudhary :1999)[245]

It is also the transformation of economic system from kind to cash. The cash economy in urban areas has also started to replace the economy in kind in rural areas.

3.13.2 Awans

There are twenty-one *Awan* families living in the village Jaffer. They are the landless and the low status, here. Most of them have no education and their women folk (the elder generation) used to work as domestic labour in nearby urban areas of Rawalpindi and contributed to the household income. The yong girls also work as domestic servants in the city before getting married. None of the married girls has continued the domestic work in the city but they do contribute to the much required labour during the harvesting seasons and paid work during marriages etc.

The collaborative practice whereby *'kammi'* familes and women helped the *'zamindar'* families in the domestic work and odd jobs and receive grains, *lassi* and clothes have to a large extent, diminished. One of the elder women talked about the changing values with time and said,

> *"Kammi aa kay kam kar daindiyaan si , hun meri noun sara kam aap kardi aa kehndi aay, " Kuj naeen jorya, sar unaan khila chorya"*
>
> [Kammi women used to come and help us in the house work. Now my daughter-in-law does all the work by herself and says "you have saved nothing and only fed the others!].

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[245] Chaudhary, A. (1999). Justice in Practice: legal Ethnography of a Pakistani Punjabi Village. Karachi: Oxford University Press.

As *Awan* men are finding labour in the cities, they also put sanctions on their women against paid work, because women's work is considered a symbol of impoverishment and detracts from male honour.

Oral traditions in the village associate *Awans* being descendants of Qutub Shah who accompanied Sultan Mehmood Ghaznavi (997-1037 C.E.) in the battle of Sumnat. After this expedition Qutab Shah stayed in Kalah Bagh for few years and from there the Awan tribe spread across the to other areas. One of the Sufi saints, Sultan Bahu (RA), was from the Awan tribe. His shrine is in district Jhang. According to Thomson[246], Awans were locals converted to Islam by Mahmud Ghaznavi. They are spread out in several districts of the Punjab. Thomson, in his Jehlum Settlement Report, adduces many strong reasons in support of his conclusion that the Awans came from west of D.I.Khan. Griffin (as quoted by Rose H.A.)[247] also agrees regarding the local Muslim origin of Awans while Cunningham holds that Janjuas and Awans are descended from Anu and calls them Anwan and that Awans are of indigenous Hindu/Buddhist/Pagan/Animist origin. In the genealogical tree of the Nawabs of Kalabagh, who are regarded heads of the Awans, there are found several native names such as Rai, Harkaran, etc.

3.14 Social Stratification and Kinship Structures

The social stratification in the village is a typical division into two main socio-economic and professional groups, the *'zamindars'* (landowners) and the *'kammis'* (village professionals/handicrafts men). These two groups have a hierarchical relationship similar to caste. Traditionally this heirarchy was also manifested economically, *'zamindars'* were better off than *'kammis'*. But this economic gap is in the process of disappearing. As *'kammis'* turned to employment in industry or the police and army, they had regular income and became richer than zamindars. The land of *'zamindars'*, in successive generations, is also being divided into fractions, rendering them poor.

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[246] Thompson, E.A., (1956). The Settlement of the Barbarians in Southern Gaul, Journal of Roman Studies, XLVI:65-75.

[247] Rose, H.A.,(1970)Jats, in a Glossary of the Tribes and castes of the Punjab and North-West Frontier Province, Reprinted by the Languages Dept., Patiala, Punjab, first published in 1883.

Kinship patterns in the village are similar to that of a Punjabi society; very eloquently described as:

> *"Punjabi kinship takes three forms: biological, fictive and symbolic. Within the family, there is intensively double kinship: your brother is your friend; your friend is your brother; and both enjoy equal access to your resources. In a traditional context, there is virtually free access to your kinman's resources without foreseeable payback. This results in social networks which are not self-oriented but are instead based on local solidarities of necessity. These reproduce not only friendly relations but a local community structure. Therefore, there is a great deal of social pressure on an individual to share and pool resources(e.g. income, political influence, personal connections). In many ways, there is an in-compatibility between the necessities of the capitalist system to pool resources for further profit, and to local solidarities of necessity which extract these resources for the local structure and allocate them for reproducing non-economic relations."*
> *(Weiss,1999:22)*[248]

The aforementioned three forms of kinship, are also used for resource sharing including meeting the sudden and un-expected costs of health care seeking.

3.15 Political Structures

Authority and power lies in the hands of those with land, money and resources. The *'nambardar'*(registrar) family among all the *'zamindars'* is more influential than others. Second come the elder educated members (such as the retired army employees) and *'syeds'* who are running the mosque. A Union Council member is also influential but, to a lesser extent, and for a limited tenure-term. The village traditions respect the elderly and give them space to sit towards *takia* (head) side of the *charpoy* (wooden cot). The role of elders is, though, diminishing but still vital to resolve smaller feuds between families.

Panchayat or jirga (para-legal community conflict resolution system) used to be in vogue till a few years back but people now tend to go to legislative/judicial bodies as they feel that the *jirga* system is not impartial. This may also be due to a decline in cohesive forces.

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[248] Weiss, A. M. (1991). Culture, Class, and Development in Pakistan. The Emergence of an Industrial Bourgeoisie in Punjab. Oxford : Westview Press

The *zamindars* (i.e. Mughals) hold higher status than the *kammis* (i.e.Awans). The expression "*kammis*" is used mostly by *zamindars* in the derogatory terms and in absence of *kammis*. One elderly lady retorted,

> *" there was a time when they could not even raise their eyes before us or sit with us on one charpoy but the time has changed now."*

3.16 Economic Conditions

Major land holdings are very few in number now. However, agriculture is still the major source of livelihood. Some of the farmers own the land while others are sharecroppers or tenants. Sharecroppers work on land they do not own, giving between a half and two-thirds of their crops to landlords. The farms they work on can be modest or vast in scale - some landowners own up to 1000 kanals of land, the others as little as five kanals. Tenants earn through wages and crop sharing. Workers often end up tied to the land, after taking a loan from the landowner and offering to pay it back by working. Sometimes, whole family ends up in this type of debt bondage, working to pay off a loan on which the interest keeps accumulating. Debts are also sometimes passed on to the next generation, condemning a whole family to a life of servitude[249].

> *"For generations all we have done is work on land that belonged to others. We have never owned land. It has owned us."*

Land holdings for owners have also become less productive with division and subdivision into smaller units. Villagers tilling their own land say that inputs of fertilizers and pesticides have become too expensive; they are living hand to mouth and the yield of wheat is just enough for their own consumption. Those who are in service and have given their land to sharecroppers, say that the land does not yield a dependable income.

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[249] Also mentioned for other farmers in Attock in *Tied to the Land*, Written by Muhammad Ishtiaq, Panos Published Tuesday, January 09, 2007.

Table 10: Land Holdings

Area	No. of landowners
1000 Kanal	1
800-900 Kanal	3
600-900 Kanal	5
500-300 Kanal	6
200-50 Kanal	8
49-5 kanal	11
Landless	All Remaining

Source: Census Survey

Lesser reliance on agriculture and the spirited and rugged nature of the people with strong martial traditions makes this area one of the main recruiting areas for the armed forces.

There is a famous saying that,

"Every second person is a soldier and every third one is a poet in Potowar".

Historically this area has been famous for army recruitment. Most of the Jaffer men employed in army are *'sepoys'* and get promotion upto the level of *'hawaldar'*. There are only two who have risen to the level of commissioned officers.A significant number also joins the police and railway departments. The proximity of village Jaffer to the twin cities of Rawalpindi and Islamabad also provides economic opportunities to the village people, many of whom are working there as labourers or commute daily for business, selling milk, and poultry and other produce.

Table 11: Source of Livelihood (Men)

S.No.	Broad categories	Occupation	No. of Persons	Percentage
1.	Farmers *(kashtkar)* (38%)	Landowners	34	18.5
		Tenants	21	11.4
		Sharecroppers	15	8.1
2.	Government Service (22.2%)	Army	18	9.8
		Police	10	5.4
		Teachers	6	3.2
		Railway	5	2.7
		Health Department	2	1.09
3.	Labourers (28.8%)	Daily wagers	31	16.9
		Masons	5	2.7
		Cobblers	1	0.5
		Drivers	10	5.4
		Gardeners	5	2.7
4.	Private business (11%)	Selling milk	4	2.1
		Running a restaurant	2	1.09
		Shop keeper		
		Village shops	2	1.09
		Fateh Jang shops	5	2.7
		Selling poultry and eggs	5	2.7
		Running video game centres	2	1.09

Source: Census Survey

Among women in paid employment, there are two school teachers, two lady health workers, three *dai's* and six domestic workers. Women are participating in income generating work like embroidery, sewing clothes, rearing cattle and poultry, assisting their husbands in grazing cattle and in cutting hay and weeding in the fields.

3.17 Amenities of Life

The village has a small shop near the mosque that keeps grains, lentils, biscuits, sweets, soap and small items of household use. People buy dairy produce and eggs directly from other households. All meat, vegetable, clothing, medicines etc. are usually bought from Fateh Jang town.

3.18 Educational Facilities

A decade earlier, there was hardly any educational trend in the village but the inhabitants see a significant difference now. There is a public primary school for girls at the edge of residential area of the village. The approval exists to up-grade it to middle school level. There is another private girl's middle school and a tution academy in the midst of houses. The boys' high school exists on the main Fateh Jang - Kohat Road opposite the side where village is located. For college and higher education, students commute to Fateh Jang. *Maulvi sahib* (the clergy man) of the local mosque conducts classes, teaching Holy Quran to young children.

3.19 Sanitation

The village lanes are clean except when it rains and the mud makes the path slippery and difficult to walk. All households do have a flush pour latrine and septic tanks, though an organized sewerage system is missing. Open sewage lines to dispose of water used for cleaning etc. run parallel to the *'kacha'* (mud) lanes. As, the village is located at a height as compared to the field, water easily drains out under gravity. There is no system for garbage disposal which is usually dumped in fields adjacent to the village.

3.20 Key Social Indicators

The social development of any area has a strong effects on the health of its population. The village population is progressing on literacy and access to improved source of drinking water. There is no telephone land line, thus a greater ownership of mobile phones is seen.

The Table 12 on next page represents the key social indicators of the village as calculated dur census survey of the village.

Table 12: Key Social Indicators of the Village Jaffer

Indicator	Percentage
Adult[250] literacy rate (total)	51
Adult literacy Rate (male)	73
Adult literacy rate (female)	40
Access within households to improved source of drinking water	77
Households with a sanitary latrine	42
Kacha (mud) house	33
Pacca (cemented) house	67
Households without electricity	15
Households with agricultural land	34
Households with tractor	2
Households with livestock	47
Adult Unemployment	18
Family possession	
Television	70
Radio	50
Mobile phone	82
Refrigerator	30

Source: Census Survey

The female population of the village, like other rural areas in Potowar, exhibit inadequate utilization of modern reproductive health services.

[250] Those 10 years of age and above who can read and write their name

Table 13: The Status of Reproductive Health Indicators in the Village

Indicator	Percentage
Antenatal Care (at least 1 visit) by a doctor/nurse/LHV in last pregnancy	45
Birth by a doctor/nurse/LHV in last pregnancy	28
Post Natal Care by a doctor/nurse/LHV in last pregnancy	25
Ever use of any family planning method	33
Ever Use of a modern family planning method	24

Source: Semi-structured Interviews

3.21 Formal and Informal Reproductive Health Care Services

The village has a Basic Health Unit manned by a male doctor, a female para-medic (lady health visitor), a medical technician, a dispensor and a *'dai'* (traditional birth attendant). The nearest hospital is Tehsil Head Quarter Hospital, Fateh Jang. Other nearby referral level hospitals are DHQ Attock, POF Wah, Hospital, CMH Rawalpindi and RGH Rawalpindi. Two lady health workers work in the population. There are also *dai's, Syed/imam , shrines and hakeems* in Fateh Jang and Jand whose services are commonly used. Tehsil Head Quarter Hospital Fateh Jang is the nearest referral level government facility accessible in about 40 minutes by a public van. The plant and plant materials available from the local land are also used as medicine; similar to other villages of the area where native medicinally important herbs are gathered in different seasons of the year for personal and community use[251].

[251] Ahmad Mustaq, Ajab Khan Mir, Zafar Muhammad and Sultana Shazia (2006). Ethnomedicinal Demography and Ecological Diversification of Some Important Weeds From District Attock-Pakistan Pak J. Weed Sci. Res. 12 (1-2): 37-46

3.21.1 Basic Health Unit (BHU) Jaffer

Basic Health Units are first level-care facilities set up by the government. Each BHU serves a population of 5-10,000 people and is manned by a doctor, a lady health visitor, a dispensor, a vaccinator, a *'dai'* and a '*chowkidar*' (guard). BHU Jaffer is built on land donated by a local zamindaar. The family has its own three bunglows built next to the BHU. Table 14 presents the brief demographic profile of the catchmnets population of the basic Health centre.

Table 14: Catchments Area of BHU Jaffer

Village	Population	Distance in km	No. of LHWs	Trained TBAs	Un-trained TBA
Charat	918	15	0	0	1
Ajjuwala	940	17	1	0	2
Sadqal	32100	15	1	2	3
Dhoke sailu	4224	22	0	1	3
Gharala Kalan	2164	4	0	0	4
Jaffer	2011	0.5	2	2	1
Bhal Syedaan	2085	4	0	3	3

Source: Record of Basic Health Unit Jaffer

Photograph 1: Basic Health Unit, Jaffer (the boundary wall is being reconstructed)

3.21.2 Tehsil HeadQuarter (THQ) Hospital, Fateh Jang

The Tehsil HeadQuarter hospital, Fateh Jang, is the nearest referral level hospital. Each THQ Hospital has a position for a gynecologist, a surgeon, an anesthetist and a woman medical officer, a lady health visitor, laboratory and operation theatre personnel. At the time of this study, the only female health care providers available at this facility were a female medical officer and a lady health visitor. All the surgical emergencies, including those of reproductive health, were being referred to the nearest teaching hospital, in Rawalpindi.

Photograph 2: Tehsil Head Quarter hospital, Fateh Jang

3.21.3 Family Welfare Centre, Gali Jageer

This is an outlet of the Population Welfare Department, Punjab where exclusively family planning services are provided. This centre is about 10 kilometers from the village and one needs to go on a public van to go there. A family welfare worker (a female paramedic) is deputed there who provides all clinical methods of family planning. Clients for surgical procedures are referred to Tehsil Head Quarter Hospital, Fateh Jang where monthly surgical camps are organized by team visiting from Attock.

From the geographic dimensions of the village, the emphasis will now shift to the status of women in the village and measure of their autonomy in different day to day and major decisions. This can help to understand the context of female reproductive health decision-making in the later discourse.

CHAPTER 4

FEMALE AUTONOMY AND STATUS

Female status and autonomy build the foundation on which rests their decision making power in matters of reproductive health. The socio-economic profile of households, age at marriage, literacy, education, employment and property ownership are some of the indicators used for measuring female status in a given population[252]. While the word 'status' is used in reference of a population group or position of an individual relative to others, the word 'autonomy' is more reflective of an individual's status regarding decision-making power.

The decision making process occurs in an environment of un-evenly distributed economic resources and power structures where different actors play their role according to the different familial patterns. Each decision having an impact on the reproductive health of a woman is thus a product of cultural practices and norms, her social status and how it is influenced by economic factors.

This chapter, will be looking at the concept of female autonomy, family patterns and their impact on female autonomy, the socio-economic profile of women in the village Jaffer, female empowerment, the decision-making patterns at the household level, and the role of significant others i.e. husband, mother-in-law etc.

4.1 Definition of Female Autonomy

Autonomy is "independence or freedom, as of the will or one's action"[253] The term is derived from ancient Greek words *'auto'* meaning self and *'nomos'* meaning law i.e. one who gives oneself his/her own law. It refers to the capacity of a rational individual to

[252] Status of Women, Reproductive Health and Family Planning Survey, National Institute of Population Studies, Islamabad, 2007.
[253] http:dictionary.reference.com/browse/Autonomy accessed on 10-06-2009

make an informed, un-coerced decision. Female autonomy may therefore be defined as the ability of women to make choices/decisions within the household. As rightly pointed out by Anderson and Eswaran,

> *"The whole question of autonomy does not, of course, arise if the household is viewed as a monolithic unit, with a single decision maker. However, there is an ample evidence contradicting this unitary model of the household. ....instead of being automistic, the household in developing countries is better modeled as conflictional."*
> *(Anderson and Eswaran : 2007)*[254]

There is no single word for 'autonomy' in the local language. Its many shades are reflected in different words '*apni marzi*' (own will), '*khud mukhtari*' (sovereignty) and '*apna faisala aap karna*' (own decision by oneself). In a culture that values female obedience, this is not a trait which is much talked about and when used for females by females themselves, it is always in a negative connotation of being '*ziddi*' (stubborn) or '*nafarmaan*'(disobedient).

One of the elderly men who had roamed the world being in British army during the world war provided moral support to many women of the village to get their right to the ancestral land. However, he categorically discarded my notion of letting women speak their minds. He said,

> *" Mughal aurat ki kia majal kay sar utahai"*
> [A Mughal woman can not dare to raise her
> head (being rebellious)]

Perhaps his vocabulary came from his British military history where *"sar uthaana"* (raising head) was a term used for 'mutiny'. It is interesting to note that most of the men, appreciated the strong headedness and management skills of women known to them but from a different family and perspective. Another commonly given example is of a lady among their ancestors who took leadership of the clan when her father died leaving no male offspring.

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[254] Anderson Siwan and Eswaran Mukesh (2007). "What Determines Female Autonomy? Evidence from Bangladesh" Report of Department of Economics, University of British Columbia.

An old man described the particular example of a Mughal lady regarded as a heroine among their ancestors,

> *" Aap us ki tasweer dekhein. Yeh roub daar chehra aur mardoun jaise parwattay. Kehtay hein usey talwar bhi chlaani aati thi. Us ko apnay muqaablay ka koi mila nahin, phir us nay angraiz commissioner say shadi kar li"*
>
> [You should see her picture. This dignified face and (thick) eye brows like men. (People) say that she also knew how to use a sword. She could not find anyone of her match so she married the English Commissioner]

A proudly quoted example is of the wife of a '*namabardar*' whose husband was imprisoned for some time in a political feud and she had to manage all the farming as their was no adult male in the family to look after things. Men say that she proved to be a better administrator than her husband.

4.2 Women's Empowerment and Link with Health Care

The links between women's health and status of empowerment, entitlement and improved self esteem are widely acknowledged. "Empowerment" literally means the investing of power and authority. The word has come to mean enabling or equipping individuals or groups to have power, with the aim of creating and fostering relationships of equality in society.

> *"For women, the process of empowerment entails breaking away from the cycle of learned and taught submission to discrimination, carried from one generation of women to the next."*
> (Tomasveki, 1993 as quoted by Kitts J.1996: 24)[255]

A sense of empowerment is critical to get women to accept health related information and translate this knowledge into behavioural change. The generally lower status of women and their internalization of the status, results in the marginalization of women's physical, psychological, and emotional needs.

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[255] Kitts, J. and Roberts, J.H. (Eds). (1996). The Health Gap: Beyond Pregnancy and Reproduction. Ottawa: International Development Research Centre, Canada.

"Women's position in society directly or indirectly influence their ability to participate in child bearing, sexual conduct, and fertility rate decisions." (Lin Tan 1995 as quoted by Kitts J.1996*: 23)*

A woman must be encouraged to take control over her own health and the notions of self-care and control over one's life need to be felt at every emotional level. Furthermore, women need skills that enable them to effectively change their reality. Self- esteem is necessary because a woman is considered as having self-esteem once she begins to "*find the person within the woman*", and starts to take responsibility for her own health needs. (Udipi and Varghese as quoted by Kitts J.1996)

4.3 Socialization of Young Girls

Young girls are socialized to be obedient and especially guard one's family honour by not asserting their choices especially in the matters of selecting a husband and complying with what elders decide. An orphan woman, raised by her grandmother, remembered time of her adolescence, when she frequently heard one advice over and over again. She said,

"Daadi kehti thein baap dada ka naam kharaab na karna; Koi aisaa kaam na karna kay un ka janaza bhari ho jaye."

[My (paternal) grandma used to say, never tarnish the name of your father and grandpa; never do anything that will make their funeral cot heavy (her misdeed will be counted as their sins)]

If a young girl does not agree to the choice of spouse made for her, she is coerced by her mother on the basis that her disobedience will trigger disapproval of her father and more physical violence and verbal abuse by him.

Girls are also strongly advised at the time of marriage to

"Enna ral mil kay rehna kay koi dekh kay na keh sakay keri dhee aay tay keri noun"

[Live so mixed up in your in-laws so that no one can tell between the daughter and a daughter-in-law]

One lady recalled that her father feared, she may cause trouble so he threatened her,

"Agar sas nandaan na lari tay tukray kar dawaan ga"

[If you pick a fight with your mother-in-law and sisters-in-law, I will cut you down in pieces.]

4.4 Choice of the Marriage Partner

Marriage is a mean of allying two extended families in the village; romantic attachments have little role to play. However, there are stories of '*aashqi mashhooqi*' (love-affairs). Girls are quoted as having runaways from the homes with their beloveds or have been reported to commit suicide if parents do not agree on their choices of spouses. Some have intelligently used their confidantes' among elders, to influence their parents. The husband and wife are considered primarily representatives of their respective families in a contractual arrangement, which is typically negotiated between two male heads of the household. It is fundamentally the parents' responsibility to arrange marriages of their children, but older siblings may also become actively involved, specifically in the cases where the parents die early. The terms are worked out in detail and are noted, by law, at the local marriage registry.

Table 15: Women Who Were Asked For Their Consent in Matter of Spouse Selection

Category	Number	Percentage
Women who were asked for their consent	16	32
Women who were not asked for their consent	34	68
Total	50	100

Source: In-depth Interviews with women

Marriage is also a process of acquiring new relatives or reinforcing the old ties one has with the others. To participate fully in society, a person must be married and have children, preferably sons, because social ties are defined by giving away daughters in marriages and receiving daughters-in-law. Marriage with one's father's brother's child is

preferred, in part because property exchanged at marriage then stays within the patrilineage. The relationship between in-laws extends beyond the couples and well past the marriage event. Families related by marriage exchange gifts on important occasions in each others lives. If a marriage is successful, it will be followed by others between the two families. The links thus formed, persist and are reinforced through the generations. The pattern of continued intermarriages coupled with the occasional marriage of non-relatives creates, interlocking patterns of descent.

4.4.1 Preference for Endogamy

Families prefer inter-marriages among cousins. It was interesting to note that, only thirteen women were brought in marriage from other villages (in the present cohort of 15-49 year old ever-married women). The trend is, however, increasing for marriages outside the village, especially among the families residing out of the village.

The choice of the bridegroom, is done usually on the following criteria,

> *"ghar, nokri, khandaan acha ho to log apni baitey dey 'dai'tay hain; lofar say nahin kartey; kehtay hain apney maan baap ka nahin bana to hamara kiya baney ga?"*
>
> [People do give their daughter if the match has a good house, a good job and a good family; nobody gives his daughter to a wanderer; they say if he has not owned his parents, how will he own us?][256]

Sometimes the prospective bride-groom is very poor and parents give their pretty daughter to him, saying

"Is nay kiya dena hay?"

[what will she give us?]

On some occasions, the boy does not have a secure job but still parents do get him married-off, especially when the mother-in-law is alone and an extra pair of hands is

[256] Quote from an elderly village woman

required for the domestic chores. Girls are usually married around the age of 15-16 years and boys at the age of 20-22 years.

Beauty and possession of essential skills to manage a house, are preferred in a girl for selection as the daughter-in-law. A girl is considered pretty if she is good looking and has attractive '*naqsh*' (features). The shape and size of eyes and nose is considered important. To be considered *'pur kashish'* (attractive), a girl needs *'gora rang'* (fair complexion) and *'darmiana qad'* (medium height). The medium height is referred to the norm of an average of five feet.

Some illustrative quotes from the village women about the required attributes in a girl to be selected as a daughter-in-law, are:

> *"parhi likhi, saleeqa ho aur khoob soorat ho"*
> [(People want a girl who is) educated, versatile, good mannered and pretty]

> *"Parha likha mard unparh larki sey shadi nahin karna chahta, farz karein dost aajayaey to achey tareeqay sey baat nahin kar sakti"*
> [An educated man does not want to marry an uneducated woman for fear of facing possible embarrassment if she can not socialize with his friends and acquaintances properly]

The trend for endogamous marriages, has been the norm in the village, to protect one's identity and prevent any mixing of traits of different blood.

4.4.2 Using One's Agency to Influence Marriage Decisions

The village girls also use their affinal networks to show their liking or disliking for a particular proposal. One girl was in love with her cousin and 'the *nikah*' (Muslim legal matrimonial ritual) had happened without *'rukhsati'* (shifting of the bride from her natal home to that of in-laws). The *'nikah'* remained for six years till the final marriage ceremony and meanwhile differences developed between the two families and the father

of the girl demanded divorce for his daughter. The boy's family said that they had already spent six thousand rupees on the *'nikah'* and can agree if the girl's father pays back the amount to them. The girl's father agreed but she was very disturbed. She talked to her maternal uncle with whom she was very comfortable since childhood and requested him to intervene. The uncle told his father that if he goes through with the divorce, everyone will forget that he had asked for it and any future prospective proposals for the girl will not come. Everybody will think that she must have a defect and that is why the divorce took place. This convinced the father to keep the *'nikah'* intact and not press for divorce.

There were also cases where girls committed suicide because of the family pressurizing them to accept a person they did not like or did not agree to the one liked by them. Just a year or so before my stay, one such girl had set herself and her dowry on fire and was burned to death. This suicide had really shocked everyone and the young girls admitted that since then the parents are more careful to at least ask for the girl's '*marzi*' (approval). It is customary for the families to start preparing dowry for girls when they are very young and to keep buying and collecting things as only meagre resources are available to them. Mothers are considered wise and '*sughar*' (adept in home management) if they think of such preparedness.

Marriage marks the onset of exposure to a woman's reproductive role and this decision is important for the village women in terms of their health and as a marker of their autonomy in their pre-marital status.

Table 16: Responses for Suitable Age at Marriage[257]

Age at marriage	**<19 years**	**20 years**	**21 years**	**25 years**	**Average Age (years)**
Suitable age considered for a woman to marry	15	15	0	20	21
Actual self age at marriage	30	10	0	10	17
Actual husband age at marriage	20	15	0	>30 years 20	25

Source: In-depth Interviews with women (n=50)

[257] Marriage here refers to co-habitation after *'nikah'*

As evident from the table above, the female respondents were married at an average of 17 years and they considered 21 years to be a suitable age for women to be married.

Recently, there is an increasing trend of giving more preference to a daughter's choice in matters of spouse selection than the trends seen in the older generation. However, serial polygamy is seen in the older generation, where a first marriage was solely the decision of parents but the subsequent marriage had a more say from the woman herself.

"pehli shaadi baapne dena kiya tha. Doosri shaadi ki dafa apni marzi thi.Wadera ghar tha, daadi bi kehti thein keh moqa hey warna bhabiyoun key kaam karti reh jayo gee"

[in the case of my first marriage, my father had given his word for giving my hand in marriage. In the case of second marriage, it was my own will. The family was well-off, my grandmother also said, this is the opportunity, and otherwise you will end up doing chores for wives of your brothers'.]

In another case, the woman was very young when her father died. Her parents had already made the decision for her when she was an infant. When she got married, the two did not get along well. She said their temperaments did not match. The marriage stayed for 10 years and then she fought a court case for divorce. She thinks she was a child at the time of the first marriage, and had no sense of what was good or bad for her.

A sense of no control of one's fate is evident, from a common saying by the village women,

"Maan Baap hi zubaan detay hein. Un ka faisla hi larki ki kismet hay chahay kouainay mein phaink dein. Acha bura to larki ko hud hi guzarna hay"

[The mother and father would give their word. The girl is at the mercy of their decision, if they want they can throw her in a well. Whatever good or worse comes out of the match has to be borne alone by the girl herself]

In the times of the older generation, girls did not express their opinion in such matters as they felt shy (i.e. they may be taken as immodest). Even when asked, it is not a real choice in a situation with minimal opportunities of interaction with the opposite sex and knowing some one in depth. Moreover, betrothal at birth would mean no alternative proposals for the girl.

Some feel that this situation is changing,

> *" pehlay to jhalla sa zamana tha, jahan bhi beti dey do. Aaj kal to larkiaan mobile par doosrey admioun sey baat karti hein"*
> [In the old days, people were simple and so were the girls. The parents' decision was final. Nowadays girls talk to stranger men on mobile phones.]

Running away from home by girls was more common in the past than in the current generation.

> *"pehlay aashqi mashooqi bohat thi. Auratein bhag jati thein. Agar koi pasand na aye to talaq dey di."*
>
> [Initially we had many romantic affairs. Women used to run away. Couples would divorce if they did not like each other].

Girls with a liking for a specific person do confide in their sisters, friends, uncles (*mamoon)* and aunts (*chachi, khaala, phupi*). In most cases, this is a person with lesser age difference and the one whom she can discuss matters of the heart without severe repercussion. None of the respondents confided in their parents on such matters. The confidante` will broach the subject tactfully to the girl's and boy's parents and negotiate a successful ending to the proposal.

4.5 Female Social Status and Autonomy

In the village households, power is acquired by acquisition of land and the right to manage the resources. The power of control over economic resources gives authority to father over sons in a typical patrilineal society. As the elder men have more authority

than the younger ones, their wives share the same hierarchy in a joint family situation. The mother-in-law has the greatest say followed by the eldest daughter-in-law. Having a patri-local family structure, the girl is usually married into her husband's family. The young husband is either fully dependant on his father if he has no other work apart from farming on his father's land, or partially economically dependant if just at the start of his career where establishing an independent household may not be economically viable. This is very much the case of men working in police or army in the lower ranks. Thus, the young couple usually lives with husband's parents and his unmarried siblings.

It is natural, in this situation, to have strong patrikin bonds, both inter-generationally (father and sons) and intra-generationally (between siblings) as a strategy to survive and thrive as a joint household rather than a nuclear household. Too strong an affinity between the new couple, is discouraged and the new bride is under tremendous social pressure to prove her loyalty to her in-laws' family over her natal kin. This is tested by constraints on her visits to her natal family, prioritizing attendance in social events in the in-laws family over her own, intense scrutiny of her behaviour towards her husband's brothers and sisters and strong sanctions against leaking any family secrets of her in-laws' family. The family will give this treatment to their daughter-in-law but is strongly sensitive to what happens to their own daughters in their marital homes. The parents thus prefer endogamy and '*watta-satta*' (exchange marriage) to control the fate of their daughter by controlling the fate of the girl from other family.

4.5.1 The Girl in Her Natal Home

The sons gets preference over daughters in allocation of household resources for their food and education. However, a girl gets more affection from her parents as they fear for her future. My host family had a little girl of four who had a thrashing from her mother for ruining her clothes in mud during her street play. The father was very upset to see the young daughter crying and said,

"Apni beti ko kaun marta hay? Larki sirf maan baap kay ghar mein khush reh sakti hay. Kia pata dossaray ghar mein uski kia kismet ho? Agar tum nay phir issay mara to mein thumhein wapis chor aun ga".

[Who hits one's own daughter? It is only in the parent's home that a girl can be happy. Who knows what is in store for her in the other home? If you (his wife) do it again I am going to send you back (to your parents)]

4.5.2 The Bride and the New Home

Close bonds between patrikin marginalizes the young married woman but she finds solace in same age neighbours and other daughters-in-law living in the same household (though a silent competition is always going on between the daughters-in-law as they compare how parents in-laws and their husbands treat them).

The younger daughter-in-law will get the most household chores to do and also those that are physically demanding. One of the younger women said,

" larki umar mein sab say chohti ho to bhi sab ki zimmedari poori karay,maan baap ki, apnay miaan ki, us kay behan bhaioun ki"

[the girl even if younger to all in age, is supposed to fulfill all responsibilities as regards her parents-in-law, her husband and his sisters and brothers.]

The married girls when they do get a chance to visit their natal family, use that occasion to be on vacation from household chores. A young girl who always enjoyed visits and hearing gossip from her married sisters, said:

"hamari bari behnaein ghar aati hein to kehti hein tum kaam karo, ham to pehlay hi kam kar kar kay thak kar aayee hein. Mein un ko kehti houn mein saraa kam karoun gi, tum log sirf apanay bachoun ko khud sambhalo"

[our elder (married) sisters, when they come home, say 'you do the work, we have already come tired of working and working'. I say, "I shall be doing all the work, but you people should only take care of your children.]

Whenever possible, sisters will try to visit their parents simultaneously so they have an opportunity to see each other as well. As visits to their natal home are so important, if a new '*bhabi*' is not taking proper care of them, this is complained about to the brother and becomes a source of quarrel or even divorce between him and his wife.

One woman recalled her early days when she got married at the age of eleven and was not able to do most of the work to her mother-in-law's satisfaction. She used to get hit on her hands and the mother-in-law used to say that she has wasted her time playing before marriage.

She recalled,

> *" woh kehti thein, khailti na kaam seekhti; mein chup chup kar ro leti thi; pehlay bachay kay baad kuch behtari ho jati hay magar aadat to toray tak jaati hay"*
>
> [she used to say, (you) should not have played but learnt (how to do) chores; I used to cry in hiding; things get better after the first child but the habit goes till end]

Parents are increasingly demanding more security for their daughter's in case of dissolution of the marriage and '*haq meher*' (bride's money to be paid at the time of marriage or definitely in case of divorce) is kept high to be a deterrent for a possible divorce. Women often refer to this as '*makaan larki kay naam karwana ya zewar larki kay naam karwana*' meaning 'getting the boy's house transferred in the girl's name or getting (gold) ornaments written in girl's name (in the marriage contract)'.

Both the man's mother and wife talk their hearts out to him and try to win him over to one's side. The continuous power struggle is a norm in most joint households. The young men are also weary of the wife-mother domestic wrangling and squabbling. Women said that nowadays their unmarried sons were clearly saying,

> *" wakhriaan rakh saan, na beewi diaan suno na maan diaan"*
>
> [I will keep them separate, not listening to wife's chatter and not listening to mother's chatter]

In an environment of mistrust and suspicion, it is even difficult for young wives to get other family members convinced that they are really sick and not pretending to get relaxation from their sexual duties or household chores; that they need outside care and that the illness is not relieved with home remedies. Getting money for the fee of the health care provider and to comply with any nutrition advice becomes a big ordeal. Women usually try to save whatever they can for such occasions. The poor women will often let go of expensive options and one time big payment in favour of small expenditures e.g. buying a medicine for a day or two rather than buying the full course at once and stopping the medicine as soon as a little relief is felt (common in case of antibiotics or other time bound prescriptions). It was a common request by antenatal clients to the LHV to write down the nutritional advice on a piece of paper which their husband or another literate family member can read and the family gets to believe that she really needs milk and meat prescribed to her.

" Parchi par likh dein who parh lein gay"

[Write on the piece of paper, they will read]

The new bride has very little autonomy in matters of running the household and her own care including that of her health. Any preventive care like getting an antenatal check–up without a physical complaint, is considered an unnecessary extravagance. One of the older women said,

> *"Mein nay to itnay bachay ghar par hi paida kiyee, us waqt 'dai' ko bula laitay thay; kabhi koi check-up nahin karwaiya- ab to bohat fazool krchiaan ho gayee hein"*
>
> [I delivered all my children at home, called the *'dai'* at that moment; never had any check-up- now there are many ways to waste money]

Women often would get required services when at their parent's place or if visiting their brother or sister in another city. This would give them the necessary freedom to go out without specific permission from their mother-in-law. It is common to avail family

planning and abortion services while at a woman's natal home or to call their mothers at their place, if living in a nuclear family, to support them.

4.5.3 The Mother of Sons

The status of a woman grows with the number of sons she has. Her health needs become worthy of seeking care if they threaten the well being of her sons. For example, post partum care with good food and some rest to the mother, is allowed if a baby boy is born. Women have access to more nourishing food to ensure that the baby gets proper nourishment. As the children grow to marriageable age, the husband and wife try to tie the knot with their own nephews and nieces to strengthen the bond with their own respective brothers and sisters. Availability of a suitable match, corresponding willingness of their sibling's spouse and inclination of their children, gets the bargain settled. Even if the man has to lose out in this negotiation process, he punishes his wife later on by repeating the fact that she was not obedient to his wish' in all the hot exchanges. He would not involve her in any future mediation; neither extends any material or financial support to the couple who tied the knot without his permission.

This trend of blaming the one who made the decision, is seen in other facets of life as well including that of making choices for one's healthcare. As a principle of risk sharing, the strategy is to defer the decision or let others make it or involve as many people as possible. The decision maker has to bear the burden of being held responsible for its consequences i.e. the impact on life and heath, financial loss in case of a wrong choice or winning a potential blame for mal-intention.

4.5.4 Becoming a Mother-in-law

Old age brings the menopause, increased mobility and relaxation in *'purdah'* (veil) as the woman becomes the '*bari*' (elder) in the family. The son, she had invested in through her life with greater care than her daughters, more display of affection and prioritizing his liking and dis-liking in food and other matters, has now grown up and is loyal and

obedient to her. She will choose a daughter-in-law who can take on the burden of taking care of her household. As she becomes older, the physically hard jobs will be passed on to the younger women (her daughters and daughters-in-law) and she will now take up the socializing role of her mother-in-law who by that time has passed away. She has more influence in household decisions at this time of her life than ever before. Her own general health is deteriorating with age and the life long burden of reproduction and hard work has also left her with some physical complications and disabilities. Widowhood is common (as men are usually older by at least 5-10 years when the couple marries, and die earlier than their female spouse; average life expectancy for males and females being the same). Sons are thus the old age security after the husband's death for a woman.

Till she can walk, she will be able to go out for healthcare seeking for herself, her family and grand children. However, she is still dependant on her son for the money to buy her medicines and food. As she becomes senile and bedridden, her daughter-in-law and grand daughters look after her. Upon her death, her brothers will shoulder the funeral cot to the graveyard and her sons will cry for her and at last, the girl who was considered *'paraya dhan'* (others' property) in her natal family till marriage and struggled to get recognition as a 'family member' in her husband's family gets the social recognition of belonging to both.

4.6 The Autonomy Profile of the Village Women

The autonomy profile was built on the women's educational attainment and the decision-making prowess they have or have not exhibited in the key areas of educational status, land ownership, freedom of mobility, such as permission to go to the market, to go to the health centre, to go to the natal home, or having one's opinion sought in important family matters.

4.6.1 The Educational Attainment

Women's participation in decision-making is hindered by their marginalization from information and knowledge. Having access to education means access to information and choice and thus women are able to make informed decisions about their health. Educated women and mothers may have greater decision making power on health and related matters within both the family and the community, be more knowledgeable about disease, prevention and treatment, and be more likely to adopt new codes of behaviour that improve their health.

Although education to some extent increases the possibility of women obtaining better jobs, the link between education and employment particularly, for women is fragile. Even, when women have the right skills, gender stereotypes and cultural dictates as well as socio-economic factors can present barriers to equal opportunities for women (Grandea 1994 : 21).

The education status of married women in the village Jaffer is given in the table below:

Table 17: Education Status of the Married Women of Reproductive Age in the Village

Education level	Percentage (%)
Illiterate	54.5
Primary	10
Middle	24
Matric	11
Higher than Matric	0.5
Total	100

Source : In-depth Interviews with women (n= 50)

As it is obvious, more than half of the women are illiterate and among the educated ones, the biggest proportion is those having the middle or eighth class qualification. This is because of the fact that the government's village school is only up to class eight.

Almost half of the women had themselves decided to stop their education while for the other half, it was a family decision.

Table 18: Woman's Decision for Continuation/ Discontinuation of Her Education

Category	Number	Percentage (%)
Woman who themselves decided about continuation/ discontinuation of their education	27	54
Woman who did not participated in decision about continuation/ discontinuation of their education	23	46
Total	50	100

Source : In-depth Interviews with women (n= 50)

A woman narrated the story of the very first private girls' school which was established in the village. She told me that a private high school was opened in the village and the male principal and a female teacher entered into nikah (marriage) secretly. People got scared and said, *"if the teacher is like this what is going to happen to her students?"*

There are exceptions, however. For example, a girl who was the last born among eight others was a pampered one. She got education till eighth grade while her other sisters could only go up to fifth grade. She got a very high score in her fifth grade examination and her teachers persuaded her parents to let her continue her studies. She got married after 8th class and did her 10th grade after marriage privately, after having a son and while pregnant with her second child. She appeared in the examination together with her younger brother-in-law. Her father-in-law encouraged her to study further saying,

> *"I have educated my daughters to tenth grade. You should not be behind them, so nobody should be able to taunt that you are less qualified or your husband throws this argument at you during a quarrel."*

Another married lady had left school as no science subjects were offered and she did not want to study arts. She thinks she may continue her studies now.

4.6.2 Land and Property Ownership

The number of families that own land is only 34 and only 2% of the women own any property or land in their name.

Table 19: Land/Property Ownership by Women

Category	Number	Percentage
Women who own land/property in their name	1	2
Women who do not own land/property in their name	49	98
Total	50	100

Source : In-depth Interviews with women (n= 50)

Most of the women inherit land upon death of their fathers according to the Islamic and state laws, but do not claim it in order to keep ties intact with the brother's family. Social pressure is exerted to surrender one's right in favour of one's brother, to keep a strong bond with the natal family. Women are reminded that after all it is their brothers who will lift their funeral cot according to the village customs. Those resisting this tradition have resorted to court cases and suffered from severed ties with their brother's families.

An elderly woman exhorted,

> *"hamarey ghar main baap ney zamin di, to beti key naam dalwa di, lekin bhai nahin detay. Jawai kay naam zamin nahin karwani chahiyee".*
>
> [In our family, when a father distributes land he gives in the name of the daughter, but the brothers never give (to sister the inherited share after the father's death). One should not give the land in the name of the son-in-law]

The women who were orphaned at a young age also have a tough time getting their rightful share upon reaching adulthood. The successful strategies employed by them are

to raise hue and cry at every public gathering and build social pressure on their uncles (father's brothers) to release their property.

4.6.3 Employment for Income

Employment is called *'begani intizari'* or waiting for an external order, thus losing self-control on one's life. A salaried job is neither a preference for men nor women. For men, it is unavoidable if agriculture cannot sustain all the sons but for women, it is only an option but not a preferred one. A woman from the village remarked,

> *"mulazmit to begani intizari hey - Mulazmit key sath pabandi ho jaati hey. Bachioun ko school nahin bhejtey thay keh kon sa nokri karwani hey.dartey they keh izzat par koi dagh na lag jaye. hamarey mard kehtay hein: bhook hamein manzoor hey lekin apni auratoun ko bahir nahin bhejnaan. Betioun key ghar machineein hein lekin who doosray ka kaam nahin karney detay."*
>
> [Employment is waiting for other's order. One becomes bound after joining a job. People did not send their daughters to school saying that they do not need it as they are not going to join an employment. They were afraid of something bad happening that will tarnish their honour. Our men say that we can tolerate hunger but would not send our women out of the home. My daughters have sewing machines but their families do not let them sew for others.]

She emphasized this fact particularly, to differentiate her family from that of her daughter's in-laws. Her daughter's mother-in-law had been running a sewing school to make ends meet.

One of the lady health workers was on a field duty to do home visits and I accompanied her to have a chance to meet some women. Her husband kept on transmitting to her missed telephone calls to tell her that she should come back. We came back to her mother's home to tell that she was leaving for her own home. Her mother wanted her to stay for lunch but she could not. When she left, her mother remarked sorrowfully,

"Hun oonhoun chulla jalana pay si"

[now she will have to burn the stove]

It meant that other ladies at home would have taken care of her husband's lunch but nobody would have taken pains to cook for her (though she is an earning member and deserves a similar treatment).

The employment market for women is also very limited and the jobs available are usually low paid, which can become a supplementary source of income to a family but not as the major means of income.
This has led to a belief that,

"mard kamaye to barkat hoti hey, aurat kamaye to barkat nahin hoti"

[A man's income has blessing but a woman's income does not have blessing]

Women are engaged in informal employment by rearing cattle and selling milk, sewing or doing embroideries. A few entrepreneurs go to nearest urban centre and bring orders for embroidery. The un-married girls usually take this job as a useful pastime. Others think it as very low paid and look down upon this activity.

Women, however, do realize the independence gained by generating one's own income. They quote the story of two sisters who got educated as their father, employed in the gulf, sent sufficient income back home. They took nursing jobs and now even being in their thirties, are averse to getting married. The village women say that the girls are enjoying their self-reliance,

"Khud kamana khud khaana"

[Self earning, self eating]

The employment and income bring some independence and relax mobility constraints on a woman but they do bring in additional responsibilities by virtue of increased expectations from others.

> *"beti ka miaan zimma dari nahin leta, aur phir har kaam main naqs nikalta hey. Pata nahin who kabhi badlay ga bhi ya nahin, tab badalnay ka kia fayeda jab zindagi hi guzar chuki ho."*
>
> [The daughter's husband does not take responsibility, and then finds faults in everything that she has done. Don't know when the situation will improve? What is the good in changing ways when (the better part of) her life is already spent][258]

Many women have to live alone when their husbands are away working in another city. They gain more autonomy and freedom by virtue of circumstances and an increased burden of responsibilities fall on their shoulders. One woman resented the long period of her life when she had to live without her husband around.

> *"miaan railway mein mulazim they. Saas ki binai nahin thi to main peechay rehti thi. Jawan betioun ki rakhwali karni parti thi. Pachees saal main nein apni neeend sari"*
>
> [My husband was employed in Railways. My mother-in-law had no eyesight so I had to stay back. I had to keep on guard for grown up daughters. For twenty five years, I burned my (night's) sleep]

She thus had to take charge of her disabled mother-in-law and even could not have a peaceful night's sleep as with every little sound, she would be worried lest some one enters their house taking it as an easy target without the presence of an adult male. Once her daughters reached puberty, protecting their virginity and reputation became a big issue for her. No wonder, she married them off at the early ages of fourteen and fifteen years!

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[258] Quote from mother of a salaried female worker

4.6.4 Female Mobility

Constraints on both physical mobility and access to information for women in rural areas, undermine their ability to acquire key services and pursue life opportunities. The restrictions on women's movement outside the home arise from concerns about their security and reputation. Fear and taboo restrict female access to medical care, education, opportunities for paid work, voting, and other forms of political and community participation.

In many parts of the world, transport failures (poor roads and inadequate transport system) limit female mobility. Distance to services and transport failures are implicated in maternal mortality rates and cause obstetric fistula (from obstructed labor), result in reduced uptake of pre-natal and other health services and pregnancy complications resulting from load carrying.

In the village Jaffer, physical access to health facilities is not an issue due to the location of the BHU and easy road access; however, the cost of transport is one of the main limiting factors. Women mentioned that each trip to Rawalpindi, where reliable reproductive health care is available, costs at least five hundred rupees for a round trip fare for two people. This limitation is aggravated in situations where household has low income and when women face 'time poverty'. The young women and girls with their reputation at stake are particularly frustrated by eves teasing on the roads in the city and village men standing on the roads staring at passing by women. A young girl said,

"*In aadmioun ko aur koi kaam nahin, sara din auratein gintay rehtay hein*"
[These men do not have anything else to do except keeping a count of the women (out of their homes]

The village men and women also relate female mobility with promiscuity. Two women traveling together are considered alone, especially if they are mother and daughter. A third person is necessary, either a boy or a woman from her in-laws. Men generally

suspect that a woman who travels a lot is befriending other men and that is why she is traveling. Thus to avoid similar comments about their women they become extra stringent about not allowing them to travel outside the house, except in cases of extreme emergency. These restrictions often mean that women only visit hospitals when their health has reached a critical stage. Like in other rural areas of Pakistan (Iqbal 1995 as quoted by Kitts and Roberts, 1996)[259] females are not allowed to travel long distances alone. As one woman remarked,

"mard sakht hein, kehtay hein akeli na jain"
[men are strict, say that they should not go alone]

A member of the family, even the youngest brother or son is required to accompany a woman. In case a male member is not available, an adult middle aged female companion is chosen (possibly a sister-in-law, aunt or a neighbour). In these instances, accompanied mobility reflects the strength of a woman's social resources.

Mumtaz and Salway (2005)[260] have asserted that class and gender hierarchies interact to pattern women's experiences. Poor women's higher unaccompanied mobility was associated with a loss of prestige and susceptibility to sexual violence. Among richer women, such movement did not constitute a legitimate target for male exploitation, nor did it lead to a loss of status on the part of their families.

A similar pattern is found in the village Jaffer, where teachers and lady health workers by the nature of their jobs, and women from comparatively richer households, have more freedom of movement than others. An elderly woman from the richest household said

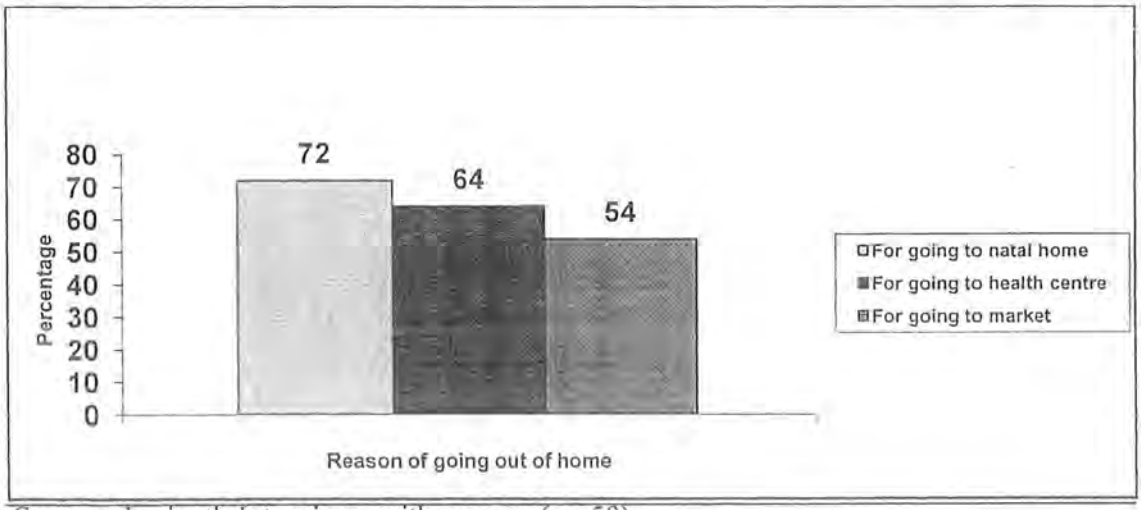
"jawan thi aur chal sakti thi to akeli Islamabad aur Wah Cantt chali jaati thi. Auron ki cheezain bhi lay ati thi"

[259] Kitts, J. and Roberts, J.H.(eds). (1996). The Health Gap: Beyond Pregnancy and Reproduction. Ottawa: International Development Research Centre.
[260] Mumtaz, Z. and Salway, S. (2005). "I never go anywhere" extricating the links between women mobility and uptake of reproductive health services in Pakistan. Social Science and Medicine. 60(8): 1751-1765.

[When I was young and could walk, I would go alone to
Islamabad and Wah Cantt. I would also bring in things for others.]

Women also require formal permission to go to market, to the health centre and even to the natal home. Going to one's parents home (especially when it is located within the same village) is easiest, followed by going to the market. More women said that they need a formal permission for visiting a health centre, as depicted in the table below:

Figure 8: Percentage of Women Who Required Formal Permission for Going Out



Source : In-depth Interviews with women (n= 50)

This may also be due to the fact that visiting the natal home and market are normative practices while going to a health centre is considered an occasional and specific requirement. Many women said they did not need to specifically seek permission to go to their parents home or market if done once and the norm set as a routine.

"ek dafa ijaazat mil gayee hay"

[have been granted permission once (no need for asking every time)]

In this situation, just informing the husband or mother-in-law is considered sufficient. When asked about the companion required to visit the natal house, the mother-in-law mostly accompanies the woman followed by the husband and then the brother-in-law, usually the younger one who is yet unmarried and not bound by employment.

Table 20: Woman's Company to Visit the Natal House

(Response in Percentage)

Mother-in-Law	Husband	Brother-in-law	No one	Total
38	26	10	26	100

Source: In-depth Interviews with women (n=50)

The pattern of accompaniment differs greatly when it comes to seeking care for reproductive health care. If a *'dai's* care is sought, the mother or mother-in-law would call her, the visit to the shrine may be with the mother-in-law or husband.

If clinical or hospital care is required, a mother-in-law or a sister-in-law usually accompanies a young woman to the nearby health facility. For traveling to a city hospital, the husband or some acquaintance/family member who knows the place is preferred.

4.7 Interactions with the Natal Kin

Opportunity to meet the natal family can be taken as an indicator of the availability of social resources, if she needs to visit a health care provider. Endogamous marriages within the village, provides an ample opportunity to be close to the natal kin.

Table 21: Frequency of Interaction with Natal House (Responses in Percentage)

Visit	Daily	Once a week	Once a fortnight	Once every year	Occasionally or as needed
	38	18	26	10	8
Telephone Call	Daily	Once a week	Once a fortnight	Once every year	Occasionally or as needed
	26	26	12	-	26

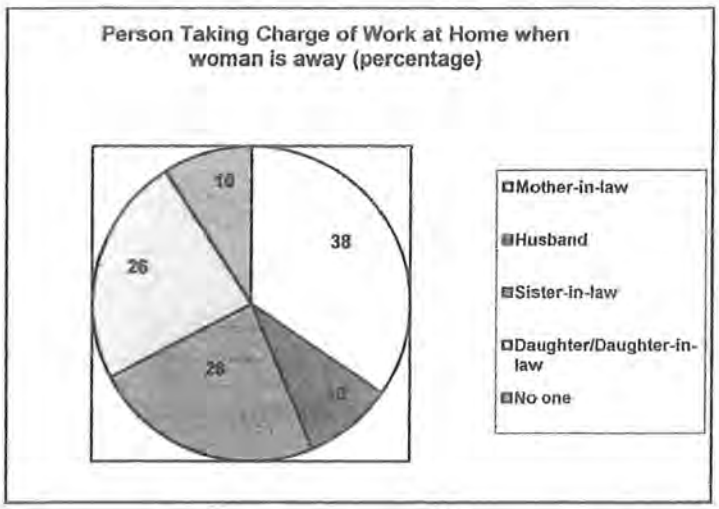
Source: In-depth Interviews with women (n=50)

More than 80% women can visit their natal families frequently and are able to communicate with them. This frequency sharply declines after the death of woman's mother and father. Visiting a brother's house requires a reason to do so and many women said,

"baghair waja kay jaana achha nahin lagta"

[It does not look good to visit without a reason]

Figure 9: Person Taking Charge of Work At Home When Woman is Away



Source: In-depth Interviews with women (n=50)

Visiting for seeking health care means leaving household chores which must be managed by someone else in a woman's absence. In joint and extended households, other women in the family provide this support. In nuclear families, the elder daughter would take up the additional responsibility and in the absence of a grown up daughter, the husband would try to manage. Thus, the prospects of going out for health care are better in joint and extended families as far as alternative home support is concerned. On the other hand, the decision-making in such families also becomes shared and woman's own autonomy decreases.

4.8 A Woman's Status in the Family

Respondents were asked whether their opinion was sought in family matters considered important. 90% women responded in affirmative.

Table 22: Woman's Opinion Sought In Important Family Matters

Responses	Number	Percentage
Opinion sought in important family matters	45	90
Opinion not sought in important family matters	5	10
Total	50	100

Source: In-depth Interviews with women

Simultaneously a significant number also confirms facing opposition to their choice by others. Thirty eight percent women remembered instances when others had differed with their decisions.

Table 23: Women Who Faced Opposition to Their Decisions

Response	Number	Percentage
Ever faced opposition to their decision	19	38
Did not ever face opposition to their decision	31	62
Total	50	100

Source: In-depth Interviews with women

4.9 Patterns of Decision-Making in Day to Day Affairs

Mukhtar and Mukhtar (1991)[261] recommend that the status of women should be understood in the light of their role not only in public sphere but also within the domestic domain; especially where very few women interact in the public sphere. They categorize household decisions into economic decisions such as expenditure on various consumer items (e.g. durables and non-durables) and social decisions (e.g. education of children, marriage of children etc.). The decisions regarding the acquisition of consumer durables

[261] Eshya, M. M. and Hamid, M. (1991). "Female Participation In Household Decision-Making : An Analysis Of Consumer Durables' Acquisition In Pakistan". Pakistan Development Review. Winter.

are regarded as more important due to their "life-long" value, compared to most routine decisions e.g. daily purchase of food, clothing etc.

In the present study, decisions about the food choice are taken as analogous to purchase of non-durable items and purchase of jewellery or land as a proxy of durable goods. In the area of reproductive health-care seeking, the persons involved at the household level were identified. Decision-making about seeking care for a child's illness was also sought to enable a comparison whether all patterns of health care decisions are similar or different.

For day to day routine decisions such as the choice of food to cook, the husband emerges the single most important actor though most respondents categorized it as a joint decision, meaning the provision of space to compromise to accommodate choice of all in a joint or extended family. One woman from an extended household remarked,

"Har koi apni marzi bata deta hey"
[Everybody tells his choice]

All can tell their choice and the final decision is made considering the availability of that food item and a final say by the mother-in-law.

Decisions regarding major purchases (land/jewellery) of high economic value are mostly joint or decided by the husband (who holds the purse). For non-health decisions, the mother-in-law and father -in-law are rated similarly. However, the father-in-law has not been stated to play any role in illness care while mother-in-law is quoted to be an important actor for care seeking decisions when the woman's health is concerned. The husband's choice carries the greatest weight for a woman's healthcare followed by her own will. In case of widows, the husband's role is taken over by the son who pays for the treatment. It is with regards to child's health that the woman has the greatest decision space. It is also interesting to note that more respondents categorize child-care decisions as joint compared to those for woman's own health.

Table 24: Patterns of Decision-making at Household Level

Who makes the decision		Respondent	Husb-and	Mother-in-Law	Father-in-Law	Son	Joint	Total
What to cook ?	No.	5	13	9	9	-	14	50
	%	10	26	18	18	-	28	100
Major purchases (land /jewellery)	No.	5	13	9	9	-	14	50
	%	10	26	18	18	-	28	100
Seeking care for respondent's illness	No.	13	23	4	-	5	5	50
	%	26	46	8	-	10	10	100
Seeking care for child illness	No.	23	19	-	-	-	8	50
	%	46	38	-	-	-	16	100

Source: In-depth Interviews with women

4.10 Patterns of Decision-making in Spouse Selection (For One's Children)

This is another major area of "important social decisions" after one's own marriage. There is only slight improvement in woman's agency in this decision as compared to when her own spouse selection was being made (32% versus 36%).

Table 25: Woman's Choice For Spouse Selection For Her Children

Response	Number	Percentage
Yes	18	36
No	32	64

Source: In-depth Interviews with women (n= 18)

When a woman has made the decision herself, she would proudly say,

"apni marzi sey baitay ki shadi ki hey"
"have decided my son's marriage by myself"

If the decision is joint, she would say,

"donoun ki pasand hey"

[it's the choice of both of us]

4.11 Balancing Authority with Responsibility

A woman who can make her own decisions, has to suffer a lot of criticism by others as it is against the local norms. In one such case a woman who is employed has a house under construction in the village. Her husband serves in the army and had recently returned from an assignment in the International Peace Corps in Somalia. She is matriculate and a working woman. Her mother-in-law had a stroke and everyone said, *"because she has spent so much on the house, that has made her mother-in-law sick with worry and develop high blood pressure"*. Nobody is happy with the house design in the village. Someone says, '*the round design of the doors make the house look like a mosque*' or '*why to have a terrace instead of a normal roof*' ; or *'she has not kept an inner courtyard and house does not allow enough light*'. Her mother is very upset about the situation and says that the situation would have been different if her daughter's husband would have taken up his responsibility.

> *"beti ka miaan zimma dari nahin leta, aur phir har kaam main naqs nikalta hey"*.
> [The daughter's husband does not take any responsibility, and then finds fault in whatever she does.]

4.12 Patterns of Decision-making For Fertility

In an environment with strong pressures on women to produce children, most women think that a baby should be born atleast within one year's time after getting married. There are also around 10% women who thought it would have been better if they had their first pregnancy after 2-5 years, giving them some time to remain free of children's responsibilities. This has significance in determining care-seeking patterns for management of infertility and contraception.

Table 26: Suitable Time for Getting Pregnant After Marriage

(Response in Percentage n=50)

Immediately	1 month	4 months	6 -7 months	Within a year	2-3 years	5 years
13	5	5	5	12	5	5

Source: In-depth Interviews with women

4.13 Effect of Apathy and Depression on Woman's Decision-making

Depression is common among women in Pakistan and it is confirmed that women who suffer from psychological conditions, such as depression, may have a complete sense of apathy towards their own health care. Although psychological conditions often have a biological component, the particularly harsh living conditions of many women including poverty, high stress, isolation and an absence of social support, may work together to produce a state of depression or apathy. The inability of some women to express their problems may adversely affect their psychological health. For other women, childhood experiences of violence, including rape or incest, may be factors related to their apathy or depression (Ferrando etal.1992)[262].

> *"The psychological barriers of depression, negation and fears were more powerful deterrents to the use of pre-natal care than the external barriers such as the lack of medical insurance or transport. " (ibid:171)*

Self-neglect was found very common among women especially in matters relating to their health though no data is available for clinical depression cases from the local health centre.

Thus in the village, a woman's status is determined by the number of sons she bears, her age, education, economic conditions and self-confidence, inculcated in her by her parents or circumstances. She becomes empowered by her support systems and social resources

[262] Ferrando,S.J., Goldman, J.D. and Charness, W.E. (1992). "Selective Serotonin Uptake inhibitor treatment of depression in symptomatic HIV infections and AIDS: Improvements in affective and somatic symptoms." General Hospital Psychiatry. 19(2) 89-97

i.e. her brothers, her sons, her husband (if living together), her female kin and her women neighbours especially those who accompany her to the health facility when required.

This chapter has highlighted the multi-dimensionality of female status and autonomy in the village. Women's free choice to seek health care for herself is dependant upon her age, her education level, her marital status, the living and family arrangements, her mobility and her access to material resources. Social resources including knowledge about different options, power and prestige including family honour are also equally important.

The next chapter goes futher to describe how female identity is formed by socialization and the ideals of womanhood and motherhood are established. These ideals drive the choices made by girls and women at the conscious and unconscious levels. Reproductive illnesses are experienced and coping mechanisms are chosen in broader conformity to these ideals.

CHAPTER 5

FEMALE IDENTITY AND IDEALS

Reproductive Health decision-making among females cannot be understood fully without knowing about the identity formation of the 'self' and the aspirations to achieve the ideals set by the village norms and religious traditions. The body is a common entity for the bearer of identity as well as the illness. There is a need to comprehend the symbolic meanings of the 'body'[263] to understand the 'female self'. The body represents a biological sex form, an agent, and a family member with her place in the kinship structure. The body is a conduit to display gender roles and the productive and reproductive capacity of an individual. It has a religious and ritual significance portrayed by all languages and their metaphors of health, illness, beauty, shame and honour etc. It is also seen as the mortal casing of the immortal spirit and a reflection of the inner happiness, suffering and struggle. Any illness with its invoked disabilities and effects threatens the preservation of cultural values associated with the body and thus, induces a response or action for seeking a cure. In this chapter, the significance of female body, identity and ideals among the girls and women in the village in the light of cultural values, religion and rituals will be elaborated.

5.1 The Biological Body

The human body is the biological form and the physical reality of the 'self'. The 'self' is compared by individuals with the norm to distinguish one's identity and sexual attractions. Like all societies, village Jaffer, has also constructed notions of a healthy, productive and aesthetically appealing body. An adult female body is regarded as a symbol of sexuality and much valued fertility. The physical assets of an adult female body, are thought to be her clear complexion, delicate facial features, curvy physique and

[263] Reisscler, E. and Koo, K.S. (2004). "The Body Beautiful: Symbolism and Agency in the Social World." Annual Review of Anthropology. 33 (297-317)

above all, the possession of a uterus- competent to bear children. These ideals are sought and cherished consciously and unconsciously. In the realm of reproductive health, it is important for the village women, to evaluate the degree of deviation from the ideal caused by a particular illness. The repercussions of different healing techniques and available options are compared in terms of their effects on the body itself. The effects can be direct e.g. unpleasant taste, out of pocket cost, immediate side-effects or indirect e.g. loss of status or opportunity and social costs. This comprehension by an individual and the group determines the initiation, continuation and compliance of any treatment. For example, the use of oral family planning pills is associated with pigmentation of the face; and scanty menstruation is thought to cause the uterus to swell and the abdomen to become flabby.

5.1.1 The Uterus (*Jaan)*

The uterus is commonly referred to as "*bachay dani*" (the receptacle for a baby) and also as "*jaan*" (life). The word "*jaan*" is synonymous with the English word "life" signifying its importance for the survival of the body which houses it. The condition of utero-vaginal prolapse is commonly referred as "*jaan bahar nikalna*" (life coming out). One old menopausal lady who was advised by a doctor to get her uterus removed (hysterectomy) did not comply as she thought a female is only a female if she has a uterus. She said,

> *" zanana bachay dani kay sir par hi chalta hay. Itna sa bhi is mein farq aa gaya to us banday par mout hay. "*
>
> [Femininity depends on the uterus. A little variation in it is death for the person]

The women perceive the uterus to be like a container with the shape of an earthen pitcher delicately balanced in the body with its open end or mouth facing the vagina or outside. Women commonly talk about *jaan gir gayee hay* (the falling down of uterus) or *jaan ka mounh phir gaya hay* (displacement of the mouth of uterus). Interestingly they refer to the uterus as '*jaan*'(life) when talking in first person; however, when recalling the

terminology used by the provider, the word *'bachay daani"* (the receptacle for a baby) is used. For example, as one woman has quoted her *'dai'* in the following words,

" 'dai' nay kaha , bachay dani ka mounh phir gaya hay"

['*dai*' said, the mouth of the uterus (cervix) is deviated]

A non-pregnant uterus is thought to be critical to allow free passage of air and blood. In case this passage is blocked, the down-ward flowing substances go upwards and affect the head or mental capacity of an individual. A pelvic disease is often referred to as "*ander faraq par giya*" (the inner has been altered).

The conditions affecting a non-pregnant uterus, can be *sojan* (inflammation) or *apni jaga say phir gayee hay* (displacement) or *sookhna* (drying up) or involution after menopause. Any organ that is wet is alive (like a plant/ fruit) and any organ dried or withered is considered dead. A healthy uterus is considered synonymous with good health and energy. For example, a woman said,

"Jin ki bacahay dani theek hay woh mardoun ki tarha bhagti hein"
[Those whose uterus is alright , run like men (are active)]

"agar sojan ho to ander jaraseem nahin thehartay"
[If (uterus is) inflamed, germs (sperms) do not stay inside(one can not become pregnant)]

Vaginal examination is often referred to as "*anderooni muaina*" (internal examination). "*Ander*" is inside and "*bahir*" is outside. Whatever is internal, should remain inside and if it comes outside, either, it is a sign of an illness or if its secretion comes out, it makes one in need of a purity ritual. For example, passing of urine, air, vomit and stool makes one impure[264] (smaller degree of impurity) and *wudu*[265] (ablution) is required to become pure. Passing of menstrual blood and having sex creates a higher degree of impurity and makes one in need of a "*ghusal*" (a ritual bath) to become '*paak*' or pure.

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[264] The acts of defecation, passing of gas or urine, emission of semen, sleep, passing blood, vomiting, loss of senses, fainting, laughing aloud and sexual contact with other person all cause invalidation or breaking of of *wudu*.

[265] *Wudu* is the Islamic act of washing parts of the body using water. Muslims are required to be clean in preparation of ritual prayers. Purification of body is called "*Tahara*". To have ' *Taharah* ' one should do *ghusal* (full ablution) or *wudu* (partial ablution).

5.1.2 The Concepts of Purity and Pollution

Men and women both need '*wudu*' and '*ghusul*' as described in Islamic scriptures. Women, as part of their reproductive physiology undergo numerous spans of vaginal bleeding during their menstrual cycles and after the child birth.

Menstrual blood is '*najis*' (ritually unclean). Blood of human beings is '*najis*' whether it comes from a wound or is menstrual[266]. *'Ghusul'* is also required after puerperium to wash impurity ('*nifas*' or lochia i.e. blood or blood stained discharge after child birth). According to Islamic tradition, sexual intercourse is forbidden during *'haid'* (menstruation) and *'nifas'* (puerperium). As the Holy Quran states,

> *"They ask thee concerning women's courses. Say: they are a hurt and a pollution: So keep away from women in their courses, and do not approach them until they are clean. But when they have purified themselves, ye may approach them in any manner, time , or place ordained for you by Allah. For Allah loves those who keep themselves pure and clean" (Surah Al-Baqarah Verse 222)*[267]

However, apart from restriction of sex and concession from ritual prayers (no '*qada*' or compensatory prayer is required) and fasting (which has to be observed later); Islam does not regard the woman impure to touch. However, traditional practices in Jaffer especially amongst the senior generation of women, do not allow them to cook food or wash clothes of '*namazi*' men or women (who are observing five times prayers daily). The older women regret that the younger generation is not careful in these matters.

> *" Hamaray mard hamal kay saat mah say chalees din tak perhaiz kartay thay, ab to idher bacha hua aur shurooh kar latey hein. Paaki , paleeti hoti thi, agar aik paleet hoti thi to doosri larkiaan kaam kar leti thein jasay roti pakaana, kapray dhona khas tor par namaazioun kay. Ab koi ehtiaat nahin karta. "*

> [Our men used to abstain (from sex) from seventh month (of pregnancy) till after forty days (of child birth); now here the child comes and here they start. There used to be 'purity' and pollution', if one was polluted then, the second one would do the work as cooking bread or washing clothes

[266] Wasa'il, Vol 1 p.1030 as quoted by Miladi 1993. Endless Bliss. Fourth Fascicle, Hizmet Books.
[267] The Holy Quran translated by Abdullah Yousuf Ali. First edition 1934.

especially, those of the prayer goers. Now, no body takes a precaution.]

These concessions are definitely a time to break free of drudgery of household tasks for many women; with an increasing trend toward nuclear families such restrictions are difficult to practise. The older generation enjoyed prolonged periods of amenorrhea during their numerous pregnancies (nine months each time) and later prolonged exclusive breast feeding led to long periods of lactation amenorrhea (around two years as women mentioned). Lesser number of pregnancies and lesser number of occasions and practice of prolonged breast feeding, have increased manifolds the number of menstrual cycles in a woman's life. This phenomenon puts more burdens on the woman of being polluted and hence, any reproductive condition worsening this situation attracts a responsive strategy rather than a negligent approach to bleeding problems. Here is a paradox that on one hand amenorrhea signifies '*paaki*' (purity) but on the other hand also bears the meaning of loss of femininity.

The notion of impurity of menstruation is also present in Hinduism- the ancient faith practiced in this part of the world.

> *"While the period of menses itself was feared to throw a woman out of caste, because of her ceremonial impurity, throughout the middle ages in India, the physiological phenomenon was generally held to be a cleansing process. Her social degradation on the first three days of menstrual flow was thus described by the lawgiver Angiras: "On the first day of menses, the woman(of whichever caste she may otherwise be) becomes a Chandala, on the second, the murderess of a Brahmin and on the third, a washer woman; on the fourth day, she is purified." In keeping with these notions, a woman was usually isolated during her period, and was allowed to use only rags, torn mats and broken pots as befitting her degradation. (Pruthi and Sharma, 1997: 193)*[268]

The menstrual restrictions and notions of impurity have a great impact on the use and continuation of any medicine or contraceptive that may cause a woman to have menstrual irregularity e.g. spotting or prolonged bleeding. Scanty menses or absence of menstruation before menopause is equally worrisome for the women as they think that

[268] Pruthi, R. and Sharma, B.R. (eds) (1997). Aryans and Hindu Women. Delhi: Anmol Publications.

this will lead to accumulation of blood, secretions and air to be contained in the uterus and hence, cause illness.

5.1.3 The Place of Shame (*Sharamgah)*

'Sharamgah' (the place of shame) is the term used for the private parts of both men and women. Overall, the body is divided into upper torso and the lower abdomen. The reproductive organs are considered the lowest of the lower half but sacred and 'worth guarding'. The *'sharam gah'* is vulnerable to afflictions that can be embarrassing among the wide range of illnesses a woman can possibly face. The elderly women in the village, often bless the younger ones by a prayer saying,

" Rab thaloun koi dukh na day"
[May 'The One who provides subsistence'
protect you from any pain underneath]

Many reproductive illnesses are thus kept buried in silence by women as they may cause their embarrassment. At best, all female-related information is kept among the circle of females and not shared with men. The pregnant women pray that their delivery occurs at night so that men are unaware about the details.

"Dua kardi aan Allah raat day day, mardaan noun pata na chalay"
[Pray that Allah gives me night, the men do not get to know about it]

5.2 Ideals of Female Beauty

Attractive features, medium height and white complexion are considered the ingredients of beauty. Generally, the women in the village have a very positive self image, even to the extent of narcissism.

" Awrat khoobsurat wohi hay jis ka naak chota ho, aankhein bari houn, daant sahih houn. Itni moti bhi na ho aur bohat patli bhi na ho; jaisi kay mein khud hun"

[A woman is beautiful whose nose is small, eyes are big
and teeth are alright. She should not be too fat or too thin,
like myself]

Fair complexion is a treasured possession, little girls with blonde hair and blue eyes are commonly referred to as *'maim sahib*[269]*'* or women say that the girl has a complexion as golden as her hair. Unmarried girls use anything available in pursuit of fairness but some are happy being wheatish but attractive and having other positive attributes.

"khaali shakal ka kia karma hay; chittiaan tay khotiaan wi
tay hundiaan nein"
[What to do of the face and features alone; even female
donkeys are white]

One of the matriculate married girl more exposed to literature and radio, was more philosophical and said,

"Mohabbat ka jazba aur is ka chehray par nazar aana hi insaan ko pur kashish banata hay. Apnay shohar kay liyey to awratein makeup bhi karti hein."
[The sentiments of love and their expression on ones face, make one attractive. Women do use cosmetics/make-up (to look good) for their husbands]

Women do relate menstrual problems with blood deficiency and having an adverse affect on the complexion, causing it to become pale. Thus, high ideals exist when older women or sisters try to find the most beautiful girl as a match for their son or brother.

"bahu parhi likhi ho, sohni ho aur kaam karay. Sohni hona ziaada zaroori hay. Akhir hamaray ghar ki dhi, noon bahir niklay to har koi takay kay kitni sohni biaah kay lay aandi. Kam tay honday renhday ya mul lay aaye. Sohni howay tay holay holay kam wi kar laindee. Meri noon to itni khoobsurat thi kay banwaan toun wi leerh nikalda si'

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[269] *'Maim sahib'* is the commonly spoken term for "*madam sahib*" referring to British women in colonial times. Sahib is the term used for respect and also for an 'officer'. The wives and daughters or on that part any European woman was used to be addressed as a *'maim sahib'*.

> [the daughter-in-law should know how to read and write; should be pretty and should be good in her work. To be pretty is more important. After all, if our daughter or daughter-in-law goes out, every one should watch and say how beautiful is the bride they have brought in. Chores are anyway done or someone hires another's' services. If she is pretty she can learn also to do the work gradually. My daughter-in-law was so beautiful that her arms glowed due to her radiating complexion]

A male writer[270] states,

> *"If a man is asked to imagine a beautiful woman , he will describe her physical attributes but if a woman is asked to describe a handsome man , she will more often stress on his character, intelligence, wisdom and good nature". (Iqbal:7)*

He lists the following twelve characteristics of female beauty:

1. Long : the hair on the head and eye lashes
2. Delicate : waist and fingers
3. Round : breasts and hips
4. White : the white of eyes and teeth
5. Broad : forehead, chest , eyes and hips
6. Clear : complexion
7. Red : lips, cheeks and tongue
8. Thin : nose, eye brows and lips
9. Full : thighs
10. Fast : walk
11. Sweet : voice
12. Medium : height

The same figurative detail is found in description of Heer[271] – the popular folk character of Punjab who epitomizes beauty in this region.

5.3. Female Adorments (*Singhar)*

Traditionally women of the village in general, are fond of grooming and beautifying themselves, as everywhere else in the world. The art of making up is commonly referred

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[270] Iqbal, J. (n.d.). *Auratoun kay Amraz* : A complete Encyclopedia of Female Diseases. Lahore: Maktaba-e-Daniyal- page 71

[271] Waris Shah. 1766. Heer Waris Shah accessed on http://www.the-south-Asian.com.July-Aug2006/Bhera-Part1.htm on 06-06-2008

to as "*sola singhar*" (sixteen cosmetics and ornaments) used to beautify one self. As enlisted by the ancient sexologists and cosmetologists[272]:

1. Scent or perfumed oil
2. Wearing beautiful and colorful clothes
3. Wearing *'bindya'* on the forehead
4. Putting *'kohl'* in eyes
5. Wearing ear rings
6. Wearing a nose ring
7. Wearing a necklace
8. Tying the hair into a bun
9. Wearing flowers in the hair
10. *'Sindour'*(red dye) in the hair parting
11. Rubbing the body with *'Kaiser'* or using a sandal wood scrub
12. Using *'henna'* on hands and feet
13. Eating beatle leaf (*paan*) or using a lipstick to make one's lips coloured
14. Tying a waist belt (*qamar band*) made of beads
15. Wearing flower bracelets (*gajra*)
16. Wearing gold ornaments

It is interesting to note that invariably, similar adornments are used in Potowar, but with some differences. '*Bindya*' and *'sindour'* are not worn by Muslim women, in general. The use of most of the other adornments except *'henna'* is restricted to festivities of Eid and marriages. Use of *'henna'* on hands and feet and also to dye hair and using *'kohl'* in eyes is common and considered "*sunnat*"- the practice of the Holy Prophet Mohammad (PBUH).

Women in Jaffer mostly, wear their hair in one plait hanging on their backs with or without *'paranda'* (a thread hair gear in three partings which is woven into a plait together with hair to give them more volume and it is often black in colour for everyday use but coloured/golden or silver for special occasions). Tying hair into a bun called '*joora*' is frowned upon as it is considered more of a Sikh tradition. Similarly, use of beetle leaf is not practiced to colour lips but a tree bark is used as *"miswak"* called "*dandasa*".

A 25 year old young married woman, very religious and devout in following the teachings of the Quran and Sunnah; proudly said,

"mein to sirf menhdi ya surma hi istimal karti houn;
shadioun par bhi maikup nahin karti. Nakhun palish say
insaan paak nahin hota. Nahin lagaani chahiye"

[272] Ibid. Page 69

[I only use henna or kohl; do not use makeup even while going out to weddings. If one is wearing nail polish, one can not become pure (for *'wudu'* water can not touch the painted surface) One should not use nail polish]

According to Islamic traditions mentioned in the *'hadith'*(Prophet's sayings), making oneself pretty for one's husband has been equated to blessings (*sawab*) gained by participation in Holy war or Jihad. Thus married women enjoy making themselves attractive in the presence of their husbands. Similar levels of grooming is avoided in the husband's absence or death. Thus, use of makeup is frowned upon in the absence of husbands, who live separately in another city for work or if the woman is widowed.

Keeping up physical beauty is, hence, desired by all women. Any illness causing actual or potential loss of desirable physical attributes, will adversely affect their marriage prospects. A young un-married girl, if she has a problem, will tell her sister or mother who would go to a healer for advice. Girls themselves are not taken to the health facility to conceal their sickness. It is feared that her marital value will be lowered by a public perception of her physical defect. If the illness is so obvious that it becomes known to all, then the inhibition is gone (for hiding the problem) and care is sought, e.g. young girls being treated for Tuberculosis are taken to a shrine for an amulet or *dua* (prayer).

5.4 The Female Virtues

The village women have very clear ideas of what constitutes 'a good woman'. The attributes sought in a woman, are those that align them best to live the village life.

5.4.1 Chastity

Islam as a religion guides about the '*halal*' (what is permitted) and '*haram*' (what is not permitted). This concept puts sanctions on what to do and what not to do; what to eat or drink and what not to eat or drink. Having only the permitted things, is the right course of action. Sexuality of men and women is also regulated by these sanctions. Sex outside of '*nikah*' (marriage) is not permissible. The same rules apply for both sexes. Women who follow these sanctions are called '*halalan*' (righteous).

The Quran says,

> *"Therefore the righteous women are devoutly obedient, and guard in (the husband's) absence what God would have them guard"(Al Quran 4: 34)*

5.4.2 Docility

Obedience by a woman to her father and her husband is greatly admired as a virtue among the village women. The word '*qanitat*' is used for the obedient women in the Holy Quran, and interpreted by Abdullah bin Abbas, as meaning women who are obedient to their husbands. The women enjoy the right to dissent and to give advice, but once, the man has come to a decision, and it becomes incumbent upon the woman to abide loyally by the decision.

> *A certain woman called Nasibah, once came to the Prophet Muhammad (peace be upon Him) and said: "O Messenger of God, men have excelled in meriting the rewards of the hereafter. They join the Friday prayer, attend congregations and perform jihad. Then what is left for us women to do?" The Prophet replied: "O Nasibah, if your manner of living with your husband is proper and obedient, such conduct in itself is equal to all the actions performed by men, which you have just mentioned". (Wahiduddin 2001: 137)* [273]

Thus obedience from women is desired by men and by the religion and women themselves hope to seek Divine blessing and heaven in life after death by being obedient to their husbands. Wahidaddin also quotes Imam Jafer who has said,

> *"Lucky and fortunate woman is one who respects her husband and does not give him any pain, hurt or discomfort and does not makes him worried and obeys him in all the right aspects of life."(ibid: 145)*

5.4.3 Fatalism

Contentment on one's condition and the firm belief in destiny, helps the women to cope with not only the illness but also the other frustrations of every day life. They commonly

[273]Khan, W. (2001). Women Between Islam and Western Society Karachi: Hafiz and Sons

refer to the fact that one cannot escape one's destiny and has to bear the suffering, considering it un-avoidable.

" kismet mein jo dukh ho "

[if it is written in one's fate]

5.4.4 Hard working

Fulfilling obligations of running a household, managing daily chores of farming and household, rearing children, pleasing one's in-laws and husband, are required from every married woman. A woman defined as healthy is the one who is able to cope with all her duties.

" apnay miaan ka 'poora kar sake', apnay bachoun ka pura kar sakay aur apnay saas susar ka pura kar sakay "

[to be able to complete the (responsibility) of one's husband, to be able to complete the (responsibility) of one's children and to be able to complete (responsibility) of one's mother-in-law and father-in-law.]

Thus, any illness that causes an interruption in the smooth conduction of her responsibilities makes a woman concerned for her health and motivates her to seek care.

To be able to finish the daily household work in a swift manner, is also a desirable criterion for selecting a daughter-in-law. A woman said,

" Kaam mein achhi ho jaldi jaldi kar sakay "

[should be good in work, can manage her chores quickly]

A grandmother desperate to have her grandson married, alluded to the major difference of opinion between them on this basis.

" Potay ki shaadi karma chahti houn ; kehta hay parhi likhi karoun ga. Parhi likhi ko sambhaalna ziaada mushkil hay. Zamindaroun kay to kaam hi khatam nahin hotay. Kabhi gobar uthaao, Kabhi das bandoun ka khaana banao, kam khatam hi nahin hota"

[I want my grandson to be married; says he will bring in an educated one. (However)It is very difficult to manage an educated one. (women of) Landowners have unending chores. Remove the dung; cook food for ten people; work never ends].

In this environment of high expectations to perform physical tasks, illness causes a sense of incompetence among women and they fear being labelled as 'useless.'

5.4.5 Good Mannerism

A pleasant countenance is admired as this ensures harmonious relations with all in the family. This is not only a required characteristic in a wife but also in general and is applicable to the health care providers as well.

"ikhlaq achha ho, seerat aur surat achhi ho"
[Should be good natured, character and features should both be good]

"khoobsurat wohi hay jo achhi ho, gun hoon, kirdaar ho aur tareeqakar achha ho"
[Only she is beautiful who is good, has abilities, has virtues and character and has good mannerism and working style]

5.4.6 Modesty and Veil

The village women have great reverence for those who are modest and shy. Islamic concept of '*haya*' (modesty) is applicable both to men and women but practically applied more to women. A woman, who is hidden, is considered like a pearl is in a coral. Her social value lies in being un-touched and unseen by men other than her husband and immediate family. The village women refer to such ladies as

"saat pardoun mein kaji hoi"
[concealed in seven wraps]

To observe the '*purdah*'(veil) the village women use a *'chadar'* (wrap about 2.5 meter long and worn to cover head and the body). A small '*chadar*' would be worn for movement within the neighborhood and a longer one for going further out.

The use of a veil by Muslim women is exhorted by Holy Quran,

> *"O Prophet (PBUH)! Tell thy wives and daughters, and the believing women, that they should cast their outer garments over their persons (when abroad): that is most convenient, that they should be known (as such) and not molested. And Allah is Oft-Forgiving, Most Merciful. (Al Quran 33: 59)*

And in another verse,

> *"And say to the believing women that they should lower their gaze and guard their modesty; that they should not display their beauty and ornaments except what (must ordinarily) appear thereof; that they should draw their veils over their bosoms and not display their beauty except to their husbands, their fathers, their husband's fathers, their sons, their husbands' sons, their brothers or their brothers' sons, or their sisters' sons, or their women, or the slaves whom their right hands possess, or male servants free of physical needs, or small children who have no sense of the shame of sex; and that they should not strike their feet in order to draw attention to their hidden ornaments. And O ye Believers! turn ye all together towards Allah, that ye may attain Bliss". (Al Quran24: 31)*

Islam does not allow free and unrestricted intermingling of the sexes. The rule of modesty equally applies to men as well as women.

> *" Women impure are for men impure, and men impure for women impure and women of purity are for men of purity, and men of purity are for women of purity: these are not affected by what people say: for them there is forgiveness, and a provision honorable". (Al Quran 24:26)*

A woman's best jewelry is considered to be her shyness and this trait permeates in her personality to such an extent as to make all talk about their sexuality a taboo. This has strong repercussions on women's mobility and reproductive health care seeking.

5.4.7 Stoicism

To be able to bear the pain in silence and exhibit *'sabar'* (patience) in the face of adversity is inculcated among the village women. They bear all suffering saying,

"Hamara dukh to paak beebioun kay dukh kin nisbet kuch bhi nahin"
[Our suffering is nothing as compared to what the pure women had to face]

Pure women are the female family members of the Holy Prophet: his wives, daughters and grand daughters. Stories of their patience in face of brutal killing of their men-folk, give Muslim women high standards to live up to.

The village women learn endurance at an early age and find strength in their ideals of a Muslim woman, in face of adversity including illness. This causes them to delay care seeking in case of illness till the suffering gets beyond their threshold of endurance or a physical disability develops.

5.5. The Religious Teachings and Traditions

Religion shapes female identity by endorsing certain cultural practices and promoting certain ideals. When marriage is universal, motherhood is valued and the chastity glorified, all young girls aspire to be brides and mothers. Their virginity becomes a symbol of honour for their men, families and *biradari* (patrilineal and affinal kin). In such black and white stereotypes, those who are not married by the right age, those who do not have children or become accused of bad character whether being direct participant or innocent victim, the stakes are high; they may be out-casted from mainstream society and suffer discrimination.

5.5.1 Marriage - A Religious Obligation

Islam discourages celibacy and promotes marriage for a healthy and happy life.

"And among His Signs is this that He created for you mates from among yourselves, that ye may dwell in tranquility with them, and He has put love and mercy between your (hearts). Verily in that are signs for those who reflect." (Al Quran 30:21)

There is a Hadith to the same effect:

"God himself has taken charge of helping three types of person. Those who marry in their desire to preserve their chastity, and those slaves (mukatib) who want to be free by paying the money they owe to their masters, and those who want to fight in the cause of God". (Ibn Majah, Sunan, Kitab al Itq, 2/842 as quoted by Wahiduddin, 2001:178)

5.5.2 Motherhood Glorification in Islam

Islam places great stress on taking care of both the parents.

"Your Lord has commanded that you shall not worship (anyone) but Him and to be good to the parents. If either or both of them reach old age with you, say not to them (so much as) 'Ugh' nor chide them, and speak to them a generous word. And lower for them 'the wings of humility' out of mercy; and pray; 'O my Lord! Have mercy on them as they brought me up (when I was) little." (Al Quran17: 23-24)

However, out of the two, the mother has been given greater priority as far as kindness is concerned.

"We have enjoined on man kindness to his parents; in pain did his mother bear him, and in pain did she give him birth" (Al Quran 46:15).

Prophet Muhammad (PBUH) has also said that

"Be at your mother's feet and there is the Paradise"
(Ibn majah Sunan,Hadith No. 2771)

The rights of the mother are regarded three times more than the father. A hadith says,

"Once Hakeem bin Hizam came to the Prophet of Islam and asked: "To whom should I be kind?" The Prophet replied, "Your mother." Hakeem asked, "Then to whom?" The Prophet said, "Your mother." Hakeem asked, "Then to whom?" The Prophet replied, "Your mother." Only when Hakeem asked the fourth time that, "Then to whom?" the Prophet replied, "Your father." This shows that the right of mother upon the children is three times more than the rights of father as far as kindness is concerned.(Hazrat Abu Huraira as quoted by Al-Bukharihadith No:3657)

Imam Ali, said:

> *"Coming to the rights of relatives, it is the right of your mother that you should appreciate that she carried you [in her womb] as nobody carries anybody, and fed you the fruits of her heart which nobody feeds anybody, and protected you [during pregnancy] with her ears, hands, legs, hair, limbs, [in short] with her whole being, gladly, cheerfully and carefully; suffering patiently all the worries, pains, difficulties and sorrows [of pregnancy], till the hand of God removed you from her and brought you into this world. Then she was most happy feeding you, even if she herself had no food; giving you milk and water; not caring for her own thirst; keeping you in the shade, even if she had to suffer from the heat of the sun; giving you every comfort with her own hardship; lulling you to sleep while keeping herself awake. And [remember that] her womb was your abode, and her lap your refuge, and her breast your feeder, and her whole existence your protection; it was she, not you, who was braving the heat and cold of this world for your safety. Therefore, you must remain thankful to her accordingly, and you cannot do so except by the help and assistance from Allah." (The Charter of Right, p.18)*[274]

5.5.2.1 The Ideal Mother

Hazrat Hajira wife of Hazrat Ibrahim and mother of Hazrat Ismail, is the epitome of motherhood in Islamic history. She was left in the valley of Mecca with her infant son by Hazrat Ibrahim on request of his first wife Sarah who was jealous of Hajira having a baby while she could not. Alone in the desert, when the baby cried with thirst, she ran seven times between the hills of *'Safa'* and *'Marwah'* in search of water for her child. Her devotion to her child and the struggle thus was so liked by Allah that He has commanded the Muslim pilgrims in the Holy Quran to walk between these hills when they go for the pilgrimage. The ritual of walking between the two hills of *'Safa'* and *'Marwah'* seven times, is an essential part of pilgrimage and it perpetuates the memory of Hajira as a mother.

With this exalted status of the mother, the village women also want to become a mother and a threat to their fertility, is a threat to their motherhood. The self-sacrificing image of the mother makes her put her own needs and health care last and serve her children. While she may suffer discrimination as a daughter-in-law for investment in her own nutrition and health needs, she is held precious as mother of their progeny. Special care during pregnancy and child birth allow her access to otherwise denied privileges. In old age, when her children and especially sons have grown up they try to serve her with

[274] Imam Ali. 7th Century.The Charter of Rights: Risalat-ul-Huquq by Shaykh al-Harran. English Translation by Dr.Rashid MH accessed on 20-08-2009 at http://www.Rights.IslamDigital.Com

respect and cater for her health needs. Men in the village acknowledge the sacrifices made by their mothers and hold them in very high esteem.

5.5.3. Muslim Ideals of the Best Wife

According to the sayings of the Holy Prophet (PBUH), the best wife is one who is content:

> *"Such woman is the best one who becomes happy and content when her husband puts a loving glance at her, and when he orders her for something right, she obeys him immediately, and never does any thing against his will".*

The best wife should be a great cook and a good administrator:

> *"A woman who cooks neat, clean and delicious food for her husband. Allah has provided great food for such nice wife in paradise. In heaven, she will be asked to drink and eat whatever you wish, as this is the reward for the pain and services which you performed for your husband!"* - Holy Prophet Muhammad (PBUH)

A good wife should be loving, caring and patient towards her husband and only this can make her eligible for entry into paradise. According to the Prophet (PBUH),

> *"Do not you want me to tell you about those ladies who will enter paradise? A woman who is loving and caring to her husband, and gives birth to his children and when he gets angry with her, she instantly says 'my hand is in your hand' like she does not get satisfied until her husband becomes happy with her" Holy Prophet Muhammad (PBUH)*

This hadith demands Muslim women to be submissive, to be fertile and to be self sacrificing. This leaves little allowance for a woman to negotiate sex and be authoritative in matters of her reproductive health. A wife bears an un-equally greater share of keeping harmony in marital life. As a hadith says,

> *"The Jihaad of woman is that she must not lose her patience if she gets hurt from her husband. Her patience is her Jihaad" The Holy Prophet Muhammad (PBUH)*

Another Islamic spiritual leader has said,

> *"The best woman among your women is one who cooks delicious food, spends the money justly and does not waste it. Such women are the*

workers of Allah, and the workers of Allah never get hopeless and regretful!" - Imam Jafer-e-Sadiq (AS)

As the research study confirms, many village women consider spending money on their health an 'extravagance'. At the same time, this quote describes hope as part of being religious. Hope for health, is the first step towards seeking a cure to an illness.

As the present research has documented earlier, female character is stringently measured in Islam and has connotations for actions for health seeking which may not be considered as part of a good character e.g. expressing one's sexuality etc.

5.6 The Female Role Models

Islamic traditions set five women on a pedestal of special respect and piousness that directly or indirectly influence the ideals for an ordinary woman. Muslim traditions consider the following ladies to be the most noble and pious as regarded by the Holy Prophet (PBUH) to have attained the level of perfection:

1. Hazrat Aasiya wife of Pharoah as the supreme sacrificer
2. Hazrat Maryam (Mary) as the most pious woman
3. Hazrat Hajirah as the best mother
4. Hazrat Kahdija as the best wife
5. Hazrat Fatima as the best daughter

All these role models bore great hardship and made exemplary sacrifices in the way of Allah. This perseverance is also extrapolated in terms of bearing hardship or illness without complaining and becomes a necessary virtue for the Muslim women in the village.

5.7. Gender Equality and Islam

Regarding the equality of the genders, the Holy Quran states:

"Surely the men who submit and the women who submit, and the believing men and the believing women, and the obeying men and the obeying women, and the truthful men and the truthful women, and the

patient men and the patient women and the humble men and the humble women, and the almsgiving men and the almsgiving women, and the fasting men and the fasting women, and the men who guard their private parts and the women who guard, and the men who remember Allah much and the women who remember-Allah has prepared, for them forgiveness and a mighty reward." (Al-Quran 33:35)

This equality in doctrine is not seen in practice among the Muslim population of the village. The religious standards of submission to Allah are replaced by submission to father and husband for the females.

5.8 Rituals and Ceremonies

In Jaffer, people have a knack of highlighting the significance of an occasion with a particular custom. Life here, in fact, is one long, colourful ritual. The rituals are designed to entice men and women into playing one's role in life in a responsive manner. In doing so, they cushion one against some of the doubts, fears, and confusions faced by the people in more individualistic societies. To help one understand one's purpose and significance in the scheme of things, each stage of life is marked by a ceremony. This endless series of ceremonies helps him/her realize that he/she is something special, and life is worth living.

Throughout her life, a woman in village Jaffer experiences the rich symbolism of rituals which also provide a welcome escape from life's drudgery and an acceptable public space for women. However, there is only one ceremony in the whole life i.e. her marriage, when she is the centre of all attention, when she has some say in clothing, shoes and jewelry but little in selection of her life partner. This is the commonest role model visible for young women with marriage almost being universal here. The sense of prioritizing and giving respect and status to those married, is obvious. The un-married, the child-less, the divorcee and the widow, is thus being, a second rated citizenship.

5.8.1 Betrothal (*Mang*)

This may happen at birth, before birth or in child hood with verbal intention of one of the parents to another. Mostly, the parents of the son indicate their willingness to parents of

the girl, to strengthen their existing bond of relation or friendship. If not betrothed at birth, the girls proposals start with her puberty and can be actualized any time once parents agree to one of these proposals. If parents feel that the girl is too young to be married they may ask to delay the '*mang*' but this is taken in negative connotations by the family proposing as they feel it is an excuse to say "No" to them. This *'mang'* can be valid for years and terminate in formal "*dehaaray bandhna*" (keeping dates of marriage).

5.8.2 Setting Dates for Marriage *(Dehaaray Bandhna)*

The elder men and women from the boy's family call upon the girl's family for *'dua-e-khair'* (prayer for blessing), *'menhdi'* (henna ceremony) and distribution of *'mithai'* (sweets). This is an arranged event with the *'nain'* (barber's wife) playing her role.The guest women are dressed in white *chaders* (wrap) or *dupattas* (diaphanous veil). The '*nain*' has kept red and green dyes mixed in separate bowls which she sprinkles on the *dupattas* of the guest women as a symbol of *deharray bandhey* (dates being set). The lady who receives the '*rang*' (colour) sprinkles, gives a five or ten ruppee note to the *'nain'* (coins are not acceptable). As the guest's convoy returns back to their home, every one in the village witnesses the colours on their *dupattas* and knows that '*deharray bandhey gaye'*. The preparations for the wedding takes up momentum and both families start preparations. Usually dates are set in a mild weather or at least not in summer. The Islamic calendar months of *Muharram* and *Ramadan* are usually avoided so many wedding events cluster just before or after these months. With many young boys in the armed forces, the marriage dates are also dependant on the availability of their leave from duty. After graduating from their military school, the new *sepoys* or army men are allowed a spouse allowance tempting families to arrange *'nikah'* with '*deharray bandhna*' and have the legal proof of the changed marital status.

5.8.3 Invitation to the Wedding *(Pooch Keetey)*

The '*nain*' (barber's wife) goes around all the houses in the village to be invited to the wedding. Women ask for all the minute details of both families and prospective bride and groom from the *'nain'* which may be embarrassing to ask the families directly.

5.8.4 Applying Henna *(Mehndi)*

Many arrangements must be made for different ceremonies accompanying the marriage. First comes the *mayun or lagan* (the to-be bride sitting down separately), three or four days before marriage. This marks the retirement of the bride to a secluded section of the house. During this time, she is to appear shabby which will then enhance the value of her emergence as a beautiful bride.

The day before the marriage the *'mehndi'* ceremony is held during which the girl's hand and feet are painted with henna. The to-be -bride (*wohti*) sits in her room and just stretches her hand out of door, so no one can see her. The '*nain*'(barber's wife) sits besides her on the door. First, seven married women (*saat suhagenain*) initiate putting *mehndi* (henna)on her hand. As the process of painting menhdi is now sophisticated with cone replacing the paste, a broad leaf of *peepal* (maple) is placed on *wohti's* (bride's) hand and all married women put a little paste on their index finger and put that on the leaf. Each of these after putting *menhdi* (henna) puts some money into the lap of the '*nain*' sitting beside the door. The s*aat suhagenain* (seven currently married women with living husbands) are followed by other ladies and friends who would do the same. It is considered a "*bura shagoon*" (bad luck) to have a divorced, widowed or infertile woman to do the *mehndi* as their fortune is feared to be transferred to the *wohti* (bride). There is also an exchange of *mehndi* between the two houses involved. When the bride's side visits the bridegroom's house, they not only take *mehndi* but a token for the bridegroom. This is a wrist bracelet called *'gaana'* made with coloured fancy paper called '*panna'*. One *'gaana'* is tied to his wrist by the sisters of the wohti and another by her girl friends.

5.8.5 Wedding Party (*Baraat)*

The *baraat* comprising of the *'dulha'* (bride –groom), his elders and family members and friends comes to the *wohti* (bride's) house. They are usually accompanied by the music band and '*dholak*' (drum) to give it a festive appearance and sound. If they are coming from a distance, they would stay for the night at *wohti's* house. The *dulha* changes into

the clothes and shoes prepared by his in-laws for the occasion and his previous attire is taken by the *'Nai'* (barber) who helps the *dulha* to get ready for the occasion. On the wedding day, the bride usually wears the traditional red wedding dress. The bride's gown is very elaborate with a veil and heavy jewellery. The groom wears a traditional *kullah* (an off-white or cream coloured turban), sometimes with gems adorning the forehead side, in which the central one coloured red is accompanied by two smaller green ones on each side.

5.8.6 *Nikah and Haq Mehar*

If '*nikah*' has not been actualized earlier, the ceremony is done by the *maulvi sahib* (religious clergy man), who comes with the *dulha* family. The '*ijab and qabool*' (consent of the bride and the groom to the marriage) in the presence of at least two witnesses is all that is required to solemnize the wedding. The bride and groom's fathers and two witnesses, after getting consent of the groom go together to the place where the bride is sitting. The *maulvi sahib* (clergy-man) says some verses *(sabaq parhna)*. Before reading out a selected piece from the Quran, the *maulvi sahib* will ask the bride (or is done through bride's advocates called '*wakeel*') if she is happy with the marriage and accepts the groom. She says "*jee*' (yes) or "*qabool hey*" (accepted). The groom is also asked the same. The marriage is then registered on a document known as '*nikaah nama*', first signed by the groom and then by two other witnesses. Thereafter the *maulvi sahib* and the guests offer a short prayer for the success of the marriage. The ceremony is over. *Pitassey* (coin shaped coloured candies - usually white, red, pink and yellow) and dried dates are then distributed among the guests. Now sweetmeats are also served. These items are brought by the baraat. The groom is then taken to the women's section where he gets *salaami* (money gifts) from female family members on the *wohti* (bride) side. A young boy would be specially dressed as '*shah baala*' (bridegroom's accomplice) and will sit with the groom and also receive small sums of money (smaller than that of the groom). The bride's father or brother/uncle (if father is not alive) present a gold ring to the *dulha* (bride-groom). All these monetary gifts are clearly registered on a notebook by the *nai* (barber) or a literate family member to be paid back when an occasion arises. In a re-pay

the amount is equal to or more than the one received earlier. *Salaami* (money gifts) means a family wants to keep a long term relation with this family and will invite them to their weddings.

Usually the bridegroom and *shahbaala* are made to sit in the compound of the house with the the *jahez (*dowry items) displayed around. The *burry* (clothes and jewellery from groom's family) is then also added to the display. The *baraat* (wedding party) on their way back, takes all the *jahez* and *barri* items with them. There is a growing trend now to send the '*jahez*' items before hand to the in-laws house so they can be arranged for their use by the bride once she reaches there.

Then food is served separately to men and women. If the *baraat* comes from a small distance and not at the meal time, they are served with tea and *mithai*(sweat meats). If the *baraat* is coming at a meal time, a curry of chicken or beef or mutton is served depending upon the resources of the family. Usually the *wohti's* (bride's) family will sacrifice one of the cattle kept at the house for the occasion. The curry is served with *tandoor roti* (oven bread) and *makhaddi halwa* (a brown coloured sweet dish prepared from '*suji*' – wheat flour ingredients soaked in milk, ghee and sugar syrup).

The *baraat* may come with the *wohti* the same day or spend a night at the bride's house and leave for their own home at the time of *azaan* (call) for *fajar* (morning) prayers. The bride's family uses that night to have fun and try not to let anyone sleep from the *baraat*. They sing songs, make practical jokes and enjoy themselves. The bridegroom is a special target for jokes, they will bring a frame of the wooden cot without the knitted middle part and put a sheet on it to fool the groom and make him sit on it. Sometimes they would also put thorny bush branches underneath.

Marriage also involves a dower, called *haq mehar*, established under Islamic law, the *sharia*. A compulsory amount of money is given by the groom's family to the bride and the amount is decided by the elders of both the families. In Jaffer, the norm in the senior generation was Rs.125, and now Rs.500 is usually the amount agreed upon. It may be *moajjal or gher moajjel* (to be paid spontaneously or later on respectively). Some pay and

those who cannot afford ask the bride's permission to give a waiver *(bakhshwaana)*. Some families agree upon additional conditions of *haq mehar* in case of divorce which usually includes a sum of money around Rs.50,000 with the jewellery and a house in name of the bride for extra security. There is also a *riwaj* (tradition) of giving a goat, sheep, buffalo or cow in *haq mehar* as well. The ladies would use the money or commodity received as a gift for their personal use (buying clothes or a small piece of jewellery) or keeping as a security for bad days.

The indigenous wedding customs are gradually being replaced by homogenous versions of *mehndi, baraat and waleema* as seen in Indian movies and TV dramas.

A wedding does not, of course, bring to an end, the ceremonies that occur in a person's life as regularly as milestones. Yet the ceremonies that bind one so firmly in marriage constitute a high point. By the time one acquires a wife or a husband, one has learned to accept and adjust to one's place in life's complicated pattern. A woman's life is difficult during the early years of marriage. A young bride has very little status in her husband's household; she is subservient to her mother-in-law and must negotiate relations with her sisters-in-law. Her situation is made easier if she has married a cousin and her mother-in-law is also her aunt. After the pregnancy, inevitably, attention shifts to their first-born.

5.8.7 Wedding Day Rituals

These ceremonies are the only recreation for most of the women and a clear symbolic display of the common female desires and ambitions to become a bride.

5.8.7.1 *Muthi Kholna*

Muthi kholna (opening the fist) is another feature of this night where bride is behind a door or a veil and her closed fist is given in the hand of the bride-groom. He tries to open it up and places rupees in the bride's palm after opening it.

5.8.7.2 *Garholi*

When the *baraat* arrives back with the bride, there is another ceremony of *"garholi"* (small earthen pitcher). A small (pre-pubertal) girl, usually groom's sister lifts a *garholi* on her head. Other sisters and nieces (sister's daughters) put a wedding *dupatta* (diaphanous veil) usually borrowed from an already married relative on it. They play the drum and do *luddi* (dance) and go to a neighbour's house with a large compound where other female guests can join in. The girls sing and dance and come back to the groom's house. He lifts the pitcher off from her head, places it down and gives her and the other girls some money.

5.8.8 *Waleema*

Waleema is the feast arranged by the bride-groom's family on the second day of the marriage. The menu of refreshments is the same as for the wedding meal, though some may add *zarda* (a yellow coloured sweet rice dish). The bridegroom, gets *salaami* (money gifts) from the elder male and female guests while the new bride gets *salaami* from the female guests. The *wohti's* (bride's) parents do not attend the waleema. Her sisters, *bhabis* (brothers'wives) and friends are invited who bring *"choori"* (bread crumbs mixed with butter and sugar) from her parents' house. Both the newly weds are made to sit together for the first time for the eating of the *choori*. Usually the arrangement is made in their own bedroom, where the bride is already sitting and the groom is invited. After the ceremony of *choori*, the other ladies and bride groom leave and the '*nain*' (barber's wife) sleeps with the *wohti* (bride) in her room.

5.8.9 Going For a 3rd Day Return *(Tariye Mornay Waina)*

The newly weds accompanied by the mother and sisters-in-law, go to visit the bride's home on 3rd day of the marriage. The *gaana* (wrist gear) worn by the groom is un-tied and the occasion is called *gaana khulna*. This is celebrated by preparing seven *rotis* (breads) with *palak saag* (cooked spinach) and *kheer* (rice pudding) and serving it to seven *suhaagans* (currently married women) in the family. The ladies from the in-laws' house, leave and the couple stays there for three days. The couple returns after spending

three days with girl's family and its there that the consummation of the marriage takes place.

The proper performance of all the elaborate marriage ceremonies and the accompanying exchange of gifts, also serve to enhance the new bride's status. Likewise, a rich dowry serves as a trousseau; the household goods, clothing, jewellery, and furniture included, remain the property of the bride after she has married.

5.9 Funeral Rites

According to the Muslim belief, death is a departure from the temporary life of this world, followed by eternal life after the Day of Judgment. The dying person is encouraged to recite the *Kalma* (the Muslim declaration of faith). The body of the deceased person is bathed and covered with a clean white shroud. Islam encourages people to refrain from wailing and screaming. '*Namaz-e-Janaza*' (funeral prayers), led by the Imam, are usually held outdoors. The face of the deceased is turned right towards Mecca. The villagers have adopted some customs like *soyem or qul* (3rd day after death), *novin* (9th day after death), *chehlum or chaliswaan* (40th day after death). In all these events, the bereaved family recites Quranic verses and offer *dua* (prayer) seeking forgiveness and mercy on behalf of the deceased person. It is also called *khatam* or *Quran khawaani* (reading of Holy Quran). It has also become customary to cook and distribute meals among people.

Shoes are taken off before entering the house of the bereaved, and it is customary to cover one's head when talking about the person who has died. People often sit on the floor mat to pass on their condolences. Traditionally, most people wear plain simple clothes with no make up or ornaments.

The extended family network provides a great deal of support for the bereaved. Because of the physical proximity of family members and the custom of talking through the experience a feeling of loneliness and isolation is less common.

5.10 Bereavement and *'Iddat'*

The initial bereavement period lasts for three days, during which prayers in the home are, recited almost continuously. Public rites are for men only. According to religious laws, a Muslim wife is expected to stay in her home for up to four and a half months after the death of her husband or, if she is pregnant, until pregnancy ends. This is important in establishing that pregnancy was progressing before death of the husband. This is called *"iddat"* and is also practiced in case of a divorce.

In this chapter, we have reviewed establishment of female identity in the village which is related to gender role socialization and is determined by traditions and religion. Local notions of purity, pollution, modesty,religious expectations as well as wedding and death rituals are described as they have strong linkages with behaviours of reproduction and related health care seeking. The next chapter, will examine the beliefs and cultural constructs around reproductive health and illness.

CHAPTER 6

REPRODUCTIVE HEALTH AND ILLNESS

Health, in the most elementary term, refers to the highest attainable level of physical, mental and emotional well-being. Health is a subjective experience and needs to be studied at both societal and individual levels. In this chapter, the broader concepts of health and illness and prevalent beliefs about illness causation are outlined. Then the focus will converge on specific reproductive illnesses experienced by the women of Jaffer, followed by the range of services available for them to seek care.

6.1 Local Concepts of Health and Illness

Health and illness are relative subjective physical and emotional states in the minds of women in Jaffer which clearly affects one's life and social situation.

> *"Bimar ki baat aur hey aur naroey ki baat aur"*
> [The state of the sick is different from the state of the healthy][275]

"*Bimar*" is the word for 'sick' or 'patient' used both in Punjabi and Urdu. It is derived from Persian, Pahlavi version of '*vimar*' or 'vemar' meaning 'sick'[276]. "*Naroiya*" is a less frequently used word for healthy. It takes its roots from the Sanskrit word "*niraamaya*" meaning health.[277]

Another commonly used word for healthy in Jaffer is '*sehatmand*'- the one who possesses health (*sehat* – an Arabic word). Women defined *sehat* (health) as a state when one is not '*bimar*' :

[275] A quote from a Jaffer woman
[276] Behrooz Broumand (2006) Archives of Iranian Medicine;9(3) : 288-290
[277] http://spokensanskrit.de/index.php?script accessed on 01-05-2009.

"Sohna rangroop ho, khoon ho, insaan mota ho, kabhi dard ki shikayat na ho, taazadam ho, thakawat mahsoos na karey, apney aap ko ghaseetna na parey, kamzori ka ihsaas na ho, bhook lage..."

[Have good complexion and physique, have blood[in one's body], person is fat, never have complaint of pain, feels fresh (energetic), does not feel lethargic,does not have to drag oneself, does not feel weak, feels an appetite]

6.1.1 The Sick Role

Being up and about is also considered equivalent of a healthy state as evident from the commonly used statements:

" changee bhali hay, charpoy tay te nai pari"

[She is all well, she is not lying on the cot (bed-ridden)]

This also shows that lying on a bed, without an illness or for purpose of sleeping, is not very well accepted. Elderly women would lie around the afternoon for a nap but most of the younger ones, will be busy in doing their sewing or some other housework and rarely take a nap as a routine. The only others who have the luxury of lying down with the baby are the lactating mothers. Feeding one's young one while sitting is seldom practiced unless the lady is visiting someone and sitting as a formal guest. In their own convenience, it is preferred to lie down.

" Bachay ko doodh pilanaykay bahanay hi kamar seedhi kar laitay hein"
[We straighten our backs on pretext of breastfeeding a child]

With many demands on young daughter-in-laws' time and energy from the parents-in-law, the husband, the husband's un-married siblings, guests, one's own children and the cattle; most of the women devise ways and means to have a pause or resting phase in between the hectic array of everyday work. A few minutes extra spent in chatting with

the neighbour, or simply prolonging a pause in the rhythm of one activity, is not idle luxury or utter waste of time but a small reflexive act of rest which will enable her to go on non-stop.

The other conditions where lying down is acceptable, is for younger girls when having painful periods or during the post-natal period for the mothers with a new baby.
It is also interesting that both men and women sit on *'charpoys'* (wooden cots) or chairs when acting as a host or as a guest. When men are at home (back from work) they would be lying down and taking a rest. For women, whether working or non-working, lying down for a rest apart from the usual sleep hours is not visible, exceptions being for the elder ones and the very sick. Sitting on the *'peerhi'* (low wooden stool with knitted centre) while cooking or washing, is the only activity near to rest (if it is considered to be rest at all) in an ordinary woman's life.

In one's distress, the patient can offer frequent prayers for oneself, his kith and kin, friends and acquaintances. The believer's illness is a blessing for him or her, if he/she perceives the value of this blessing[278]. Visiting the sick is a common aspect of the social responsibility of all neighbours and relatives in Jaffer. Men would visit ailing men and women would visit the women and also the sick of the opposite sex if he or she is a close relative. This is called *'bimaar pursi'* or *"pooch karna"* (asking about how one is doing?) The sick (if in a state of consciousness) or a near relative present would describe in detail from the beginning of the symptom the elaborate detail of each progressive change in the patient's state, what is the cause of illness as the patient perceives it, was it *'beihtiati'* (carelessness: due to eating something wrong, over exertion or whether he did something which brought about the symptom); the sick will also talk about whether a similar illness had occurred before and what has been different this time, the sequence of treatments sought, the expenditure incurred and will give details of the effects of sickness on the remaining family (the suffering of the children, the husband and the different accommodations made by other members of the family who are helping to do the

[278] Madni, M. A.E. (1999). A Gift for Muslim Women (Tohfa-e-Khwateen). English translation by Shakir Rizwani and Professor Riaz Hussain. Lahore: Idara-e-Islamiat.Page 368

household chores or other responsibilities). The visitor would tell stories of similar illness that he/she has experienced or have heard of and provide his or her own version of the diagnosis and what should be done and from whom further care should be sought. The sick is asked to bear the suffering with patience and the visitor would beg leave to go after saying that he/she prays for his/her quick recovery. People take small gifts (usually something eatable: milk, butter, eggs, fruit etc.) for the sick and if there is nothing to be offered, a small sum of money (Rs. 10-50) is left near the pillow of the sick when one rises to go. Like the money exchanged at weddings and child birth, a record of this money is kept and is supposed to be returned as the same or better value.

The sick, as a custom, would say that she is grateful to Allah for keeping her healthy and strong previously and she hopes that she does not complain to her Creator, now that she is suffering. The stories of patience of Hazrat Ayub (PBUH) are commonly referred to as an ideal behaviour to follow in one's illness.

The visitors are entertained with a drink which may be *'sherbat'* (syrup), *'lassi'*(yogurt drink) or tea and such visits strengthen the bonds of friendship and kinship amongst the village folk. Women would hold it against each other if someone has not come to ask about the well being of the sick. The *'pooch karna'* (asking about the sick) visits are the real opportunity for exchange of information about an illness, different experiences of it and different treatment options and prospective costs are shared.

6.1.2 Recognizing Illness

Illness or sickness is referred to by women as "*bimaari*" (disease) or "*takleef*" (unease) or "*dukh*"(suffering) or "*kharabi*" (defect). Women feel *'bimaar'* when they feel a bodily change they did not feel before. Facial acne and increased physiological vaginal discharge *'pani parna'* thus, become a worrisome reality in the adolescent period and *'chayeeian'*i.e. melasma (butterfly shaped skin pigmentation on both cheek bones and in-between portion of the nose) during and after pregnancy, causes concern. Women are very sensitive to changes in patterns of their menstrual periods (presence or absence of

pain, duration of blood flow, quantity of blood passed and its consistency) and any change to the previous pattern, is considered a variation from the norm and a *'kharabi'* (defect).

Those who have lost their rosy complexion after their puberty, also consider it as a *'kharabi'* (defect) they have acquired, e.g. a woman said,

> *" mera to rang aisaa tha kay awratein pooch pooch kar tang karti thein kay konsi kream lagayee hay, ab to mein bohat kharab ho gayee houn"*
>
> [I had such a complexion that women would annoy me with their questions about which [beauty]cream I used, now my looks have really been ruined (feel herself still prettier than the rest but saying that it is a deteriorated look that she has now)]

Those unable to perform some function which they could do previously without a problem, also categorize themselves as *'bimar'*. The sick resent not being able to do the hard physical job they were able to do before, and going to distant places by foot (all such visits are chaperoned if out of the village settlement area for the pre-menopausal women).

Visible or felt changes in the body form also constitute *'bimari'* e.g., obvious increase or decrease in size of a body part (abdominal distension, swelling or lump in throat, breast or pelvic area) or an abnormal growth or swelling as in utero-vaginal prolapse; change in colour of the body or secretions (hepatitis causing increased yellowness of skin, eyes and urine; body becoming pale or whiter with loss of blood; fingers and toes becoming blue with cold; skin becoming darker etc. The change in consistency, colour and quantity of body secretions like menstrual blood, milk, faeces, urine, sweat etc. are also considered *'bimari'*. The temperature of the body is also very important *(' tatta' or 'thadda'*: hot or cold).

Illness is also having the feeling of not being your old self; and even the subtle changes in appetite are significant.

" Apna aap theek nahin lagta, kharabi ho gayi hey, khaney ko jee nahin chahta, kisi cheez ko dil nahin karta"

[I do not feel myself to be alright, a defect has set in, do not feel like eating, my heart doesn't desire any thing]

Losing appetite is a common symptom attributed to illness and a subsequent weight loss, is noticed by all but attributed mostly to a domestic problem.

"khaney ko ji nahin chahta, bohat kamzori hey, jo koi bhi dekhta hey kehta haey ghar mein kuch nahin hey ya log poochtey hein miaan to theek hey, larta to nahiin"

[I do not feel like eating any thing, feel very tired, whoever looks at me asks if I have nothing at home [to eat] or if my husband quarrels]

Thus, loss of appetite and weight, becomes a common manifestation of emotional turmoils, a woman may be going through which are not overtly shared with others. The honour of one's family, is held precious and women do not discuss domestic issues with outsiders or others except their confidantes.

Those developing diabetes (commonly referred to as the disease of 'sugar') in their later age, even if not physically active, expect the same appetite as before or enjoying food they like (depending on affluence and access though),

"Bimaarian andar war gain, bhook nahin lagti, subah sey sirf ek piali pi hey doodh patti ki. Ab giarah baj gaye hein, sugar ki waja sey froot bhi nahin kah sakti"

[Diseases have entered my body, does not feel hungry, have taken only a cup of milk tea since morning and it is 11 o'clock now, cannot eat even fruit due to Diabetes]

Being fat is considered to be healthy but those too fat are also pitied:

"motapa nahin bus Bimaariain na hon. Meri behan itni moti hey key lait jaye to uth nahin sakti aur uth jaye to baith nahin sakti"

[(Healthy is) not being fat but not to have diseases. My sister is so fat that she cannot get up if she lies down and cannot sit if she is standing]

Women are very conscious about their figure though they do not indulge in any structured exercise regime or diet. A protruding abdomen is considered an illness caused by use of family planning methods.

Pain is another sign of *'bimari'* (sickness) and a serious indication for the need of treatment. One of the ladies considered to be sick is referred to by another village woman as the one who is in constant pain and making noise.

"har waqt haye, haye karti hay"

[groans (with pain) all the time]

Women view and perceive illness on the basis of their learnings in childhood, as a socialization process from parents or during an interaction or exchange with others who have similar experience and these views are modified by each interaction with a provider who transfers vocabulary and ideas of disease.

6.2 Beliefs about Causation of Illness

Concepts of disease almost always include some idea about causes. In any cultural sphere, more or less elaborate etiological theories are developed which match notions about cause and effect, in general and can provide insights into feelings of guilt, embarrassment, helplessness etc. among the sick, hence affecting their care seeking behaviour and choices.

Women in the village view illness as an effect of a cause which may vary with type of the illness. This belief in cause is at the root of perceptions formed about the possible healing

and coping mechanisms. The common themes emerging from women in every day talk and the specific interview queries are outlined below.

6.2.1 Illness - A Mortal's Fate

Belief in fatalism predominates as the commonest cause of an illness. Women refer to illness as an inescapable and unavoidable reality which is written in their destiny.

"Dukh jo naseebon main ho !"
[Suffering written in one's fate!]

The word *'dukh'* is used for suffering or pain. According to Muslim belief, destiny is pre-decided and one can not avoid the writings in one's fate, though with good deeds and prayers, one's sufferings can be minimized and eliminated. Each soul born into this world, carries a pre-destined share of happiness *(khushi)* and suffering *(dukh)*. The illness or *bimari* is the inevitable suffering one has to bear.

"Bimari Allah ki taraf sey aati hey"
[Illness comes from Allah]

Thus *'bimari'* can not be avoided as it occurs on Allah's will and order and has to be accepted and endured by a Muslim. The word 'Muslim' itself means the "submissive", one who is obedient in all situations. According to sayings of the Holy Prophet (PBUH),

> *"When a believer falls ills, first of all his sins are forgiven in lieu of his illness and he is raised in merits, secondly, the reward of all the devotions he made in the state of health is credited to his account; thirdly, the merit of his supplication is so raised that it is certainly granted." (Ibne Maja[279])*

In another Hadith, the Messenger of Allah (PBUH) advised:

> *"When you visit a patient, ask him to pray for you, for his supplication is like the supplication of the Angels". (ibid)*

[279] Ibn Majah Sunan.

6.2.2 Illness - An Internal Body Change

Illness is considered to arise due to an altered state or function of the internal body.

"Andar farq lag giya"
[Internally, some thing has gone different]

The word "*farq*" means difference, alteration, differentiation or change from the previous state.

Health is valued among women of Jaffer, to give them ability to fulfil their duties and maintain the physical beauty. If there is a change felt in one's energy level, physical capability to perform one's chores or there is a change in complexion or physique, this may alert her to a possibility of having an illnesss. A woman defined the healthy state as the capability of being able to meet expectations and demands of oneself and of others from her.

> *"apnay aap ko pura kar sakay, apnay miaan aur bachoun ko pura kar sakay"*
>
> [can fulfill one's own needs and can fulfill needs of one's husband and children]

6.2.3 Illness – Activation of Suffering from the Dormant State

This notion implies that an illness is part of our body and remains hidden till something triggers its arousal.

> *"Kabhi ander ki takleefain Allah key hukm sey uth parin"*
> [Sometimes, the internal suffering has awakened/ rose up with Allah's order]

The phrase is very much similar to the awakening of all dead and buried on the dooms day with the Divine order. It may mean that it is inevitable and bound to happen if there

is an order from Allah almighty. Thus, all healings can also only occur if there is Allah's order for it.

6.2.4 Illness - An External Factor Gaining Entry into the Body

"Bimaari ander war gaiye"

[Illness has entered in (the body)]

This concept is similar to a disease agent invading the body and overpowering it. Similarities can be drawn to the modern concepts of germs and viruses though none of the women uses the word 'germs' as causing disease. It is only referred to by a local term *'jeraseem'* for the sperms. For a disease agent to enter the body, its defence barriers must be breached and the sanctity of the body be compromised before an illness occurs.

These concepts are attributed to Unani Tibb as Avicenna described the contamination of the body by "foreign bodies" prior to infection, and Ibn Khatima also described how "minute bodies" enter the body and cause disease, well in advance of Pasteur's discovery of microbes.

6.2.5 Illness – The Result of Being Careless

Not taking precautions or not taking care of what one does or eats is usually an explanation given for getting a *bimaari.* This means that a person's health or illness is in one's own hands to some extent and the disease can be avoided by taking care or taking some precautions or preventive measures. Thus, a person can take care of one's health by not being careless. The common term used is,

"be-ehtiati karna "

[not taking care]

The preventive measures are usually avoiding certain foods or activities or doing it in moderation. This is based on the 'balance theory' of *Unani Tibb* (Greek medicine). In

this concept the control of one's health and illness is to some extent in one's own hands (over-rided by the concept of 'Allah's will'). Thus, one can take care of one's own health and the illness can be cured if the balance is regained by 'exerting care'. It is a widely held belief that attentive care of the self, and especially for the stomach, can set a person free from dependencies. People should live up to the ethics of self-care. Thus, the level of self control and bodily sovereignty is important to be able to take independent action.

Pregnancy and childbirth in Jaffer are the domain of the *'dai'* (traditional birth attendant) to handle. However, for most of other health problems including those of reproductive health, medicine from the hakeem is most commonly sought. Unlike modern medicine where the drugs need to be bought in a prepared form, the medicine from the hakeem may be in a pre-formulated pack or usually a prescription of commonly available herbs which people can buy or obtain from their own fields and prepare themselves. This knowledge passes from one generation to the next one.

Unani medicine regards disease as a natural process and considers symptoms as the reactions of the body to the disease. It believes in the humoral theory which presupposes the presence of the four *'akhlaat'* (humors) – *'Dam'* (blood), *'Balgham'* (phlegm), *'Safra'* (yellow bile) and *'Sauda'* (black bile) in the body. Each humor has its own *'mizaaj'* (temperament) - blood is hot and moist, phlegm is cold and moist, yellow bile is hot and dry and black bile is cold and dry. Every person attains a temperament according to the preponderance in them of the humors which represent the person's healthy state, which are expressed as sanguine, phlegmatic, choleric and melancholic.

To maintain the correct humoral balance, there is a power of self preservation or adjustment called *'Quwwat-e-Mudabbira'* (medicatrix naturae) in the body. When this power weakens, an imbalance in humoral compositions occurs resulting in disease. The medicines used help regain this power and thereby restore the humoral balance and the disease is eradicated. Too many *'pareshaniaan'* (worries) are also quoted by women to cause illness.

6.2.6 Illness – Result of Catching an Evil Eye

'*Nazar lagna*' or getting an evil eye or overlooking is commonly thought to be a reason for illnesses related to children, fertility and breastfeeding problems.

The evil eye is the name for a sickness transmitted, usually without intention, by someone who is envious, jealous, or covetous. It is also called the invidious eye and the envious eye. The evil eye belief is that a person- otherwise not malific in any way - can harm a person, her children, her livestock, her fruit trees or the harvest, by "looking at them" with envy and praising them. The notion is based upon underlying beliefs about water equating to life and dryness equating to death. The harm caused by overlooking consists of sudden vomiting or diarrhoea in children, drying up of milk in nursing mothers or livestock, withering of fruit on orchard trees, and loss of potency in men. In short, the envious eye "*dries up liquids*".[280]

Women feel that usually the evil eye comes from strangers who are themselves childless or missing the quality of being envied. To ward off the evil eye, a preventive measure is "*mirchoun ki dhooni daina*" (putting red pepper on *tawa* (a sizzling hot iron plate) and the fumes directed towards the one to be protected[281].

To prevent '*nazar*' hand gestures (flexing both the hands at knuckles and placing them on one's temples in a quick move) by the woman praising the others, is common (usually for one's child) saying that '*qurban jaoun*' (may I be sacrificed on you) or "*Masha-Allah*" (all praises are for Allah).

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[280] Middle Eastern desert origins of this concept is also put forth by Dundes, Alan (ed.) The Evil Eye: A Folklore Casebook. Garland Publishing, Inc., New York, 1981

[281] In Iran, Afghanistan, Pakistan, and Tajikistan, Moslem people combine an aporopaic approach with a cure. When a child returns home after taken out among strangers, the parents will light a charcoal disk and burn on it the seeds of a plant called 'aspand', while reciting a spell -- actually an ancient Zorastrian prayer against the evil eye and directing the smoke around the child. This is done as a prophylactic measure, whether or not it is suspected that the child has been given the eye. In some families it is the custom to mingle herb leaves and Frankincense grains with the 'aspand' to make a more powerful fumigant mixture.

Information on the number of one's children or income, is sometimes given in an ambiguous way to ward off '*nazar*' e.g. if one asks a mother how many male off springs she has, she will say '*bohat hein*' (are many) rather than giving a number or if asked about the monthly income, the answer would be '*guzara ho jaata hay'* (we just make our ends meet). A similar prevention is considered necessary to protect an early pregnancy and unless a gravid abdomen is visible after three or four months, the information is not shared with those who are not the immediate family.

'*Taweez'* (amulets) are worn to ward off '*nazar*' and kohl put in newborn's eyes. It is a common sight to see an old shoe or a black rag hanging from a brand new vehicles to put away the *nazar.*

Islamic traditions also support the presence of evil eye. By just looking at someone jealously, they may be affected or their posessions to the extent that they pine away or their properties get diminished.

The Arabic word 'al-ayn' (translated as the evil eye) refers to when a person harms another with his eye. It starts when the person likes a thing, then his evil feelings affect it, by means of his repeated looking at the object of his jealousy. Allah commanded His Prophet Muhammad (PBUH) to seek refuge with Him from the envier:

> *"And from the evil of the envier when he envies"* [*Al Quran* 113:5]

It is thought that everyone who puts the evil eye on another is envious, but not every envier puts the evil eye on another. The word '*haasid*' (envier) is more general in meaning than the word 'al-ayn (one who puts the evil eye on another), so seeking refuge with Allah from the one who envies, includes seeking refuge with Him from the one who puts the evil eye on another. *'Hasid'* (envious) and '*hasad*' (envy) are the words used in the context of casting an evil eye. It is quoted from Qayyim Said Ibn Als

> *"Every one who gives the evil eye is jealous but not everyone who is jealous gives the evil eye....it begins when the person likes something and by continually looking at it, soul dwells on the matter and his venom is directed towards the other on whom an evil eye is put on. One can have an evil eye on oneself as well. (167/4 ; Maad)*

It is assumed that the evil eye is like an arrow which comes from the soul of the one who envies towards the one who is envied and on whom the evil eye is put; sometimes the evil eye hits the target and sometimes, it misses. If the target is exposed and unprotected, it will affect him/her, but if the target is cautious and armed, the arrow will have no effect and may even come back on the one who launched it.

In another tradition, the Holy prophet (PBUH) said a prayer for protection from an evil eye which used the word '*haammah*' meaning 'vermin' of poisonous animals and insects for the effect of the evil eye. (Ibn'Abbas: 3191 Al-Bukhari)[282]. It is advised that one should ask for the blessing of that person from Allah, when one likes something possessed by the other one.

6.2.7 Illness- Result of a Curse (*Bad-Dua*)

It is believed that if one is wronged by the other, the victim possesses an extra-ordinary power to curse that person, which brings *'bimari'* as a result. If a person can not associate an obvious reason to her sickness, she says,

"kisi ki bad-dua lag gai"
[someone's ill-wish has befallen]

There is a strong belief that hurting someone can cause him/her, bad luck. Those who were sick often said,

" mein tay kisi da manda naeen keeta"
[I have not done any thing bad to any one]

This is said to diffuse any thoughts on behalf of the visitor or the other person that the sick is getting the illness as a reciprocal measure for the suffering caused to the other. It is interesting that though this concept associates guilt with an illness it is associating guilt with mis-dealing with a human being and not with Allah. This is in accordance with

[282] Book of Prophets. The Sahih Collection of Al-Bukhari. Translation by Ustada Aisha Bewley. Sunni Path: The Online Islamic Academy. Accessed on 20-08-2009.

Islamic injunctions on '*Haqooq-ul-Ibaad*" (rights of fellow human beings) whereby the offending person has to seek forgiveness from the grieved one in person and no third person has authority to forgive the offender. The mis-dealings with one's Allah or sins, are dealt with in "*Haqooq Allah*" (rights of Allah) and pardon has to be requested through prayers. The boundary between the two '*Haqooq*'(rights) gets blurred whereby, a person has grieved someone against the directions of Allah e.g when a wife disobeys her husband, she does not think directly being accountable to her husband but to her Allah against whose rulings she has trespassed.

6.2.8 Illness - Effect of a Spirit or Magic Spell

'*Jin*' (Ginnie) and '*rooh*' (spirit/ghost) can affect one's condition and this is referred to as "*saya hona*" or "getting [under]a shadow". '*Saya*' in literal meaning is shadow/ something which one can not see. Any unexplained phenomenon is usually attributed to '*saya*'. Mental retardation, fits, spells of unconsciousness and migraine like headaches are supposed to occur due to a '*saya*'. A nineteen year old girl who was thought to be possessed, described her illness:

> *"pehlay saya ho giya tha, (aisey meian)ronay ko dil karta hey, raat ko ghabrahat hoti hey, raat ko neend na aye aur akeli hun to khof aata hey, ultey seedahey khiaal aatey hein, koi pareshani ho to bhi aisa ho jaata hey. Aadha ghata, 15 minute tabeeat kharab rehti hey. Aankhein band kar leitey hun aur dono hath sar par rakh leti hun. Aisa lagta jaisey koi tufaan aya ho. Ammi mujhey golra ley kar gayeen. Unhoon ney pehn-nay ko taweez diya aur peenay ko bhi. Har roz istimaal karn hota hey. Mahwaari mein chor deti hun"*
>
> [I had a '*saya*', (in my illness) I would want to cry, I get nervous attacks at night, if I am unable to sleep or am alone, I develop this fear; stray thoughts come to my mind or if I am worried about something, then this happens. My illness lasts half an hour or fifteen minutes, I close my eyes and hold my head with my hands. It seems as if a storm is passing. My mother took me to Golra and there they gave me amulets for wearing and drinking. These have to be

used daily except when I am menstruating; it is when I do not use them.]

Muslim belief in magic comes from the mention of '*jadoo*' (magic) in Quranic text and from the Holy Prophet Mohammad's (PBUH) traditions that he also once got sick due to a magic spell. Women in Jaffer think that jealousy and animosity motivate people to do '*jadoo*' on others.

A lady recalled getting unconscious once, consider this to be an effect of '*jadoo*' and narrates her experience:

> *"raat key bara bajey bair khaye aur pani piya, aur mujhey ulti aa gayi ek bajay. Chaploon par ulti ho gai, un ko dhoney gai, derh darjan choori charhai hoi thi. Chota sa haath meri kmar par aa key laga, chooriaan toot gayien. Uthi to utha nahin gaya. Mein paseenay mein bheeg gayi. Bura haal tha... beti apney ghar ley gai kuonkey bahu umrey par gai hoi thi. ....kaha keh peer sey kitaab nikalwain... Pir sahib say kaha abhi kitaab nikalein aur batayein. Unhoon nay kaha, chota sa neela haath lag giya hey aur mujhey taweez diya."*
>
> [I had berries at midnight and had water after them. I had vomiting and vomit fell on my sandals. I went to (the washroom) to clean them, I had a dozen and a half of glass bangles on my arm; a little hand struck on my back and I fell down. I tried to get up but could not. I was soaked with perspiration. I was in a bad shape... my daughter (who lives in the same village) took me to her home as my daughter-in-law had gone for a pilgrimage. I said I need to see *Pir sahib* so he can open the Book. I requested *Pir Sahib* to open the Book and tell me what happened. He said, I had a small blue hand hit me and gave me an amulet to cure]

I asked why do you think this happened to you and she replied,

> *" Jaadoo bhi hota hey. Kisi ko koi changa nain tak sakda"*
>
> [Well... Magic exists, Nobody can see (tolerate) someone happy and prosperous]

6.2.9 Illness – Effect of 'Blue Hand'

Blue colour symbolically in Islam, represent 'evil doers'. In verse 20:102 of the Quran, the word '*zurq*' plural of '*azraq*' (blue) is used metaphorically for evil doers whose eyes are glazed with fear, as if the sclera if filmed over with a bluish tint[283]. A charm of hand called *'hamsa'*[284] with an eye in its middle is used in Middle East (Fatima's hand in the Muslim world and Mary's hand in Jewish world) to ward off an evil eye. Here the blue hand describes an evil spell casted by someone.

A married woman who is exceptionally good looking, said she had a spell cast on her by her aunt for not marrying her son,

> *"shuruh mein meray miaan mujh sey bohat piyaar kartey they; meri phupi ney kuch kiya hua hey, har waqt poochti thi yeh kya khaati hey? Kya lagati hey? ; (miaan) ab ziaada baat nahin kartey. Mein theek nahin rehti, jism mein dard hey, bohat pareshaan hun; jab tabeeat kharab ho to bachey bhi achey nahin lagte; bhala kisi maan ko apne bachey bhi achey nahin lagte? Nahin to, mein to kuch kha kar mar hi jaun"*
>
> [initially my husband loved me very much; my paternal aunt has done something, she always used to ask about me what do I eat, what do I apply to my skin?; now my husband does not talk much. I do not feel well, my body aches, am very worried; when am not feeling well, I do not even like my children around; is it possible that a mother does not like her own children? Nonetheless, I wish I can eat something and die]

Witchcraft is considered real in Islamic traditions e.g. in the Holy Quran the story of magic in Babylon is narrated:

> *"but the Shayaateen (devils) disbelieved, teaching men magic and such things that came down at Babylon to the two angels, Haaroot and Maaroot, but neither of these two (angels) taught anyone (such things) till they had said, "We are for trial, so disbelieve not (by learning this*

[283] http:en.wikipediaorg/wiki/Blue accessed on 05-05-2009
[284] Dundes Alan.1992.The Evil Eye: A Case Book. London: The University of Wisconsin Press.

magic from us)." And from these (angels) people learn that by which they cause separation between man and his wife, but they could not thus harm anyone except by Allah's Leave. And they learn that which harms them and profits them not" [*Al Quran* 2:102]

Other verses having prayers asking for protection from witchcraft are from Quranic chapters of *Al-Falaq* and *Al-Nas*. One specific verse requests Divine protection from women, who practice withchcraft,

"And from the evil of those who practise witchcraft when they blow in the knots"(Al Quran 113:4)

Pir sahib, usually advises women to recite *Soorat al-Faatihah* (chapter one), *Aayat al-Kursiy (Al Quran 2:255)* and reciting some prayers, such as:

"O Allah, Lord of mankind, remove the evil and grant healing, for You are the Healer. There is no healing except Your healing, which does not leave any sickness."

These recitations are also prescribed in the Islamic literature[285].

6.3 The Common Female Illnesses

Reproductive ill-health includes conditions related to pregnancy, end of pregnancy and puerperium, including ectopic pregnancy, spontaneous abortion, discomforts of pregnancy, pregnancy induced hypertension, exacerbation of pre-existing conditions, anaemia, urinary tract infections, antepartum haemorrhage, infection, post partm infection, depression, eclampsia and obstructed labour. It also includes cumulative impact of reproductive experience, including malnutrition, anaemia, other deficiencies, STDs, pelvic infection, fistulae, relapse, sequelae of female circumcision, low back pain, chronic illness, psychological ill-health.

Reproductive Health – translated as *'tawleed-i-sehat'* by Government's Population Welfare department does not exist in local language and though this term accommodates

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[285] Shaykh al- Mutanawwi'ah li Samaahat al Majmoo'Fataawa wa MaqalaatVol. 144, p.8

both male and female conditions and needs, the term used in Jaffer is '*zanana bimaariyaan*' or female diseases. An equal term '*mardana Bimaariyaan*' or male diseases does not exist, however, these are addressed in the broad term of '*jinsee bimaariyan*' or sexual diseases.

It is a paradox thus, that female conditions are not felt as '*jinsi bimaariyaan*', or is it a notion to convey that women are not sexual beings and just men have sexuality and problems associated with it. Conditions / diseases relating to female gynecological problems are commonly therefore, referred to as *"zanaana Bimaariyan"* or "female illnesses". The word '*zanana*' is derived from Persian for a feminine attribute. '*Zan*' is a woman. It is commonly used in all local languages including Urdu, Punjabi and Pushto. Female reproductive organs are also commonly referred to as "*zanana*".

Table 27: The Common *"Zanaana Bimaariyan"* (Female Conditions and Illnesses) and Local Terminology

Name of the Condition	Vernacular Name or Local Terminology
Menstruation	*'kapray aana'; 'mahwaari aana'*
Pregnancy	*'Haml' ; 'maheenay char gaye hein'; 'pait mein bacha hay'; 'shak hay'; 'kapray ruk gaye hein'; 'ghalat hona'*
Miscarriage	*'Nuqsaan hona'; 'khoon shurooh hona'; 'khoon aana'*
Abortion	*'Zaiya karwana'; 'silaai phirwana'*
Leuecorrhoea	*'Pani parna'*
Vaginal Discharge	*'Ganda pani parna'*
Pelvic Pain	*'Chotay pait mein dard hona; 'naloun mein dard hona'*
Uterine prolapsed	*'Jaan bahir nikli hona'*
Infertility	*'bachay na hona'*
Tipping of the uterus	*'naaf girna'*
Acne	*'Danay'*
Freckles	*'Chaayiaan'*

The details of each illness as experienced by the local women are narrated in the following sections.

6.3.1 Menstruation Problems

Either the menstrual flow is less or excessive or irregular. Unmarried girls usually seek care for dysmennorhoea, irregularity of periods, because they are worried that it may cause problem when the girl is married or her body will bloat or she won't have children. Usually mothers or sisters come to take medicine from the Lady Health Visitor. If she asks them to bring the girl, they are scared that people will make rumours.

"log batain banain gey key bachi ko kia masla hey jo hasptal ley gaiyey"
[people will gossip that the girl has a problem, so they have taken her to the hospital]

Scanty menses are not a problem in her view and she would only ask them to take something *'garam'* (hot).

6.3.2. Vaginal Discharge

Women usually complain of *"pani parta hey"* (watery discharge) or *" pani buhat parta hai"* (profuse watery discharge). An unmarried girl said

"mujhey pani itna parta hey key namaaz key liye shalwar badalni parti hey"
[I get so much water dribbling that I have to change shalwar (trousers) for prayers]

Vaginal discharge, if not blood stained, does not cause *'paleeti'* or ritual impurity according to the religious teachnings; however, many women feel it is dirty and makes one's dress impure for saying prayers.

Some complain of *"naloon main dard"* (groin pain) or backache or pain in lower abdomen. Most complain of whitish discharge for which the Lady Health Visitor prescribes the anti-fungal vaginal pessaries but she says the women never come back so she can see whether they are cured. She also prescribes anti-biotics and some times does a vaginal examination.

6.3.3. Periods are Over Due

Whenever, a married woman misses her periods, she is concerned especially, if she does not want any more children. The Lady Health Visitor thinks that this is one thing about which the women are really bothered. However, for other health problems they usually delay seeking care.

> *"din char jain to bhaag kar ati hein, paisaey bhi laey lain bus mahwari a jaiey; baqi sab cheezon kay liye sochti rahti hein"*
>
> [when days are overdue they come running to seek care, (say) take money also just (do something) so menses come; for other things they keep thinking about]

6.3.4 Abortion

Medically, abortion is the spontaneous or induced termination of pregnancy. Here the word miscarriage is used for the spontaneous termination of pregnancy while abortion is used for self-induced termination of pregnancy.

Many women get pregnant while breast feeding a child and when they are not having periods (lactational amenorrhoea). In such cases, the next pregnancy is usually not wanted and women would either go to visit their mother or call her to their place to get the required domestic help and taking care of the other children, and themselves go for an induced abortion. There are many private practitioners usually female para-medics who would help women in getting abortion induced.

Dais confirm that the harvesting season is also an abortion season. It is an opportunity for some to have their sexual affairs when everybody else is out in the fields. Some girls fall victim to sexual abuse and rape. Women talk about stories of rape (without mentioning a name) whereby a male cousin or another relative would come home at the pretext of taking food for those in the fields and rape a girl. The girls usually confides in her mother who will not tell the men in the household fearing that there would be a family feud.

Usually, the mother takes the girl to a '*dai*'. Charges for aborting an unmarried girl, range from Rs. 5,000 to Rs.10,000. This is done by inserting a sharp object in the uterus to induce bleeding. Usually a knitting needle would be used.

Households remedies like *'alsi'* (linseed)[286], *'til'* (sesame seeds)[287] and alcohol (though banned for sale in local markets under the country law) are tried by women usually with little or no effect. Insertion of any sharp object is the best option. *Dais* in old days, preferred to use a weed called *'it sit'* (horse purslane)[288]growing wild in the fields. The stem was sharpened and placed in the cervix of the uterus. The stem would swell with secretions of the body and the cervix will open and bleeding would start. Women also talk about the use of hen feathers or matchstick for the same purpose.
For married women who want to end the pregnancy, *dais*, usually use Cu-T (Intra-Uterine Contraceptive Device) insertion that induces bleeding and the abortion occurs. The charges vary from Rs. 500 to Rs.1500. The Lady Health Visitor prescribes Gynecosid (oestrogen preparation which would cause withdrawl bleeding) tablets for overdue periods, and thinks that these are effective to bring periods.

6.3.5. Infertility

It may be primary or secondary. If some time passes after the birth of one child, then the women get worried. Infertility is generally considered a serious affliction and the one for which the greatest expenditure is incurred on its treatment.

6.3.6. Pregnancy Care

A pregnant woman usually visits the Basic Health Unit with one of a lady from her *'mohallah'* (neighbourhood) or with her mother-in-law. A woman usually requests that the advice about good nutrition is written down for her husband to read. The trend for

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[286]Botanical name: Linum Usitatissimum Linn. Seeds are considered aphrodisiac, hot and dry and relax the tissue.
[287] Botanical name: Sesamum Indicum. Used as treatment for amenorrhoea or dysmenorrhoea also.
[288] Botanical name: Trianthema Monogyna Linn. / Portula Castrum Linn.

coming to ante-natal care is very low. The women usually come for Tetanus Toxoid injection, or if they had witnessed a problem during earlier pregnancy e.g. miscarriage etc.

6.3.7 Delivery/Child Birth

Deliveries mostly occur at home in the hands of a local '*dai*'. Some prefer to deliver with *dai*s in Fateh Jang or at a private hospital in Fateh Jang or Taxila. Most complications of child birth are irregular labour pains or false pains for which treatment from a '*dai*' or local health facility is sought.

6.3.8 Menopause-Related Complaints

Women usually report starting the menopause in the age of 45 to 50 years. The lady health Visitor confirms that the women usually visit the BHU asking for some medicine to restore periods, saying:

> "*dawai dey 'dai'n key mahwari aa jayey, abhi to umer bhi itni nahin hei*".
> [give a medicne so menses will occur, I am not that old right now]

Other complaints in the menopausal age are body pains, blood pressure, knee pain or joint pains. Utero-vaginal prolapse cases are common. Menopausal women being older in age can come alone to the facility. They may be accompanied by a sick grandchild if the mother is unable to come or has an important chore at home.

6.3.9 Family Planning

Women usually come for family planning advice at the health facility after having 4-5 children. Recently, some even come after the first child for birth spacing. Injections are more popular in the village followed by Copper-T and female sterilization procedures.

Husbands are usually working outside the village so women are accompanied by a mother-in-law or sister-in-law or mother. Some women adopt a family planning method in secret from their husbands or mother-in-laws.

6.3.10 Breast Problems

Common problems of lactating mothers are sore nipples or redness or inflammation of the breasts. They usually breastfeed for 2 years but leave when pregnant again thinking that "*doodh ganda ho giya hey*" (milk has gone bad). The young un-married girls seek advice about small breast size through their mothers or sisters. This happens when a girl's marriage ceremony is approaching and the bride-to-be is anxious about her looks and the judgemental looks of the wedding guests and in-laws.

6.3.11. Face Freckles or Acne

Young adolescent girls have the problem of facial acne or pimples and would send their elder sister to ask for medicine from the health facility.

6.3.12. Navel Falling Down (*Naaf Girna)*

'*Naaf*" has the literal meaning of 'belly button' or 'navel'. Girls are considered to have a *'naaf'*, which has to be in the right place. It acts like a centre of gravity of the whole body. *'Naaf girna'* implies that it has moved from its original position and needs re-adjustment. Post-pubertal girls and women complain of this problem whereby it is believed that uterus and internal female organs have got displaced and cause leg pains, irregular periods, lower abdominal pain, heaviness in groins and a feeling of weight in the lower half of the body. There may also be loss of appetite or weight, general weakness and abdominal pain. Lifting heavy objects, walking a long distance or even wearing high heels, are thought to cause this problem.

The different remedial actions tried by the village women are massage by *'dai'* to re-adjust the *'naaf'* and a procedure called *'tangaan jhaarnan'* (shaking the legs). The ones using it said they have learnt it from Pathhan women with whom they had interacted. In this procedure, one strong woman stands up on the wooden cot. The woman suffering from a fall of the *'naaf'* lies down on the floor just beside the cot. She pulls herself close to the cot and raises her legs up in the air which the standing lady holds and pulls further up. This procedure is completed by pulling her legs further up so that only her shoulders and head touch the floor and the whole abdomen, pelvis and legs are above the ground. The woman holding the legs then shakes them vigorously so that the mis-placed *'naaf'* falls back in its place.

'Naaf girna' is similar to a terminology in English called 'tipping of the uterus' which usually refers to retro-version of the uterus[289]. An extroverted uterus (tilted uterus, tipped uterus) is tilted backwards instead of forward. This is in contrast to the slightly "ante-verted" uterus that most women have, which is tipped forwards towards the bladder, with the anterior end slightly concave. The symptoms of retroverted uterus include pain and backache during sexual intercourse (dyspareunia), pain during menstruation, minor incontinence, urinary tract infection and fertility problems. A tipped uterus can be repositioned by "knee-chest" an exercise that involves lying down with two or three cushions or pillows under one's bottom so that this end is higher that the woman's head. The knees are bent and are held in clasped hands and brought forwards to touch the chest. The movements are repeated 10-15 times to feel improvement. This treatment is however, not known to the village women in Jaffer.

6.4 Medical Institutions for Female Illnesses

The village has a pluralistic medical environment, including folk practitioners i.e. *'dai'/siani* (traditional birth attendant), *pir sahib* and saints at the shrines; and the qualified practitioners, i.e. hakeems, homeopaths, lady health workers, lady health visitors, nurses and doctors.

[289] http:www.americanpregnancy.org/womenshealth/tippeduterus.html accessed on 01-05-2009

6.4.1 Traditional Birth Attendants or *'Dais'*

A *'dai'* is defined as a person who assists the mother during childbirth and initially acquired her skills by delivering babies herself or through apprenticeship to other *'dais'*. She is usually self-employed and negotiates her own compensation with her clients. A trained '*dai*' is one who has received a short course of training through the modern health care sector to upgrade her skills. The term '*dai*' in this study, refers to all non-professional birth attendants whether trained or un-trained.

There are four '*dais*' in the village, two practising actively; one is sick and the other one who has left the job on insistence of her sons who think that her work is degrading for the family. Apart from these four, the *'dai'* working in the BHU also practices deliveries and related procedures but being an inhabitant of another village, using her is not a very easy option for the women of village Jaffer; especially so after the duty hours. The entire lot of village *'dais'* are from the *'kammi'* families (village professionals).

Dais have simple remedies which are effective like soaking cotton wool in warm ghee and putting in the vagina to cure false pains. They do not like the attitude of people at the local health facility,

"woh hamein achi izzat nahin detay"

[they do not give us good respect]

'*Dai*' 'A'

One particular *'dai'* was trained in a hospital in Rawalpindi under a government training programme for *'dais'*. She was lucky to get this chance by virtue of her sister-in-law who was a nurse in that hospital. She is not practicing now, but had a busy professional life in the village. In her personal life, she is blessed with an unusually loving husband and proudly states that he himself makes morning tea for her without sugar and says, "*I shall serve you myself now that you are sick with blood pressure and diabetes. We should not be dependent upon our daughter-in-laws; they are free to get up when they want and cook when they want*".

None of her daughters or daughters-in-law has adopted her profession. Her sons are working as gardeners in Rawapindi and Islamabd and come home on weekends. She enjoys her extended family of grand children. She has a very pleasant sense of humour. She introduced her youngest daughter-in-law to me laughingly, "*she is the youngest of all and fattest of all. Her husband is also very fat*".

'*Dai*' 'B'

This '*dai*' was widowed when her two daughers were very young. To make her ends meet she started the work of providing massage to the pregnant and post-partum women and then slowly learnt doing deliveries by herself.

After seven years of living with with her parents as a widow, she re-married and became second wife of an already married man. Her co-wife started living separately with her three children when her husband re-married.

The second marriage has given her the status of being married, and two more children: a boy and a girl; but she has been left alone to fetch for herself. She said her second husband never cares about giving sufficient money for household expenditure. She remarked,

> *"mein nein kabhi khhud nahin manga; chahay meray paas aik rupia bhi na ho, mein nein kabhi nahin manga.Sabr achi cheez hay. Kabhi kabhi afsos hota hey key meray naseeb main un ki kamai nahin"*
>
> [I do not ask myself; even if I do not have a single rupee, I do not beg. Patience is a good thing. Sometimes, I regret that his earning is not in my fate]

6.4.2 Spiritual Healers

Spiritual healing can be almost any positive supporting activity such as contemplation, prayer, meditation, the laying on of hands and counseling. Restoration is the intervention

of spirit to effect healing and can involve modern medicine and technology, and/or herbal medicine, support, laying on of hands, counseling, prayer, desire and will to heal. Spiritual healers exist in all communities. Primitive humans considered illness as a curse as they could not understand its cause and thus its cure. Sacrifices, special prayers and rituals were therefore used to please the gods and goddesses, so that the ailments were cured (Hafeez-ur-Rehman, 1996: 360).[290] Although with the passage of time, the causes of ailments were discovered by trial and error and by deductive reasoning and thus, the cures, societies still hold to the belief that health or ill health is a part of their destiny and need prayers and special measures other than medications.

Village Jaffer remains a stronghold of such beliefs. Almost all healings sought are initiated with either a *dam* (breath) or *taweez* (an amulet). This is followed by the use of modern medication or *'hikmat'* (Greek Medicine) if the illness was not cured. Visits to shrines are either customary or to seek a special cure e.g. for fertility or as a festive attendance at *'Urs'* (anniversary celebrations at shrines) and to pay homage to the revered saints.

6.4.2.1 Amulets

Amulets are writings considered with a healing/ beneficiary power. These are usually written on a small piece of paper, folded and placed within a locket worn in the neck or around the arm. Usually, a thick black thread holds the locket thus, these are referred as *'taweez dhagay'* (amulets and threads).

Two kinds of *'amliaat'* (verses of knowledge) are common: *Nuri ilm* (luminous knowledge) and *Kala ilm*: (black magic). Amulets of *Nur-i-ilm* contain the name of God (Quranic verses). Quranic verses themselves are considered efficacious as the Quran refers to itself as a healing (shifa) and mercy.

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[290] Hafeez-ur-Rehman (1996). "Saints and shrines in Pakistan: A case study of Potwar Area" Ph. D. thesis submitted to National Institute of Quaid-e-Azam University, Islamabad.

> *" mankind! There hath come to you a direction from your Lord and a healing (for the diseases), In your hearts,- and for those who believe , a Guidance and Mercy." (Al Quran 10: 57)*

There is also belief in the evil eye and the existence of demons and spirits who can have evil effect as part of superstitions. Some illnesses are attributed to be caused by black magic and their cure is sought by a '*pir*' to dispel it. Black magic is used by superstitious women to avenge their enemies by harming them.

'Pir Sahib' is the main provider of the *nuri-ilm* amulets and *dam* (breath) in the village . He is an educated retired man who is the caretaker of the local mosque after the death of his elder brother. The whole village respects him as he never seems to harm anyone and is equally compassionate to all, wealthy and the poor alike. There are other sources of amulets and *dam* as well.

6.4.2.2 Breath (*Dam*)

Doing *'dam'* is a common action done by saints and Pir Sahib. This is a quite a common practice at shrines. As Hafeez-ur-Rehman (1996)[291] states, it is

> *"Is the simplest and most frequently used technique whereby the saint simply utters a verse of the Quran quickly and inaudibly, and then blow on the patient. If a specific part of the body is the source of trouble, the breath is focused on that area. Otherwise, he will blow on the patients bowed head or sweep from the top of the head down to the floor. In this act, the baraka of God, channeled through the saint is transferred to the patient in the breath. A slightly more elaborate version of this technique is called dam pani (literally breath-water). Here the Pir utters a Quranic verse and blows on a vial of water instead of blowing on the patient. He then gives precise instructions on when and how this water is to be used. The blessing is transferred to the water and can thus be taken home for even a third party."*(ibid: 369)

[291] Hafeez-ur-Rehman (1996). "Saints and shrines in Pakistan: A case study of Potwar Area" Ph. D. thesis submitted to National Institute of Quaid-e-Azam University, Islamabad.

6.4.3 Shrines *(Mazaar)*

There is a mandatory shrine visit of the young couple to a shrine of family choice after marriage. Women also turn to shrines when the prescriptions from different traditional healers and modern medical men, do not cure them or their children. Mentally retarded children, psychological illnesses taken as *'saya'* and infertility or desire of a son, are the major reasons to visit the shrines. They would pray there and pledge a *'daig'*(pot of cooked food) or *'chader'*(floral/cloth sheet) if their wish is fulfilled. Visits to the shrines are a norm in the wake of inadequate medical services, patriarchal traditions suffocating women and causing psychological frustrations. Traditionally, reticent and patient women can open their heart in front of a saint or at a tomb and can talk to the dead holy man seeking his help to take her prayers to Allah. While women seldom travel outside the village, this is one of the openings available to them and also to the younger ones.
In the matter of choosing Pirs and shrines women take decisions for themselves and their children according to their own perceptions and needs and daughters usually take after their mothers or mother-in-laws choice. Lighting candles at graves is also common. There is a shrine in the old graveyard that cures tooth ache. The other one is of Pir /Baba Jaffer.

6.4.4 Lady Health Visitor (LHV) at the Basic Health Unit

The present LHV had joined two months back, in 2005. She qualified as an LHV in 1985 and lives in Fateh Jang. Her husband works in the POF Wah Cantt. She has a ten year old son and a five year old daughter. She has to commute dailly from Fateh Jang. The living quarter in the health facility premises is occupied by the male chowkidar.
She is of the view that families are reluctant to take women to a referral hospital even if she recommends so, in cases of a complication. The family women insist that she give them something "now" and they can take her to the hospital tomorrow or that their own village *'dai'* can manage this problem. She quoted an example, where the woman has an over-sized baby and she recommended the family to take her to the hospital in case a Caesarian-section is required. A *'dai'* whom the woman's sister-in-law trusted took the risk and delivered the baby at home. She said, "*After such cases the village women*

badmouth us and prove that the dais who take risks are more professional and others are just making the families scared".

There is unnecessary curiosity about the matters of others. Women in the waiting area, would ask the LHV about others before her. The questions would be *"what has she come for, what medicine have you given to her?"* The LHV tries to be evasive and changes the topic of discussion.

The LHV thinks that village people really respect her, as she comments,

> " *Bari izzat datain hain, chai kay baghair uthnain nahin daitay*"
> [They give us a lot of respect, do not let us leave(their home) without having tea]

She did not like the people in her previous duty station as she remarked,

> *"their attitude was not good, they did not respect and always argued about having medicine of their own choice."*

6.4.5 Lady Health Workers (LHWs)

There are two LHWs in the area. One for the village population and another one for hamlets. The LHW is a contract employee of National Programme for Family Planning and Primary Health Care. A LHW is usually a tenth grade qualified local woman employed to serve around 1000 to 1500 people of a village. She spares one room in her household as a 'Health House' and receives contraceptives and medicines for common ailments. She has condoms and birth control pills for family planning. She discusses the possibility of injections and operations and refers women to the LHV in the BHU or Family Welfare Centre in Gali Jageer. She organizes vaccination campaigns, does growth monitoring and records vital statistics of her catchments population. She is involved with referral for TT injections, antenatal care, postnatal care, and specifically during the pregnancy she advises women with regard to food and the need to rest.She also informs women about the benefits of child spacing. Once a month, she visits each household. She

also has a monthly meeting with her supervisor called the 'Lady Health Supervisor" who takes care of about twenty LHWs.

Another part of her work is to organize a meeting once a month with the members of the Village Health Committee, where she addresses them on topics of nutrition, garbage disposal, and reproductive health care. Among the ladies interviewed, only a few mentioned seeking advice from LHWs in the context of Tetanus Toxoid injections, referring one for a pregnancy test etc. A village woman said that the LHWs only visit them for administering polio drops.

6.4.6 *Hakeem*

The *Hakeem* is a practitioner who practices *hikmat* or *Unani Tibb* (Greek Medicine). *Unani*, as a system of medicine, originated in Greece. It was Bukrath (Hippocrates), 460-377 BC, who freed medicine from the realm of superstition and magic, and gave it the status of science. After him, many scholars enriched the system of whom Jalinoos (Galen) 131-210 A.D., Al-Razi (Rhazes) 850-925 A.D. and Abu Ali Ibn Sina (Avicenna) 980-1037 A.D. are noteworthy.

This system has a long and impressive record in India. It was introduced in India around 10th century A.D with the spread of Islamic civilization. The best known author of Unani texts is Ibn-e- Sina, known in Europe as Avicenna (980-1037). In the Indian subcontinent, Unani medical books were often in Persian, because it shares much vocabulary with Urdu, widely spoken by the Muslim population.

The Unani system is a science dealing with preventive and promotive aspects of human health by addressing problems caused by environmental factors, which may vitiate primary body fluids or humours (as described by Hippocrates). These '*akhlaat*' (humours) are the primary fluids circulating in body vessels i.e. blood, phlegm, yellow bile and black bile. The secondary fluids are hormones, enzymes and plasma etc. The *Unani Tibb* treats a patient by bringing back the balance in im-balanced humours. The humoural balance depends upon six essential environmental factors called the '*asbab-e-sitt-e-zarooriya*' (the six essentials) namely *hawa-i-muhit* (atmospheric air), *makul-o-*

mashrub (food and drink), *harkat-vo-sakun badni* (physical movement and rest), *harkat-vo-sakun al- Nafsani* (mental movement and rest), *naum-o-yaqzah* (sleep and wakefulness) and *istifragh-vo-ihtibas* (evacuation and retention).

The reproductive health of females in covered under the ambit of '*Amraz Niswan-vo-Qabala*' (Gynecology and Obstetrics) with other specialties of '*kulliyat*' (fundamentals), '*ilmul-advia*' (phramocology), '*moalijat*' (medicine), '*hifzaan-e-sehat*' (health and hygiene), '*manfeul aza*' (physiology) and '*jarahiyat*' (surgery). The disease is diagnosed through pulse reading, naked examination of urine and stool and conventional methods of auscultation, palpation and percussion.

Unani medicine is widely considered as Muslim medicine, that benefited from Greek medicine (Galen), Auyrveda (Indian medicine) and Persian medicine improved by Avicenna and further strengthened by Muslim hakeems in India. The other reason for its popularity is the use of drugs from herbal, mineral and animal '*halal*' (allowed) origin that are considered non-toxic or without side-effects as compared to allopathic or modern medicine.

The concept of hot and cold is derived from its origin in 4 *arkan* (elements) and their *mizaaj* (temperament properties): air (hot and moist: *garam, tar*), fire (hot and dry: *garam, khushak*), earth(cold and dry: *thanda, khushak*) and water (cold and moist: *thanda, tar*). All the six essential elements including food and drinks and the medicines can also have the above basic element properties in different combinations. The hot food/drug increases the body temperature by stimulating the thermostat (centre of hypothalamus in brain), by increasing the Basic metabolic rate (BMR) and by releasing various hormones. Conversely, the cold food/drug lowers the body temperature, depresses hypothalamus, decreases Basal Metabolic Rate and suppresses release of certain hormones.

Photograph 3: An advertisement of a hakeem at a local bus stop claiming cure of diabetes, piles, male impotence, itching, premature ejaculation, wet dreams, joint pains, dermatitis, infertility, blood pressure and leucchorea.

There is no hakeem resident in the village Jaffer though all elders have acquired some experience of Greek medicine or *Unani Tibb*. Mostly visited hakeems are in Fateh Jang and the nearby town of Jand.

In this chapter we have applied Kleinman's semantic approach to illness and explored the village construction of the female sick role. Religious obligations, beliefs about magic, spirits and curses, and their relationship to bodily processes have been reviewed. The mapping of existing reproductive health services and traditional and modern medical providers has been provided. In the next three chapters, common reproductive health illnesses and subjective experiences of the village women are presented to illustrate the relevant decision-making processes.

CHAPTER 7

MENSTRUATION, SEXUALITY AND MENOPAUSE

Womanhood is marked by the beginning of menstruation. A woman's fertile period of average 29 years (between 15-49 years of age) has potentially 348 monthly cycles of menstrual bleeding unless interrupted by periods of pregnancy or amenorrhoea due to breastfeeding. These cycles can be aberrant and lead to illness. Most of the gynecological complaints are related to menstrual problems. Fortunately issues of illness related to menstruation are given the due recognition by both the women and the health practitioners. On the other hand, sexual health is often an ignored area. Issues of female sexuality are mostly shrouded in ignorance, misconceptions and shame and thus seldom discussed with healers. Old age is marked by cessation of monthly menstrual cycles often termed as menopause and poses a different set of health challenges.

This chapter explores the local meanings of menstruation, sexuality and menopause and describes relevant reproductive health problems. The indigenous methods employed for healing and healer preferences for each type of illness are discussed. The examples from every day lives of the women and individual narratives are included to provide an insight into the cultural contexts of decision-making.

7.1 Menstruation

Menstruation marks the beginning and end of the female reproductive potential.

> *"Menstruation is a function peculiar to women and the higher apes. It may be defined as a 'periodic and cyclical shedding of progestational endometrium accompanied by loss of blood'. It takes place at approximately 28 days intervals between the menarche (onset of*

menstruation) and the menopause (cessation of menstruation)." (Jeffcoate: 72)[292]

In Islam, menstruation is called *'haidh'*- meaning running. It is a stage of *'nifas'* (impurity)where one is not *'paak'* (pure), can not say prayers, can not touch the Holy Quran and fasting is to be deferred.

Menstruation is a universal biological process: every female will menstruate for some portion of her life. It is not confined to bodies or biology; menses is also linked to women's reproductive health, material culture and the political economy through the feminine hygiene industry, as well as culture and social structure.

7.2 Adolescence and Puberty

"Adolescence (Latin : adolescence =to grow) is the period of life during which the carefree child becomes the responsible adult.(ibid: 80)

Puberty (Latin: pubertas = adulthood) is the state of becoming functionally capable of procreation. Puberty is characterized by physical sexual differentiation and by the onset of activity of the sex organs. It is really the first part of adolescence, the remainder being concerned with the mental and emotional adaptation to sexual functioning and with the development of full maturity. The *menarche* (Greek: month + origin) is the onset of menstruation and is merely one manifestation of puberty."

"During puberty and adolescence the psychological changes are profound. The happy go lucky tom boy changes into a self conscious girl who is interested in her appearance, may be moody and secretive, and is often imaginative and curious. She begins to feel that she is grown up, finds it more difficult to obey orders, and looks for independence. Her confidante' becomes another girl than her mother. The sex urge becomes manifest and is often homosexual at first being evidenced by an unreasonable 'passion' for a particular older girl or woman. This phase is usually followed, sooner or later, by heterosexual impulses and activities."(ibid: 81)

[292] Jeffcoate, Sir Norman. 1987. Principles of Gynaecology. Tindall V.R.(ed) 5th edition. Frome and London: Butler and Taylor Ltd.

7.3 Menarche

First menstruation in a girl marks her transition from childhood. This is a time of great anxiety for a young girl especially, if she does not know that all girls have this bleeding. Many a times, the class mates and friends happen to provide the first information. A woman recalled,

> *"Skool mein huey, bilkul hi pata nahin tha, saheli ney apni shameez phaar kar kapra bana kar diya; bohat din roti rahi, ghar par kisi ko bhi nahin batiya bohat din".*
>
> [I started my first periods while in school, I was totally ignorant about that, my friend tore a piece from her slip to make a cloth (pad) for me; I kept crying for many days, did not tell any one at home for many days.]

And another instance, quoted by a woman who had her first periods during a '*dars*' (Quranic lesson).

> *" pehlay pata nahin tha, ro ro kar bey haal ho gaiyee; bari sahelian jo saath Quran parhti thein, unhoon ney kaha, yeh zanana hota hey, ghar jao aur kapra rakho"*
>
> [I did not know about it earlier; I cried and cried; my friends reading Quran with me who were older in age told me: this is '*zanana*' (womanhood), go home and keep a cloth]

Another woman recollected the day of her first periods and said,

> *" peeshaab kiya to daagh laga hua tha, ro pari maan kay samnaay, I ander ley gai aur kapra bana kar diya aur kaha, khabardar jo kisi ko pata chala"*
>
> *[I went to urinate and noticed a stain; I just could not hold my tears in front of my mother; she took me inside, made me a cloth (pad) and warned me against letting any one know about this.]*

Another girl said that her mother had advised,

> *" kisi ko pata na chalay, apnay kapray saaf rakhna"*

[Do not let any one know about it, keep your clothes clean (unstained)]

With a strong advice to keep one's menstruation a closely guarded secret, there is a clear message to the girl to keep all reproductive health issues confidential and strictly in the female domain.

7.3.1 Age of Menarche

The age of menarche is 12-13 years presently while the older generation had it on average a year later i.e. at the age of 13-14 years.

The LHV in the health facility said,

"Taqreeban baara saal ki bachi ko mahwaari aa jaati hey, aurateen kabhi aati hein keh dawa day dein, ruk jayein, bachi abhi choti hay, panchween parh rahi hay"

[About twelve or thirteen year old girl get the periods, women sometimes come that give some medicine, so they stop; the girl is (too) young, studying in the fifth grade]

Mothers realize that the burden of menstruation is too much on a young girl and hence wonder if there was any thing to delay the inevitable. High nutritious value food as eggs, meat, milk and butter is avoided for girls as this food is considered *'garam'* (hot) and thought to induce early menarche.

Girls themselves resent the initiation of menstruation as their carefree childhood days abruptly end; she is not allowed to play in the street as before and expected to suddenly show signs of emotional maturity with this one sign of physical maturity. She is expected to cover her self at all times especially in front of the male family members including father and brothers. A *'chader'* is to be worn when going out. One repeated advice a girl listens from her mother is

" apnay aap ko sambhalna seekho"

[learn how to carry yourself, appropriately]

The word '*sambhaalna*' has a combined connotation of 'carrying yourself properly', 'holding with care', ' balancing', 'taking precaution', 'keeping safe' and 'keeping a trust'. She is supposed to be cautious in her looks and speech, making sure that she keeps her voice and gaze low while interacting with others, especially the elders. Her clothes should be covering her full body except face, the hands and the feet. She should be wrapped properly, no part of clothing should hang loosely or is dragged on the floor. Her menstrual blood flow needs to be managed properly so she does not reveal her status by blood stains. She is repeatedly reminded to be patient and exhibit stoicism. Matters pertaining to her body and health, are now closely guarded secrets. Giggling, laughing aloud and affectionate hugging of her father and brothers is immediately discontinued. Islamic teachings direct the father, only to display his affection for his daughter by putting a hand on her head. Now her family's '*izzat*' (honour) reside in her body and her chastity needs to be guarded. Her virginity is precious and the whole village now keeps a watch on her.

7.3.2 Menstrual Taboos and a Girl's Confidantes'

The knowledge obtained from experienced others forms the basis of attitudes formed about menstruation and menstrual taboos are passed on from one generation to the other. There is no specific pattern of preference about the others whose advice is sought by the girls in these matters. They can be friends, cousins, mother, grandmother and aunts depending upon the presence of the other experienced female person at the time and the level of girl's intimacy with her.

A woman in her early forties remembers:

> *"Mujhey tera chauda saal ki umer mein kapray huey. Saal pehlay meri saheli ko huey they tab usney batiya tha. Jab mujhey huey to kapray geelay lage. Meri khaala nay kapra rakhna bataiya tha. Kehnay lageen, kisi ko pat na chaley, kaprey ko dhona batiya. Nahaaney ka tareeqa bhi bataiya. Kehnay lageen paani mein hath nahin marna aur thandi cheez nahin khani."*

[I got my menses at the age of 13 or 14, my friend started a year earlier so she had told me. When, I had them for first time I felt my clothes to be wet. My maternal aunt told me how to keep a cloth. She said, no one should know and told me how to wash the cloth and purify myself with a bath after the menses. She said, do not wet your hands in water and do not eat any thing 'cold'.]

Another girl recalls her experience,

"Mein samjhi dana hey jis sey khoon nikel aya hey; roti rahi; Cousin say poocha tha; larkiuon key saath yeh masla hota hey; neechay nahin bethnaan, nahana nahin, wuzu nahin karna, thanda pani nahin peena. Thandi taseer wali cheezain nahin khani jasey chai, doodh."

[I thought I have ruptured a boil which has bled; asked my cousin, she said this problem occurs to girls; do not sit on the floor, do not bathe, do not wash yoursel (genitals) with water, do not drink cold water; do not eat any thing with cool effect e.g. tea or milk.]

Experienced friends at school or in the neighborhood, also brief the novices,

" meri saheli ney batiya, usay bhi tabhi huey thay"

[my friend told me, she also got them during that time]

Mothers and grandmothers also provide the initial guide especially, if the girl has no elder sister or cousin available at the time of the first periods.

One of the girl raised as an orphan by her grandmother said,

" mein ney daadi ko batiya to unhoon ney kapra rakhna bataiya; lassi dahi nahin khaana,paani se wuzu nahin karna"

[I told my grandmother and she taught me how to use a cloth; asked me to abstain from *lassi* and yogurt and not to wash myself with water.]

During the periods, the physical contact with *'thandi'* (cold) things is to be avoided including water and any cold surface for sitting. A girl told that her mother had

particularly told her not to eat any cold food e.g. yogurt, yogurt drink, water melon etc. She was advised not to take a bath. Her mother will not let her take a bath even in very hot weather saying,

> *" nahaney say dard shurroh ho jaata hay; parhaiz karein aur apni jaan sambhaal lein to theek rehta hey."*
>
> [Bath will start pain; if one takes prevention and takes care of oneself, then one can be alright.]

The other necessary advice from the elder women, is about the '*ghusal*' (ritual bath) required for purity after the menses.

> *"Ammi ney wuzu ka tareeqa bataiya"*
> [Mother told me the way to purify myself after the menses]

A woman is exempted from saying prayers during menses with no obligation to say '*qada*' (saying the prayers left, afterwards). She does not fast during the holy month of Ramadan but has to complete the fasting days, later on.

The village women use old rags as sanitary pads. A piece of about a half meter cotton cloth is taken and tucked in the belt of the '*shalwar*' (trousers) in front and the back usually without use of underwear. These rags are commonly called '*kapra*' (cloth) or *'taaki'* (rag). Women wash the used ones; dry them in an isolated corner (which may not be getting enough sunlight). The normal clothes line in the '*sehan*' (compound) to hang the washed clothes, are not used for drying these rags. This '*kapra*'(cloth) needs similar '*purdah*' (veil) as her private parts. If a woman can afford to get rid of the old '*kapra*' or is too sick to wash these, she also burns to dispose off them. This '*kapra*' is too '*paleet*' (polluted) to be touched by anyone else. The *'dai'* is the only other person who would help the woman by washing her stained clothes etc. after delivery and during postpartum period.

Women are not aware that drying in the sun or ironing the washed rags can sterilize the used ones for reuse. Thus vaginal infections are common due to insufficient hygiene

practices during the menstruation i.e. not washing the genitals, not bathing and use of possibly infected rags.

7.3.3 Significance of Menarche in a Woman's Life

Menstruation is an affirmation of adulthood, femininity and fertility for the women in the village. Girls are told,

"Bari ho gayee ho"
[you have grown up]

The village women also refer to it as '*zanana*' (the feminine). The occasion is neither celebrated nor mourned but definitely invokes feelings of concern and anxiety amongst the parents. An elderly woman said,

> *"agar mahwaari ho jaye to samjhein larki jawaan ho gayee. Log kehtay hein shaadi na ki to gunaah ho ga. Aqalmand jaldi apni beti ki shaadi kar detay hein."*
>
> [If a girl gets menses, it is understood that she has grown up. People say if you do not wed her off, it will be a sin. Wise people marry their daughter at the earliest]

A similar expression of sentiments by a father is quoted here who was extremely worried until his daughter got married. He had said to his wife,

> *" jawan beti ki shaadi nahin ki, meri namazon ka koi faida nahin, meray sajday bhi zameen ko takren marna hein"*
>
> [(We) have not married our grown-up daughter yet; there is no advantage of my prayers and my prostrations are equivalent to hitting my head on the ground in vain (Allah will not accept them)]

Delayed menarche is a cause of great concern for all as until the menses occur, a girl's future fertility remains doubtful. Scanty blood flow during the menses is considered one of the possible causes of infertility.

7.4 Painful Menstruation (Dysmenorrhoea)

According to Jeffcoate (1987)[293],

> *"Dysmenorrhoea means painful menstruation"*(ibid : 532)

Women in the village, have learned to use different concoctions to cure the pain of the menses. *'Ajwain'* (seeds of Bishop's weed)[294] and green tea are mostly used to ease the menses pain. A grandmother said,

> *"ajwain ki chutki sabz qahwey mein daalkar piyeen to theek rehtay hein. Lassi na piyeen*
>
> [A pinch of *ajwain* in green tea if taken, one keeps well. Do not drink yogurt water.]

Girls suffering from dysmenorrhoea, also take another recipe,

> *"larkiaan qawa bana kar peeti hein; sawa qahwa, moti laichi, choti ilaichi , daar cheeni aur cheeni dalkar"*
>
> [Girls make and drink green tea with big and small cardamom, *dar chini* (cinnamon)[295] and sugar]

The *'dais'* prescribe local remedies similar to those used for other painful illnesses. As a mother of two daughters, said:

> *" 'dai' to dam hi ka batati hey, eent ki takor ya cheeni daal kar angarey lay lena"*
>
> [The 'dai' only tells about getting a *dam*, fomentation with a warm brick or putting sugar on burning coals to get fumes]

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[293] Jeffcoate, Sir Norman. (1987). Principles of Gynaecology. Tindall V.R.(ed) 5th edition. Frome and London: Butler and Taylor Ltd.

[294] Botanical name: Trachyspermum Copticum. Commonly used also as anti-spasmodic, digestive and antiseptic. Seeds are like thyme or caraway.

[295] Botanical name: Cinnamomum Zeylanicum Breyn. Considered to be stimulant of uterine muscle and used also in menorrhagia and protracted labour due to deficient uterine contractions.

Hence, use of heat for fomentation is advised in line with the notion that pain is caused by 'cold' and balancing it with 'hot' fomentation will cure the pain by restoring the balance. The hot brick wrapped in a sheet and applied to the lower abdomen, eases the menstrual cramps and fomentation from the coals soothes the perineum.

The blessing sought from Quranic verses in '*dam*' (breath)

> *"Fateh Jang pansaari say bazaari booti milti hay. Taaj aur beejband koot kar shakar mila kar subha nihaar mun khain to theek ho jaata hey. Taj dandasey jesi cheez hey aur beej band mein beej hotay hein."*
>
> [The herbalist at Fateh Jang has a herb.(If one has pain) grind *Taj*(Cinnamomum bark)[296] *and Beejband*(Bala)[297], mix in brown sugar and take them early in the morning on empty stomach to get well. *Taj* is like a tree bark (used to clean teeth and colour the lips brownish red). *Beejband* has all seeds in it].

There are others who had never taken any treatment for the menstrual problem due to time constraints and feelings of embarrassment preventing them from discussing such private matters with others, as one post menopausal woman said,

> *"dard bohat hota tha, kabhi goli bhi nahin khai; sufaid paan bhi bohat para, kabhi ilaaj nain karwaya, waqt bhi nahin tha aur sharam bhi aati thi. Khud he huy (kapray) aur khud hi khatam ho gaye"*
>
> [I had a lot of pain, never took a single pill; got a lot of white discharge, never took any treatment, did not have the time and also felt shame. The menses started on their own and ended on their own.]

[296] Botanical name: Cassia Lignea. Considered to have 'hot' properties and improves menstrual flow.
[297] Botanical name: Sida Cordifolia. Seeds are considered to have 'cold' properties with anti-inflammatory action.

7.5 Scanty menstrual Bleeding

Scanty menstruation is defined by Jeffcoate (1987)[298] as:

> *"Uterine bleeding may be slight in amount, short in duration or both, but the menstrual function varies so widely, within normal limits that the definition of an abnormally scanty loss is a matter of opinion. Bleeding which lasts 2 days or less is unusual if not pathological, and is sometimes termed hypomenorrhoea".* (ibid : 510)

The village women refer to scanty menses as *'mahwari khul kar na aana'* or *'kam aana'* and consider it as a family trait. As a woman said,

> *"kam aana khandani baat bi hoti hey. Log kehtay hein keh aulad is leeye nahin ho rahi keh kapray khul kar nahin aatey lekin meri ammi ney kaha keh hum sub ko khandaan mein ka matey hein."*
>
> [To have scanty menses is hereditary. People say that I am childless because my blood flow is not open but my mother says that in our family every one gets less bleeding]

The heavy or scanty flow is regarded as a disease, as this concept is also promoted by some medical doctors. A woman remarked,

> *"kam ya ziaada hun to matlab hey bachey daani kharaab ho gai hey, tez ayeen to sojan hoti hey- dactar ney batiya hey"*
>
> [Heavy or scanty menses means a defect in the uterus, if one gets heavy bleeding, it means there is internal inflammation, the doctor told this.]

A similar view expressed by another woman is:

> *"lady dactar ney batiya keh aap key jism mein khoon kam hey, isi liye kam pata hey, koi dawa nahin dee; koi mashwara nahin diya"*

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[298] Jeffcoate, Sir Norman. (1987). Principles of Gynaecology. Tindall V.R.(ed) 5th edition. Frome and London: Butler and Taylor Ltd.

[The lady doctor told me that I have less blood in my body so I have little bleeding; (however) she did not prescribe any medicine or give any advice.]

If bleeding is scanty, diet improvement is recommended by taking juice and fruit. Young girls brief their mothers about the issues with menstruation but are too shy to tell others and request their mothers to tell no one.

7.6 Excessive Menstrual Bleeding

Excessive uterine bleeding is called 'menorrhagia' in medical terminology.

> *"Menorrhagia is cyclical bleeding at normal intervals which is excessive in amount or duration, for example 5/28 or 8/28. It is caused by conditions affecting the uterus and its vascular apparatus, rather than by any ovarian disturbance."* (Jeffcoate :512)[299]

The village women acknowledge variations in menstrual flow among individuals and relate it to Allah's will

> *"kisi ka kaam kum hey aur kisi ka ziaada. yeh to khudai amal hey"*
>
> [to get little or more is all God's action]

However, it is considered problematic when one's routine and flow gets disturbed from her normal pattern.

Fibroids uterus is a known problem in the village and related to excessive bleeding.

> *"ziaada khoon ayae to rasoli hoti hey, thora aye to jism mein khoon kam hota hey."*
>
> *[One gets heavy bleeding if there is a tumour, and get scanty menses if one is deficient in blood (anemic).]*

Women also blame contraceptives for causing heavy menses,

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[299] Jeffcoate, Sir Norman. 1987. Principles of Gynaecology. Tindall V.R.(ed) 5th edition. Frome and London: Butler and Taylor Ltd.

> *" waqfey wali cheezon sey kamar mein dard hota hey aur mahwari ziaada aati hey ya agar rasoli waghera ho"*
>
> [(birth) spacing things cause backache and heavy menses or if one has a tumour etc.]

The duration of menstruation is also important and a week-long bleeding is considered excessive.

> *"sahih hun to 3-4 din khoon aata ey, agar sahih nah hun to poorey saat din aata hey."*
>
> [If (periods) are alright then they last for 3-4 days; if not normal the bleeding lasts for a whole seven days.]

According to the *Unani Tibb*, menorrhagia is considered to be caused by mental strain, heavy work; excessive sexual activity; contraceptive use; anaemia ; pelvic illnesses; uterus displacement (*reham tal jaana*) and hormonal imbalance. Hot foods cause the illness so are cured by cold foods e.g dried coriander seeds are ground and either mixed with brown sugar or crystal sugar (*misri*) and eaten or taken mixed with water.

7.7 Watery Vaginal Discharge (Leucorrhoea)

> *Leucorrhoea means 'a running of white substance' and the term should be restricted to mean an excessive amount of the normal discharge..... Leucorrhoea is a nuisance in that it stains clothing and, if the patient fails to bathe and change frequently, causes excoriation and soreness of the vulva. But it never causes pruritis and is never offensive.* (Jeffcoate:551)[300]

In the village, it is commonly known as '*pani parna*' (watery discharge) among the village women. The *Unani Tibb* medicines are used which are unique for each kind of leucorrhoea, described based on its consistency; on the colour of the discharge, its form, smell and kind of stain on clothes. It is called as "*sailan-ur reham*" (secretions from uterus) by hakeems and the treatment includes forbidding sour and spicy food. Using alum for external wash of genitalia and using as a vaginal douche, are prescribed for

[300] Jeffcoate, Sir Norman. (1987). Principles of Gynaecology. Tindall V.R.(ed) 5th edition. Frome and London: Butler and Taylor Ltd.

treatment. *Chach* (curdling) mixed with salt and *'zeera'* (cumin seeds)[301] is used and *Gond kateera* (Gum)[302] is soaked in water and taken as a drink to cure leuccorhoea.

7.8 Obesity and Protruding Abdomen

Women in the village want their figures to be slim and smart. A protruding abdomen is considered as an issue worth treatment. The elderly women have a local remedy which is used in the village. It is described as:

> " *sufaid podeena, suey aur saunf marore kar chillum mein piyen to pait sookh jaye ga. Tambakoo nahin dalna; subah sham chillum kheinchein. Aik aurat ney kiya hey to us kay kapray bhi dhelaay ho gaye hein*"
>
> [If one takes white mint seeds, fennel and rubs them in one's palm and then smokes them in a pipe (*huqqa*) without using tobacco, morning and evening. One woman did that and her clothes have loosened]

Thus, menstruation is seen as natural, cleansing, an indication of fertility and an affirmation of womanhood. Menstrual bleeding is considered good for women, whereas *'band mahwari'* (amenorrhoea) is considered as a sign of illness. Obesity and protruding abdomen are often related to scanty or no menses. In the absence of any menstrual disorder, obesity itself is considered as a female problem worth seeking care for.

7.9 Sexuality Language in the Village

There is no one word in local language that would describe one being as more sexual than another etc. For the in-depth interviews, thus, different queries were framed to find the ideal and attractive attributes of a marriage partner and desired frequency of the sexual act. Women would usually refer to being *"ishqi"*(like affairs) *or 'raghbat hona'* (libido). Some elderly women feel that affairs were more common in the days of their youth,

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[301] Botanical name: Cuminum Cyminum Lnn. Considered to have a cooling effect.
[302] Botanical name: Tragacanthum. Dried sap of the legumes from the plant Astragalus Tragacanthus. Considered to have 'cold' effect and has anti-secretery properties, also used as anti-diarrheal and treatment of leucorrhoea.

"Pehlay aashqi mashooqi bohat hoti thi"

[Earlier, there were a lot of love affairs]

The others blame the recent introduction of mobile phones for causing corruption among the village women.

> *"ab mobile phone aa gaye hein, teen bachun ki maan bhi bachey chor kay kisi kay saath bhag gai, mein to kehti hun, mobile honay hi nahin chahiyein."*
>
> [now that mobile phones have come, even a mother of three, ran away with someone leaving her children behind; I say, mobile phones should not be there]

7.10 Sexuality Among the Village Women

Women in the village had a strong recognition of '*khwahish hona*' (having a sexual urge) or *'raghbat hona'* (having an inclination/libido) as a female phenomenon and not only something linked to masculinity. Subtle jokes and remarks between married women occur on this topic.

It is thought that *'garmaish'* (an unreleased sexual heat) in men can occur if their sexual urge is not fulfilled and this can harm their health. The married woman is taught to obey her husband's wishes lest any harm is caused to his health. However, too much sex is thought to cause debilitation.

Hot food can cause '*garmaish*' (sexual heat) and thus needs to be avoided by a woman if her husband is away, to suppress her desire.

The young couple after the marriage is conditioned to regulate their sexual relations in line with the norms. In a joint household, nothing remains a secret and also if the couple bathes in the morning after for the religious purity. This is why sex is also referred to as *'sar dhona'* (washing the hair); *'haath munh dhona'* (washing hands and face) and *'nahana'* (taking a bath/ ghusal).

A girl was married at the age of fourteen and did not have an elder sister or a close friend to guide her in the matters of sexual relations. She had no guidance earlier and then, followed what she was advised by her mother-in-law. She narrated her story as below:

> *" Miaan beewi ko pandra din kay baad milna chahiye, shurooh mein das din kay baad. Mein nay to aqal yahan aa kay seekhi; meri saas nay batiyah kay roz roz na nahiya karo. Paanch ya cheh din kay baadkiya karo to phir ham nay das ya pandra din kay baad karna shurooh kiya. Kehti hein na karo to mardoun kay ander garmaish ho jaati hay".*
>
> [Husband and wife should unite after fifteen days; initially after ten days. I learnt wisdom after coming here (to the in-laws house); my mother-in-law told me, do not do it every day, do it after five or six days so then, we started doing it after ten or fifteen days. She says if not done, the men develop heat inside]

It is interesting to note from her narrative that the couple became extra cautious after receiving an advice on sexual frequency from the mother. She had recommended five or six days but they adopted a stricter regime for themselves. Keeping the balance is also sought by simultaneous warning that the practice should not be abandoned because it is necessary to keep the husband in good health.

The religious significance of Friday for Muslims, is observed by taking a thorough bath, cutting ones nails, removing hair from the pubic area and the armpits, wearing clean clothes and going to the mosque by men for special prayers. Many villagers have conveniently combined the '*ghusal*' (ritual bath) after sexual intercourse and the Friday '*ghusal*'. This was elaborated by an elderly woman,

> *"Khuda ka hukm hay ek jumeraat aur phir agli jumeraat; warna gunah hota hay; ab to din raat chimtay rehtay hein ya miaan khainchtay rahein to suntee nahin. Miaan paani mangay to beewi sarhanay lay kar khari rahay saari raat, itna hukam manna chahiye. Abmardoun ka adab izzat koi nahin. Ab zananiyun ka apna dil hota hay, subah saam nahatay rahein; agar samajhdar hun miaan beewi to aathwein din munh haath dhoein. Meri to pehlay doodh pilaati jawaan behan mar gai phir bhai fout hogiya. Us kay*

baad mein nay apnay miaan ki baat nahin mani; Allah ki bhi chor bani lekin phir mujhay mard acha nahin laga.

[Its God's order to do on one Thursday and then on another Thursday; otherwise it is a sin; now either, they are clinging to each other day and night or women do not listen if their husband pull them (towards their side). If a husband asks for water, the wife should keep standing by his pillow side with the water the whole night; this is the required level of obedience by a wife. Now the men are not held in esteem nor respected. Now the women have their own desire to keep taking a bath day and night; if husband and wife are sensible enough they should wash their hands and face every eighth day. In my case, first my young sister who was breastfeeding died, and then my brother died. After that, I did not comply with my husband; have also become Allah's thief (having embezzled by not obeying him) but then I never liked the man (husband)]

In the above quoted passage, the woman has a very black and white image of the right and the wrong sexual practice. It is considered right to have sex once a week, upon the whims of the husband, and the wife's total devotion and obedience is demanded. Woman's own desire is frowned upon but at the same time, she has eluded to the fact that she could not maintain the same interest in her husband after the trauma of her young sister's death and the loss of her brother. The feeling of guilt is very strong as she feels that she has failed in fulfilling a religious duty. This dilemma is faced by many women who, on the one hand, are strongly socialized to suppress their own sexual desire but comply with those of their husbands' considering this as their foremost religious duty as wives.

There are many couples who are happy with each other as one of the woman in her early fifties remarked,

"Hamaray ghar mein bahu hein aur beti hay, aapus mein hansi mazaq waisay hi hay"

[we have daughters-in-law and daughter in our house, still we have the same laughter and jokes]

Widowhood poses another set of challenges for the woman who is supposed not to remarry especially if the children are grown up. A widow shared her feelings as she said,

> *"Kabhi teesray deeharday dhota kabhi chay chay maheenay aisay he rah gaye.Mein aap ishqi hun lekin peechay say sucha moti ban kar rahi hun. Bohat see randi dekhi hein; chor bhi wahein aatay hein jahaan gandi zananiann hun. Meri bahu bhi aisee hay; saat pardoun mein kaji hui; mardoun sa baat nahin karti mujhey aagay kar deti hay. Beewi changi ho to khawand changa hi changa.Nakhra dikayo to woh bhi paraye puter hotay hein, bahir say thakay aatay hein. Beewi ka kaam hay aagay say jawab na day; hans kar milay; hamara to sohna waqt guzra. Beewi baat na manay to miaan nakhray dikhanay lagta hay; baat baat par ghussa dikhanay lagta hay. Apnay miaan ki baadshahi Kabul aur Kashmir hay. Un kay baad pareshaani rehti thi, pata nahin Saaen kay marnay kay baad sar ka satar na rahay; bachay kaisay niklein gay? Bachay bohat bhi karein lekin dartee hun ki aisee baat na ho keh ghabra jayein.*
>
> [(used to) sometimes washed (myself) after third day, sometimes six months elapsed and remained like this (without sex). I am myself flirtatious but have remained like a real (untouched) pearl after him. Have seen many widows (be corrupted); even thieves come only where the women are filthy. My daughter-in-law is also like this (like myself); hidden in seven curtains; does not talk to (stranger) men, keeps me in front, to face them. If a wife is good, the husband is no doubt good (to her). If the wife shows arrogance they are after all sons of another family, (and) come (home) tired from outside. A wife's job is not to question him; should greet him joyfully; our time (together) was spent nicely. If a wife disobeys, the husband starts showing his mood; shows his anger on trivial matters. Living happily in one's husband's empire is like ruling Kabul and Kashmir. After him, I kept worrying whether I can keep a cover on my head (keep my shame), how will the children come out to be? Even if the children do a lot (for me), I keep dreading anything that causes them to panic]

The woman has described the ups and downs of her whole life. At the start of the marriage they indulged in each other more often, progressing to periods without sex

spanning over several months. She clearly misses her husband's companionship. A widow is supposed to guard her chastity like a virgin, so she stresses her efforts to remain pure and abhors any foul play. The risk of a widow to be molested or sexually abused is greater than for a married woman; although she clearly places all the responsibility and blame on the woman to guard her chastity. Talking to stranger men is considered immodesty. She associates a husband's treatment of his wife directly with the wife's behaviour and alludes to the fact that it is the woman's disobedience which induces maltreatment by her husband. Thus, a woman has no choice but to serve him and fulfill his desires, irrespective of her own. She recalls her happy married days as being in one's own little empire which is none less than being the ruler of Kabul and Kashmir (the Mughal link is obvious)[303]. The husband is regarded as guardian of one's head cover and one's honour.

Female sexuality is thus acknowledged as a real entity in the village; however, it has to be subsumed under male sexuality. Chaste women are supposed to be shy in front of stranger men and totally submissive to their husbands. A woman's defiance invites the wrath of her husband and his rude behaviour. The equation may not be balanced but for a woman in the village Jaffer, her happiness and fulfillment comes from being in the secure confines of her home. Her husband's presence (which may not even be physical) dispels any rumours and suspicions as many women have to live alone with the children when husbands are away for work in other cities. The '*randi*' (widow) cannot be trustworthy like a '*suhaagan*' (woman with a living husband).

This power relationship between the spouses determines the decision-making by the woman on matters relating to her sexuality and sexual health, as we shall explore in the next section.

[303] The Mughals coming from Afghanistan pined for the cool mountains of Kabul and when they conquered and experienced Kashmir, the delight was like coming home.

7.11 Local Norms of Sexuality

The subject is difficult to be encompassed by participant observation considering the private nature of sexual relationships; hence, in-depth interviews were structured to cover these aspects indirectly.

One of the relevant queries was the desirable frequency of sexual intercourse among the two partners. A young woman opined,

> *"Hamaray miaan say pochein to roz; meray khial mein haftay mein do dafa ho to insaan pursukoon rehta hay"*
>
> [Ask my husband and he would say, every day; I think twice a week keeps a person pacified]

Another woman thought it is negotiable and variable,

> *"Har shakhs ki apni zarooriat hoti hein; ek ki marzi nahin hoti: khawand ki marzi, beewi ki marzi yaa dono ki; ek yaa do dafa haftay mein das dafa ko pur kar sakta hay?"*
>
> [Every person has his or her own needs; it is not a choice of one person, one has to have the husband's choice or the wife's choice or of both; once or twice a week (is enough).Who can manage ten times?]

Women in their own circle of sisters, *dewaraani, jeethaani* (sisters-in-law) and friends do discuss their issues and secretly compare one's situation with others. Managing ten times is referred to the bragging by some women to prove remarkable affiliation and love between them and their husband. Living in joint households and observing others, sometimes creates frustration among women if they feel that their husbands are not equally inclined towards them like others' husbands. This frustration grows into anxiety and women start thinking that some one has cast a magic spell on their husbands to create distance between the two. A *'taweez'* (amulet) is commonly sought for such problems.

7.11.1 Sexuality Narrative 1

A young woman, 25 years old and living in a nuclear family, while discussing whether she is satisfied with her sexual life, said:

> *"Pehlay mujh mein defect they, ab kehtay hein tum theek ho gai ho. Mujhey kabhi farigh honay ka pata nahin chalta tha, ab kuch mahsoos hota ha".*
>
> [Initially I had defects, he says now you are alright. I never knew orgasm but now I do feel something]

Me: "Can it be improved?"

She: *"Haan agar un main ziada sabar ajaye. Gharailoo halaat aur kaam ki ziaadati say bhi farq parta hay"*

[Yes, if he becomes more patient. Household circumstances and increased workload also causes a difference (to libido)]

Me: Have you ever refused him?

She : *"Pehlay, pehlay nahin, jab chutti par aatay they; ab kabhi kabhi keh deti hun " Aaj nahin", jab dekhti hun inkaar chal jaye ga. Kabhi ghussay mein aa jatey hein; kabhi kehtay hein theek hay agar tumhari marzi nahin".*

[In the early days never, when he used to come on home leave; now occasionally I do tell him "not today", when I see that he will take my refusal. Sometimes he becomes angry; sometimes he says it is alright if you do not want to.]

7.11.2 Sexuality Narrative 2

She is a mother of four children having three girls and one son ranging from the age of 10 years to 16 years. She has a graduate level education and lives in an extended family in the city with her husband's family. She was visiting her parents during the summer vacations of the children when I interviewed her. She is the only daughter of her parents and very fond of her mother and brothers. She had developed Hepatitis C three-four years back and had recovered by then.

Me: What do you say is the ideal frequency of having sex?

She: *"Do teen din haftay mein. Aadmi ki marzi hoti hay jab woh aye"*

[Two or three days in a week. It's a man's prerogative when he wants to come]

Me: *"Kabhi apni marzi nahin hui ? "* [Did you never want it yourself ?]

She: *"meray miaan bhi yehi poochtay hei. Meri marzi na ho to keh deti hun, pai mein dard hay, daant mein dard hay, koi na koi bahana bana latey hein. Unko is baat par ghussa aa jaata hay.*

[my husband also asks about this. If I do not feel like it I tell, I have pain in my tummy, pain in my tooth, make one excuse or the other. He gets angry on this]

Me: *How do you want it?*

She: *" Meri marzi ho to aik hi dafa balkay maheenay mein ek dafa; neend puri nahin hoti, sehat kharaab hoti hay, sar dard rehta hay; mera nahin khiaal keh woh is cheez par mutmain hein; mera chitchitdah pan shurooh ho jaata hay. Mein nay taawun nahin kiya kabhi khushi say nahin kiya. Woh kehtay hein, "tum gaiey ho, insaan nahin ho"; Aksar shikayat kartay hein; mujhey is baat par thappar bhi par jaatay hein; bus mera dam ghutnay lagta hay. Mein khud hi is par khush nahin hun; mujhey pata hota keh yey muamla hay to mein shaadi hi na karti; bistar par to sukoon chahiye hota hay phir tansion mein teen chaar ghantay guzar jatay hein".*

[if it is my choice, it should be only once rather, 'only once a month'. I do not get full sleep, my health deteriorates, there is headache all the time; I do not feel he is satisfied with this (attitude of mine); I become irritable. I have never cooperated, never done it by my own will. He says, "you are a cow, you are not human"; he often complains; I also get slapped on this (refusal); Its just that I feel suffocated. I am not happy with this (sex business) myself; had I known that this in fact, is the matter, I would not have married; one needs to relax on the bed, (when we disagree) then three or four hours are spent in tension]

Me : Do you both talk about it?

She : *" Haan, shaid unhein mujhay tang kar kay maza aata hay ya mujhey unheen kar kay; aksar jab bachey na hun to hum is tapic par baat kartay hein.*

[Yes, perhaps he enjoys making me annoyed or I enjoy making him annoyed; often when children are not around, we have a talk on this topic]

Me: Do you think it is a *'masla'* (problem), have you consulted someone for it?

She : *"Masla nahin hay. Yeh miaan beewi ka masla hay; kisi teesray banday ka kaam nahin banta keh baat ki jaaye; har doosray teesray din to janlewa masla ban jaata hay. Haftay mein ek dafa phir bhi theek hay haftay ke din kuunkeh aglay din jaldi uthnay ki pareshaani nahin hoti;"*

[It is not a (health) problem. It is a problem of husband and wife, a third person has nothing to do with it so it does not need to be talked to with anyone else; (having it) every second day becomes a fatal issue. Once a week is bearable, 'on Saturdays' as there is no worry to get up early the next day]

Me: How does he react, when you say 'no'?

She : *"woh dekhtay bhi nahin keh Bimaar hay; kehtay hein tum bahana bana rahi ho; kehti hun aap so jayee mein aap ko uthaa lun gi subah; phir subah uth kar shikayat kartey hein keh tumnay uthaya nahin. Saara din naraaz rehtay hein"*

[he does not even see that I am sick; says that you are making an excuse; I say you go to sleep now, I will wake you up in the morning; then he complains as he gets up in the morning that you did not wake me up. He remains upset the whole day(then)]

Me: Was it like this from the beginning or has this changed over time?

She: *"pehlay doosray bachey tak to mujhay itna bura nahin lagta tha; ab ziaada lagta hay"*

[I did not mind it so much till the time of the first (and)second child; now I mind it more]

The above narrative illustrates the negative association developed among girls and women about sex and how this affects their relationships. She does not allow herself to enjoy and take pleasure but considers it drudgery. Being more educated, has not changed her attitude and belief to be different than others who are not educated. She describes all the problems but does not feel that this is a health issue that merits discussion with others or need therapy.

7.11.3 Sexuality Narrative 3

She is about 50 years old with grown up married children and living separately with her husband. She is a frail modest woman who is suffering from ill health off and on.

Me : How often is alright for you?

She: *"Ath ya das din baad; miaan to ek din bhi nahin chortay, chahay koi maray ya koi jiye, woh nahin chortay"*

[After every eight or ten days; my husband does not spare me for a single day, whether one lives or dies he does not spare]

Me : Are you satisfied with your sexual life?

She: *"Jee agar apni marzi ho"* [Yes, if it is my choice]

Me : Do you tell him, if you do not feel like it?

She: *"Kehti to hun lekin naraazgi nahin honi chahiye , waqt to guzarna hay. Na kar wainay aan phir bhirh wainaday; us rolay ko yeh sahih hay; duniya ka waqt guzarna hay; krrapa bana latay hein; ek do dafa maara bhi hay; ziaada naraaz hun to khaana peen chor datey hein ghussay mein. Mard to saath jatay hein lekin dactar kabhi bhi uhnein nahin samjhatay".*

[I do say but (he) should not be offended, (I) have to pass time. If I say no, he picks a fight (with me); this (being submissive) is better than that noise; have to pass the time in (this) world. He blows up the issue into a quarrel; once or twice he even hit me; if he is more angry (with me), he stops eating and drinking in anger. Men go along (to a health facility) but the doctor never makes them understand.]

It confirms that she enjoys sex if it is her choice but not if it is forced upon her. She has given up any resistance or negotiation to avoid marital rape and an unpleasant situation at home. The possibility of violence also coerces her to give in. Unlike the other, who thinks sex is a bilateral matter, she thinks the doctor should intervene and advise the husband to abstain when a woman is too sick.

7.12 Menopause and Old Age

Old age among women in Village Jaffer is a mixed bag of emotions. When a woman's reproductive system slows down and eventually stops around the age of 50, this is called a menopause. Menopause occurs as the ovaries stop producing estrogen, causing the reproductive system to gradually shut down. Each and every one of the aged females has to pass through the period of menopause.

7.12.1 Medical Definition of Menopause

Menopause literally means a woman's last menses, which can only be determined in hind sight. Once, a woman stop menstruating for 12 consecutive months, she is post-menopausal. However, before the final period, hormonal shifts gradually occur over several years; this transition time is known as peri-menopause.

7.12.2 Local Definition of Menopause

The menopause is commonly referred to as '*kapray sookhna*' (drying up of menstruation). Drying up is used as for a plant where it shrivels, reduces in mass and loses its moisture and suppleness ending in death, eventually. The same terminology is applied to all other female organs and attributes as well. Uterus (*bachay dani sookhna*) and breasts (*thanjoo sookhna)* dry up (has no secretions/ bleeding and reduce in size), the skin dries, there is loss of hair and teeth.

The end of menstruation is a termination of her feminine aspect or *'zanana'* and her power of fertility. The physical demands of bearing and rearing one's own children are over as menstruation and fertility end. The restrictions on her mobility and *'purdah'* (veil) are significantly relaxed. However, the problems of the aging body creep up in the form of arthritis, knee pains, blood pressure, diabetes, vision impairment and loss of teeth, etc. For women, this stage of life is transition to gain some of the privileges allowed only otherwise to men. These include more influence in decision-making in family matters and play the role of a mediator to resolve an intra-family conflict. These roles were denied to them when they were young, so the overall gain in status is positive.

From the perspective of reproductive health, issues related to menopause and utero-vaginal pathologies pose an additional challenge to already existing complexities of old age and family adjustments. The decision-making processes for these reproductive health problems thus embrace the realities of changed social context of a woman's life in perspective of her new status and added physical challenges.

7.13 Cultural Expectations

Cultural expectations about menopause, gender and hetero-sexuality influence how women experience biological changes. Indeed, research on women's menopausal experiences suggests that attitudes and experiences of symptoms, such as hot flashes, vary across cultures (Chornesky 1998[304]; Lock 1993[305]; Martin and Jung 2002[306]). For example, where women view menopause positively, they rarely report symptoms, perhaps because they gain power after the menopause. In contrast, pre-menopausal women in the the United States may view menopause negatively and think that depression increases (Avis and McKinlay1991[307]) because aging women are devalued in the United States (Lorber and Moore 2002[308]). Thus, it is also important to examine the social context of midlife.

7.14 Gain in Status at Menopause

Menopause thus, becomes a symbol of seniority and a precursor of old age debility. Seniority is cherished as the woman becomes the *'bari'* or the 'elder'; has more say in matters of household decision-making and becomes the main family member responsible to socialize and keep the network of relationships alive. Going to attend marriages, *'aqiqa'* (sacrificing animal on child birth), to congratulate for a *haj/umra-* pilgrimage to the Holy 'Kaaba', the birth of a new baby, a new job; meeting short time visitors with other families (from abroad or other cities); going to funerals, condolences, and *pooch karna (visiting an ailing)* etc.

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[304] Chornesky, A. (1998). "Multicultural Perspectives on Menopause and Climacteric." *Affilia*.13(1):31-46

[305] Lock, M. (1993). "Cultivating the Body: Anthropology and Epistemologies of Bodily Practice and Knowledge" *Annual Review of Anthropology*. 22: 133-155

[306] Martin, L. and Jung, P.(Eds.) (2002). Taking Charge of the Change: A Holistic Approach to the Three Phases of Menopause. NewYork: Delmar.Thomson Learning.

[307] Avis, N.E. and McKinlay. S.M. (1991). "A Longitudinal analysis of women's attitudes toward the menopause: results from the Massachusetts Women's Health Study." Maturitas. 13(1): 65-79

[308] Lorber, J. and Moore, L. J. (2002). Gender and Social Construction of Illness. Oxford: Alta Mira Press.

7.15 Old Age Dependency and Female Health

Debility, on the other hand, is dreaded as it will lead to '*muhtaaji*' (dependency on others). *Muhtaaji* can be physical, emotional or financial or all three. Women at this age endure widow-ship and keeping a good relationship with one's daughter-in-law is important to secure her cooperation. As children are married and split due to moving to independent houses or due to reasons of employment in another city it is usually one son and a daughter-in-law who take care of the elders. In case of extended families, the household chores are divided between the daughters-in-law to ensure the smooth running of the household. Daughters-in-law usually take turns to cook, sweep, wash pots and do the laundry. Older women ensure that they appreciate the services and devotion of their daughter-in-law to the visitors in an audible enough voice to sustain their obedience and favourable attitude, such as:

> *"mein to munji par houn, paka hua khana hay, dhula hua pehnana hay"*
> [I am bed ridden, get cooked food to eat and washed clothes to wear.]

After a lifetime of similar services for their own in-laws and children, the elder women do appreciate their daughters-in-law tolerance and servitude. Keeping an amicable relationship with one's mother-in-law and daughter-in-law, is considered a necessity and a good characteristic of a woman who manages to keep the cohesion amongst household members. One mother-in-law said,

> *"Noun naheen rusaai mein- ouh meinoun 'Ammi ji' kenhdi aay tay mein usaan 'puter ji' aakhdi aan"*
>
> [I have never made my daughter-in-law angry- she calls me 'Ammi ji' (Mum) and I call her 'Puter ji' (Sonny)]

Winning the hearts of others is a matter of giving respect and calling each other affectionately. Another old woman said,

" Bohat achha guzara kia apni saas kay saath ' maan ji keh keh kar'- mein nay to paraye bhi apnay kar liye."
[I passed the time with my mother-in-law in a very good manner by calling her 'maan ji' again and again- I even managed to win the hearts of outsiders and get them on my side.]

Thus, selecting a daughter-in-law in the village is a crucial matter for determining old age peace and security for the mother-in-law. A woman comments:

"Log aisey bahu dhoondhtay hein jis kay saath Saas ka guzara bhi ho sakay. Agar meri bahu achi na hoti to mein kia karti?'

[People try to find such a daughter-in-law who can go along with the mother-in-law. If my daughter-in-law was hostile to me, what could have I done?]

Women invest in their relationships with their daughters-in-law, as the menfolk are usually away and it's the older and the younger women who have to depend on each other. A mother-in-law said,

" Meri bahu nay to kabhi chhanani bhi nahin uthai thi. Shurooh mein saray kalay bartan mein nein khud doey. Is ka salook bohat achha hay aur mein bhi kadi na ugri (biphri). Maan houn chahti houn kay baitay ka ghar sohna ho."

[My daughter-in-law had not even lifted a sieve before (marriage). I used to scrub all the pots with soot myself in the beginning (to pamper her, not to put too much burden at once and keep her hands and finger nails clean of black deposits of smoke on the cooking pots). Her dealing with me is very good and I also avoid being offensive. I am a mother and want my sons's home to be a good one (peaceful).]

7.16 Changing Values and Life Style in the Village

The life styles of the older and the younger generation, are highly variable. Life was tougher for the previous generation in terms of the required physical labour. The present

generation has electricity and the machinery to do previously hand-done jobs. However, the increasing competition for material resources has changed the values of life drastically. An older woman had her daughters not at school but at home to help her. Access to the city was limited and so was the exposure to it. Now the younger generation is more aware of the latest trends and has become more demanding, adding to the tensions and frustrations of the mother.

Most of the elder women do not taunt their daughters-in-law for not being able to cope with similar kind of hard work which they themselves were used to do and blame the adulteration in food for the decreased physical capacity. However, it means that they have to over-stretch themselves to keep up with their rural life style or to give it up altogether if they are incapacitated. A mother-in-law said,

> *" Aaj kal ki larkioun say kaam nahin hota- Itni jaan nahin hay- Jaan bhi kaisay ho- Koi cheex khalis nahin, " har cheex mein to khaad hay" Desi anda bhi char rupaiy ka ha- Doodh bhi wohi hay jo ghar ka ho- Ab to gaoun mein doodh bhi khalis nahin milta. Gaoun mein ghee bhi koi nahin banata sab doodh baich 'dai'tay hein. Sirf meri bahu ki Ammi ghee banati hein kuon keh unko Pir nay doodh baichnay say manah kia hay. "*
>
> [Nowadays, girls are unable to do the work- they do not have the strength- How can they have the strength when nothing is pure (natural), 'every thing has fertilizer in it'. A pure egg (not from farmed poultry) costs Rs. 4. Milk is only good if you have it from your own home. One can not find pure milk in the village now. Nobody makes the *ghee* (Butter oil) in the village, all families sell the milk. Only my daughter-in-law's mother makes *ghee* because the Saint (*Pir*) has advised her not to sell the milk.]

7.17 Self-sacrifice

The ideals of self-annihilation for the interests of husband and children linger on in the old age as well. A woman said,

" meray shohar ko dil ki takleef hay is liyee bari pareshaani hay aur mein nay bhi is liye apni taangou nkay dard ka ilaaj nahin karwaya. Yeh choozay bhi Hamamd ka shouq hein, warna nahin rakhnay datay. Bohat gand daltay hein. Thoray baray hotay hein to Bimaari par jaati hay, teekay lagatay lagatay bhi Bimaari aa jati hay- bahir choozay baichnay wala aata hay to yeh zid kar kay lay laita hay. Baiti ka shohar zima dari nahin laita aur phir har cheez mein naqs nikalta hay- pata nahin halaat kab sudherein gay, jab is ki (meri baiti ki) zindagi guzar jaye hi to phir karnay ka kia faida."

[My husband has a heart problem, thus there is so much worry and that is why I also have not gone for treatment of pains in my legs. My grandson is fond of these chicks, otherwise, I would not have been allowed to keep them. They make a lot of mess. As they grow up they get infected by disease, we get the chicks inocculated even then the disease comes- when the hawker comes on the street selling the chicks, he (my grandson) insists on getting them. My daughter's husband does not take any responsibility and then finds fault with everything (she does)- do not know when the situation will improve, what will be the use of his changing ways when she would have passed the prime time of her life'.]

In cases where the daughter-in-law does not live with the mother-in-law, either due to a clash between her natal and in-laws' family or amongst the two, the elder ladies do resent their absence and not being able to see their dreams fulfilled (a courtyard beaming with life and happiness). A mother-in-law said,

"Mein nay kothay banaye khud to jhuggi mein bhi reh laitay, lekin bahu kay muqaddar mein nahin tha, phir baad mein sulah hui".
[I got the house (new rooms) built; we (the old ones) could have lived even in a hut, however, this house was not in the destiny of my daughter-in-law, we had the agreement later.]

7.18 Fulfilling the Unfulfilled Dreams

Old age brings serenity and a strong urge to see the next generation surviving and thriving. The things the women themselves pined for and dreamt about, are now sought

for their next generation. The dreams remain the same but the focus changes from self to the younger ones. A woman remarked,

> *"Hamari to guzar gayee , chahtay hein kay bachoun ki achhi guzray".*
> [We have spent our life, and want that the children should have a good one.]

7.19 Loneliness

Loneliness is felt less in joint and extended families and when old women are mobile, but becomes a reality when they are bed ridden or living alone.

As women say,

> *'Ral- mil behna, ral mil khaana achha lagta hay, barkat hoti hay."*
> [Sitting and eating jointly feels good, it is an omen of divine blessing]

The partitions emerge in between houses when they get divided in inheritance and brothers who used to live together, now live independently. Women lament that this causes fragmentation.

> *'Aaj kal kisi ko pata nahin apni deewar kay paar kia hay- Har koi apnay mein magan hay- Aisey zindagi mein sawaad nahin".*
> [Nowadays, nobody knows what is happening on the other side of their wall- Every one is self-absorbed- such a life is without taste.]

Patience is the religious advice to deal with adverse circumstances and a reward is promised.

> *'Hum donoun boorhay hi baithay hein- hamari kabhi aik baiti milnay aa gayee to kabhi doosri, warna sabar kar kay baithay rehtay hein.'*

[Only we two old ones are sitting put - sometimes, we have one of our daughters visiting us or the second one, otherwise, we are patiently sitting here.]

Loneliness can trigger depression and the village women cope with it by increased religiosity and greater participation in communal gatherings.

7. 20 Son Preference and Old Age Security

As girls are married off to live with their in-laws. An average woman has to live about ten years or so as a widow (life expectancy being equal of males and females and the average difference in age at marriage is ten years). With no independent income, the older women are dependant upon their sons in the later part of their life time. The quality of life depends thus upon the presence of sons. The more one has, the more secure a woman is in her old age.

Even with one son, women are content, as one old lady said,

> "*Aik baita jis par badshahi hay, baicharay nay das hazaar meray par kharach kia.*"
> [I have one son on whose basis runs my monarchy (make me feel like a queen), the poor man spent tens of thousands on me (for treatment)']

Mothers clearly invest more time and energy to make sure that their sons are well cared for. Even under circumstances of poverty, the breadwinner of the family (usually the son), is given better food and care than other men and women in the household. Eggs, meat and milk, are usually only consumed by the sons.

Another lady shared her fears and experience when her husband died,

> *"Shadi na hoti to baita na hota. Baita to Saeen say ziaada badshahi karwata hay- Woh fout huey to mein chup chup kar rotey thi kioun kay hamaisha achha khaiya, achha pehna lekin bahu nay kaha keh hum pehlay say ziaada 'ji*

karein' gay, pehlay do dafa kartay thay ab hazaar daf karein gay aur us nay duniya ko kar dikhaya."

[If, I would not have married, I would not have a son. My son makes me feel like a queen more than what my Lord (husband) did. When he (my husband) died, I used to cry secretly because I was used to always eating the best and wearing the best but my daughter-in-law said, we shall say 'yes' to you even more than before, if we did say 'yes' twice before; now we shall do it a thousand times and she showed the world by doing so.]

However, men seem to be tired of the common tug of war like situations at home and women refer to the young men saying,

"Wakhriaan rakh saan- na beewi diaan suno na maan diaan'.
[I'll keep them both separate- neither have to listen to the wife nor the mother]

The trend of living separately is seen where the family has the means to afford it. It definitely improves privacy for the old couple but is very burdensome for the old mother who still has to cope with physical chores to keep up to the needs and demands of her husband.

7. 21 Menopause – A Period of Purity and Worship

Achieving a perpetual status of *'paaki'* (purity) after the cessation of menstruation is a great relief for many women and given the increasing religiosity, this age is considered to be meant for *'namaaz roza'* (prayers and fasting). An elderly woman said,

'Bimaar rehti houn- dar lagta hay namaaz , roza chohrna na par jaye'
[I am sick and scared lest I have to leave my prayers and fasting.]

7. 22 Common Reproductive Health Problems in Old Age

Post-menopausal women in the village usually refer to two main reproductive health problems, i.e. prolapse of uterus and presence of uterine tumours (fibroids). Feelings of altered sexuality are also recorded.

7.22.1 Altered Sexuality

Libido is not usually materially reduced but, as the years go by, atrophy and dryness of the vagina can cause painful coitus.

> *"…… the menopause represents the end of the reproductive era and this means something to all women, even those who have as many children as they want. It inevitably means more to the barren and unmarried women who had previously lived in hope. Married women are sometimes worried by the idea that the menopause means the end of sexual desire and physical one. In fact and unless the woman wills it otherwise, libido usually remains as it was before and marital relations continue after the menopause…… Sex life only wanes gradually as part of the ageing process in both partners. The sex urge may even be temporarily increased by the menopause, especially if it has previously been inhibited by fear of pregnancy." (Jeffcoate 1974:89)*[309]

The village women specifically discuss loss of sexual desire with age. They attribute this less to the menopause and more to their emotional state, failing health and loss of energy.

7.22.2 Prolapse of the Vagina and Uterus

Prolapse or downward descent of the vagina and uterus causes protrusion of tissues through the introitus or opening, due to lax pelvic muscles and ligaments[310]. The prolapse may affect the anterior or posterior vaginal walls or the vault of vagina. The symptoms are usually a sensation of swelling or fullness in the vagina and a dragging discomfort in the lower abdomen and pelvis. Backache, difficulty in emptying the urinary bladder, urinary infection and burning sensation or constipation may also occur.The otherwise soft lining of the vagina, being constantly exposed to the air and possibly to trauma, becomes

[309] Jeffcoate, N. (1974). Principles of Gynecology revised by Victor Tindall (1986) Fifth Edition, Buttersworth and Co. Ltd.: London
[310] Ibid.

thickened, corrugated and white with keratin. Ulcers may be formed due to constant friction with the thighs and clothing.

Prolapse occurring in the old age, is usually due to injury sustained during childbirth and may be due to premature bearing down before full dilatation of the cervix; downward pressure on the fundus of the uterus during attempts to deliver the placenta; constipation or strong bearing down efforts in postpartum period when ligaments are slack; or attempted retro-version of uterus to prevent pregnancy (all practices are common in the village) or atrophy of the supporting tissues after the menopause.

7.22.3 A Prolapse Case Study

Tall and confident, 'B' is in her late forties. She was very young when her father passed away and her mother was too busy raising her and her other siblings. Her parents had given word at her birth and also she was married young. She and her husband were a total mismatch (*aadatein nahin mileen)* and she was not happy with him, had two sons when she finally decided to get divorced after ten years of marriage. None from her family supported her decision. She filed for divorce in the court. The court decision came after three years of legal fighting in the court. After the divorce, she got re-married to her present husband by her own choice after completing the period of Iddat. The boys were kept by her previous husband and he still has not married again. Her life has been a continuous struggle as she was strong headed and wanted her own way. She is used to struggling alone and says,

> "*Allah wala sang hay; mein to tehsil kuchehri bhi khud gayee. Pandra saal narazgi rahi bhai say, doosri shaadi par.Pehlay to bachpana tha , ab to zindagi say sabaq seekha hay. Kehtay hein " thuda paray to Thakur bunta hay" (thokar kha kar hi insaan aqlmand hota hay).*
>
> [Only Allah is my companion; I went alone even to the tehsil courts by myself. For fifteen years, my brother was not on speaking terms with me as he was mad about my decision for a second marriage. First it was childhood, now, I have learnt a lesson from life. There is a saying, "One becomes *Thakur* (wise) only after stumbling].

I asked about the details of her pregnancies. She responded,

> *" Mujhey saat mah kay baad hamal hua. Awratein azaad rehna chahti hein, phir kuch na kuch kar leiti hein.Mohallay walay poochtey thay agar mein achaar khaati thi, mein kejti thi aagay hi aana hay, nazar aa jaye ga. Sirf aakhri waqt par 'dai' ko bula leti thi. Allah bara razi tha. Ab to fazool kharchiaan bhi ho gaye hein. 'Ganjo' naam ki 'dai' thi Fateh Jang mein. Pandra din malish bhi karti thi. cheh so ya saat so rupay 'dai'tay thay ya kaproun ka jora. 'dai' saath kaam bhi karwa deti thi. Pehlay koi takleef nahin thi ab shaid hawa ho gai hay, sojan aagai hay".*
>
> [I got pregnant after seven months (of marriage). Women want to keep their freedom and then resort to doing one thing or the other (to terminate pregnancy). My neighbours would be curious when I ate pickles; I said what ever, will be there will come in front, so will be visible. Only at the last moment, did we call the '*dai*'. Nowadays people have become spendthrift. 'The bald' named '*dai*' was there in Fateh Jang. She also gave a massage for fifteen day. We gave six or seven hundred rupees or a set of clothes. The '*dai*' would also help in household chores. I did not have any problem before, now perhaps there is air or there is a swelling (inside).]

I probed her further for any other *'zanaana'* illnesses. She said,

> *"Sufaid paani bohat para kabhi ilaaj nahin karwaya. Waqt bhi nahin tha aur shram bhi aati thi. Kapray khud hi huey aur khud hi khatam ho gaye. Pehlay kapray bohat aatay thay jaisay koi zaya karwaya ho. Ab to do din sirf daagh hi laga jaisay puna hua khoon ho. Ander bojh lagta hay jab wuzu karti houn. Ultrasound ka kehtay hein, jo paisay ultrasound ko 'dai'nay hein wohi apnay par laga lein " desi ghee lay kar kha loun". M.H. walay kehtay hein bees hazaar lagay ga. Makaan bananay lagi houn, farigh ho kay ilaaj karwaoun gi."*
>
> [I had a lot of white discharge but never took any treatment. Did not have the time and also felt shy. Menstruation occurred by itself and stopped by itself. Initially, I had very heavy bleeding as if an abortion has been done. Now it is

only a spot or small blood clots as if sieved (in shape of small curdlings). Feel something heavy bearing down when I wash myself (after urination). Ultrasound is advised by them, why not to spend the money on oneself rather than spending on the ultrasound- should buy and eat *desi ghee* with that. The M.H. people said it (the operation) will cost twenty thousand (rupees). Iam going to start construction of my house, will go for treatment, once I am free.]

She added,

> *"Muhtaji ban jaati hay- Safai karwoun koi rukawat na ho.larkioun ki to safai hoti rehti hay- Pata nahin safai ho bhi sakti hay ya nahin".*
>
> [Dependency is created- should go for cleansing if there is a blockage. Girls get cleansing now and then. Don't know, whether my cleansing can be done or not.]

I asked her whom she has consulted and if her illness has been diagnosed. She paused to think and then replied,

> *"Pareshani mein hi waqt guzarti rahi. Ghurbat hay , soch hay. Gaoun mien aik awrat hay, us ko masla hay saat saal say- usey dekh kar mujhey bhi dar par giya hay. Bimaari pakri jaye , ilaaj karao to Bimaari ka naam dactar bataey ga- hum to dehaati hein- yehi kehtay hein kay ander sojan ho gayee hay- Un kay paas to paisay bhi thay- kehtay hein nuqs koi nahin. Yehan to ya time nahin ya paisay nahin !"*
>
> [My time was spent in worries. There is poverty and there is fretting. If a disease is caught or if one seeks treatment, the doctor will tell the name of the disease. We are villagers and say there is a swelling inside. There is a woman in the village with a similar problem since seven years. I am scared after looking at her. They (her family) also had the money- (doctors) say there is no defect. Here, (in my case) either there is no time or no money!]

7.22.4 Fibroids

'*Rasoli*' is the word used for any cyst, tumour or growth. "*Bachay dani mein rasoli*" are the words used for Uterine Fibroids. Fibroids are benign tumours of muscular tissue of the uterus. The characteristic symptom of fibroids is menorrhagia, that is an increased

loss at normally spaced intervals, which is gradual in onset and progressive.[311] Anaemia occurs due to blood loss leading to palpitations, lassitude, and even loss of weight.

7.22.5 Oral History 1

She is 53 year old, was married at the age of 14 when she got her second periods to a cousin 34 years old who was an orphan and raised by her father. Her husband asserted his authority and said, "*I have in a way brought her up and played with her when she was a baby*". She does not challenge him but as our conversations grew I understood she is a strong person with her independent opinions which she seldom has opportunity to express in the presence of her husband.

She had six pregnancies in total including two stillbirths; two dying in the newborn period at the age of two days as they were born premature; and two children a boy and a girl who survived to adulthood. The girl later died of tuberculosis which she herself did not mention but I got to know from others. All the births were handled by a local '*dai*'. She initially had a problem of pelvic infection developed soon after the birth of her daughter, twenty five years back. She recalled,

> *" bachi hui- Saat din kit hi, daanay kar rahay thay- meray pait mein shadeed dard hua or pait sooj giya. Factory lay kar gaye. Unhoun nay kaha ander peep par gayee hay- pandra hazar rupia lag giya- Aik dactar nay dekha-Meri untariaan sooj gayee thein- bohat si ultiaan kein, ander say peep aani shurooh ho gayee thi."*
>
> [I had a daughter, when she was seven days old, we were harvesting wheat, and my tummy had severe pain and swelled up. I was taken to factory (POF Wah Cantt). They said pus had developed inside- it costed us Rs.15,000- A doctor saw me- My intestines were inflamed- I had many vomits and pus started coming out from within (through vagina)]

[311] Jeffcoate, N. (1974). Principles of Gynecology revised by Victor Tindall (1986) Fifth Edition, Buttersworth and Co. Ltd.: London (Page: 422)

She recovered after treatment, though she felt week and never regained her previous strength

"mein bohat tagri thi, ab kamzor ho gayee houn"

[I was very stout, now I have become weak]

Since the last two to three years, her periods have become erratic and there was bleeding after twenty days or so and she never had a full month's break between her periods as before. She got herself checked by a LHV who examined her from inside and said,

"ander kuch nahin"

[there is nothing inside]

Now, since the last one year the bleeding occurs after every two or three months. She has visited Tehsil HeadQuarter Hospital Fateh Jang where she was told that she has fibroids and was referred to Central (Rawalpindi General) Hospital as treatment was free there.

> *"Centre aspatal mein unhein bihari aur hamein unki samajh nahin aye. Aik kahe yahan jao, doosra kahay wahan jao. Chaar ya Panch dactaroun nay check kia , aur mujhay laga , meri jaan nikal jaye gi. Unhein samajh nahin ayaa to apnay say bana liya kay mujhey yeh Bimaari hay. Wahaan say aik goli bhi nahin mili, chaar so phir bhi lag gaye- Hum donoun miaan beewi bhi aik jaisay thay 'anjaan'. Samosay kha kar Pindi say aisay hi wapis aa gaye (laughs). Agar koi parha likha saath hota to aisa na hota"*
>
> [In the Central Hospital, they could not understand the illness and we could not understand them. One said, go here and the other said go there. Four or five doctors checked me, and I felt as if my life would be taken out of me. They could not make out so they invented that I have this illness. Did not get a single pill from there despite spending four hundred (ruppees). Both of us, the husband and wife alike – are 'naïve'. We returned back as such from Pindi after having *samosas* (laughs). If there was someone able to read and write with us, this would not have happened like this.]

Now, two months back she showed herself to a private doctor in Attock. She took Rs. 600 just for examining her internally and another Rs. 900 for doing an ultrasound examination. The doctor told that she had tumors (fibroids) inside her uterus.

> *"dactar keh rahi thi apration karwa lo, cheh din mein aperation theek ho jaye ga. Tees hazaar rupiya aur khoon ki teen botlein chahiye houn gi. Kehtay hein kay khandaan say khoon lana. Aik baita hay woh kahan say itna khoon day. Mein nay kha 'mari to mari' lekin baitay ko kioun kharab karoun. Us say to pehlay hi kam nahin hota."*
>
> [The doctor was saying, go for an operation, it will heal in six days. Thirty thousand rupees and three pints of blood would be required. They say bring blood from the family. I have one son, how can he donate so much blood. I said, 'I shall be dead anyway' so why should I make my son suffer. He already cannot do much labor.]

She thinks this bleeding has generated a hundred or so other illnesses. Her ears feel closed, she has headaches, pains in her eyes, body and feet. If she takes injections, capsules or tonics, she feels somewhat better. It is difficult to get injections due to her old and hardened slippery veins.

She is concerned about her physical weakness turning into disability.

"Bohat farq ho giya hay , pehlay bohat kaam kar liya karti thi, gandum katna, channay kappna, matti laga laiti thi- ab kapray bhigo kar rakh deti houn, mal kar dhoey bhi nahin jatay- Haath mein dard hota hay- Seedhay haath mein dard ziaada hota hay- teekay lagwaati rahoun 'rattay rang kay" to theek rehti houn- Ab to haath bhi kaam nahin karta is liye bhains nahin rakhi. Miaan ko bhi TB hay."

[There is a big difference, I used to do a lot of work before, cutting wheat and chick pea crop, plastering mud walls- now, I leave the clothes to be soaked but can not rub and wash them. My hands hurt. My right hand hurts more. If I get injections of red color, then, I feel better. Now my hand does not work that is why, I have not kept a buffalo, my husband also has TB.]

Before the illness, with her normal menstruation, she would have bleeding for two days only and used four pieces of cloth for the day and another two for the night. Now for day and night combined, she soaks 8-10 *'taakian'* (rags) and one big cloth. She washes them when she can or when she can not wash, she buries them or burns them. She particularly dislikes the fact that she can not be carefree like her other age mates and socialize freely as they do.

> *"Bohat pareshaani hoti hay khoon ziaada parnay say- Khaas tor par jab koi faut ho gaya ho to jaana parta hay aur kapray ganday honay ka dar laga rehta hay."*
>
> [It is a big worry when blood sheds more- especially when some one dies and one has to go (for funeral or condolence) and there is constant fear of staining my clothes.]

She has also a problem of having *bojh aata hay* (weight bearing down). Some say, that uterus has fallen down or displaced from its original position, that is why she has all these problems. She can not squat down because of the '*bojh*' (weight bearing down) problem. Some times she has burning when she urinates. She feels as if from below, '*ja khuli khuli lagti hay*' her place is getting more open.

The couple is living alone by themselves in a single '*kacha*' room with a little paved courtyard with an earthen stove on one side for burning wood and a hand pump located on the other side for water. They used to live with their son's family and their six children but moved out in this separate room as there was too much noise. The current arrangement means that when she is sick, there is no one to help them.

> *" Miaan to gharay say paani bhi bhar kar khud nahin peetay. Agar mein bimar houn to anda bana leti houn ya doodh pee laitay hein- Roti to doodh ya mirch kay saath bhi kha laitay hein- Dil na karay to aisay hi so jao."*
>
> [My husband does not even fill his own glass of water for drinking from the pitcher. If I am sick, I cook an egg or we drink milk- *Roti* can also be eaten with milk or red peppers- If does not feel like (even doing this) just go to sleep like that (hungry).]

She thinks that maybe her bleeding illness will be cured by medicines and she may not require surgery after all. She has heard and known many other women during her visits to clinics and hospitals who have recovered by medicines alone.

7.22.6 Oral History 2: Her Illness: A Myth or a Reality

She is in her sixties and married to a *'zamindaar'* (land owner). She was thirteen years old at the time of her first wedding and had her first periods after marriage. When her first daughter was six months old, her first husband died and she came back to live with her grandmother and father.

> *"Pehli shaadi Baap nay 'dai'na kiya tha- Dossri dafa meri apni marzi thi. Wadera ghar tha, zameenain thein- Dadi bbhi kehti thi keh moqa hay warna bhabioun kay kaam karti reh jao gi"*
>
> [The first marriage was arranged by my father but the second was of my own choice. It was rich family with lots of land. My grandma used to say that it is the opportunity, otherwise you will remain busy in doing chores of your sisters-in-law.]

Her daughter was taken away by her ex-husband's mother and after that she re-married. At the time of her re-marriage, she was twenty and her husband was thirty years old. It was also his second marriage. His first wife did not want to come and live with him so their marriage had broken.

She had two sons and a daughter from the second marriage; all delivered by a *'dai'*. When her youngest was five or six years old, she became pregnant again. She had so severe vomiting that she felt miserable and wanted to get rid of that pregnancy. A *'dai'* was summoned when she was overdue by fifteen to twenty days. The *'dai'* said the blood has gone '*watla*' (separated)- the sign of pregnancy. She placed a small sharpened stem of a shrub into her uterus's opening.

"jab kas charhi aur ander say khoon nikla to who buti bhi nikli. Mein nay dawai rakhai lejin bana hua bacha zaiya nahin karwaya."

[when infection occurred and blood came out then that piece of flesh was also expelled. I got the medicine inserted but did not aborted a formed child]

The *dai's* treatment had also included hot fomentation of the left *naal* (groin) and *naaf* (at the site of the navel) with an inverted glass. In a metal glass, *'dai'* would put some dry husk of the rice /paddy stems and burn it, and as it is burning she would place a small *'roti'* (bread) called *'gogi'* on top of the glass to seal its opening. With this *'gogi'* on the glass she should provide *'takore'* (fomentation) to separate out the early pregnancy from uterine wall so it can melt and come out. She thinks some thing went wrong during that procedure. She felt as if a stone had formed at the site of *'naaf'* and stomach.

She asked,

" Kya ander battery daal kar nahin 'dai'kh saktay- patta nahin bachay dani sooj gayee ya jareen ban gayein. Ander hawa chalti hay to bachay dani sooj jati hay aur khoon ruk jaata hay- Bachay dani kay munh kay aagay boti si ban gayee hay- Ander pani bhara giya lekin ander say raasta koi nahin. Koi teeka ho jo ganda pani nikal jaye- Dakaar nahin aata. Peeshab nahin aata(qabz ho gai hay)."

[Can't they see inside by putting in a battery- don't know whether uterus has got inflamed or has developed roots (of another disease). When the (trapped) air moves inside, the uterus gets swollen and the blood stops flowing. A piece of flesh has developed in front of the mouth of the uterus- the inside is filled with water but there is no channel to flow out. Wish there is an injection to get rid of this water- can not belch and can not get rid of my waste (has developed constipation).]

She continues,

"Bachay dani mein say zara hawa nahin nikalti- pakhanay kay munh kay aagay bacha sa ban giya hay- Dil aur maida theek ho to chalo chal sakti houn. Donoun peeshaboun par bojh hay- Aik chara dard hota hay yehaan to ragein bhi sooj gayee hein aur haath paoun bhi sooj gaye hein- nal

mein soj hay aur lagta hay keh peechay say kuch aa raha hay. Saari ragein phool gayee hein. Dactar nay qamar ka X-ray kia to bataya keh qamar kay mohray baith gaye hein, khaas tor par neechay wali kundi (kamar) kay mohray aj (baith)gaye hein. Naal say dard wakhi mein chala giya hay , phir choti choti sab ragoun mein phail gaiya hay".

[Not even little air oozes out of the uterus. There is a little body formed in front of the mouth of my rectum. I can continue if my heart and stomach are alright. Both my orifices (for urine and stool) have developed a weight. There is a type of bachelor pain (that comes alone) but here my veins are swollen and hands and feet have swollen- my groin has a swelling and feels something coming out from behind. All veins have swollen. Doctor got an X-ray of the backbone and said that the pieces of vertebral column, have sat down; especially the vertebrae of the lower back have squeezed thin. The pain from the groin has gone to my ribs, and from there, has spread to all small veins"]

She continues further,

"Ab sar mein phail giya hay. Maghaz ki rag phat sakti hay. 'A' dactar to saray Pakistan ki mani hoi hay lekin mujhey dekh kar kaha kay mujhey to ander kuch nazar nahin ataa. Teen so so kay kaghaz diye – kya faida hua. Aik aur aspatal gayee to choti dactaroun nay dekha. Kaha kay kamar ki haddi kay saath meri bachay dani lagi hoi hay . bachay dani to naaf kay saath sookhti hay –lagta hay meri bachay dani kamar kay saath chimat gai hay. Bohat 'dai'oun nay kaha , bachay dani nikalwa do lekin mein darti houn. Zanana bachaydani kay sar par hi chlata hay. Itna sa bhi farq aa giya is mein to us banday par mout hay. Ander hawa aur khoon band ho giya hay. Jareen ban gaye hein".

[Now it has spread to my head. A vessel in my brain can rupture. Dr. 'A' is well recognized in whole Pakistan but she said after examining me that she could not see anything (wrong) inside. Gave her three papers (currency notes) of Rs.100 each - but without any benefit. In another hospital, junior doctors saw me and said that the uterus is lying near to my backbone. Uterus dries out near the navel- seems that my uterus has adhered to my backbone. Many *dai's* advised

me to get the uterus removed but I am scared. Feminine-hood survives on the uterus. If it develops even a little difference, that person is doomed. Air and blood has been trapped inside and roots have developed.]

I asked if she has consulted a physician and she replied,

"Dactaroun kay paas janey kay liye kai maslay karnay partay hein-Gaoun say pindi janay kay liye gari karo, phir koi hushiar banda saath bhi jaye- Aik bachi hay khandan ki , nurse lagi hoi hay- chahoun to us ko saath lay jaoun lekin us ki bhi apni duty hoti hay".

[Many arrangements have to be made to visit the doctors- to hire a car for going to Pindi from the village, then one needs a sharp person to accompany you- there is a girl in the family- she is deputed as a nurse- if, I wish, I can take her with me but she has her own duty to do.]

She elaborated further,

"Dactaroun nay doodh peenay ko kaha hay lekin doodh ko rooh nahin manti. Dactar nay kaha hay, roti na chorna warna charpoy kay saath lag jao gi".

[Doctors have advised me to drink milk but my soul does not agree to it. Doctor has told me "Do not leave the *roti* (bread), or you will just lie on the bed]

She paused and asked her daughter-in-law to bring roti for me. The room, she was laying in, seemed more like a sitting lounge of modern houses as far as the human traffic was concerned. On the cot just in front of the door, lay the old lady and on the other end of the room, was a little makeshift kitchen where her daughter-in-law sat kneading the floor for *'roti'* and making *'sabzi'* (vegetable curry). There was also a little cemented area for washing dishes with a rounded hole for drainage opening in the compound. A small wooden table was laid before me and I had the food. She was served similar food on her cot in a chaaba (rounded tray made of straw with colourful patterns).

We finished the food and I reminded her that we were talking about the advice from doctors she has consulted. She picked up the discussion thread and continued,

"Panch so dactaroun ko dikhaia, CMH, Attock, MH, general Aspatal , har jaga. Unhoun nay X-ray bhi kia, hawa machine mein nazar nahin aati baqi har shay nazar aati hay- TV par bhi laga kar dekha, sab kuch nazar aa raha tha sirf bachay dani nazar nahin aye. Attock waley dactar nay kaha keh ander say aperation ho ga. Us nay kaha tha do teen hazar lagay ga. Dotri saath thi dar gai keh dactar gurda hi na nikal lay. Waisay usay samajh aa gai thi keh ander bachay dani mein nuqs hay – Dukh jo naseeboun mein ho."

[I have shown to five hundred doctors, in CMH, Attock, MH, Gnereal Hospital, at every place. They even did an X-ray, the machine could not show the air, the remaining everything becomes visible. They also hooked me to the TV and saw, every thing could be seen but the uterus was not seen. The doctor in Attock told me that an internal operation needs to be done. He said, it will cost two to three thousand (ruppees). My granddaughter was with me and was afraid that the doctor may not take my kidney out. Anyway, he had understood that my uterus has a defect- Only if one is destined to have the pain]

Her daughter-in-law after putting away the dishes, joins the discussion and laments that doctors are very expensive but only good enough if one is cured. The old lady remarked,

"Meray naam zameen thi jo baitay kay kehnay par mein nay Bhai kay naam kar di. Ab Bimaar houn bhai ka haq tha us nay mur kar poocha bhi nahin. Agar abhi zameen meray paas hoti to kam az kam char lakh maleeut kit hi aur mein apnay ilaaj par who paisay laga sakti thi phir chahay jeeti ya marti!"

[I had land in my name which I gave out in my brother's name. Now I am sick, it was my brother's right to take care of me but he never turned back to ask how was I doing. If I had the land in my name now, it was worth Rs. 4 Lakh minimum and I could have used the money for my treatment, it was my luck then to survive or to die!]

She becomes very gloomy and I assure her that she is not the only one to have been deprived of her lawful inheritance, it is the same story for women, everywhere in Pakistan. I probed her about the possible causes of her illness. She replied,

> *"Meray to bees saal huey mahwari band ho goi hay. Mera miaan naraz hay. Bohat gham dakhein hein. Pehlay doodh pilaati behan ko kas charhi to who mar gai. Phir Bhai fout ho giya. Behan fout hoi to aik bacha dhai saal ka tha aur aik cheh mah ka. Behan kay bachay bari mushkil say palay. Lekin woh bhi jawan huey , shadi hui aur fout ho gaye. Aik larkay ko current laga aur doosray ko pait mein dard utha. Do aur bewa ho gauein. Itnay gham kay baad mein nay apnay miaan ki baat nahin mani. Allah ki bhi chor bani lekin phir mujhey mard achha nahin laga. Bahu aur beti kehti hein keh tumhein is ki bad dua lagi hay aur sab kuch ander dakka giya hay".*
>
> [My menses have stopped since the last twenty years. My husband is angry with me. I have seen much grief. First my breastfeeding sister had an abcess and she died. Then, my brother died. When my sister died, one child was two and half years old and the other one only six months old. I raised her children with great difficulty. But even they grew young, got married and died. One boy got electrocuted and the second one had severe pain in abdomen. Two more got widowed. After so much grief, I did not obey my husband. I committed theft in fulfilling the order of Allah but then I never got an inclination for the man. My daughter-in-law and my daughter say that you have been cursed by him and everything has gotten trapped inside you.]

Her family members were worried about her continued illness as there were many rumours circulating in the village. They felt embarrassed that with all the money, they could not buy a cure for her. Her daughter-in-law asked me,

> *"Bari ko waqai koi masla hay ? ya sirf shak hay?"*
>
> [Does the elderly woman really have a problem? Or is it her imagination?]

I did not have an answer but assured her that I will discuss with a doctor friend and come back to her.

Interpreting descriptions of her illness is quite challenging. She has picked up vocabulary from the *dais* and the practitioners of the modern medicine during her provider shopping. Her decades of life experience has taught her many lessons. She seems to absorb all the knowledge and process it to come to a conclusion about what has gone wrong with her.

The description of secretions and air being trapped is closest to Ayurveda concepts whereby the human physical body is made up of seven different types of tissues called *dhatu*. These body tissues are nourished through food materials that get digested by action of digestive fire (*agni*). The digested materials are carried to different tissues through *srotas* (body channels). At each tissue level, there is a digestive fire that works on the food material to activate absorption of nutrients into the corresponding tissue. As a by-product of this process, *mala* (waste materials) are formed which are eventually eliminated. Nourishment of body tissues does not happen when there is any block in body channels or impaired function of any of the digestive fires; this results in the indigestion of food in the body. This undigested or waste material (*ama*) clog the body channels and manifests in different disease conditions. Management of these conditions has to be done by removing these clogs or blocks and improving metabolic processes. During the treatment by oil massage, waste materials, clogged in the body channels become *pakva* (digested and disintegrated), and they move into the *kostha (main channel)*. During emesis and enema, these are expelled through natural orifices. Ayurveda does not mention these materials as *visha* (toxins) but they are considered *ama*. *Ama* refers to the material that is a drop out of the body's metabolic process i.e. the undigested materials. The body's natural processes need to be activated for eliminating '*mala*' (waste) from the body.

Thus, the old lady thinks that she is sick because her orifices have been blocked and that is why she is getting constipation and no air or secretion is coming out of vagina. This blockade has been caused by the curse of her husband. She finds reasons for her illness in her deeds which were against the Divine order and attributes the condition at one point to the abortion she had and on another occasion, to being disobedient to her husband. The

physical pain and discomfort are borne with the belief that it was pre-destined for her. The grief of losing her natal kin is coped by challenging the order of her husband. She has tried the *'dai'* as well as the allopathic medicine. In her narrative, we find mistrust in the modern medical system (as she fears removal of kidney) and a strong conviction not to part with her uterus. The inability of a lay person to fully benefit from the hospitals is explained. The complicated procedures to access the right doctor and cost factor are also mentioned as the inhibiting factors. Her whole dilemma is to find a diagnosis of her condition. She is perplexed by the fact that when she feels a problem, why even a renowned gynaecologist fails to understand it.

In this chapter, we have reviewed the outlook of the village women on menstruation, sexuality and menopause related issues. It is evident that reproductive health and illness in these aspects is not only confined to the symbolism of menstrual blood but includes bodily aspects of the process and their implications on woman's overall status in the society. Menopause is experienced not only as the transition to the post-reproductive life but also means relaxation of '*purdah*', greater mobility and a better position for decision-making in the important household matters. Reproductive health illnesses, especially associated with bleeding in this age threaten the potential gain in status. The correlation between sexuality and reproduction is un-deniable. Sexual socialization is seen to affect marital relations and the agency of women is obvious in these matters as they negotiate these relationships with their husbands.

In the next chapter, the focus is on procreative events of a woman's life and their cultural significance. Decisions for care-seeking at this stage are important as they have an important bearing on the prestige of the family and the woman's future health and fertility.

CHAPTER 8

PREGNANCY, CHILDBIRTH AND PUERPERIUM

Pregnancy, child birth and *'chalees din'* (postpartum period of 40 days) are the most important events in the life of every woman in the village. This is definitely considered a critical process in one's life time when special care, food taboos, restrictions on activities and certain other concessions are offered. The woman enters pregnancy at conception alone and with its successful completion, becomes a mother. The childbirth itself is thought to be a test of her patience, strength and performance. There are transitions in status involved as the woman becomes pregnant from non-pregnant ; pregnant to mother in *'chalees din'* (puerperium) and from mother in *'chalees din'* to regain normal life with an enhanced status of a mother and more so with a male offspring than with a daughter. The special food offered to a mother during the postnatal period also varies and depends whether she has produced a son or a daughter. The whole process is critical as an abnormality can occur any time which can jeopardize life and health of both the mother and the baby. Every possible effort is made to make the pregnancy, child birth and *'chalees din'* period safe. The generations of women pass on the knowledge and traditions to new mothers to cope with different problems that might occur. The mother - in-law has the lead role in the decisions to be made and *'dai'* is the repository of knowledge in the village. In this chapter, the beliefs, practices and decision-making processes of pregnancy, child birth and puerperium are presented.

8.1 Pregnancy

Pregnancy in medical terms, "*results when the liberated ripe ovum is fertilized by a spermatozoon. The opportunity for their meeting is provided by the deposition of semen in the upper vagina and on the external os during coitus*". (Jeffcoate: 103)[312]

[312] Jeffcoate, Norman (1974). Principles of Gynecology revised by Victor Tindall (1986) Fifth Edition, Buttersworth and Co. Ltd. : London

It is commonly called *'haml'* by the village women. *'Haml'* is an Arabic word meaning "carrying". The village women also refer this condition as *'pait mein bacha hona'* (having a child in the tummy). As jeffcoate writes,

> *"Pregnancy can temporarily alter the whole outlook of a woman. In early pregnancy depression, irritability, lethargy and apathy are all common. Middle pregnancy is caused by a feeling of well-being and the woman is full of energy. She then becomes and remains more placid, quietly happy and proud in the fulfillment of her allotted purpose. Sometimes, just before the onset of labour, it is noticeable that she has a few days of emotional disturbance and is often impelled to an orgy of unnecessary house cleaning. This may be comparable to the nesting instincts of animals." (ibid:117)*

8.1.1 Diagnosis and Confirmation of Pregnancy

Women in the village believe that conception causes the uterine blood to become *'watla'* in form of a clot. If it is not formed as this clot, it will flow as menstrual blood.

As the woman misses her periods, she becomes suspicious of pregnancy. Women with lactational amenorrhoea, get alert with the feelings of giddiness and nausea. *'Dai'* is the *'siaani'* or the wise woman. She is the one to diagnose pregnancy. Very sensitive diagnosis is required especially in women who were not having regular menstruation before.

> *"Pandra bees din ooper huey to 'dai' ko dikhaa liya aur us nay bataiya kay khoon waila ho giya".*
>
> [As fifteen twenty days were overdue, showed to the *'dai'* and she would tell the blood has become a clot (turned thick)]

The words *'khoon watla hona'* meaning formation of clot, is also the concept put forth in the religious text and may have been derived from there. The formation of a new life in mother's womb is described in the Holy Quran as

> *" Procalim!*
> *In the name of thy Lord and Cherisher, who created-*
> *Created man, out of a mere clot of congealed blood. (Surah 96:1-2)*
>
> *and*
>
> *"Verily, We created man from a product of wet earth, then placed him as a drop of seed in a safe lodging, then We fashioned the drop to a clot, and of the clot We fashioned bones, and We clothed the bones with*

flesh.Then We produced it as another creation; so blessed be Allah, the best of creators". (AlQuran 23: 12, 13, 14)

Whether the blood has thickened to become a clot, is checked by the *'dai'* from *'khabay naal'* (left groin).

As an older woman recalled,

"dai hi batati thi kay hamal ho giya. Khabbay naal mein check karti hein. Khoon watla ho jaata hay. Unhein pata chal jata hay."

[The *'dai'* would tell if one has gotten pregnant.They check in the left groin. The blood gets thickened. They can know.]

The *'dai'* feels for the pulse and temperature in the left groin. If the pulsations are strong and there is heat, the woman is diagnosed as pregnant. From the point of view of modern medicine, it is the femoral pulse that is felt and the slight quickening of the pulse from a non-pregnant state. Women usually hide the pregnancy till it becomes obvious from the bulging abdomen. This is done to prevent *'nazar'* and any bad action by some one with mal-intentions. Not letting any one know in the initial days, wards off the evil eye. During their conversations, women hardly use the word *'hamla'*- they would use code words as *'tabeeat ghalat ho gayee'* (has a wrong feeling), *'tirikhi ho gayee'* (has become sharpened) or *'dehaaray char gaye'* (days are overdue).

8.1.2 Choice of Provider for Pregnancy Care

Among the village women, pregnancy is considered a normal physiological process for a woman's body as is the monthly flow of menstrual blood. Modern medical preventive care is not thought to be necessary unless care for a specific complaint has to be sought or the pregnancy is precious or an antenatal booking is required for availing delivery services. However, special pregnancy taboos dictating precautions and intake of special food, is common. The pregnant woman and her family seek the advice of a *'dai'* or *'siaani'* (the wise woman).

Midhet (2004)[313] has divided the *dais* or Traditional Birth Attendants (TBAs) in the Pakistan context, into several categories.

[313] Midhet F.2004. Baluchistan Safe Motherhood Project, Pakistan Report.

"It could be someone who just cuts the cord at the birth or cooks and cleans in the house in the run-up to the birth, and supervises women in the house to help deliver the baby in the house. Or there are the professional TBAs, who usually work in the local hospital and come to the house for the birth, but charge a heavy fee of US $10 [a monthly wage for some families]. So women opt for the cheaper inexperienced women to help with the birth."

The choice of *'dai'* is made by the more experienced woman in the household, usually the mother-in-law or the sister-in-law. Special care is exercised during the first pregnancy as the girl is inexperienced and if anything goes wrong, people would blame the mother-in-law for being negligent. It is not even imaginable that a mother-in-law can ignore special care and guidance of her daughter-in-law in such matters. A village *dai* said,

"Saas par to lazim hay kay aisay dinoun main bahu ka khial rakhey- Aakhir khud hi to usay biah kar layee hoi hay aur jo bachey paida hotay hein aakhir us ki hi to nasal hein"

[It is obligatory for the mother-in-law to take care of the daughter-in-law in such days. After all, she has herself brought her in marriage (with her son) and the children who are born are her progeny.]

With the LHV in the BHU, now one can also get the urine checked to know about one's pregnancy. It is mostly used as a diagnostic preference, if the pregnancy is unwanted and subsequent measures are desired to terminate it. The LHV at the health facility considers this as the only time when women do not ignore their symptoms and do not unnecessarily delay seeking care. She says,

"deeharay char jayeen to bhagi aati hein, kuch kar do"

[they come running if days are overdue, (saying) do something]

There are two lady health workers in the village. Each lady health worker registers the pregnant women and makes home visits every month. She refers pregnant women for antenatal care and tetanus toxoid injection to the LHV. She feels hostility from mothers-in-law sometimes as they feel their conventional authority in matters of pregnancy care is being challenged. The mothers-in-law are used to attending to the expectant mother's need themselves within the household with the help of the *'dai'*.

8.1.3 Pregnancy and Care seeking

Nausea (*dil kharaab hona*), vomiting (*ultiaan aana*), and weakness (*kamzori mehsoos hona*) are the common complaints during the early pregnancy. Towards the last trimester, women complain of heartburn (*kalaijay/ dil mein jalan hona*), backache (*kundi mein dard*) and foul vaginal discharge (*ganda paani parna*). Spotting or bleeding (*daagh lagna or khoon parna*) during pregnancy is considered normal until it is so profuse as can be termed as abortion (*nuqsaan ho giya*: literal meaning 'suffered a loss') or miscarriage (*hamal /bacha gir giya*: literal meaning 'the pregnancy/child has fallen').

One of the young women had suffered a miscarriage in her first pregnancy and narrated her story,

> *"Saal pehlay hamal gir giya. Bas khoon shurooh ho giya aur chotay pait mein lagataar dard honay laga (note not colic). Kiya karti , dactar ko dikhaya to us nay tincture diya keh glass mein daal kar piya karo. Saas aur Susar saath gaye thay. Phir zayia honay say pehlay teeka lagwayia tha , 45 rupay ka. Fateh jang say chota dewar lay kar ayia. Pehlay dabbay lagnay shurooh huey. Sab yeh keh rahay thay keh faalto khoon ho to waisay bhi aisa hota hay aur mein isie bhool mein rahi. Jab khoon taiz hua to mujhey fiker hui;, Miaan ko batiya, unhoun nein kalcium ki goliaan la kar dein; LHV say mashwara kia, phir us nay teeka batiya aur ham nein mangwaiya. Din mein lagwaiya to shaam ko Bimaar ho gayee. Sab nay charpoy paoun ki taraf say oonchi karnay ko bhi kaha. Peeshab kay liye bethi to gir giya. Sab nay keha, ab kuch na karo. Ziaya ho giya hay. Hamsai ki bahu ka mearay baad aisa hua. Pehlay suna tha lekin dekha nahin tha.Bhaari ghara lay kar aye thi – is liye yeh masla ho giya".*
>
> [A year back I had a miscarriage. I just started bleeding and had continuous pain in my lower abdomen. What should I have done, showed to the doctor and he gave me a tincture, said pour in a glass and drink. My mother-in-law and father-in-law had gone (there) with me. Then I got an injection before the miscarriage happened, for rupees 45. My younger brother-in-law had brought it from Fateh Jang. First, I started having spotting. Every one said it happens if there is extra blood and I remained in this wrong

impression. I started worrying, when blood (loss) became rapid (profuse); informed my husband, he brought me calcium tablets; consulted the LHV, then she advised an injection and we arranged to fetch it. Got the shot in the morning and became sick in the evening. Every one also advised to raise the foot end of the charpoy (the cot on which she was lying). I sat to pee and it fell. Every one said, do not do any thing now. It has been wasted (aborted). Similar thing happened to a neighbour's daughter- in-law after me. I had heard (about) it before but had not seen it. I had brought a heavy (water) pitcher – that is why this problem happened.]

It is worthwhile to note that she mentions "every one said" thrice in her story. 'Every one' for her were elder women in the household i.e. her husband's paternal grand mother (who used to practice as a *'dai'*) and grandmother's three daughters-in-law including her mother-in-law who live together or nearby. Living in an extended family, a consensus of opinion is important for her and it also makes the advice more credible. Scientifically, a pregnant woman sometimes does get spotting around six weeks after conception (implantation bleeding) or later in the pregnancy if the placenta is low lying (placenta praevia- normally placenta is attached to the fundus or upper portion of the uterus). Being in the lower half of uterine body, it is more liable to get detached partially and bleeding occurs in such instances[314]. The matter remained among the female circle until her condition worsened and she grew concerned. Only when she felt that the matter cannot be dealt by the females, did she inform her husband (for the first time as she told upon my further probing). He had gone to a chemist shop without a prescription and was given calcium tablets by the pharmacist. When there was no improvement and the problem has persisted which was fatal for the unborn baby, did she finally seek care from a modern medical provider, the LHV at the local BHU. Considering both her parents-in-law have accompanied her to the health facility which is at a furlong's distance from her house means that they may have anticipated a possible referral to the hospital in Fateh Jang town. The injection (probably a progesterone preparation commonly prescribed by LHV for similar cases) was not available at the health facility and had to be obtained from the

[314] Jeffcoate, Norman (1974). Principles of Gynecology revised by Victor Tindall (1986) Fifth Edition, Buttersworth and Co. Ltd. : London

town. The raising of the foot end of her cot was another acquired technique from modern medical advice to do so in case of severe blood loss and low blood pressure to save life. However, when asked specifically the usefulness of raising the cot's foot end, she thought it was to redirect the blood upwards and not downwards (as was happening with vaginal bleeding). She specifically mentioned her gain of experience with this incidence as she said I had heard but not seen it (the miscarriage). Reflecting backwards and discussing with other women later on, she had found that it probably occurred because she had lifted a heavy object. She did not have a hand pump in her house and fetched water from next door neighbor's house, who happened to be close relatives as well. Water had to be collected and stored for drinking, washing and bathing. She filled the buckets and the pitcher at least twice a day. Her '*dewarani*' (sister-in-law) and she took turns to do this work. She was nine months' pregnant again at the time of the interview (three years after her miscarriage) and had not gone for any ante-natal check up, as yet. I thought maybe she has done so because the BHU or LHV had not made any difference earlier. Upon my asking, she tld that she had not felt the need and being poor, her mother-in-law was afraid of additional expenses. The cost factor was also evident as she herself remembered how much they paid for the injection even after three years had passed since then. All the other therapies she had tried had either no cost or were significantly cheaper i.e. calcium tablets and raising foot end. Her younger brother-in-law was fetching water this time as her '*dewarani*' (sister-in-law) was also pregnant and this time the whole household was very conscious and wanted to prevent the same mishap from happening again. Her un-married sister-in-law about thirteen years of age, was very unhappy with shifting of the other weight-lifting jobs to her and used to grumble all the time, saying that it was just a pretext to take rest, on behalf of the two '*bhabis*' (brothers' wives).

8.1.4 Food Preferences during Pregnancy

One of the most recommended foods in pregnancy is *desi ghee. Desi ghee* or butter oil is made by heating butter and separating oil from the other contents.

An elderly woman from a well-off household said,

> *"Kehtay hein doodh piyo, saib khao, pehlay to taqat kay liye desi ghee khatay thay, halwa khatay thay, ab kehtay hein froot lein taqat kay liye. Murgh roast kar kay desi ghee mein khaa lo ya desi ghee ki choori, doodh aur anday. Halwa banatay thay suji, desi ghee, maghaz, badaam pees kar. Agar halwa na khaana ho to doodh mein mila lein. Mein nain badaam maghaz nahin khaye kuonkay doodh naheen pilaana tha. Mujhey saib aur kaila pasand thay"*
>
> [(People) say 'drink milk', eat apples, earlier (people) used to eat desi ghee(butter oil) for gaining strength, used to eat halwa (sweetmeat), now (they) say eat fruit for gaining strength. Either roast (fry) chicken in desi ghee and eat or choori[315] in desi ghee, milk and eggs. I used to make halwa with wheat flour (with a grainy texture), desi ghee, seeds (nuts/kernels) and grinded almonds. If one does not want to eat halwa, one can have it (desi ghee and nuts) mixed in milk. I did not take almonds and nuts as I did not intend to breastfeed. I liked apples and bananas.]

Women in the village associate intake of high caloric food like *desi ghee* with a better development of the foetus and improved birth weight, as one of them remarked,

> *"mairay baitay bari mushkil say paida huey. Donoun bohat bhari thay. Mein aatay jaatay , kaam kartay jab moqa milta, thora ghee kha leti thi.*
>
> [my sons were born with a great difficulty. Both were very heavy. I used to take a little desi ghee every now and then, coming here and there, while doing my work, whenever, I had an opportunity.]

It is considered important to improve the nutrition of the women during pregnancy and postpartum period for gaining strength for the time of delivery, to improve health and development of the baby in the womb, to ensure better lactation and to gain strength after the physical exertion in the process of labour and childbirth.

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[315] Bread (roti)crumbs mixed with desi -ghee or butter and sugar

The beliefs and the food preferences of the village women during '*haml*'(pregnancy) are very similar to Ayurvedic prescriptions of the past which *Unani Tibb* also endorses.

"During the era of ayurved, ...sages roughly knew about the various stages described by embryology. For example, they have given the name kalal to a one month old fetus (intrauterine age), in which the fetus is still in a semisolid state. During the first three months, fetal growth organs are only in a stage of formation. Thus, ayurved suggests a wholesome diet and moderate household work for the mother during this period. In the fourth month, the formation of fetal dhatu (tissues) starts and thus ayurved suggests a diet to boost this dhatu formation, ... In the fifth month, rakta (blood) and mansa (muscles) are formed; in the sixth month, med (fatty tissue) is formed and around the seventh month, fetal growth is practically complete, after which only refining work remains. ...It is for this reason that ayurved suggests a satvagun yukta diet, which is a diet rich in ghee, milk, proteins, green leafy vegetables, fruits, etc. This type of diet is useful for fetal growth, for maternal health and for further lactation. Ayurved also says that pregnancy is the time to consume nutritional food substances like udid dal (phaseolus radiatus), amla (emblica officinalis), etc. Modern science says that a pregnant lady should take a high protein diet in addition to vitamins and minerals. The above mentioned ayurvedic dietary plan matches this modern dietary thought. By the sixth or the seventh month, fetal organs are well formed, well organized, and they also acquire strength. Updhatu like skin, hair and nails also enter the picture. Hence, this is the month when medicated ghee is recommended. .....a garbhini (pregnant woman) should avoid constipation and should take mild laxatives if constipation is a problem.....Herbs supporting dhatu (tissues) are shatavari (asparagus racemosus), ashwagandha (withania somnifera), bala, white musali, salam musali and kapikachchu".[316]

The locally available produce of milk, butter, butter oil and eggs, makes them easily available options of nutritious food in the village. Both '*zamindars*' (land owners) and their '*kammis*' (village professionals) had access to such food in the past. However, with increased monetization of payments for the labour and trend of selling milk, this nutritious food is becoming unaffordable for the most of the poor women of '*kammis*'. The household living in poverty talked of the cost of this expensive food in the smallest portions: milk in *'pao'* (one quarter of a litre); one egg; one kilo ghee etc. The intake of nuts and fruits is only limited to the better-off families. Despite limited household resources, even the poor families try to invest in better nutrition for a pregnant woman. A mother-in-law said,

> *"kehtay hein' hamal mein khoorak khaein'. Doodh piyein. Ghee khaein, roti ki choori bana kar ya doodh mein daal kar. Hasti ki baat hay. Kuch log chalees din tak khatay rehtay hein. Ghee chaar so rupay kilo hay. Yeh pehlay hi derh kilo khaa chuki hay."*

[316] Dr.Satish Kukarni " Pregnancy care" accessed on 30-7-2008 at http://www.health-enz.com/ayurveda/pregnancy.shtml

[They say (recommend) 'take (high nutrition) food in pregnancy', drink milk, eat ghee, mix small bits of bread with desi ghee and sugar or take it mixed in milk. It depends on one's pocket. Some people used to eat (this) till the forty days after child birth. Ghee is rupees four hundred for a kilo. She (referring to her pregnant daughter-in-law) has eaten one and a half kilo already]

8.1.5 Similarities in Human and Animal Diets in Pregnancy

It is interesting to compare human diet patterns with those for the cattle in this agrarian set up. Raising goats is common here among all households and the veterinary knowledge for special food for goats and buffaloes in pregnancy, is common among both men and women. In the goat's five month pregnancy the last two months are considered critical when special food is introduced. A woman said,

"Bakri ko hamal ho to chauthay maheenay mein khaas khoorak shurooh kar 'dai'tay hein jaisay insaanoun kay liye. Pisi hui gandam aur sarsoon ka tail aur shakar 'daitay hein bakrioun ko."

[If a goat is pregnant, special food is introduced in the fourth month just like in the case of human beings. Ground wheat grains, mustard oil and brown sugar are given to goats.]

8.1.6 Food Cravings

Food cravings among pregnant women are also common especially for meat (mostly seen in poor household where it is rarely cooked).

" Yeh zara si ghalat hui hay to khanay ko gosht maangti hay"

[since, she has become wrong (pregnant), she is asking for meat to eat]

During pregnancy, women are also inclined towards more animal proteins (maybe to compensate for the usual deprivation) as one of the older ladies said,

"jab bhi meray pait mein bacha hota tha, mera gosht khanay ko bohat dil karta tha. Mein nay apnay ghar waloun say kaha, " mujhay gosht la do chahay kuttay hi ka ho"

[Whenever, I was carrying a child in my body, I had this intense desire for meat. I requested my family, to 'bring meat for me even if it comes from a dog']

According to Auyrveda, animal proteins are also recommended in pregnancy,

"A garbhini who is weak, multi-para or has previous history of abortion, is advised to take a non vegetarian diet"(ibid)

In joint households where the choice of food rests with the mother-in-law, pregnancy provides a cherished relaxation in rules to allow the daughter-in-law to talk about her preference.

Use of pickles (*achaar*) is common among women to lower the nausea due to pregnancy and improve appetite. Pitta is also common. Women do eat mud.

"Pehlay bacahy ki dafa matti bohat khai. Kehtay hein kamzori hoti hay. Jab dawa shurooh ki to matti say nafrat hoi"

[At the time of my first child, I ate a lot of mud. (People) say it is (a sign of) weakness. I started disliking the mud when, I started medicine.]

The LHV usually prescribes calcium tablets and multivitamins for treating weakness and thus, the urge to eat mud.

8.1.7 Avoiding Hot Food during Pregnancy

The concept of hot and cold is especially considered for food taken during pregnancy. Hot food is avoided during pregnancy (especially during first trimester for fear of inducing bleeding) but taken during labour and after childbirth.

Water is considered cold but the '*baraf*' (ice) is considered hot. Women have an urge to eat ice because of heartburn in the later half of the pregnancy but also feel afraid that it may cause harm.

The prescription by the doctor or LHV is considered incomplete if it does not have strong proscription of what to eat and what not to eat. For example, a woman when interviewed said that she was not happy with the food recommended but she was particularly unsatisfied with not having any advice on '*perhaiz*' (what to avoid), which is an essential element in a hakeem's advice according to the *Unani Tibb*.

> *"Khoorak tajweez ki hay lekin na mujhey doodh acha lagta hay na anda. Koi perhaiz naheen batiya."*
> [(Hakeem) has recommended (good) diet but I neither like milk nor eggs. He has not told me any precautions.]

The word '*khoorak*' (food) is more commonly used to refer to body building diet (as for *'pehalwans'* i.e. body builders). It does not carry the distinction of caloric value or nutritional significance.

According to Islamic traditions, melons are one of fruits recommended during pregnancy and were also abundantly available in the village.

> *"Melon contains a thousand blessings and a thousand mercies, The Prophet SAW said "None of your women who are pregnant and eat water melon will fail to produce offspring who are good in countenance and good in character".(Hadith)*

8.1.8 Other Precautions during Pregnancy

Activities like going out of the house without a justifiable reason, talking to unknown people, looking at things which create fear in the mind, including going to graveyard and attending funerals, are avoided. Special *taweez* are worn for protection of the pregnancy and to dispel the effect of an evil eye. The common ones from *Pir sahib* in the village are worn around the belly of the pregnant woman.

> *"But Allah is the best of guardians; and He is the most merciful of the merciful.(Al Quran 12: 64)*

Allah knows what every female bears, and that which the wombs fall short (of completion) and that which they exceed. And every thing with Him is measured." (Al Quran 12: 8)

Solar and lunar eclipses are feared to be potentially harmful for the pregnancy. It is thought that the baby in the uterus will adopt a similar position as the mother during the time of an eclipse. Thus the elderly women advise the pregnant woman to loosen the string of her *shalwar* (trouser) to avoid pressure on the uterus and and to lie down straight. Sexual activity is prescribed to be avoided in the seventh month as it is thought to hurt the baby.

8.1.9 Antenatal Examination

The allopathic medical system (WHO[317]) recommends at least four antenatal care visits during the pregnancy to screen the mother for possible high risk fators and complications, to counsel about nutrition, rest, breast feeding and to assess the growth of the baby according to the age of gestation. At each visit, a physical examination i.e. weight, blood pressure and the uterine size are measured togther with laboratory tests for urine (checking for the presence of sugar and proteins) and blood (checking for the blood group once and as a routine to assess haemoglobin for anemia).

The LHVs at the BHU and private clinics in the nearby towns of Fateh Jang, Wah cantt, Taxila and Attock, are visited by the women in Jaffer to avail these services. Only women of wealthy families and wives of men on the payroll of the army, police, railways and other departments enjoy special medical facilities and use their antenatal care services.

The general mobility constraints on young women do affect antenatal care-seeking as well. One of the women said,

"mard sakht hein, kehtay hein akeli na jayein"

[men are strict, they say that (women)should not go alone]

[317] Pregnancy Care and Post Natal care Guide, WHO 2008.

If men see a woman going alone somewhere, they do taunt her husband saying,

" tumahari beewi khud ja rahi thi akeli"

[your wife was going all alone, herself]

Thus women also put extra restrictions upon themselves to avoid unnecessary gossip and speculations among the villagers. In case they meet other women outside their own compound, in the street or on the road, it is ensured that information is exchanged on the whereabouts of each other and the purpose of the visit is known. Even, mother and daughter going alone, are frowned upon without a male accomplice. A male family member, even a young or minor boy going with the women, is thus a common practice.

Another deterrent for going to the BHU for antenatal care, is the unwelcome attitude of the providers there unless some money is paid as an 'under the table fee'. When, I asked a mother-in-law whether her seven-months pregnant daughter-in-law had any check-up from the hospital, she said,

"Ghar day munh tay aspataal aay , fir wi naeen jaandi"

[The hospital is just in front of the house, even then she does not go]

The daughter-in-law replied,

> *"Minnataan arzaan naal check karday nein. Check up day tees rupay tay peeshaab check karan day phachaas rupay."*
>
> [One has to beg and request them to do a check. (have to pay)Thirty rupees for the check-up and fifty rupees for the urine test.]

Pregnancy is considered a normal thing to happen to a married woman and the elder generation having survived child births without a significant problem or disability, considers these antenatal checks a sheer waste of money. A woman remarked,

> *"ab to bohat fazool kharchiaan ho gayee hein; pehlay to 'dai' ko waqt aanay par bula laitay thay"*
>
> [there are many extravagances now; earlier we would only call the *'dai'* when the moment comes (of delivery)]

Most of the women rely on *'dais'* to confirm pregnancy and then to examine them in the seventh month to determine the position (whether the baby's head or buttocks or shoulders are facing the cervix and thus will come first at birth) and the lie of the baby (position of the fetal body vis-à-vis mother's vertical posture i.e. vertical or transverse). The *'dais'* in the village are confident of their ability to perform vertex or breech deliveries but refer the transverse ones to the hospital. One *'dai'* also attempts to correct the transverse lie by maneuvering the baby through hand- massaging the uterus. The advice of *'dais'* is also sought if there is any abnormal vaginal discharge or pain. The mother-in-law usually sends for the *'dai'* to do *'maalish'*, (massage) starting from the eighth month. This develops the necessary rapport and trust between the mother and the *'dai'*.

8.1.10 Patient-Provider Interactions

The observation of the patient-provider interactions particularly provided an insight about the negotiations between the healer and the pregnant women; and the circumstances under which decision-making processes take place.

8.1.10.1: Patient-Provider Interaction-1

I had gone to interview one of the ladies whose house was near the BHU, we started talking and then it was time for her to cook food for the children. I left her to her chores and we agreed that I should visit her in two hours, when she is finished with her work. It was hot, so I thought rather than going back home, I should spend some time at the health facility.

It was the season of '*kharboozay*' (melons); and the village was known for its produce of melons. Both the LHV and the TBA were sitting enjoying the fruit. As I entered, they offered me a slice and I told them that I just had some at another place and asked about permission to sit there and wait. The portion of the BHU for female patients had a lounge with a wooden bench for patients waiting for their turn, an office of the LHV and an

adjacent examination room partitioned with a curtain. The office was a small space with a wooden office table and a chair with a knitted seat and small cushions placed on the seat and at the back. Their red covers were worn out and had turned brownish due to dust. In front of the LHV's table were a chair and one bench for the patients. Behind the chairs was another examination table covered with a white sheet that had yellowed with use. Women come from far-off villages on foot and as they enter the room, they would put the child they are carrying in their lap on that table. Anything else that cannot be accommodated on the office table was seen placed on this examination table but I never saw it being used for examining. All examinations took place in the room behind the curtain. At one side near this examination table were the *'chadars'* (wraps) of the TBA and LHV hanging from nails in the wall.

There was no patient at that time and we had a chat about how hot the weather was becoming and the inconvenience with long hours of power shut-down. The TBA removed the plates and cleaned up the table and went out of the room. She came back saying that the LHV's baby had woken up from sleep and was crying. They were using one of the vacant residential quarters to keep things of their necessity and use it also as space to keep the children. The only female washroom that both workers used was also in these quarters.

The LHV went out to breastfeed her baby and the TBA accompanied her to pick up her things and get ready for closing the clinic. After ten minutes, a petite patient in her early twenties clad in a black '*chadar*' entered along with an elderly woman in her early fifties. There were two young girls, one about two years old carried by the older woman and the other one about three years holding the finger of her mother.

They asked me about the LHV and I told them that she had gone to feed her child and would be back soon. They were curious about me, whether I was another patient waiting (meaning their turn will be after me). I told them that I was a guest.

The younger baby girl sat on the examination table and the women loosened the chadars around their necks to allow the fan air to cool them. I learnt that the younger one is the mother of the two young girls. The older woman accompanying her was her mother-in-law; who told me that her daughter-in-law was seven months pregnant and had come for an antenatal examination. In the same breath she requested me,

> *"dua karna is dafa Allah meherbani karay aur isay beta day"*
> [pray that this time Allah be kind to her and gives her a son]

Half an hour passed and the two ladies become restless that the LHV had not come and they had to get back home. Then, the TBA came and they requested her to call the LHV. She went out and in another ten minutes the LHV came. The woman handed over her previous prescription. The LHV glanced over it. The woman said,

> *"mera dil jalta hay , aur baraf khanay ko dil karta hay- Agar baraf khaoun , to us ki taseer bhi garam hay"*
> [My heart burns and I want to eat ice- but even if I eat ice, its tempertese is hot]

LHV advised her,

> *"Mein goliaan likh deti houn lay laina ya doodh lay laina. Hamaray paas BHU mein bhi goliaan hein ya bahir say khareed sakti hein- aik hi qeemat hay paanch rupay. Mein aap ko check kar loun."*
>
> [I can prescribe tablets for you to take or drink milk. We also have those tablets at BHU and you can also buy from the outside- the cost is the same, Rs. 5. Let me examine you]

LHV motioned her to the examination room behind the curtain. In another five minutes they were back. The LHV asked the woman to stand on the weighing scale and recorded her weight.

Woman: *"Has the weight increased (with concern)?"*

LHV: *"Yes, a little. You need to eat better. Here is your prescription and the date of the next visit. Next time, I shall be giving you the injection (Tetanus Toxoid) as well. You want to take tablets for heartburn?"*

LHV asked the TBA to see if the dispensar was there and she came back saying that it was already one-thirty so he had left as the facility closed at two.

The LHV said, *" bazaar say lay laina"* [buy it from the market]

The pregnant woman put the prescription in the little hand purse she was carrying and both the women left with the little girls.

8.1.10.2 Patient-Provider Interaction 2

I had come to see the female health service providers at the hospital and the acting Medical Superintendant asked the *'chowkidar'* (guard) who had accompanied me to take me to a female doctor, a paediatrician but also a person who was examining general female patients. The *'chowkidar'* took me to the official TBA/ female helper trained as a *'dai'* (an elderly woman with blue *'shalwar kameez'* and a white thin *'chadar'*) who ushered me into the doctor's room. I introduced myself briefly and requested the doctor to see the patient first as I may take a bit longer of her time.

The doctor who is young (must be a recent graduate) and wearing a white coat (coverall) turned to the woman sitting besides her on the patient's stool (a revolving height adjustable steel stool with a round seat and no back); I sat in the other corner and the TBA on the bench in that room with her feet up to rest them and started kneading her calves. A woman was seeking care from a Woman Medical Officer. Presented below is the dialogue between them:

Woman : *"Mujhay chotha maheena hay aur dekhain meray jism par yeh sab nishan hein"*

[I am with the fourth month and see my body has all these blemishes]

Doctor : *"Phir mein aap ko koi dawai to nahin day sakti"*

[then I can not give you any medicine (to eat)]

Woman : *"Koi tube hi likh dein. Mera sara jism kharaab hota jar aha hay"*

[Then at least prescribe some tube (ointment). My body is all getting bad.]

Doctor: *"Mein tube likh kar day rahi houn bazaar say mangwa laina"*

[I am prescribing a tube for you, send some one to get it from the market]

Woman: *"Bazaar say kon laa kar day ga, yahaan wali likh dein*

[Who will get it from the market for me, write the one (available) from here]

Doctor: *"Yehaan wali khatam ho gai hay"*

[the one from here, is finished (out of stock)]

Woman: *"Achi si likh kar dein. Achi tube likh kar dein- Hath pair bhi so jatay hein, koi samajh nahin aati"*

[Write a good one. Write a good tube- (My) hands and feet also go numb, (I) can not understand why]

Doctor: *Yeh parchi lay lo- Hamal ka check up kamra number cheh mein karwaein.*

[take this prescription-get the check-up for pregnancy from Room No. 6]

Woman: *Woh kidher hay?, thora bata dein*

[Where is it? Tell me a little]

Doctor looks at the TBA (expecting her to respond)

TBA: With arrogance to the woman, still squeezing her legs

"Bahir niklo gi to nazar aa jaye ga- Ham kis kis kay saath jayeen".

[You will see it when you go out- How many should we accompany]

As, the doctor turned towards me, I briefly explained the objective of my visit and was also referred to room No. 6 as that was the place where all 'female reproductive health' was being dealt with. As I came out of the doctor's room, the same woman patient was sitting with her four or five year old son, in front of Room No.1. Obviously she was unable to read and find Room No. 6.

8. 2 Childbirth and Care

Child birth at home, has been the norm in the village. Women prefer delivering at home as there is a lot of help around and the advice of the *'dai'* is considered more convenient to follow than the strict un-friendly regime at the hospital. A woman recalled her child birth experiences and shared then with me,

> *"bacahy ghar par hi hotay thay. 'dai' so rupiya leti thi. 'dai' kehti thi keh dardoun mein chaltay raho. Aspataal mein ta dak chordiaan haur teekay bhi lagandiaan nein".*
>
> [Children were given birth at home. The *'dai'* would take hundred rupees. The *'dai'* would say, keep walking during the pains. In hospital, they hold the women captive and also put injection needles into them.]

Even if the *'dai'* gives shots, her technique is considered more humane. A woman who had very heavy babies, appreciated the fact that the '*dai*' would prefer to leave the body to its natural course in the process. She recalled,

> *"dai aati to tangoun mein teekay bhi lagati magar kabhi khaincha taani nahin ki.bas intizaar karwaati rahein"*
>
> [The 'dai' came and would inject in the legs but never pushed or pulled. Only asked to wait (for the baby to come).]

A positive characteristic of the '*dai*' as a provider is her full time reliable availability in the village. The '*dai*' is called just when she is needed, as one woman remarked,

"dai ko us waqt hi bula laitay thay"

[I would call the '*dai*' at that (precise) time]

The village people acknowledge that the '*dai*' has no formal training. One of the husbands said,

"Jaatwan kaam hay yehan, log khud hi karigar ban jatey hein. Phhir pehlay itni museebat nahin hoti thi. Khoorak achi thi. Ab to dactaroun kay paas bhaagtay hein"

[We have novices working here, people by themselves become specialists (develop workmanship). Then we did not have too much inconvenience earlier. Food was good. Now people run to doctors.]

He also refers to the good nutritional status and more stamina in women in the old days. Women were shyer earlier and even wanted to keep their delivery a secret from the menfolk in the family. As one elderly woman remarked,

"Dua kartay thay keh Allah raat day day keh zachgi ka mardoun ko pata na chaley".
[We would pray that Allah gives night (as time for the birth) so that the men do not come to know about the delivery.]

Keeping pregnancy, child birth and its related eventualites a secret from men does not fare well for the women in case of complications when men's support is required to shift to the hospital. This sense of shame is still prevalent and men feel that they are kept in the dark and not made part of the decisions unless there is a need to shift the woman to a hospital at the last moment. A young father shared his experience of being pushed out of the house at the time of delivery when many older kin women had gathered in the house and scolded him for roaming in between the womenfolk.

Women take *desi ghee* (butter oil) in the last days of the pregnancy not only as a diet but to act as a lubricant in the birth canal and facilitate the delivery. A village *dai* said,

"Qahwa bana kar desi ghee pila dein, to bacha jaldi ho jaata hay. Aathwein maheenay say thora thora desi ghee laina shurooh kar 'dai'tay hein."

[If a woman is made to drink tea with added *desi ghee*, the child comes quickly. From eighth month onwards, *desi ghee* is started to be taken in small amounts]

8.2.1 Amulets for Easing the Pain of Childbirth

As girls start menstruating and experiencing some kind of discomfort, their mothers often tell them that this pain is nothing as compared to the one in childbirth. They are scared, rightly so, during their first pregnancy more than other times. It is a common practice among the village women, to seek a *taweez* (amulet) from the *Pir Sahib*.

These include amulets for fastening to the groin of the pregnant woman or reciting for easing the pain of childbirth by using the following Quranic verses:

"Verily, with every difficulty there is ease, Verily with every difficulty there is ease.O people, fear your Lord. Verily, the quake of the hour is a terrible thing!The day you shall behold it, every suckling mother shall forsake her suckling, and every pregnant female shall drop her load. You shall behold the people (as) drunken, yet they will not be drunken, but the wrath of Allah will be terrible".(Al Quran94:5,6 and 22:1,2)

Another prayer is written with saffron on a piece of paper and tied to the right arm or the neck of the mother as an amulet for as safe childbirth.

يَا خَالِقَ النَّفْسِ مِنَ النَّفْسِ وَ مُخْرِجَ النَّفْسِ مِنَ النَّفْسِ وَ مُخْلِصَ النَّفْسِ مِنَ النَّفْسِ خَلِّصْهَا۔

"O He who creates life from life, O He who brings out life from life, O He who delivers life from life, deliver (the child from the womb)".

The following prayer is also recited at the time of birth of a child for a safe and smooth delivery.

اَللّٰهُمَّ لَا تَذَرْنِیْ فَرْدًا وَّ اَنْتَ خَیْرُ الْوَارِثِیْنَ
وَاحِدًا وَحْشًا فَیَقْصُرُ شُکْرِیْ عَنْ تَفَکُّرِیْ بَلْ
هَبْ لِیْ عَاقِبَةً صِدْقًا ذُکُوْرًا وَ اِنَاثًا اٰنِسْ بِهِمْ مِّنَ
الْوَحْشَةِ وَاسْکُنْ اِلَیْهِمْ مِنَ الْوَحْدَةِ وَ اَشْکُرُکَ
عِنْدَ تَمَامِ النِّعْمَةِ یَا وَهَّابُ وَ یَا عَظِیْمُ وَ یَا مُعَظِّمُ
ثُمَّ اَغْطِنِیْ فِیْ کُلِّ عَافِیَةٍ شُکْرًا حَتّٰی تَبْلُغَنِیْ
مِنْهَا رِضْوَانَکَ فِیْ صِدْقِ الْحَدِیْثِ وَ اَدَآءِ
الْاَمَانَةِ وَ وَفَآءِ بِالْعَهْدِ۔

"O' my Allah, do not leave me alone (childless), though You are the best of inheritors. Sorrowfulness due to loneliness and sense of abandonment made me fall short of what I should have done to thank You, but (I beseech You to) give me an upright and honest posterity, male and female. On account of them change my loneliness with companionship and let there be ease and comfort instead of desolation, so that I should thank You on the completion of bounty, O' the great, the giver of greatness, then keep me continuously in ease and comfort, till I am favoured with Your pleasure, because of my truthfulness in whatever I say, I promise and I do".

Women have learnt these from the previous *Pir sahib* and one of the female relative would do '*wudu*' and recite these when the pregnant mother is in the process of labour.

8.2.2 Management of False Labour Pains

False pains are not the true labour pains as they do not progressively increase in duration and intensity. These contractions are common during the last week of the pregnancy and may cause concen among the women if the labour has started.

The term '*hawaai dard*' means that the pains are caused by the movement of air inside the uterus. According to *Unani Tibb*, air is cold and thus the *'dai'* treats it with internal fomentation. A '*dai*' advises,

"rui mein dalda kosa kar kay ander rakhein to hawaai dard theek ho jatay hein."
[Warm '*dalda*' (commonly used brand of vegetable ghee) in cotton and keeping it inside (vagina) will cure the false pains.]

A little ball of cotton wool is soaked with ghee and warmed in a utensil over fire. The '*dai*' puts her finger in the warm *ghee* to see if it was just the right temperature (warm but not too hot to cause an internal damage). She then rolls the cotton ball with her fingers and squeezes the extra *ghee* out. This cotton ball in shape of a tampon, is thus inserted into the vagina. She would then, visit the woman the next day to check upon her and if the tampon has not fallen out itself, she pulls it out with her fingers. If the pain persists, a new tampon is placed.

The '*dai*' provides reassurance to the woman and asks her to watch for continued pains and send for her. An adult man or a woman comes to call the '*dai*' at the time of delivery asking her to come and see. A child is not considered appropriate to bring such a message.

8.2.3 Notion of Hot and Cold Feet (*Tatta Per/ Thadda Per)*

Labour is the time for a woman to focus her energy and concentrate on achieving the task of pushing the baby. It is common for elder female members of the family to gather in the house out of concern and to participate in the immediate happenings. They will then, relate the minute details to other women later. Too many people around may distract the mother to be.

Dai's think that labour pains become slow with many people around and because of this reason, they try to minimize the number of women in the room together with the woman in labour. Further scrutiny of those fit to be present or absent is done on having '*thadda per*' (cold feet) or '*tatta per*' (hot feet). If a person/woman has cold feet, the labour pains slow down and if she has hot feet, the labour pains will increase in intensity and progress.

"banday, banday say farq parta hay , is liyee sahih logoun ko saath hona chahiyee."
[each individual makes a difference, that is why the right people should be accompanying]

Thus, the '*dai*' manages to screen the women on this basis and allows only those she finds useful. In a very non-offensive and diplomatic way, the un-wanted relatives are kept out.

8.2.4 Giving Birth *(Laveri Hona)*

'*Laveri*' is the local term used for a female giving birth. The same wording is used for the female cattle. A woman must become *'laveri'* in her in-laws house. As opposed to traditions in central Punjab, it is the house of in-laws where the childbirth takes place.

The *Dais* use injections to induce labour. They justify oxytocin injections on the ground that when a woman has been given injections of Tetanus Toxoid during pregnancy, she needs a shot to induce labour. A '*dai*' explained,

> *"aap hifazati teekay lagatay ho to phir zachgi bhi baghair teekay kay nahin hoti."*
> [you (modern people) give preventive injections so similarly then the birth also does not take place with out an injection]

In one of the deliveries that I witnessed, the '*dai*' after arrival immediately examined the mother to be internally, with bare fingers. She had wiped her hands before that with her shabby *'chadar'* and rubbed them to warm them a little. She was silent during the process and in deep contemplation. She removed her fingers and gave assurance to the anxious mother that every thing would be alright now that she had come.

In another woman's case, the '*dai*' had said,

"jaan wee khulli nahin aay"
[uterus has not opened yet]

She then told the mother-in-law that she is going to fetch a *'taweez'* (amulet) because without it the baby will not be born.

The things collected by the '*dai*' in preparation of the labour would be bricks to sit on, '*taat*'(jute rag), brick or sand for warming and providing fomentation and luke warm water for the baby to be bathed. The woman in labour is advised to walk around till she cannot walk any more. As there is leakage of the water bag or bulging is seen at the perineum, the '*dai*' advises her to make the position for delivering.

The woman's perineum is cleaned with a cloth dipped in warm water to ensure that the baby did not come into the world via a dirty environment. *Desi ghee or dalda* (butteroil or vegetable ghee) is warmed and applied in the vagina and on the perineum by the '*dai*', dipping her fingers in it and massaging it inside and around the vagina. Lubrication is seen as a mean to encourage birth, to make the birth canal more slippery and to encourage an easy fetal descent or to support the lower body to stretch and thus prevent any skin tears. *Dais* felt proud that by doing so the woman does not need an episiotomy (a cut in the perineum performed at hospitals which is painful during the healing process).

The *'dai'* applies warm compresses on the back, perineum and shoulders and massages the area to comfort the woman in labour. The woman keeps wearing her shirt but the shalwar is taken off before squatting down in the final stage of labour. The woman in labour will sit in a squatting position with her feet, one each on two bricks to elevate her from ground level and keep room for the baby. A folded cloth or '*taat*' (jute bag) is kept underneath on which baby will descend. If the floor is not cemented the *'dai'* digs some mud out and this little ditch will hold all leakings and blood underneath the woman.

The '*dai*' sits on the back of the woman. The bricks are placed close to a charpoy (cot). The woman in labour will either hold the *charpoy* and push or if there is a female relative around, she sits on the *charpoy* in front of the woman and she embraces her with her arms going below the armpits of the woman and *qalaaba marna* (cris-crossing at the back of

her shoulders). As the woman's urine leaks or there is bulging of the perineum, the '*dai*' knows its time for the delivery to occur.

The '*dai*' supports the perineum from the back as the woman leans forwards and pushes, as the baby comes out and falls on the cloth, '*dai*' pushes the woman reclining her backwards slightly and rubs her abdomen and put pressure on the abdomen to deliver the placenta.
In an alternative practice by another '*dai*', a wooden frame of an un-knitted *'peerah'* (wooden stool), is used for sitting by the woman in labour. A piece of un-stitched cloth or an old bed sheet is tied at its ends to all the legs (*paye*) of the stool. It thus, acts like a hanging sling below the mother and catches the newborn baby.[318]

The baby is set aside until the expulsion of the placenta. The cord is not cut till the delivery of the placenta and the crying of the baby. The sweat from mother's forehead and face is wiped with her *'dupatta'* (diaphanous veil) and her back is supported so she can lean backwards on the '*dai*'.

Once the placenta comes out, the *'dai'* will cut the cord off and tie it. She will give the baby a bath, and clean its mouth for any membrane or dirt. She will wrap the baby in a cloth, put 'kohl' in his/her eyes, press his forehead and collect all the mess to bury. The *'aanwal'* (placenta) is buried below the '*parnala*' (the passage where the water flows from the roof top). The men from the family will dig the pit and the '*dai*' will bury the placenta. The placenta is always buried near the house to ensure its mystical power will pull the child and keep him/her loyal to the family home.

Many women do not want to go to a clinic or hospital for delivery fearing that their legs will be tied to the poles of the delivery table and they will not be allowed to move. Even when they request the doctor or nurse to allow them to sit, they are not allowed to do so.

[318] I learnt from one of my Japanese friends that she had opted for a natural birth and the midwife put a big clean towel on the commode seat and made her sit on it and push, which is quite similar to the use of the unknit peerah.

Thus a '*dai*' refers to her clients who say that they prefer her to handle their delivery at home.

"Asi aithay sokhaliaan aan"
[we are at ease here]

The '*dai*' takes her payment in cash or kind depending on the capacity of the household, as one woman recalled that for own deliveries, she had given,

"Taray cheeray dittay tay hazaar rupia ditta"
[gave three pieces of clothing (a matching suit:kameez, shalwar and a dupatta) and a thousand rupees]

8.3 Puerperium (*Chalees Din)*

The post natal period is commonly referred to as '*chalees din*' (forty days) when the mother and her baby need special attention and care. The 'forty days' get reduced to twenty or ten in terms of relaxation from household chores if the mother has other children to look after and no domestic support from the in-laws or natal family is available. Unmarried sisters are called to stay over and help if the in-laws do not have another young woman to take this burden. As the child birth takes place at the house of in-laws, a woman spends the first twenty days of parturition with her in-laws and the next twenty days in her parents' house.

The *'dai'* after giving a *'ghusal'*(bath) and dressing up, places the newborn baby in the mother-in-law's lap and says *'mubarikbaadi'* (congratulations) and the mother-in-law in return gives her money as a tip for saying *'mubarik baadi'*. The mother-in-law takes the baby in her lap and shows it to all the family members. A woman had expressed the joy as she related,

"hamaaray mard baray khush hota hein ; bhagay bhagay aatay hein bachey ko deikhnay"
[our men get very happy and come running to see the baby]

Someone from the family (the father or grandfather) or the Pir/Maulvi Sahib is called to say *'azaan'* (prayer call). This is a Muslim practice to ensure that the newborn child hears

the name of Allah upon his/her arrival into this world. The *'moazzin'* (the one who recites *azaan* and *takbeer*) faces the Kaaba (*qibla*). The baby is placed in front of the *moazzin* in a way that the right ear faces him and '*azaan*' is said in the right ear. Then the baby's place is changed so the left ear faces the *moazzin* and the *Takbeer* (Allah is Great) is said in the left ear.

If the baby is a boy, he is placed in a *'chaj'* (flat surfaced tool used to separate grains from husk) by the grandmother when taken to *moazzin* for *azaan* (prayer call). If the baby is a girl, she is placed on a *'peerhi'(small wooden stool). 'Chaj'* signifies grains and abundance. It is a token that the boy will grow up to be the bread winner (hence the link with grains) and the girl will take over the hearth (sitting on a *'peerhi'* doing *'haandi choolha'* : cookng pot and the stove). To commemorate this occasion, sweets are distributed among those present after saying *'azaan'*. After the *'azaan'* the baby is given a *'gurti'* (a sweet pre-lacteal). It is usually honey placed on the finger of an adult and put into the mouth of the baby to suck. It is thought that whoever gives gurti, his/her traits are transferred to the baby. It is *Sunnat* (way of the holy prophet) to rub honey or pulp of a softened date on the baby's gums. This is called *'Gurti'* in the village and in Urdu called *'Ghutti'*.[319]

The baby's eyes are lined with kohl or '*surma*' (colirium) to make the eyes look bigger. A black dot is placed on the forehead and a black string is tied around the wrist of the baby. Since, a black mark is commonly regarded as a blemish, the belief is that both the black dot and the black string, will outwit the evil eye into thinking that the baby is unattractive and leaving it alone.

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[319] It is stated in *Tafseere Roohul Bayan* that the first one giving the sweet to the child has a certain effect on the child that the child develops habits similar to his/hers. It is *Sunnah* to have the *Tahneek* of the child. *Tahneek* is when a *Salih* (Pious person) bites or chews on *Khurma* (Date) and gives it to the baby so that the first nourishment that reaches the child is *Khurma* and from the mouth of a *Salih* person. The *Sahabae kram* (companions of the holy prophet) would get *Tahneek* of their children done by the Holy Prophet (PBUH), himself. (Islami Zindagi by Hakeemul Ummat Mufti Ahmad Yar Khan Naeemi.)

The tradition of not selecting a name until the baby has actually arrived on the scene is explained by the wish not to tempt fate. In most families, naming the baby is the prerogative of the grandfather. Parents have little say in the matter. Partly, because of the superstition but mostly due to sentiments, the first garment of an expected baby's layette is made from an old shirt of the grandfather. An old garment is not likely to tempt fate. Besides, some of the grandfather's fine attributes, it is piously hoped, will be passed on to the infant when he wears a *'kurta'* (shirt) made of the old man's shirt.

8.3.1 Sacrificing Animal for the Newborn (*Aqeeqah)*

The *'aqeeqah'* is a sacrifice made for the newborn child. Two sheep for a boy and one sheep for a girl, are sacrificed mostly on the seventh day after the birth. The meat is distributed to the relatives, neighbors and poor. After the sacrifice or *'aqeeqah'*, the baby's head is shaved. The hair is weighed and an equivalent weight in silver is given in charity. Baby boys are circumcised mostly when they are seven days old. It is also traditional not to choose a name for the baby till the seventh day.

8.3.2 Pain of Involuting Uterus (*Gola)*

'Gola' refers to the ball/sphere like shape of the contracted uterus after the birth of the baby and the placenta. In the early postpartum days, the uterine contractions cause pain which is called *'golay da dard'* (pain of the ball). It is believed that the empty uterus longs for the child and tries to find it in the belly by moving and this movement causes the pain. Fomentation with a hot brick and taking hot foods are tried to treat this pain.

8.3.3 Treatment of Soreness of the Perineum

The d*ais* recommend '*angaray laina*' (taking fumes from hot coal ambers) to ease the sore perineum after the child birth. The technique is described here in words of a local woman,

"Koilay lein jaltay huey. Patti cheeni mila kar daal dein. Phir in par baith jayeen. Dhuaan khatam ho to chor dein. Eentein rakh lein neechay; bacha paida honay kay do teen din kay baad. Pait halka ho jaata hay , dard naheen hota. Takor hoti hay, ander say jism halka lagta hay. Mahwari ki takleef kay liye larkioun ko bhi kehtay hein. Ander ki sojan kay liye bhi angaraay lein. Sojan mein pait mein bhari pan hota hay; bhari bhari hota hay"

[Take burning coals. Mix tea leaves and sugar and put these on them. Then, sit above them. Stop when the fumes end. Keep bricks underneath (the feet); two three days after the child is born. The belly gets lightened, the pain stops. It provides fomentation, the body feels light from within. It is also recommened to girls for the pain of menses. Take '*angaaray*' (burning coals) also for inside inflammation. There is heaviness in the belly during the inflammation; feels heavy, heavy.]

8.3.4 Food Preferences during Postpartum Period

Special food is given to the woman in the post partum period to revive her strength and for promoting lactation. However, this preferential treatment is only metted out to her if a boy has been born. In case of the birth of a girl, this privilege is either withdrawn or lowered drastically. Even the cattle get better treatment as they get the priviliged diet irrespective of the sex of the offspring (though a female buffalo or goat is more cherished due to its milk and baby-producing capacity and higher economic value). The cattle is fed a mixture of *ajwain* (seeds of Bishop's weed), brown sugar (*shuker*) and boiled wheat grains.

8.3.5 Body Massage

The *'dai'* comes for massage of the mother and also helps her in other chores such as washing, cooking, cleaning etc. There is immense social pressure on the mother-in-law to take care of the new mother and her performance is observed by the visitors coming to give '*mubarikbadi'* (congratulations). This care is more focused on the massage of legs

and the body and abstaining from hard work, and especially work that involves putting hands in water.

> *"Agar saas nay sambhaala nahin; malish nahin ki to taangein dukhti rehti hein. Pait aur taangoun ki maalish honi chahiye."*
>
> [If the mother-in-law did not take care; did not (arrange) massage, then the legs would keep hurting. The belly and the legs need to be massaged.]

"*Hawa lagna*" (catching the air) and *'thand lagna'* (catching cold) needs to be avaoided both by the mother and the baby. It is believed that *'hawa'* or the air, not only can cause body aches and fever but also harm the internal organs of the mother which get inflamed. In the newborn baby the manifestation of this affliction is 'pneumonia'.

8.3.6 Problems in Labour and Post-Partum Period

The common problems mentioned by the *'dais'* and the women are retention of placenta, heavy bleeding (ante-partum or post-partum), obstructed or prolonged labour, transverse lie, prolapse of the cord and breast abcess (*chahti mein kas charna*). The other direct obstetric complications- Pregnancy Induced Hypertension (PIH), Post partum Sepsis (fever) and tetanus, listed in the causes of maternal mortality in chapter one, are not reckoned as common complications.

In one case of a maternal death in the village, the daughter of the deceased woman told that her mother had kept some saving aside for difficulty in labour but her father never took her condition seriously enough to bother himself despite the pleas of the *'dai'* (traditional birth attendant). The woman had died as it was night time and neighbours could not help as they were not informed- the woman had no natal kin in the village to provide essentially needed help.

8.3.6.1 Retention of Placenta (*Anwal na parna)*

If the placenta does not deliver within half an hour of the delivery of the baby, it is a serious threat to the mother's life. The '*dai*' would put pressure on the abdomen to assist its expulsion. If it still does not come, vomiting is induced by putting the end of mother's pig tail in her mouth and throat and it is considered that this would help expulsion.

8.3.6. 2 Heavy Bleeding/ Haemorrahge (*Khoon Ziaada Parna)*

In this case the '*dai*' raises the foot end of the mother's *charpoy* (cot) and rubs her abdomen to help the uterus contract and stop the bleeding.

8.3.6.3 Obstructed labour (*Bachay Ki Pai'Dai'sh Mein Rukawat Hona)*

If labour pains are strong and still the baby does not come out after 12 hours, this is a danger sign. It is said that the woman in labour, starting from sunrise, should deliver by sun set and vice versa. Seeing two sunrises or two sunsets with labour pains is very dangerous and the woman and her baby may die.

8.3.6.4 Referral of Complications to a Hospital

Dais think that it is not the nature of the problem but how the mother behaves, that determines whether her family would take her to the hospital or not. The one who endures all suffering with patience and in silence would not be taken to the hospital even, if the *dai* or LHV refers her. A woman would only be referred to hospital if she was fatally ill. However, if the mother-to-be makes a big hue and cry, she is likely to be taken immediately to the hospital. A *dai* remarked,

> *"Agar larki nazuk ho aur parhi likhi ho aur ziaada shor machaey to narmal case ko bhi Taxila lay gaye aur jo case mushkil bhi ho to usay nahin lay kar gaye"*
>
> [If the girl is sensitive and educated and makes more noise then even a normal case is taken to Taxila and the one which is difficult is not taken]

Dais feel they can convince the family for referral if they switch the focus from the mother to the baby in the womb and say,

"bachay ko khatra hay"

"the baby is in danger"

This strategy usually works and the family is convinced, especially if they are hoping for a male child. Poverty is another factor in not seeking hospital care in pregnancy. Sometimes, the woman is taken to the hospital and advised for an operation, the family brings her back if they cannot afford the treatment costs.

8.3.7 Patient-Provider Interaction 1

I was interviewing one of the LHVs at the out patient department of the hospital, when a mother and daughter entered her office for examination.

The mother was very frail, in her forties; the girl looked like she was in her late teens. Both were wearing colourful *chadars* and typical Afghani long frocks. Many Afghanis have stayed in Pakistan after their migration during Afghan war and still about 1.5 million are waiting to be repatriated.

Daughter: *"Ammi ko dikhana hay" (in broken Urdu)*
[Have to show Ammi (mother)]

LHV: *"Tum kioun bolti ho"?*
[Why do you talk?]

Daughter: *"Is ko zubaan nahin aati".*
[she does not know the language.]

LHV: grumbles
"Bachay paida kartay hein zubaan nahin aati. Yeh bachay band kioun nahin karti?"
[litters (gives birth to children), (but) does not know the language. Why does she not get the children stopped?]

Daughter: *"Gunah hay, is liee band nahin karti. Panch maheenay hein, harkat nahin ho rahi".*
[It is a sin, so she does get them stopped. She has fifth month and movement is not happening.]

LHV: *"To yeh jo pait mein bacha tang kar raha hay, yeh gunah nahin hay".*

[And the child in her abdomen, making her miserable, this is not a sin.]

Daughter: Keeps silent

LHV: *"Itni bari beti hay, beti lay kar phhir rahi hay. Nangi hoti hay , tum log dekhtay ho. Tumhein sharam nahin aati. Pehlay giaara bacahay hein. Yeh ab mar jaye gee".*
[Such a grown up daughter! daughter is taking her around (roaming). (she) gets naked and you people see her. Don't you get ashamed? She already has eleven children. She is going to die this time.]
Pauses
"Tum kanwari larki ho. Tumhein yeh patta hay keh panchwein maheenay mein harkat hoti hay".
[You are an unmarried (virgin) girl. You know this, that (foetal) movement occurs in the fifth month]

Meanwhile she signs the mother to get on the couch and palpates her abdomen.

"Paisay ki dawai lay kar aa nahin saktay. Idher nahin aana. Damagh kharaab... mein case nahin karti... bacha itna sa hay. Is ka miaan kia karta hay?"
[Can not get medicine with money. Do not come here. Insane.....I do not do (your) case..... the child is this (small)...what does her husband do?]

Daughter: *"sabaq parhta hay. Masjid mein parhaata hay".*
[reads lesson(Holy Quran). Teaches in a mosque.]

LHV: as if remembers ...
"yeh woh hay.....Jab yeh pehlay aai thi to tumhari behan ro rahi thi".
[she is the one....when she came earlier, he was about to die and your sister was crying.]

Starts writing a prescription and say to the girl,

" Tum kitni baitiaan ho. Maan ko lay kar chal pari ho. Tumhaaray baap nay kisi ki shaadi bhi ki hay ya nahin?"
[how many daughters are you? Pulling your mother around. Your father has not wed off any of you?]

Gives prescription to the girl and says,

"Yeh store ki dawaai hay. Doodh do aur achi khoorak do. Warna tum bathi raho gi, baap kay saath."
[This is medicine from the (hospital) store. Give her milk and give her nutritious food. Otherwise you will be left sitting with your father.]

Turns towards me and says,

"jab pehlay aai thi, khoon shurooh ho giya tha OPD mein baithay baithay. Yaheen bench par delivery karwani pari. Ab yeh phir koi museebat banaye gi. Mein aisay case nahin leti. Mera naam bhi badnaam ho ga."

[when she earlier came, bleeding started while she was sitting (waiting) in the OPD. Had to do the delivery right here on the bench. Now again she will cause a problem. I do not take such cases. My name (reputation) will also be ruined.]

As, the mother and daughter leave and I resume my questions, asking how many children does she have?

LHV : *" Meri apni paanch beitiaan hein. Aik ki shaadi ki hay. Har dafa baitay ki aas mein. Phir socha bohat ho chuka, phir aur bachay paida nahin kiye."*
[I have five daughters of my own. One I have married off. Every time in hope of a son]

I asked : *You seem very experienced. Have you ever had to refer a case?*

LHV: *"Mujhey sab kuch karan aata hay. Har qism ka case. Forcep laga leti houn. Epi day deti houn . Sirf section nahin kar sakti. Woh bhi agar chaar ya panch dekh loun to kar sakti houn. Lekin hamein is ka ikhtiaar nahin."*

[I know how to do every thing. Any kind of case. Can apply forceps. Can perform *'epi'* (episiotomy). Only can not do a (caesarian) section. Even that I can do if I see four or five of them (happening). But we are not authorized to do that.]

The narration of this encounter with a Lady Helath Visitor, brings us to the end of this chapter. Pregnancy and childbirth are important landmarks in life of the village women. Understanding the impact of local culture for management of an illness at this stage provides the insights about the important actors in the process. This complex and shared decision-making process involves the spouse, the in-laws and other women. The indigenous healers and *'dais'* are preferred due to their better communication abilities and shared understanding. The modern pregnancy care system is not considered friendly due to limits set by the economic capacity of the villagers to pay for services, problems of distance travel for women in purdah, and the alienation felt from western medical practitioners and practices.

The next chapter describes the desires and aspirations of women for having children, how they manage to control their fertility and how some of them facing problems of infertility shape their decisions for care-seeking.

CHAPTER 9

TO HAVE OR NOT TO HAVE BABIES

The village Jaffer, like any other human population, thrives on the continuous supply of children. A woman's life revolves around her fertility; the pre-puberty period at one's natal home socializes her to the role of the mother. With menarche, comes the power of fertility and the need to preserve her chastity. As she gets married, the demands of childbearing and especially, having sons push her into an early motherhood. Once the desired number of at least two sons is attained, she tries to control her fertility by indigenous techniques, use of modern contraceptives and abortion. There are some women whose wish for children will not come true and their energies will be focused on trying anything to get pregnant. This entire struggle to have or not have a baby involves multiple and complex decisions involving the woman herself, the couple, the family and the providers. In this chapter, various dimensions of these decision-making processes are explored. Firstly, the concepts of fertility are presented with the perceived value of children. Secondly, the motives of fertility regulation or family planning, are examined. Thirdly and lastly, the problems of infertility are discussed. Relevant oral histories of women are presented to illustrate the various decision making-processes and their impact on reproductive health of the village women, in general.

9.1 Fertility

Fertility is the biological function of giving life. This is different from fecundity, which is defined as the potential for reproduction (influenced by gamete production, fertilization and carrying a pregnancy to term). Hence, where 'fecundity' refers to capacity to produce living offspring; 'fertility' refers to actual performance. Thus fecundity, is the procreative capacity while fertility is natality.[320] Human fertility depends on different factors such as

[320] Frank, Lorimer (1954). Culture and Human fertility: A study of the Relation of Cultural Conditions to Fertility in Non-Industrial and transitional Societies. Paris: UNESCO

nutrition, sexual behaviour, culture, instinct, endocrinology, timing, economics, way of life and emotions etc. Sub-fertility refers to lowered fertility and infertility, is deficient or absolute absence of fertility. Though, fertility involves the reproductive capacity of both the partners, it is the women who get all the blame for not producing children.

The various cultural factors which impact on fertility, are the systems of marriage, the family and religion; regional sub-culture, norms concerning desired family size, astrology and breastfeeding. The changing role of women in the kinship network also affects fertility.[321]

Although women can become pregnant at any time during their menstrual cycle, peak fertility occurs within just a few days of the cycle: usually two days before and two days after the ovulation date. The ovule is usually capable of being fertilized for upto 48 hours after it is released from the ovary. Sperm survive inside the uterus between 48 to 72 hours on the average, with the maximum being 120 hours (5 days). Women's fertility peaks around the age of 19-24 years, and often declines after 30 years.

Fertility is the capability of a person to conceive and to reproduce, though it takes a heterosexual union of two adults, but the burden of failure to reproduce is usually borne by the woman alone. The concerns of fertility thus lie at the core of the cultural context of female reproductive health decision-making.

> *"....the threat that infertility itself poses to a woman's femininity and a man's masculinity. At the core of each woman is her ability to carry a child , and at the core of each man is the ability to get a woman pregnant and to continue his lineage.(Mealey 2004 : 18)* [322]

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[321] Nibhon, D. Noppovan C.(1981) Journal of Thai association of Voluntary Sterilization Vol. 1 Dec.(p. 5-18)

[322] Mealey, S. E., 2004-08-14"The hidden Society: A sub-culture of Women dealing with infertility" Paper presented at the annual meeting of the American Sociologist association, Hilton, San Francisco and renaissance Parc 55 Hotel, San Francisco, CA, Online <.PDF>.2009-03-04 from http://wwww.allacademic.com/meta/p109090 _index.html

9. 2 Perceived Value of Children in the Village

The value of children in a given society is crucial to develop understanding about the fertility desires. The village women favour children for the reasons described in next sections.

9.2.1 Fulfillment of Aspirations of Motherhood

Marriage and childbearing are the ideals portrayed and sought by all females in the village Jaffer. The young girls play the mother role by dressing and cuddling their dolls, singing to them lullabies and occasionally asking them not to do a certain thing. Small girls also get small earthen or plastic pottery as toys to emulate cooking and serving. The elder daughter is also supposed to act as a surrogate mother for her siblings and start child minding at a very young age. Upon marriage, there is an extreme urgency to prove one's fertility and become a mother.

A woman's status advances with fulfillment of her role as a child bearer. It is a good omen for the stability of the marriage. Women's role as mothers allow them to connect families by creating, reinforcing and maintaining networks and relationships, allowing them to deploy idioms of kinship with strangers or authoritative figures, providing them with the 'un-contested ' access to the public domain as mothers of all.

> "*har koi maan ji, maan ji kehta hay; ab to apna naam bhi bhool giya hay*"
> [every one calls me "*maan ji*" ; I have now even forgotten my own name]

9.2.2 Gaining Identity of Responsible Adulthood

Having the status of being married and having produced children is the foundational requirement for being considered a grown-up and a responsible person. Women who have not married or produced children, are novices with limited understanding and experience of real life challenges. I was often asked to re-affirm my identity as a married woman and mother of children, by my respondents. The frequent query will be,

"Tumhari shaadi hui hay? Tumharay bachay hein?"

[Are you married? Do you have children?]

Questions abut sexuality and marriage relationships would not be answered without confirming my marital status and if the women want to disclose a more private fact, it was a routine to ask whether, I had children and had gone through the experience which makes a woman transformed to an adult responsible status by becoming a mother.

9.2.3 Continuity of Lineage through the Children

In the predominantly agrarian economy of the village and patrilineal kinship system, the biradari or clan and the lineage is vested with a significance to renew its life and extend its power and prestige. Numerous children are valued as fortifying the position of continuing the lineage, in which the security and prestige of its members, are rooted, increasing its economic and military power, enriching its life, and projecting this life into future. Interest in fertility is, in large measure, an expression of the internally collective, externally competitive, ethnocentrism of the '*biradari*' (kinship unit). This interest is reinforced by the mystical association of human fertility with the fertility of fields and flocks.

Sons are wanted by a mother because they enhance her prestige and that of her husband's lineage, bring added military power in family feuds and contribute to the increase in wealth. Both the early costs and the later benefits are larger for male children than the female children, hence sons are preferred. Children's most significant economic contribution is old-age support and insurance against extreme adversity, especially in this rural setting where other forms of insurance or alternate investment opportunities are non-existent.

In the realm of rituals and ceremonies bringing colour to the life, women want more children to revel in that experience.

"ik da ik hee deehara aay"

[One child has one day (to celebrate) only]

For a single child, a mother can enjoy one marriage only and that occasion of happiness will come only once in her life. However, if she has more children, there are many days to celebrate.

9.2.4 Gaining Status

Child bearing and especially having a son, not only elevates the woman's position in the household but also means greater old age security and authority over the daughters-in-law.

One woman related this phenomenon when she said,

> *"Pehlay zamindarun ki do teen beewiaan hoti thein aur ek doosray ki zid mein ziaada bachay paida karti thein"*
> [Earlier landowners had two or three wives and each kept producing more children in competition]

9.2.5 Signs of Divine Blessing

Children are considered gifts from Allah and signs of His bounty. Women pray and hope for "*goud bhari hona*" (having their lap filled).

Planning the pregnancies and the number of children are considered interference in the Divine plans and women are afraid that it may be equal to insubordination and challenging one's destiny. Power resides in Allah and human beings are powerless in front of the power of the Almighty. Doing something which is against Allah's commandment, may provoke His wrath and be considered by the villagers as against the unconditional submissiveness demanded from a Muslim.

"dartay hein keh Allah na dey to zor nahin; Allah dey to naan nahin karni"

[We fear Allah, if He does not give, we cannot fight him and if He gives we shall not refuse]

Many among the older generation did not use any family planning method and said,

"mansooba bandi dekhi bhi nahin"

[I did not even see the "planning"]

There are many women who accept the fact that they themselves wanted many children. For example, one of the women said,

> *"Mujhey bachey achey lagte they; do pehlay miaan say phir doosray miaan say sotaaley chaar aur teen meray; is liyee Allah miaan ney dher diye. Miaan to ab bhi kehta hein keh ek beta aur ho!"*
>
> [I liked children; had two from my first husband then from my second husband: four step children and two of my own, that is why, Allah gave me in abundance. My husband still says if only we have one more son!]

Family planning should be a joint decision but many women felt that their husband's have never exhibited any interst in the number of children they should have. A woman said,

> *"Miaan nay bachoon ki tadaad kay barey mein kabhi kuch nahin kaha; bus kehtay they, jo Allah dey ga, roti to naseeboun ki hay"*
>
> [My husband said nothing about the number of children, he just used to say, whatever Allah gives, and subsistence comes with destiny]

Another similar comment shows that many men are simply not interested or expressive enough to share their thoughts with their wives.

> *"Mein to sochtee hun do bhi bohat hein; miaan kuch nahin kehtay jitney bhi ho jayeen , Un ko itni soch samajh koi nahin"*
>
> [I think two are enough, my husband does not say anything no matter how many are born, he does not have much thought or understanding]

In an environment with high child mortality, fatalism provides women with emotional support to cope with loss and go on with life. A couple who had only two surviving children out of five born alive, said,

> *"Ham donoun inhi do par khush hein*
>
> [We two are happy with these two]

Two of her children had died in the early newborn period due to pre-maturity and one girl had died due to tuberculosis in her teens.

9.2.6 Proof of a Mother's Procreative Capacity

The term fertile is also used for soil. When early people witnessed the earth bringing forth fruits and grains, they identified it with the same feminine characteristics of creation and nurturing. It was, the mother who fed the young, and the earth that fed the people. In this way, the concepts of a feminine deity of fertility and abundance were evolved and thus the notions of mother earth and mother nature evolved in many pre-patriarchal societies with goddesses of fertility.

The Holy Quran also has this concept when wives are called the fields where seeds of next generation are sowed.

"Your wives are a tilth unto you; so go to your tilth when or how you will." (Al Quran 2:223)

9.2.7 More Children:A Cushion Against High Child Mortality

It is very interesting to note that women in the village have imbibed the messages from the government's family planning campaign on television and radio but still adhere to their own thoughts of what exactly should be the family size given their reality of life.A young married woman commented,

> *"Tee wee dekhti hun, mashwara datey hein kay kunba chota hona chahiyee; beewi ka bhi khiall rakhein; bachey ko waq par doodh pilayeen; bachi ko teen saal pilayeen aur bachey ko dhai saal. Betiaan Allah ki rehmat hoti hein. Khiaal rakhti hein wa'dai'n ka; baitun ki apni marzi hoti hay".*
>
> [I watch TV, they advice for a small family, (a husband) should care for the wife as well, a child should get breastfeed on time; a girl to be breastfed for three years and boy for two and a half years. Daughters are a blessing from Allah, take care of parents; sons follow their own wishes]

Another woman explained further,

> *"Bachey do hi honay chahiyeen sohnay aur suthray, bus achey hun laiq hun lekin koi pata nahin hota; is liyee do larkay hun aur do larkiaan"*
>
> [Children should be two- lovely and neat, should be good and intelligent but one can never be sure; so for this reason, one should have two boys and two girls]

9.2.8 Old Age Support (*Barhaapay Ka Sahara)*

In the absence of any other old age security, sons are the only assurance that the old parents will have someone to take care of them. This strong reliance on sons in the old age, translates into a strong son preference. A widow said,

> *"ek beta hey jis par baadshahi hey"*
>
> [I have a son on whom rests my kingdom]

Thus a mother can only feel secure in their old age if they have a son who can take care of her.

9.2.9 Means of Getting Heaven

Parents want children because they can pray for them when they are dead. Moreover, even the children who are dead can be a source of winning a pardon for one's sins and getting a place in paradise in the next life. A woman had remarked,

> *"Agar bacha chota hota mar jaye to maan baap ko jannat me lay kar jaata hay, lekin mera to koi fot nahin hua"*
> [If a child dies young, he takes his mother and father to heaven, but none of mine has died]

9.3 Prayers – the Semantics of Fertility Desire

Common prayers said for the young women include phrases like :*Allah bachay day* (May Allah give you children)*; Allah goud bhari rakhay* (May Allah keep your lap filled) and *Allah teri nasal bari karay* (May Allah grow your progeny).

Thus decision-making about having children is done in a strong pro-natalist environment. Words from a prayer in the Holy Quran, commonly recited are:

> *"O my Lord, do not leave me alone (childless), though You are the best of inheritors."*
> (Al Quran 21: 89)

Another prayer recommended by the Pir sahib, is

> *"O my Allah, I beseech You in the name of that which Zakariyyaa referred to: O Lord, do not leave me alone (childless), though You are the best of inheritors. O my Allah, bestow on me a goodly offspring from You; verily, You are the hearer of prayers. O my Allah, in Your name I have lawfully taken her (as my wife) and I have appropriated and treated her (as) Your bounty entrusted to me, so if You decide to put a child in her womb, please make (this child) submissive, blessed, intelligent and do not let Shaytan be one of the two therein and let him not plant (himself with the child).*

9.4 Fertility Regulation

Reproductive health implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition, 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. Similarly, reproductive rights rest on the recognition of the basic right of all couples to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so and the right to attain the highest standard of sexual and reproductive health.

Family planning helps women protect themselves from unwanted pregnancies. Thus, many women are saved from high–risk pregnancies or unsafe abortions. If all women could avoid high risk pregnancies, the number of maternal deaths would fall by one-quarter.[323] The field of family planning has very clear standards of quality of care unlike other areas of gynecology and obstetrics. It promotes 'informed choice' which means that a person can freely make a thought-out decision based on accurate and useful information. This implies that clients understand their own needs and make their own decisions.

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[323] Hatcher, R.A., Rinehart, W., Blackburn, R. and Geller, J. S. (1997). *The Essentials of Contraceptive Technology. A hand book for Clinic staff.* Baltimore, JohnHopkins School of Public Health, Population Information Programs.

9.5 Family Planning motives

Once, a woman has proven her fertility, she may be inclined for either spacing the birth of the next child or limiting her family size. The drive for family planning comes from a diverse range of reasons, as outlined below.

9.5.1 Meeting Desired Family Size

The lady health visitor is the main provider for family planning services. She says the women come when they have at least one living child.

> *"ek bachey ke baad bhi aa jaati hein lekin ziaada tar 4 ya 5 ke baad hee aati hein; yahaan injection ka riwaj ziaada hey, Kapper Tee bhi karwati hein aur apration bhi"*
>
> [they come even after one child but most come after 4 or five children; here an injection is more in vogue, they go for Copper-T and an operation as well]

The small family size is gaining acceptance and even the older generation is now pushing the younger ones to limit their family size. A mother said,

> *"beti say kehti hun, " kadoon tak wijondi reh sein, chaar hundey teh band kara chor"*
> [I say to my daughter till when you'll keep breeding, once you get four go for ligation]

9.5.2 Dislike for Having Many Children

There are women who from the beginning do not want many children e.g. one of them admitted,

> *"shaadi hui to dua ki, "Yaa Rab-ul-Alimeen mainu thorey bachey de, mainu jatak nai pasand"*
>
> [I prayed when I got married, "O Lord of all worlds, give me a few children", I did not like children]

9.5.3 High Financial Costs of Rearing Children

Women in the village realize that with progressive division of the cultivated land, many sons can not earn their livelihood from the land. The children have started getting education which is expensive for an average family, the joint family system is breaking down and it is difficult for a single woman to manage the cattle and the household. Earlier the elder daughters would help with the household chores and child minding. Now, they are going to school and not available to share the burden.

The cost of living has increased manifold.[324] Families are concerned that they should only have the number of children they can afford to feed and educate. An elderly woman was worried about her daughter having many children and little resources, as she said,

"Beti kay aath bachey hein... uska dukh mujhey kha giya; paanch cheh hazaar mein itney bachun keh saath mushkil hay"

[My daughter has eight kids.... her worry has consumed me; it is very difficult to live with so many children on seven or eight thousand (rupees)]

9.5.4 Fear of Young Orphans

There are many stories in the village about the miseries of widows whose parents or brothers were unable to help them and they had to suffer a great deal to make ends meet and raise their children. An elderly widow was grateful to Allah for a few children, she said,

"Acha hay thoray bachey thay, (un ke fot ho janey ke baad) ab agar chotey chotey reh jaatey to main kiya karti"

[It was good that I had a few children, now (after his death) if there were many, still young, what could have I done ?]

[324] ADB Report June 2009, The NEWS dated 21-06-2009 that quoted 8% percent poverty increase with 20% overall increase in food prices and poverty head count increasing from 36% to 44 % with the negative impact of food prices falling disproportionately on the rural poor.

9.5.5 Staying Free of Responsibility

While young women feel pressures of the increasing cost of living and try to limit the number of children they have, the elderly women suspect it is just a pretext to remain carefree.

> *"Ab bey imaani buhat ho gai hey; mujhey to saat mah keh baad hamal hua; aurateen azaad rehna chahti hein, phir kuch na kuch karwa leti hein"*
> [Now cheating has increased; I got pregnant after seven months (of marriage); women want their freedom so, they do get something or the other done (not to have a child)]

9.5.6 Avoiding Divisibility of Inheritance and Property

The poor can not afford children while the rich do not want many as it will divide the wealth to many small portions. The wife of a landlord said,

> *"Saas kehti thein keh sirf do baitey hein ziaada honay chahiyein. Un ki baitiyaan bohat thein. Malikun keh do batey theek hotay hein warna larte hein"*
> [My mother-in-law used to say that you have only two, you should have more sons. They had more daughters. Having two sons by (land) owners, is alright otherwise they fight (amongst themselves)]

9.5.7 The Social Insurance Value of Siblings

Siblings give a sense of solidarity versus others and develop friendships and strong bonds with each other. They can share with each other, the gossip and concerns that they feel unable to share with their parents.

A woman who did not have a sister always longed for one and wanted to have at least a pair of sons and another pair of daughters but she changed her mind when they grew to adolescent age and wanted to have the best clothes and the best education.

> *"Ek beta, ek beti theek hein. Mein ek behan hun to chahti thi keh beti ki behan zaroor ho magar ab barey ho gaye hein, ikhrajaat bhar gaye hein to sochti hun keh ek beta ek beti hi kaafi hein. Miaan to ziaada bachun par khush hotay*

hein. Meri Saas to teen bachiyun ke baad kehti thein kay bus karo tum log thaktay nahin ho"

[One son, one daughter are alright. I am one sister so I wanted my daughter to have a sister but now that they have grown up, expenses have gone higher so now I think one son and one daughter are enough. My husband is happy for more children. My mother-in-law said after (I had) my three daughters, finish off now, are you people not tired (of producing)]

9.6 Inter-spousal Communication for Family Planning

Family planning requires some minimal discussion and negotiation between the two partners. However, talking to most women, I felt that inter-spousal communication was missing on this more in the previous generation than it is now. The quality and depth of inter-spousal communication is directly proportional to the educational level of both the partners. The educated ones can better articulate their concerns.

One's life circumstances also determine the importance and time given to planning. If the battle for survival is fought anew every day, there is hardly any time to devote to a long term planning. One woman who had husband of her own choice felt they were never able to have any discussion on this subject.

"Pareshaani mein moqa hee nahin mila kaeh sochtey keh kitnay bachey honey chahiyeen; yeh to tabhi hosakta hay jahan sirf do log hun jo sakoon say beth kar baat kar sakein"
[Worries never gave us the opportunities to ponder about the number of children one should have. This is only possible where there are only two who can sit at peace and talk about the issue]

The '*dai*' at the BHU felt that most of the couples are afraid of side effects or mishaps happening in case of contraceptive use. For example,

"Kuch kehti hein khawand apration ki ijazat nahin deta, agar koi masla ho giya to phir kiya karein gey"

[Some say that husband does not allow the operation (sterilization) fearing what they will do if there is a complication]

Women usually come for family planning advice with other women of the family and seldom together with their husbands.

"Miaan ziaada bahar hotey hein; saas , nand ya walda key saath aati hein; miaan say chup kar bhi karwa leti hein"

[Husbands are mostly out; the women come with a sister-in-law or mother; they can get it done without husband's knowledge]

9.7 Choice of Family Planning Methods

Choices of family planning methods depend upon the availability, preference of women for a certain method and fear of side effects of others.

9.7.1 Lactation Amenorrhoea

The Lactational Amenorrhea Method (LAM) is the use of breastfeeding as a temporary family planning method, (lactational means related to breastfeeding; amenorrhea means not having menstrual bleeding). A woman is naturally protected against pregnancy when, her baby gets at least 85% of his/her feeding as breast milk, she breastfeeds her baby often, both day and night; her menstrual periods have not returned, and her baby is less than six months old. If she keeps breastfeeding very often, her protection from pregnancy may last longer than six months and as long as nine or twelve months or even more.

Mostly, women breastfeed their children for two to three years and hence manage a natural gap between childbirths. They are cognizant of this fact as one of them said,

"Doodh pilaati rehti thi to bachi rehti thi, doodh choraun to ho jaata hay"
[I was safe while I breastfed, as soon as I weaned the baby I got it (pregnancy)]

The older generation found this method more doable. The younger generation of women in the village found it difficult to exclusively breast feed a child due to diverse social demands on their time and the perception of not having enough milk to satisfy the hunger of the baby. It is believed that a son should be breastfed for two and a half years and a girl for three years. Women proudly acclaim that they have breastfed their children,

> *"mein nay apney bachun ko teen saal (apna)doodh piliyaa, gandi mandi shay kabhi nahin khilai."*
>
> [I breastfed my children for three years, never gave them anything dirty or below standard to eat]

9.7.2 Oral Pills and Injections

These constitute a range of contraceptives called hormonal methods. Combined Oral Pills available from the government outlets contain very low doses of hormones similar to the natural hormones in a women's body i.e. oestrogen and progesterone. These are available in packs of 28 pills where 21 are active pills with the hormones and 7 inactive pills without the hormone content. A woman takes one pill each every day. The "morning after" or 'emergency oral pills' are not available in the village. The hormonal injectables are available in two formulations, a formulation called Depot which needs to be given every three months and another called Norigest to be given every two months. The hormonal methods mainly stop ovulation (release of eggs from ovaries) and also thicken cervical mucus, making it difficult for sperm to pass through.

The oral pills and injectables are available with the lady health worker, the LHVat the BHU, the nearest Family Planning Centre at Gali Jageer and at major pharmacies and chemist shops in the nearby towns. The oral pills are easy to obtain and their intake is totally under the control of the user. The injectable is considered a more discreet method, as it requires only one visit every two or three months to the provider. Common side effects of hormonal methods include, changes in menstrual bleeding i.e. it may cause spotting, heavy bleeding (more so with an injection) or amenorrhea. The other side effect is weight gain in some women, and skin changes like acne or pigmentation.

The local *dais* in the village do not recommend the hormonal methods saying,

"Teekay golioun say jism sooj jaata hey"

"Injections and pills make one's body swell"

However, there are many women in the village using these methods. In one family, the mother-in-law who was young and still menstruating and her three daughters-in-law were all using oral pills and perfectly happy with their choice. Though the pills are available free of cost from the local lady health worker and just for Rs.6 per pack at the BHU and Family Planning Centre, they preferred to get these at higher prices from the chemist shop. The women give the empty packing to the men in the house to show as a sample to buy for them. The mother-in-law shared that she had five children (four boys and one girl) when she ultimately decided to start using contraception. She used the oral pills for years and was satisfied and recommended the same to her daughters-in-law too. A few years back, she developed mild chest pain and consulted a male doctor at one of the public hospitals. He advised her to discontinue the pills as she was already forty five years old at that time. He said,

" aap ki umer ziaada hay, ab aap ko bachoun ka koi khatra nahin"

[your age is much greater now (to become pregnant), now you have no danger of (having) children]

But six months later, she got pregnant again and had a son equal in age to her grand children. She blushed at this fact and said it was very embarrassing for her to become pregnant when she had a grown up marriageable daughter and daughters-in-law at home at the same time. After the last born, who was seven years old at that time, she re-started taking pills. It is difficult to tell if she has achieved menopause now but she does not want to take the risk again. She has a good figure for her age and defies all fears of obesity with the pill use.

There are others who still fear this method. The LHV at the BHU herself favours the injectable and rather than giving a free choice to her patients, would recommend an injection. This gives her an excuse for charging money for giving a shot. The injection itself is free of cost at the public facilities. Women themselves also prefer an injection as

they can go for a shot every three months and can practice family planning without the knowledge of other family members, especially the mother-in-law.

Another woman who had started this method but discontinued due to heavy bleeding said,

> *"Teeka lagwaiya to ziaada khoon shurooh ho giya; pehlay teen chaar din rehtay they, phir ek maheena khoon aata raha, mein nay teeka chor diya; khoon ruka to hamal ho giya; ab apration karwa lun gi iske baad"*
>
> [The blood got started when I got the injection; first periods lasted for three or four days, but then blood kept coming for one month; I stopped getting the injection when bleeding stopped, I got pregnant; now I'll go for an operation after this (currently pregnant)]

9.7.3 Intrauterine Contraceptive Device

An intrauterine contraceptive device (IUCD) is a small, flexible plastic frame. It often has a copper wire or copper sleeve on it. It is inserted into a woman's uterus through her vagina. The device works by preventing sperm and egg from meeting and probably also interfering with implantation of a fertilized ovum into the uterus. The previously used Lippes Loop (commonly referred to as *'challa'* meaning coil) are not available now. Present choices include Copper –T (available at government outlets) and Multiload (available with private providers). Copper –T has an effective life of ten years in the womb while the multi-load is effective for five years. Both are commonly referred to as 'tubes' by the village women. The common side effects are heavy and prolonged bleeding (in the initial three months), spotting and menstrual cramps. There may be perforation or piercing of the wall of uterus if the IUCD is not properly inserted. The village women commonly refer to this phenomenon as "*challa ooper char giya*" (coil has gone up). Common perception about this method is reflected in the words of a local '*dai*',

> *".... tube theek rehti hey; challa jur jaata hey, haspatal jaana parta hey"*
> [.. tube suits alright, coil gets impacted and have to go to hospital to get it out.]

This method is quite popular because of its long term efficacy but the women need a special visit to the family planning centre or a private clinic to get it inserted, in the first place.

9.7.3.1 Oral History of Using an Intra-Uterine Contraceptive Method

Here, I present the story of a single woman to illustrate that family planning choice is not an isolated event but linked to a woman's circumstances, her obstetric history and her previous experience of any method.

A woman, now around forty, had an experience of both kinds of devices. She was managing alone at home as her husband was away for his army duty and her mother-in-law was too frail to help her with household chores. She had some school education and was thus able to read and write. Her husband had seven sisters, all married and living outside the village and one younger brother who was unmarried and was serving in army when she got married. Her mother-in-law had difficult times when all her surviving children were girls and the two boys she had earlier, died in infancy. Her husband and the other brother were born last and really pampered by their mother and sisters. The interviewee was under immense pressure to conceive and produce a son. Luckily, she did have her first son born after one year of their marriage. However, the birth was a difficult one. Firstly, she did not have pains till the expected dates told to her by the doctor in the Military Hospital and then finally, when they artificially induced her through an intra-venous drip, her baby in the womb was diagnosed to have 'distress' (fluctuation in fetal heart rate). She was too drowsy to remember any thing but the concerned movement of the hospital staff. Her mother-in-law and husband had accompanied her to the hospital. As baby's heart rate did not improve, doctors decided to apply forceps and take the baby out. A healthy baby boy was born but she had severe bleeding. The nurses later told her,

> *"...the mouth of the uterus was not open fully but your baby had a problem, so the senior doctor wanted to deliver the baby at the earliest. She said, she will try forceps but if not the patient will go for a caesarian section. But in the process of forceps use, your uterus was torn and this is why, you bled so heavily. You should thank Allah for saving you and your baby. You could have seen the doctor*

stitching you, it felt as if a cloth is being sewn, so many stitches..."

She got two pints of blood transfused to her later but she was still too anemic. Whenever, she used to sit up in the bed, for a moment, she would go blind. Every one was happy to see the baby boy. She was discharged from the hospital and came back home. The '*dai*' also came to massage her and advised her not to take too much water lest her belly become swollen. She was thirsty but would try to restrict her intake. The other problem was the long episiotomy wound that she had, running from her perineum to one of her buttocks. "*I was so sore, I dreaded going to toilet. In the hospital, it was better, I had the sitting type but at home we have to squat and I literally screamed there.*"

The '*dai*' told her mother-in-law, "*this is what happens at the hospital; did you ever get this type of a cut when I delivered you*". The woman slowly regained her strength but the scarring in her vagina and the bottom made sex immensely painful.

She said,

"*I dreaded visits of my husband from his duty station. I would just go numb by the thought of it. It was so painful, I would cry with tears. He used to be very upset and said that I had stopped loving him and it was only the baby I cared about. I was so desperate, I requested the doctor to suggest some method in my next visit so I do not get pregnant again. I was not having my periods as I was breastfeeding the baby, she said the pills would be harmful in the first six months and suggested either the injection or the coil. I went for the coil because my mother had it and she was alright with it. For a year, I had no periods and no problem. The baby was taking other food in addition to my milk. Then, I had my menses. I was content that I need not worry because of the coil. When my periods were due next time, I waited but nothing happened. I thought maybe they have stopped again. Then, I started having severe cramps in*

lower abdomen. I went to show to the doctor, she said, it is your coil causing the trouble because it has moved from its place and got impacted in the mouth of the uterus, let me remove it and you can get another one once you finish with your next periods. She removed the coil and I waited for the periods. They did not come and I started having sick feeling. This time, I went to Fateh Jang to a private doctor with my neighbour. The doctor tested urine and told that I was pregnant. I was horrified, because of what had happened to me at the time of delivery and also because my son was so young and still on the breast. I went to see my mother and cried and cried and told her that I want to get it aborted. She said, it is a sin and then pregnancy is after all not a bad thing. It is good to have all the children in series, so you get over the period of nappy changing, once and for all."

She went ahead with her second pregnancy and had a daughter whom she really adored. She was herself the only daughter of her parents and always dreamed to have a daughter with whom she can share and discuss things as she used to do with her mother. Besides, she felt that with a baby boy one can not do much to clothe or adorn him but with a girl she could buy little bangles, ponytails and colourful clothes. Fortunately, her second delivery was normal and she had no problem. Soon after completing the forty days, she went to her doctor again and requested for a fool proof method. The doctor smiled and said, "*will your husband cooperate?*" She said he will because he thinks having just a few children is a good thing and all the army officers also have just one or two. So, the doctor inserted a tube this time and asked her to request her husband to use condoms as well. That way, they will have double protection. Her husband, however, was not convinced about the condoms. He bought them but always resented their use saying that it causes a barrier between him and her. Sometimes he would use them, at other time he would not. The tube used to cause very heavy periods and whenever she had a backache, she would think of the tube inside but she endured all that thinking that whatever

problems may be but at least, she is not getting pregnant. Indeed, she did not have another pregnancy until three years later, when she herself had wanted another brother for her son. Everybody said, even a tree wants company, and elder women pray

"Allah rukh noun wee kalla na paida karay"

[Allah should not even produce a tree alone]

Her experience of side effects with IUCD also resonated in the everyday talk of women when they refer to someone who had lost her rosy complexion due to heavy bleeding.

"Mundriaan tay challay ander rakha rakha
keh kuri kharaab ho gai hay"

[This repeated keeping of rings and coils
inside her has spoiled the girl]

9.7.4 Female Sterilization

Female sterilization provides permanent contraception for women who will not want more children. It is a comparatively safe procedure provided free of cost by the public hospitals and involves tying the two fallopian tubes so the egg does not reach the uterus and fertilization does not take place. A similar procedure for men is also available called 'vasectomy' but is not as popular and easily available as the female sterilization.

The government's family planning programme run by the Population Welfare Department provides free transportation to sterilization clients and a small monetary incentive for the woman and her accompanying female health worker which is too little a sum to be labeled as an incentive. The written consent of the woman's husband is required for the female procedure but a similar requirement of spousal consent does not exist for cases of vasectomy.

This is a very popular method among women to terminate their reproductive capacity once the desired fertility has been attained of four or five children. The procedure is commonly called *"bachay band karwana"* (closing down the children). A woman with five children expressed her intention to use this method as she said,

"Apration kay liyee Fateh Jang jayoon gi, haspatal wali khud hi lay jaati hein"
[I'll go for (a sterilization) operation to Fateh Jang, hospital women will get me there themselves]

Many women adopt this termination method instead of using any birth spacing or temporary method. Perceptions about side effects include, gaining weight and developing frigidity. Not aware about the exact nature of the procedure, many think that they are castrated in the process and the frigidity is the result of that. One woman, replying to my query about the family planning said that she is using it and laughed,

"mein to khasi ho gayee houn"

[I have been castrated]

It is a common practice in the village to castrate farm animals e.g. the goat, sheep and calves by removing their testicles to improve the quality of meat thus obtained. This is the analogy known to the village women to explain the procedure.

9.7.5 Condoms

A condom is a sheath, or covering, serving to contain the semen and thus avoid pregnancy as well as transmission of any sexually transmitted disease. These are also called rubbers or '*ghubaray*' (balloons) locally. Medically, the only side effect can be allergic reaction to the latex or rubber used as the manufacturing material.

These are easily available from any goods store, chemist shop, the local BHU and the lady health worker. The method usually is initiated by the husband and sometimes, without any prior discussion with his wife. A few women are appreciative that their husbands have taken the responsibility of family planning upon themselves and they do not have to use any female method and thus suffer from side effects. However, some are concerned about their husband's health and the impact of condom use,

"kandom istimaal kartay hein, pait thora barh giya hay; maloom nahin us ki waja say ya kisi aur waja say"
[He uses a condom; his belly has become somewhat bigger; I do not know if it is because of this reason or for some other reason]

9.7.6 Withdrawl Method

Using the withdrawl method means taking the male sexual organ out of the vagina before ejaculation. It is also called coitus-interruptus and "pulling out". This method is referred to as '*azal*' in the literature of Islamic history and was the method in vogue at the time of The Holy Prophet (PBUH). It was used mainly with the female slaves to avoid pregnancy and keep their physical beauty intact. It was also permissible with one's wife, provided her prior consent was there (as it may hinder her sexual fulfillment).

The village women refer to this method as "*miaan ehtiaat kartey hein*" (husband takes a precaution). As seen in the case of condom use, one woman felt that it is too taxing for the husband to use a male method and she should take on the responsibility herself,

> *"Miaan ehtiaat kartey hein. Un ko takleef hoti hay kehtay hein bahir farigh hona mushkil hota hay; sochti hun mein koi tareeqa istemaal kar lun".*
>
> [Husband takes care (withdrawl). He feels unease as he says it is difficult to get climax outside (vagina). Think, I should use some method]

9.8 Oral History of a Woman with Experience of Injectable Use

This woman was 30 years old. She had one still birth followed by six live births and was seven months pregnant at the time of the interview. She had lost both her parents by the age of six years and her elder sister and herself were raised by her '*Khaala*' maternal aunt. She was not interested in studies and could only complete the eighth grade at the insistence of her aunt. Her *khaala* took her elder sister as her own daughter-in-law and gave her hand in marriage to her paternal cousin, who was the eldest and only son of his parents. Both were 15 years of age when they got married. Her in-laws were keen to get their son married at the earliest date. She thought she was married at a very young age as she was an orphan and a liability and responsibility for her '*khaala*'. She conceived her first baby after five years of being married.

> *"Kehtay thay bacha nahin ho raha, koi ilaaj karo to mein dawa kay teekay, goliaan ar sharbat leti rahi. Phir thak kar hamal kay aik saal pehlay dawa chor di, to khud hi Allah*

kay hukam say (bacha) ho giya. Pehla bacha moyea ha hua. Mein nain kabhi hamal mein muaena nahin karwaiya, Allah ka hukam hota hay to khud hi ho jaata hay."

[They used to say you are not having a baby, get some treatment so, I kept taking injections, tablets or syrup - Then I got tired and left all medications a year before my first pregnancy, and then the child was born with Allah's will, regardless. The first child was a still born. I never had any antenatal check-up in pregnancy, with Allah's will everything happens by itself.]

All her babies were born at home in hands of the local *'dai'* (the same one who had looked after her mother-in-law). The *'dai'* was flexible in charging for her services. She was paid Rs.500 for a boy and three hundred rupees for a daughter.

"Jo kuch ho day do, beta ho to paanch so rupiya aur beti ho to teen so rupiya."
[Give whatever one can, five hundred for a son and three hundred for a daughter]

She had her eldest son one year after the still birth and then she would have a baby every three years.

"Doodh pilaati rehti houn to bachi rehti houn; churhati houn to ho jaata hay"
[I am safe as long as I keep breastfeeding the child; as I start weaning, I get it (pregnancy)]

She has never used any family planning method except before the current pregnancy when she tried a contraceptive injection that could prevent pregnancy for three months by one shot. She started heavy bleeding after the first shot and was apprehensive as she is also suffering from tuberculosis and taking drugs for that. She discontinued the injections and she was pregnant again with this baby. Now she intends to have a permanent sterilization procedure after completion of this pregnancy from Tehsil Hospital Fateh Jang. She said, it would not be a big inconvenience as she has heard that workers from the hospital can come to her home and take her for the procedure and drop her back.

I asked about her husband's preference for the number of children they should have. She dismissed my question saying that he has never given this matter a serious thought.

"kuch nahin kehtay, jitney bhi ho jayein. Un ki itni soch samajh nahin hay"
[He does not say anything, whatever number may be. He does not have that much understanding]

9.9 Infertility

In a scenario where children are valued and a married woman's status and old age security is dependant upon the number of sons she has, infertility is a major reproductive health issue and seeking cure for it is a felt need not only by the woman alone but also by the family (natal and in-law).

Infertility is the inability of a couple in the reproductive age group to achieve pregnancy within 12 months of unprotected intercourse. It may be primary or secondary. Primary infertility refers to couples who have never conceived whereas secondary infertility refers to couples who are unable to conceive after one year of unprotected intercourse following previous pregnancy and not using any contraceptives.

Mothers and mothers-in-law of such women, run from pillar to post to get the much desired grandchild. One such lady had a *'mannat'* (pledge) for her grandson, now 16 years of age. He fractured his leg in a recent accident. The old lady was apprehensive that he has been sick because she had been ill herself and not able to fulfill her pledge that she had made for his birth. She said,

"Mera pota aath saal baad hua. Mangla mein Lal Badshah kay mazaar par bakray ka chrhawa dia. Baba kehnay laga, har mahinay halwa bana kar giarhween par dena. Mein deti rahi phir Hattar waley pier say poocha kay saal baad paka loun aur gaown waloun ko bula loun. Ab Bimaar houn to log kehtay hein keh na karo. Mein nay to mannat mangi thi jab tak zinda rahoun gi karoun gi. Ab Bimaari tez ho gai hay to reh gayi houn. Log ab hafta peer nahin kartay- Sab ko doulat ki hawas hay , apni apni pari hay."

[My grandson was born after eight years. I sacrificed a goat at the shrine of Lal Badshah in Mangla (District Jehlum). The Baba (saint) asked me to cook 'halwa' (a sweet dish made of wheat flour, sugar syrup and ghee) and give it away at each eleventh of

the month (lunar). I kept giving, then I asked a Pir in Hattar (near Taxila), if I can give it annually on a mass scale and invite all the villagers to eat. Now, that I am sick, people say, do not do this. I have made a *'mannat'* (pledge) to do it while I am alive. Now that my sickness has gathered speed, I am unable to do it. People now do not do Saturdays and Mondays (specific almsgiving on particular days of the week). Every body is greedy for wealth and cares about no one else but themselves.]

Women fear infertility to avoid taunts of the relatives or a situation where the man deserts her or brings another wife. As a childless woman said,

"dar lagta hay log baat na karein ya miaan na kahay keh awlad nahin hoti to chorh dein ya doosri shaadi na kar lein. Ziarat Pak Pattan aur jand mein awlad kay liye dua ki, mannat mangi hay- allah hamein khushi day"

[I fear that people will talk or my husband will say that he would leave me for not bearing children or lest he re-marries. I prayed on the shrines of Pak Pattan and Jand for children, have made a pledge- May Allah give us happiness]

Women would go anywhere to pray for having a son, as one woman narrated the story of her mother-in-law,

"meray Miaan teen behnoun kay baad pehlay batey thay- Meri saas nay Un kay liye Bari Imam par phera lagiya aur un kay liye hamesha Bibi ka roza rakhti thein"

[My husband was the first son after three sisters- My mother-in-law had gone for a revolving ritual at Shrine of Bari Imam for him and always kept a fast of 'Bibi' for him.]

The expectations to have a baby, as early as possible, exerts a lot of social pressure on the new couple. This is elicited by the following quote from a woman,

"Pehla hamal to shaadi kay saal ya cheh mah ya foran hi ho jaana chahiye- Hamaray haan shadi kay baad larka aur larki slaam karnay aur bachay kay liye dua karnay Gudday mein Khanqah hay wahaan jatay thay- Yeh Khanqah Agral gaoun mein hi hay- hamaray Pir wohi hein. Ham bakray aur degein detay hein- awratein wahan halwa deti hein aur kehti hein yahaan ki jharioun say patttay lay jaana aur haml mein kha laina to baita ho ga"

[First pregnancy should occur within a year, six months or soon after marriage – it is a tradition here that the boy and girl go to say '*salaam*' (pay compliments) at a monastery in Gadday- this monastery is within the village Agral and they are our *saints*. We give goats and '*daigs*' (food) there. Women give sweetmeats there and say take leaves from the shrubs here and eat them in your pregnancy- you'll get a son.]

But then, they also blame the saint if the son does not grow up to their expectations.

"*Mera Miaan kehta hay, yeh kaisa baba hay? Baita to diya, woh choda jamaatein bhi parha, nokri lagi to aisa kuarter mila Wah Cantt mein kay log 'dai'khtay lekin ab nashay mein par gia*"

[My husband says, what kind of Saint is this? Gave us a son, who also studied fourteen classes, entered into the service and got such a living quarter in Wah Cantt that people admired; but now he has fallen to addiction]

9.10 Oral Histories of Infertile Women

The plight of a woman in search of fertility and in quest of completing her identity is only perceptible from her own verbal account. Two oral histories are presented below to illustrate the depth of the problem of infertility.

9.10.1 Infertility Oral History 1

She was 35 years old, married to a professional driver, for 12 years now. She had conceived once soon after the marriage but miscarried at four months of pregnancy and never conceived again.

She was pregnant and went to visit her *Phuphi* in Fateh Jang where she fell from the stairs and starting having pains the same night. The *Phuphi* consulted one of her sisters who called a 'dai'.

"*us nay kaha bacha ander hi hay, safaai ho gi*"

[she said that the foetus is still inside and cleansing needs to be performed]

'*Dai*' did scraping and cleansing but baby's head was left inside and was expelled later when she had come back home to the village and left her shrieking with horror. After a month passed, she returned to the same 'dai' for advice and was prescribed an intrauterine contraceptive device

(Lippes loop) to be used for 3 months to regain the strength of the uterus by avoiding pregnancy for some time.

> *"dai' kehnay lagi, "Aap waqfa karaa lein keun kay aap kamzor hein aur uus nay teen mah kay liyee challa rakh diya"*
> [the 'dai' said, "You should get some spacing done as you are weak, she placed a loop inside me for three months]

She had the loop inside her for three months. The '*dai'* removed it and three months followed of prescriptions of tablets and injections; every time she charged Rs.50 for a check-up and another Rs.100 to Rs.1000 for the medicines that she provided. This went on for a few months without any sign of getting pregnant. Meantime, her brother-in-law used his personal connections to get her examined free of charges in Combined Military Hospital, Rawalpindi. The Gynecologist there did fallopian tube patency test on her and reassured that her tubes were open and capable of transporting the ovum to the uterus. The Gynecologist reassured her and recommended her to see a private lady doctor practicing on the Sixth Road, Rawalpindi. She visited that doctor who did an ultrasound examination and diagnosed a fibroid (a benign tumour) in her uterus. Her husband was also recommended to have a semen test, which had normal results. The doctor prescribed her a course of medicines for three months. She visited the doctor again, after completion of the course. The doctor said, "*the treatment has been completed. You shall conceive after mating*"; but conception did not happen.

She quotes the doctor saying,

> *"kehnay lagein, bus khawand kay saath milaap karo, tumhara hamal ho jaye ga; lekin nahin hua"*
> [Just make sex with your husband, you will get pregnant; but this did not happen]

She also tried a Lady health Visitor in Fateh Jang town, who treated her for vaginal infection.

"Woh ander saafa rakh deti thi dawa laga kar; Mein khud sbah nikaal leti thi aur who niya rakh deti thi"

[She would insert a medicated piece of cloth (tampon) inside me, which I would pull out in the morning and then she would insert the new one again.]

On the average, about every six months, she would switch to a new provider and try all options suggested to her.

"Jo bhi batata hay, har jaga chalay jatay hein"
[whatever some one suggests, we go there]

The couple has also tried amulets and praying at the shrines. From Syed Bibi's shrine in Fateh Jang, she was given special black peppers and '*ajwain*' (seeds of Bishop's weed) with '*dam*'-breath to be grinded and mixed and taken on an empty stomach daily for three months.

"kaali mirch aur ajwain mila kar datey hein nihaar munh lenay kay liye- Teen mah istimaal kiye"

[He gave me black pepper and seeds of Bishop's weed to eat after being mixed to be taken on an empty stomach in the morning-
I used this for three months]

She and her husband have also visited *Daata Darbar* in Lahore and the shrine of Sultan Bahu in Shorkot. They laid special floral sheets on the graves and pledged to give rice and sacrifice a black goat for the poor if their wish is fulfilled. She also took *taweez* (amulet) from *Pir Sahib* in the village to wear and those written ones to be dissolved in water for drinking. She was using those till her mother returned from Umrah and brought special 'dates' for her to cure her problem.

Her sister had a daughter and then did not conceive for seven years. She says that her sister and her husband were treated by some capsules which have not worked out for her.

"unhoon nay Fateh Jang mein aik Medical Store say lay kar taqat kay capsule istimaal kiyee- mujhey bhi parchi likh kar di ; mein nay istimaal kiya lekin (hamal) nahin hua".

[They took some capsules for strength from a Medical Store in Fateh Jang and I was also given the same prescription. I also tried those capsules but in vain.]

She is currently taking treatment from the LHV in the nearby BHU.

"daiyaan kehti hein bachay dani ka munh phira hua hay lekin LHV kehti hay kay bachay dani bilkul theek hay, apni jaga par hay- Aaj kal LHV say ilaaj karwa rahi houn- Sharbat likh kar diya hay- Achi hay- kafi logoun ko us say shifa mili hay- meri baaji nay bola tha keh us say ilaaj karwain. Phachaas rupay fees hay jab bhi jatay hein- dactar ki fees alihda hay- Aik rupay ki parchi hay- Goli rakhi hay ander bachydani ka munh kholnay kay liye."

[The *dais* said that the opening of my uterus was displaced, but LHV says that my uterus is completely alright, very much in its place- I am undergoing treatment from LHV nowadays- She has prescribed a syrup for me. She is good- many people were healed by her- my elder sister told me to seek treatment from her. (We) Have to pay Rs.50 as a fee whenever we go; doctor's fee is separate from this; the out-patient's ticket is for one ruppee. She has kept a pessary inside to open the mouth of uterus.]

Some other women she knows also have similar problem.

"Phuphi ko no saal baad aulad hoi-mein sochti houn phuphi par chali jaoun lekin bas nahin lagta. Meri jithani ka bhi yeh masla hay- 11 saal baad bhi awlad nahin hoi lekin un ko motaapa hay un ka masla faraq hay. Aik aur rishta dar hay us ki bhi meray saath shadi hui thi- usay kabhi hamal hua h nahin.Ab gurday ki takleef ho gayee hay; us ka ilaaj karwa rahi hay."

[My paternal aunt also had a child after nine years; maybe I go after her but (one) does not have any control over the events. My sister-in-law has a similar problem- even after 11 years she does not have a child but she has obesity, her problem is different. Another relative who got married at the same time as me has never gotten pregnant- she now has kidney problem for which she is undergoing treatment.]

She is tired of trying different concoctions and hopes,

"Kaash kay ghar mein ho jaye- Aik doctor kuch batati hay aur doosri kuch- tension hoti hay"
[I wish pregnancy to occur at home. One doctor tells one thing and another tells something else. It causes tension.]

She looks straight into my eyes and asks,

" Aap kya sochti hein, kya meray maslay ka koi hal hay?"

[What do you think, is there a solution to my problem?]

Now she is also thinking about adoption.

"meray bhai kay do bachay hein- Aik larki aur aik larka- bohat hi piyaare hein- Bhabi to kehti hein 'dai'ney ko lekin bhai apnay munh say kahay to tab hay warna hum kehtay hooey achey nahin lagtay- Phir mein kehti houn un kay bhi to sirf do hi to hein."

[My brother has two children- one girl and one boy- they are very good looking- His wife says that she can give me one but it is only if my brother says it from his own mouth; otherwise it is not appropriate that we say that – then I say , they have only two for themselves.]

Recently they had celebrations for the wedding of her brother-in-law.

"Dewar ki shaadi is liye ki hay kay un ki awlaad ho to ham goad lay lein- 'dai'dh lakh lagaya hay hum nein- Dewar say baat ki hay woh razamand hay. Pehli hi raat us nay apni beewi ko tatola keh door kisi rishtaydar ko apna bacha day dein to us nay kaha kay mein nay to baji ko daina hay."

[I got my brother-in-law married so when they have a child we can take that child in our lap. We have spent one hundred and fifty thousand rupees (on his marriage). I have talked to my brother-in-law, he has consented. On the very first night (of the marriage) he probed his wife that let us give our child to a distant relative and she said,"No I have to give my child to sister"]

Her talk kept oscillating from determination to adopt her brother-in-law's child and yearning for her own child.

"Apni goad mein apna bacha hi ho to piyaas bujhti hay"

[Thirst can only be quenched by having one's own child in one's lap.]

Her in-laws are good to her and this is quite a consolation. She says,

> *"Meri nand bohat achi hay kabhi kuch nahin kaha- meray miaan nay bhi kabhi doosri shadi ka naam nahin liya, kehtay hein kay kismet mein awlad ho gi to inhi say ho jaye gi" Lekin phir bhi jab kisi naye doctor kay paas ley janey ko kehti houn to lay jatey hein- Aaj kal 200 rupiya dehari mein kiya banta hay- Itna paisa laga chuki houn-Ab chahti houn kay Khuda nay dena ho ga to ghar baithay bhi day day ga. Chalo ab Dewar ki shaadi ho gayee hay Hum us ka bacha goad lay lein gay."*
>
> [My sister-in-law is very nice, she never said anything- my husband has also never brought up the topic of second marriage, he says if he has children in his fate he will get them through me. Even then, when I ask him to take me to some doctor he takes me there- nowadays what can be done with a daily wage of Rs.200- I have already spent so much money- Now I want that if God has to give, he will give me while sitting at home. It is good that my brother-in-law is married now, we can take his child into our lap.]

She appreciates her husband for not tormenting her on not having a child. She thinks not every one is bothered about not having children.

> *"Aik aur rishtaydar hein jin kay bachay nahin hein lekin unhun nay kabhi fikar nahin ki- khaati peetay hein aur donoun khoob motay hein. Behan Bhai ziaada lagtay hein."*
>
> [There is another relative family who does not have children but they never worry about it. They eat and drink and are both very fat. They look more like brother and sister (because of fatness)]

Her worrisome nature is also affecting her health.

> *" meray miaan ki sehat achi hay lekin mein bohat kamzor houn kuoun kay fikar ziaada karti houn bas kaam waghaira khatam kar kay, charpoy idher kar kay lait jaoun gi aur sochnay lagoon gi ab kia karoun? kis doctor kay paas jaoun? meray waldein bhi meray barey mein bohat pareshaan rehtay hein"*
>
> [My husband's health is good but I have become very weak because I worry more (her eyes get tears) just that after finishing my work, I shall pull the cot here and lie down and start thinking: what to do now? which doctor to visit? my parents are also very worried about me.]

9.10.2 Infertility Oral History 2

This woman was 28 years old, married for eight years and living separately but adjacent to her in-laws and running the business of selling milk and yogurt together with her husband. She has been educated to grade five, was betrothed at the time of birth to her cousin and married at the age of twenty. The first two years passed uneventfully, no pregnancy and no explicit concern by any one.

> *"Do saal guzray to log kehnay lagay kay tumhein koi aas nahin hay abhi tak?*
> [Two years passed and people started asking, "is there any hope yet?"]
>
> *"Miaan say baat ki to unhoun nay kaha dakhein Allah kab raazi ho- Panch bars kay baad Miaan nay kaha " kaheen jao"*
> [I talked to my husband and he said, let us see when Allah is happy with us. After 5 years of marriage, husband asked me to go somewhere (for cure)]

She sought advice from her mother-in-law and her grandmother. The mother-in-law had some '*majburi*' (problem) so she could not go but her grandmother accompanied her to an LHV clinic in Fateh Jang. She completed a treatment course of 3 months which costed her Rs.1500; no test was done, medicine was given to be taken by mouth and to be inserted inside the vagina but to no avail. After a year or two they sought treatment from the Social Security Hospital. Her husband was employed at Koh-i-noor Mills, Rawalpindi at that time and the treatment was free. Both of them were tested and declared fit and advised to engage in sexual intercourse during the fertile days of her periods (14^{th} day since date of starting menstrual periods). When nothing happened for another year, her mother-in-law referred her to the '*dai*' in Fateh Jang saying, 'she is wise' (*samajhdaar hay*). This '*dai*' gave her seven injections and used to keep cotton balls soaked in a yellow medicine inside her with a thread which she used to pull to take out the insert. '*Dai*' had told her that

> *"ander sojan hay- bachay daani ka munh aik taraf mura hua hay. Koi faeda nahin hua".*

[There is swelling inside- the mouth of the uterus is tilted towards one side. No advantage was gained (with treatment)]

A year earlier, her husband suggested that they show their previous reports to the new doctor who had joined the BHU. The doctor told him that his test had a problem and the wife had cysts on both sides of the uterus. Her husband dismissed his own result but was very worried and angry with her that she did not tell him about the cysts. Upon referral from the BHU doctor, they went to see a gynecologist in Rawalpindi. The doctor charged Rs.500 and repeated the tests. She said,

"sab theek hay- yay paani wali rasoliaan hein- in say awrat banjh nahin hoti- pareshaani nahin karni chahiye."

[Everything is alright. These are cysts with water and do not make a woman barren. You should not be worried]

She continued her story about the visit to that clinic.

"Mujhey koi dawai nahin di, koi mashwara nahin dia- Miaan ko goliaan aur capsule diyee kay do mah kha kar wapis aayeen- do baara phir gaye – unhoun nay kaha kuch farq nahin hua is liye Miaan nay goliaan khani chor dein- mein to sab kuch aazma rahi houn"

[No medicine was given nor any advice to me. My husband was given tablets and capsules to take for two months and then to come for follow-up. He went again and they said there is no difference so, my husband stopped eating those tablets but I am trying everything.]

She feels people are concerned but do not malign her for not being able to bear a child.

" rishtay dar tanay nahin detay, peeth peechay kehtay houn to pata nahin- saamnay kehtay hein, Allah day"

[relatives do not malign me, if they say something behind my back, I do not know- on my face they pray that Allah gives me (the child)]

She kept wondering what can possibly be wrong with her and quotes opinion of others.

> *" log kehtay hein kay awlad is liye nahin ho rahi kay kapray khul kar nahin aatay lekin meri Ammi kehti hein kay hum sab ko khandaan mein kam hi aatay hein."*
> [people say I am not having an offspring because I do not bleed openly during my menstruation but my mother says that everybody in our family has scanty menses]

She digs out reports from the trunk (steel box) for me to see and her husband's semen test reads "sperm count: zero ".

This account of a young woman coping with problem of infertility is a clear depiction of the fact that women are held accountable for infertility and pushed to un-necessay medical interventions, even though the physical problem may be with the husband.

In summary, this chapter has highlighted the fact that fertility is not only biological but also a social phenomenon. Fertility aspirations are cultural specific as the issues surrounding child-bearing reflect widely shared perceptions of family continuity. Similarly, local meanings of infertility are shaped by cultural context. The necessity to have a child is basic in the village. Motherhood defines an individual woman's understanding of womanhood, her status in the community and her self-respect. The children are valued as a contribution to family continuity and as evidence of divine blessing. Despite public family planning campaigns, women tend to exert their autonomy when deciding how mnay children to have. They also have their own, individual ideas about family size, spacing children, the importance of siblings in promoting family solidarity, and what the economic responsibilities of more children can be. It is clear that despite strong preference for '*dai*' in matters of child-birth, village women do selectively utilize western medicine and are aware of ideas about contraception and infertility that might on occasion benefit them.

The next chapter, concludes this thesis by discussing the documented findings and their correlation with relevant anthropological discourse.

CHAPTER 10

DISCUSSION AND CONCLUSION

This study of decision-making processes for female reproductive health in the Potowar region, focused on one typical village of the area called Jaffer, located in Tehsil Fateh Jang, District Attock. It was intended to present the cultural context in which decision-making processes occur and understand common reproductive health issues faced by females in the area. The study aimed to identify cultural determinants of female reproductive health-seeking behaviours; understand beliefs and attitudes around sexuality, puberty, fertility and gender roles and their influence on women's health; map pathways of decision-making from recognition of symptoms to care seeking and comprehend the choice of providers in a medially pluralistic environment.

The present study explored the meanings and significance of female reproductive health in the scheme of daily life and rituals, the profile of local women and their role in decision-making processes and identification of significant others in making care-seeking choices. The thesis portrays the construction of female identity in the village and how the ideals and role models shape this identity. The broader concepts of health and illness and prevalent beliefs about illness causation are outlined. The study maps specific reproductive illnesses experienced by the women, followed by the range of services available to seek care. The traditional practices are described and the role of '*dais*'(traditional birth attendants), spiritual healers and *hakeems* (practitioners of Greek medicine) are established together with the mapping of modern medical health facilities.

10.1 Decision-making Processes for Female Reproductive Health Care

Decision-making processes are social situations in which decisions for action (or inaction) are made. Visandjee et al. (1997)[325] have advocated considering the cultural environment, access to economic resources, spatial mobility of women and role of expectations concerning reproductive behaviour, in the study of decion-making processes. They found in Gujrat, India, that, 'factors such as women's occupation and sanitation facilities, were not significant predictors of the use of a service; instead women seemed to be more sensitive to travel time to the health service and its associated costs, *purdah* (veil) restrictions, transportation and time costs) than to the direct costs of services, i.e. provider fee, medicines etc. In the village Jaffer of Potowar, we find that geographic access to modern health facilities is not a significant barrier considering the lady health worker and lady health visitor are deputed in the village. *Purdah*, mobility restrictions and time poverty are found to limit the use of modern health services especially outside the village. The perceived utility of use of preventive antenatal and post-natal services is very low. Those who happen to visit the public health facilities face a hostile attitude, especially if they cannot offer below-the-table money or do not belong to a family of high socio-economic status. The private health facilities are located in the urban town and need at least three hours time to be spent in travel, require an adult male to accompany the woman, need specific permission from the husband or in-laws and are relatively costly.

The concept of 'Therapeutic Management Group' posited by Janzen(1978)[326] and used by Katzan(1999)[327] suggests that power relations, social networks and gender relations all interplay to determine the dynamics of this decision-making process.

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[325] Visandjee, B., Barlow, R. and Fraser, D.W. (1997). "Utilization of Health Services among Rural Women in Gujrat, India" Public Health 111(3): 135-148.
[326] Janzen, J.M. (1978). The Quest for Therapy in Lower Zaire. Berkley: University of California Press
[327] Katzan, J. T.(1999). 'Decision Making Processes and Power Relations at the Household and Village Level in the Union Council of Gali Jageer Tehsil Fateh Jang' HSA Press : Public Health Monograph Series No.1

The findings from the research in village Jaffer on female reproductive health issues, confirm the presence of a 'Therapeutic Management Group' which is comprised of significant others involved in the decision-making processes. However, it was found that though the ultimate decision involved many actors, the initiation of the action for care seeking in most cases was dependant significantly on one person in the household. For child health, the mother had more autonomy to decide about the choice of the treatment sought. In case of her reproductive health, her husband, the joint family and her mother-in-law control the decisions. The influence of '*biradari*' (affinal kin) is found to be strong. The present study exhibits different players for child care and a woman's own health. One fourth of all ever-married women could themselves make a decision to seek health care when sick. A large proportion (46%) depends upon the decision of their husband; 10% of their sons, 10% of the joint family and another 8% of the mother-in-law to decide getting external help for health care. Only 36% of ever-married women can go to the health centre without seeking special permission. The mother-in-law, sister-in-law, daughters and a woman's husband take care of household affairs in her absence. Another 10% women with no other adult female in the household lacked any support for completing daily chores in their absence. Thus, women in extended families were more constrained than in joint families and those in joint families had more restrictions than the ones in nuclear families. However, in terms of actual care seeking, women in nuclear families had more time poverty and less social capital to rely on.

Women's decision-making power in the context of health seeking also seems to depend on several factors, including residential patterns. Doan and Bisharat (1990)[328] found in Jordan, that a daughter-in-law in an extended family had less autonomy than if she was head or co-head of the household. The present study has also noticed similar trends in the village of Jaffer.

[328] Doan and Bisharaat. (1990). "Female Autonomy and Child Nutritional Status: The Extended Family Residential Unit in Amman, Jordan." Social Science and Medicine. 31(7): 783-789

10.2 Validation of the Study's Hypothesis and the Role of Culture

The hypothesis of the research was proven that *"The cultural beliefs and values regarding female reproductive health guide the decision-making processes involving choice of the healer"*. The cultural beliefs and value system for female reproductive health are the critical variables for decision-making, provided there is no difference in economic cost of the treatment options. The symbolic portrayal of a woman in the village's social set-up, religion, ritual and folklore highlights her fertility, chastity and docility. Her authority in the household decision-making processes, in general and for her reproductive health, in particular, is undermined by her economic dependence on other family members and the need to have a consensus. Autonomy is gained by the number of sons she has and entering into menopause. Beliefs about reproductive health and illness emanate from teachings and ideals set by religion and local culture. Her illness like herself needs to be concealed and put last on the list of household priorities due to prevalent expectations of self-sacrifice. Diverse healer choices in the village are present but the preferred ones are the *Pir sahib* (faith healer), visiting shrines and seeking care from a *'dai'* (traditional birth attendant) due to reciprocity in the beliefs about illnesses, their causation and hence, their management. The modern medical system is mostly considered dis-empowering, un-friendly and in-accessible due to the disparity among the patient and the provider as regards language, culture and different causal frameworks (local ideas of hot/cold imbalance, magic, evil eye and curse as opposed to physiological aberration and the germ theory of modern medicine). At the same time, village women do utilize western medicine selectively, and are aware about contraception and infertility that might on occasion benefit them.

Female autonomy patterns in matters relating to her education, marriage, perceived status of health, number of children desired, use of contraception and the choice of providers for various illnesses, are dependant upon different cultural factors that vary with role expectations for that age group.

Fertility desires play an important role in guiding decisions for reproductive health in general. Reasons for wanting children by women include motherhood as a natural instinct and as a social expectation. Motherhood is constructed as physical, psychological and social completeness and fulfillment for women. Consequently, infertility is experienced as a guilt, inadequacy and failure, reinforced by the language used to describe infertility. Women also discuss their desire for children in terms of reproductive decision-making, emphasizing notions of agency, becoming a parent as a change in status in the household and infertility as a disruption of life plans.

10.3 Socio- economic and Structural Determinants

This study also found a complex relationship between economic, social and cultural factors determining female reproductive health but has clearly highlighted culture as an important factor given the other two are kept constant. This is very clearly illustrated, for example by the fact that a woman on anti-TB medicine visits the health facility frequently but never had one antenatal visit in her last six pregnancies. Better socio-economic conditions, however, do have a positive correlation with better female status and autonomy. This may be attributed to greater opportunities of education, exposure through access to radio and television and lesser reliance on family resources for health seeking. In the case of obstetric complications (which may lead to maternal death), the woman herself is dependant on others to transport her to the hospital and spend money on her.

10.4 Reproductive Illness and its Cultural Construct

Health is a subjective experience and it is difficult to have a global definition. Wolinsky (1988)[329] has presented a tri-dimensional concept (medical, socio-cultural and psychological) of being healthy or otherwise. His perspectives are confirmed by the present study to be prevalent among the village women as well. The perspective of "Physical Variability" in body shape, colour, size and volume of blood or vaginal

[329] Wolinsky, F.D. (1988). "The Professional Dominance Perspective, Revisited." The Milbank Quarterly 66(2): 33-47.

secretions as documented in Sections 7.5 to 7.7. can be an added dimension to the socio-cultural concept of illness. Health and illness, in general, have very vivid notions in the mind of the village women. The healthy is called *'naroeya'* and a sick as *'bimar'*. Health is valued among women as it gives them ability to fulfill their duties and maintain their physical beauty. On the other hand, illness or sickness is referred to as '*bimaari*' (disease) or '*takleef*' (unease) or '*dukh*'(suffering) or '*kharabi*' (defect). Women defined '*sehat*' (health) as a state when one is not *bimar*. Good looks, enough blood in the body, plumpiness, feeling fresh and hungry as appropriate defines health. A woman is healthy if she can fulfill duties expected of her in the household maintenance, taking care of her husband, the children and the family. One is sick if one feels tired, has to drag oneself for doing chores and feels weakness etc.

This finding is similar to Blaxter and Parson's (1982)[330] analysis of lay models of disease in three generations of working-class Scottish women. These women defined health not in terms of specific structural or anatomical conditions, but rather in terms of being able to work and acknowledged that a person could have a disease without being ill and health and illness can both co-exist. For example, a person designated diabetic may not have any incapacitating symptom and may regard herself to have a disease but not an illness. Polgar (1962)[331] has mentioned a concept of "breakdown" which is the failure of functioning and equilibrium of the body. Four dimensions of degree of pain, prevention of role and task performance, threat to life; and external recognition that the condition needs care have been described. In the present study, the ideas of "*purzay naqis ya nakara hona*" (parts becoming defective or non-functional) has been documented though, there is no mention of an overall breakdown. All the other dimensions are similar (refer to Section 6.1.2).

As a religious belief prevailing in the village, illness or '*bimari*' is believed to come from Allah, it can not be avoided as it is written in one's fate but has to be accepted and

[330] Blaxter, M.and Parson, E. (1982). Mothers and Daughters: A Three Generational Study of Health Attitudes and Behaviour. London: Heinemann.
[331] Polgar, S. (1962). "Health and Human Behaviour: Areas of Interest Common to the Social and Medical Sciences." Current Anthropology. 3(2):159-205

endured. It may be due to a defect or alteration in the functioning of the human body. The disease may have been present already in the body but was dormant and it has surfaced with Divine order. Illness is also considered as an external factor that gains entry into the body. Other perceived causative factors include, '*be-ehtiati karna*' (carelessness). Not taking precautions or not taking care of what one does or eats is usually an explanation given for getting '*bimar*'. It is also believed that catching an evil eye, '*bad-dua lagna*' (getting a curse), effect of a spirit or having too many worries may induce an illness. Women in the village think that jealousy and animosity also motivate people to do '*jadoo*' (magic spell) on others.

Female reproductive health decision-making processes are guided by an inherent desire to preserve cultural constructs of well-being and gender roles of productivity and reproductivity. Fertility is valued and importance is placed on having more sons which signify gain in status. Greater number of children, is a cushion against child loss, an assurance of old age security and ultimately getting access to heaven. Marriage and other ceremonies give a woman greater freedom for expression and semblance of status, especially if she is married and mother of many sons.

10.5 The Role of Individual Autonomy and Status vis-a-vis Significant Others

Most of the adult women in the village are poor, overworked and illiterate. Greater individual autonomy is positively associated with land ownership, connection with the natal family, exercise of choice for spouse selection and opportunity to manage external affairs in the absence of one's husband (reference chapter 5).

Gupte et al. (1997) [332] have used four important landmarks in a woman's life to assess her role in decision-making, namely: choosing a spouse, contraception and the first pregnancy, place of delivery and children's education. They found that the process of

[332] Gupte, M., Bandewar, S., Pisal, H. (1997). "Abortion Needs of Women in India: A Case Study of Rural Maharashtra" Reproductive Health Matters. 5(9): 77-86

decision-making involves not only the couple in question, but the larger family, as well. Multiple factors intervene during the decision making phase, making the process dynamic and situation specific. Thaddeus and Maine, (1994)[333] have documented that cost, distance, as well as quality of care affect women's decisions to seek health care, as also do the interactions between the various actors involved in decision- making. In the present study, the greater role of the joint family; the status of women; opportunity, social and financial costs; previous experience with the service and perceived efficacy of a provider have been observed.

Women have comparatively greater say in seeking care for a child's illness than their own where husband's decision and joint family consensus is more prevalent. Among significant others influencing decision-making for female reproductive health are the husband, mother-in-law, and a known other who has suffered a similar problem. There is an over-riding desire of individuals for family consensus especially when an individual herself has low authority. Confusion is avoided either by not seeking care or abandoning care when different providers of modern medicine make conflicting diagnoses and give inconsistent advice and prescriptions.

10.6 Provider Choice

The present study confirms, and is in close agreement with the earlier findings on provider choice and patient-provider interactions by Sargent (1982)[334], Roger and Shoemaker (1971)[335], Hall et al. (1981)[336] and Kleinman (1978)[337]. Application of the criteria of homophily and heterophily to the available medical providers in the village

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[333] Thaddeus, Screen and Maine, D. (1994). "Too far to Walk: Maternal Mortality In Context". Social Science and Medicine: 1091-1110.
[334] Sargent, C.F. (1982). The Cultural Context of Therapeutic Choice. Obstetrical Care Decisions among the Bariba of Benin. London: Reidel Publishing Company.
[335] Rogers, E.M. and Shoemaker, F.F.(1971). Communication of Innovations: a cross-cultural approach. NewYork: Free Press.
[336] Hall, J.A., Roter, D.L. and Rand, C.S. (1981). Communication of affect between patient and physician. Journal of Health and Social Behaviour, 22: 18-30.
[337] Kleinman, A.(1978). "Concepts and a model for the comparison of medical systems as cultural systems." Social Science and Medicine.12(2B): 85-95

Jaffer clearly show that women would have higher rating on both domains (functional and socio-emotional) for the traditional providers. Examples of client-practitioner encounters have been given in the present study. The narratives of hospital encounters mirror the general inadequacy of medical providers on both domains. The *'dai'* (traditional birth attendant) and the *'Pir'* (faith healer) are local village residents; have the necessary authoritative knowledge and shared beliefs. They are relied upon traditionally, generation after generation, and they have acquired the community is confidence. The therapy offered by them depends upon the use of local, easily available materials; and in terms of cost and time spent these are both very economical options. Where joint decisions matter as for women's reproductive health, there is no conflict for using any of these and thus, no social cost is involved.

The *hakeem* (practitioner of Greek Medicine) and his prescribed herbs are known to the people in the village. They can easily remember and say their names (in the local language) unlike the allopathic medicines. The herbs need to be ground, boiled or cooked before use. This handling of herbs removes any fears and provides a sense of familiarity and confidence. There is something hot to treat the illness caused by the cold and vice versa; so no adverse effect is considered likely. It is the allopathic medicines that are considered to have side effects mostly because they are *'garam'*(hot). The *'dai'*, *'pir'*, *'hakeem'* or the saint at the shrine, are consistent in their advice and treatments. However, in case of the LHV or doctor, the diagnosis or prescribed management may vary, which confuses the women. The LHV is not trusted because she gives the same red and orange tablets (multi-vitamins) for every disease, is un-friendly in attitude, charges money for otherwise free services. A LHV is not available round the clock, so she cannot be relied upon for delivery services.

The doctors have practices that women do not like e.g. tying one's legs with poles of the delivery table, exposing women for examination, costly treatment, and the need to go to the city. They are also considered inconsistent; sometimes they will just say that there is no problem when the patient is suffering and her symptoms are totally ignored or no satisfactory advice is given; at other times a cause is told without any suitable

prescription or a fee for consultation is charged without a prescription or even a single tablet which women are expecting. They do not counsel men on the care of their sick wives. In the hospital encounters, their careless remarks made to each other cause great distress to the women. Other complaints include inhumane treatment in teaching hospitals and inability to satisfy the patient, for example if they are able to see every thing on a screen, then why do they tell that the uterus cannot be seen or the '*hawa*' (air) which is causing internal trouble. (Please see section 7.22.6)

Different opinions of doctors for the same illness also disturb the women, especially if a lot of money is spent without a perceptible difference in one's condition. They feel comfortable with the *'dai'* who cares about the woman's convenience and the *'pir'*, as both listen to them, maintain confidentiality and also provide counsel on different family matters.

The other significant factor for provider choice is that the provider can relate the cause understood by the woman to the therapy recommended. If humoural imbalance has occurred, the *'hakeem'* can provide the herbs to re-establish the balance. If there has been a magic spell, spirit possession or evil eye, an amulet can cure it. At the shrine, the woman can pour her heart out, and comes back satisfied. Please see table 28 for common preferences for choosing a provider.

Table 28: Provider Options

Provider	Preferred for
'dai'/Siaani (wise lady)	Pregnancy care, child birth, post-partum care, vaginal discharge, fertility treatments, traditional FP methods, abortion
Pir sahib	Fever, unknown illness, any illness associated with *nazar* (evil eye), *jadoo/saya* (magic)
Shrines	Honeymoon attendance, fertility, *nazar* (evil eye), *jadoo/saya* (magic)
Hakeem	Menstrual disorders
LHV (Basic Health Unit)	Modern FP, vaginal discharge, confirm pregnancy
Doctors (public, private hospitals)	Any illness of chronic serious/debilitating nature-not responding to a traditional treatment
Self care/ Family elder woman	Pregnancy care, *pani parna*(vaginal discharge), *chalees din* (forty days)

Jeffery P, Jeffery R and Lyon A. (1989)[338] have highlighted issues related to women status and child bearing in a selected district of Utter Pradesh in India. It is interesting to note that issues related to status of women are quite similar as well as do's and don't's during the course of a pregnancy and concepts of hot and cold. One thing that differs is intake of fat rich diet; women in the village Jaffer are encouraged to take *desi ghee* while in India the prevalent concept is that it will lead to a heavy baby resulting in obstetric complications. In Jaffer '*dai*' controls the presence of women at the time of birth. However, in case of India, 'labour' is not considered a private event but rather an occasion in which neighbours and relatives participate freely.

10.7 Theoretical Approaches

The study employed cultural interpretive theory and a critical approach to analyze different aspects in the equation of reproductive illness and decision-making processes.

10.7.1 The Application of Cultural Interpretive Theory

Cultural Interpretive Theory applied to this research has been vital to understand the meaning of being a woman in this Potowar village. The femininity survives on the presence of a fertile uterus which is called '*jan*' or life. The illness beliefs confirm that health and disease are Divine decisions and a person has to be submissive to her destiny that is decided even before one's arrival into this world. According to this belief, prayers, amulets, breath(*dam*) and saints(*pir*) are the means to seek Divine blessing and cure. For some illnesses such as disturbance in menstrual bleeding, pain during the monthly cycles and backache; hot and cold imbalance, is the reason and a person herself is responsible for bringing that condition upon herself by being careless. For illnesses which do not fall into a specific known category, they are thought to be effects of sorcery, magic and possession of a spirit. These beliefs are consistent with religious traditions and hence services of *Pir sahib* and other saints are sought. If the illness becomes too debilitating, a

[338] Jeffery, P., Jeffery, R. and Lyon, A. (1988). Labour Pains and Labour Power: Women and Childbearing in India. London and New Jersey: Zed Books.

hakeem or a doctor is visited. Some of the *hakeem's* prescriptions are learnt and used at home, especially where the herbs and other ingredients are easily available. Doctor visits are a last resort for conditions believed to be cured by surgery or those resistant to other methods such as infertility.

Beliefs carve the patterns of decision-making for reproductive health, and the rich symbolism and rituals add colour to one's life and give women a sense of 'meaning' in the drudgery of every day life. Elaborate rituals of marriage and the '*wohti*' (bride) and '*suhagan*' (the married) status forms the epitome of a female life. Her biological body is the symbol of her identity as a female and the token of utility of her existence. Hence her reproductive health care seeking actions revolve around preservation of her female attributes i.e. femininity and fertility. Menarche, marriage, pregnancy, child birth and menopause are all important life transitions with positive status changes for the village women. Any illness or abnormality, associated with these life transitions, become a direct threat to this status gain. Irregularity of periods is a sign of disruptive fertility and worthy of seeking care. Pregnancy and motherhood is a normal event happening to all females in the village universe, so it does not merit special health care. The foetus is considered the progeny of the males of the family so needs nourishment through her mother (dietary practices in pregnancy and lactation period). *'Hawa'* (exposure to air) and cold things cause pain, so the pain needs treatment with a 'hot' therapy i.e. hot food, fomentation or *'angaaray'* (burning coals); shame lies in the '*sharam gah*'(private parts) so all ailments related to genitalia are kept secret and endured silently.

10.7.2 Application of Critical Anthropology

In the light of critical anthropology, we find that power is synonymous with the possession of resources (material: direct when woman possesses her own property or indirect by virtue of grown-up sons; or having freedom of mobility or having education and thus access to information). At individual level, the important power dynamics are those between a woman and her husaband/son, between the woman and her mother-in-law and between the woman and the providers. The balance of power between a woman

and her husband is more evident from narratives on sexuality and oral histories on fertility regulation. Infertility is a symbol of failure of her womanhood and thus a demoralizing experience. The low autonomy in making critical health decisions for oneself makes her dependant on family consensus and more so on the mother-in-law who wants to keep the traditions alive and discourage expensive options of treatment. In relation to the providers, she is more empowered where the provider shares her language, beliefs and culture. The low utilization of modern medical services is a manifestation of resistance to contemporary medicine and its subjugation of women to embarrassing examinations, humiliation at the hands of providers at the public health facilities and low satisfaction by private providers despite the exorbitant costs. During the initial interactions with a modern medicine provider, the women are naïve and the expectations are high. When these expectations are not fulfilled at the cost of domestic time lost, inconvenience of travel and abandoning her social roles, a woman changes her future course of action and finds an alternative solution or a compromise to deal with the situation. This compromise can be adoption of a child instead of going for infertility treatment or deciding on no action despite her suffering (as seen in oral history of fibroids and prolapse, Section 7.22.5).

At the micro-social level, a woman herself is a part of the input to the economic system. The agrarian economy and life style sustains itself on the production of labour. Women's role is important in the domestic economy, to provide the un-paid labour for the less strenuous but multiple and tedious jobs of maintaining the household such as cooking, washing, cleaning; cattle rearing, poultry keeping and helping in sowing, harvesting and storage of the produce. She should be healthy to manage all this and, more importantly, able to produce off-springs to continue production of the human labour. Her good reproductive health is thus a mean to high productivity in economic terms as well. The loss of children by still births and infant or child deaths is compensated by higher than ideal fertility. More family resources are spent on her pregnancies and post partum care, especially in cases of the birth of a son. To ensure the desired fertility level and investment of time and energy in rearing the next generation of adult males, motherhood is glorified. Endogamy and *watta- satta* (exchange marriage) are mechanisms to keep

wealth within the family. Traditions of honour and strict control on female sexuality coupled with early marriage ensure the reliability of delivering off-springs to be those of the father and nurture fidelity within the *biradri* (affinal kin). Thus, there is a general deprivation of good food and reliance on low-cost and easily available folk medicine. Suffering with patience is a virtue for females worthy of the highest reward in the world hereafter.

Clements (1932)[339], has suggested that the distribution of culture traits related to health and the control of sickness may be mapped and analysed into five major causes of disease in the non-industrial world: sorcery, soul loss, breach of a taboo, intrusion by a disease object, and intrusion by a spirit. The present study confirms the role of sorcery, intrusion by a disease object and intrusion by a spirit. The breech of a taboo in this instance is related to digression from religious proscriptions and falling into an imbalance between hot and cold.

10.7.3 Folk Medical Model

Concepts of disease and its causes, and the characteristics of healers are interdependent as suggested by Ackernecht (1971)[340], Wellin (1977)[341] and Garroutte et al. (2008)[342]. The cognitive and cultural concepts have become the dominant theoretical paradigms to study institutions of health care. Greater prominence has been given to a society's conceptualizations of illness (the causes and cures), the role of healers, and the relationship between the concepts of disease and cosmology.

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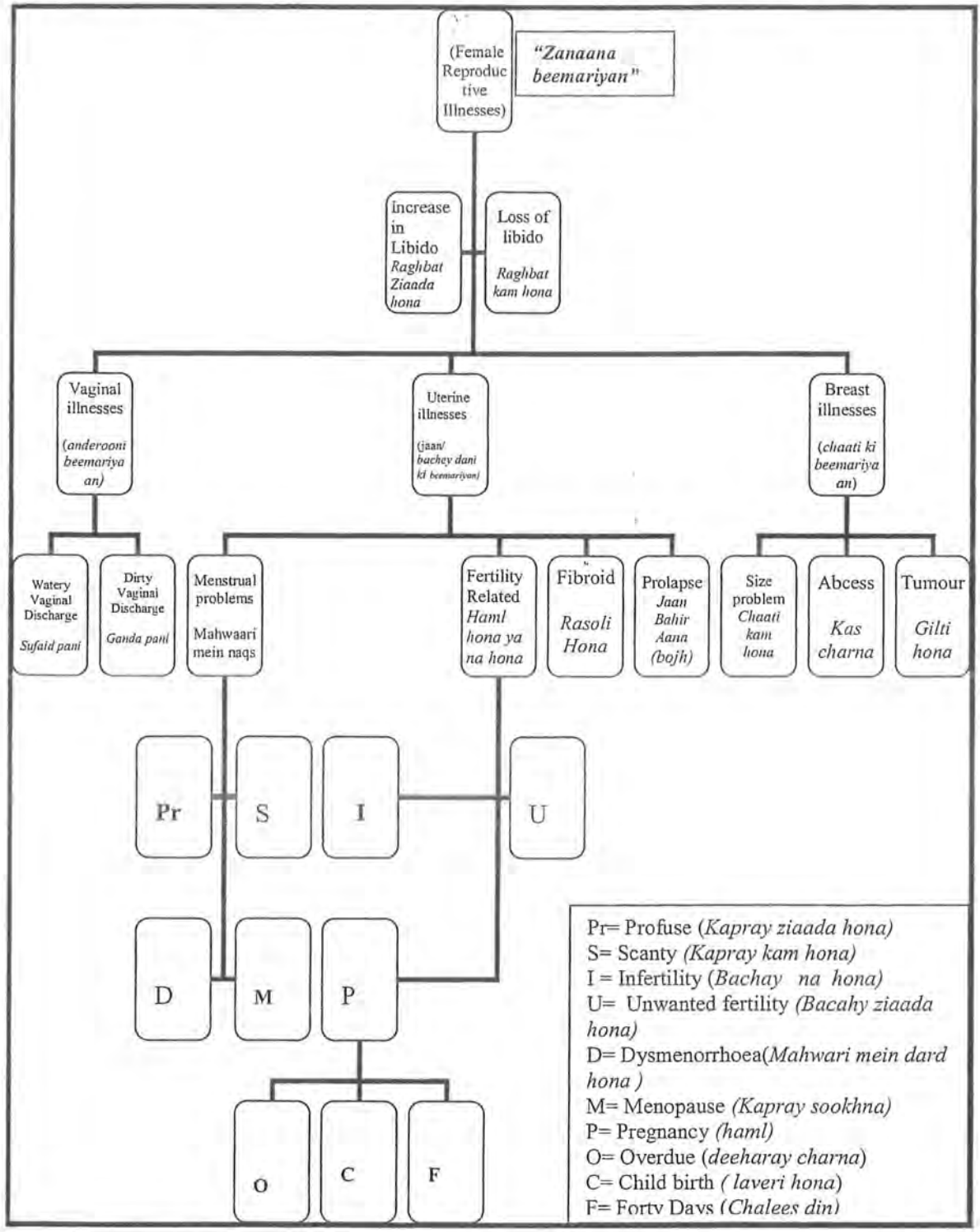
[339] Clement, F.E. (1932). Primitive Concepts of Disease. California: University of California Press.
[340] Ackernecht, E. (1971). Natural Disease and Rational Treatment in Primitive Medicine. Bulletin of History of Medicine.
[341] Wellin, E.(1977). "Theoretical orientation in medical anthropology: continuity and change over the past half century" (pp. 47-58) In Landy, D. (ed.) Culture, Disease and Healing: Studies in Medical Anthropology. New York: Mac Millan.
[342] Garroutte, E.M., Sarkisian, N., Goldberg, J., Buchwald, D. and Beals, J. (2008). "Perceptions of Medical Interactions between Health care providers and American Indian Older Adults". Social Science and Medicine. 67(4): 546-556.

It has been found that women in Potowar area also draw parallels between the causes and cures which thus, determine the choice of a healer. The illnesses caused by evil eye, magic and possession by a spirit, are considered to lie in the domain of the *Pir sahib* and the saints at the shrines. The sickness caused by cold, can only be cured by something hot, which restores the balance to normal.

The folk medical model also provides a basis for classification of female reproductive illnesses. *"Zanaana Bimaariyan "* (Female Reproductive Illnesses) include all changes related to what constituted the '*zanana*' (feminine): the vagina, the uterus and the breasts. '*Sufaid pani*'(white discharge) and '*ganda pani*'(dirty discharge) describe the vaginal discharge, and are considered to be *'paleet'* (polluting) but care is seldom sought except household *'totkay'* (tips). Uterus comprises the central core of the female body, its illnesses are either related to the variation in blood flow i.e. menstruation problems '*kapray kum ya ziaada hona'* (heavy or scanty flow), *'dard hona'*(pain) or *'bachey na hona'* (inability to conceive and produce a living child).

Figure 10: Local Classification of Female Reproductive Illnesses and Conditions



10.8 Traditional Medicine and the Sick Role Behaviour

Ethno-medicine refers to culturally oriented studies of illness. The concern of the ethno-medical investigator is to explain

> *"an illness – its genesis, mechanism, descriptive features, treatment, and resolution- as an event having cultural significance" (Fabrega 1975:39)*[343].

Nichter (1992)[344] has described ethno-medical inquiry as the study of how well-being and suffering are experienced bodily as well as socially, the multi-vocality of somatic communication, and processes of healing as they are contextualized and directed toward the person, household, community and state, land and cosmos.

The 'sick role behaviour' is defined by Kasl and Cobb (1996)[345] and Parsons (1951)[346] as actions taken by persons, either uncertain whether one is well and wants confirmation and clarification of the meaning of one's experiences or those already designated as being sick (by themselves or others). These actions include acceptance of a medically prescribed regimen; limitation of activity and responsibilities; and actions related to recovery.

The current research has mapped the cultural significance of a particular reproductive health condition and the contextualized response by a woman. In many instances, the spirit of self-annihilation prevails and the symptoms are ignored till the condition causes a physical debility. In other situations, it was observed that women find ingenious ways of bargaining and negotiation at household and healer level to achieve their reproductive health goals.

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[343] Fabrega, H. J. (1975). The Need for an Ethnomedical Science. The Journal of Mol. Biology.189(4207): 969-975

[344] Nichter, M. (1992). Anthropological Approaches to the Study of Ethnomedicine. Amsterdam: Gordan and Breach Science Publishers.

[345] Kasl and Cobb. (1996). Health Behaviour, Illness Behaviour and Sick Role Behaviour. Archives of Environmental Health. 12: 246-266

[346] Parsons, T. (1951). The Social System. Glencoe: The Free Press.

The female body is a symbol of cultural ideals of a woman in person, her sexuality and her fertility. The '*biradari*'(affinal kin) '*izzat*' (honour) is housed in her which must be protected at the cost of her independence, mobility and reproductive health.

10.9 Socialization and Coming of Age

In her famous study, 'Coming of Age in Samoa', Mead (1928)[347] has reported that adolescence was not a stressful time, compared with the expectation of adolescent "storm and stress" in western societies. She has attributed this difference to cultural factors. She has argued that, living in a homogeneous culture, Samoan adolescent girls did not face numerous conflicting personal choices and demands as in western culture.

In Potowar area, we found that such a homogenous culture is disintegrating. The modern day village women are pulled and pushed by conflicting demands of living up to present day standards but at the same time are constrained by illiteracy, poverty and age old traditions. They are aware of family planning methods and advantages of a small family but are unsure of the survival of their offspring (due to high under-five mortality as 1 in 10 children do not reach their fifth birthday in Pakistan). For un-married girls, their sexuality is a taboo and a threat and they are conditioned to be passive but upon marriage, their husbands demand them to be equally desirous (reference Sections 7.11.1 - 7.11.3).

10.10 Application of the Conceptual Framework

The Life cycle approach of reproductive health has enabled us to obtain a holistic examination of female decision-making processes. Females have generally low status and the only semblance of status they can acquire is by preserving their chastity, fertility, sexuality, productivity and fulfillment of social roles. For example, priority is accorded to

[347]Mead, M. (1928). Coming of Age in Samoa. NewYork: William Morrow and Company.

care-seeking for pre-marital girls with illnesses that can have a potential negative impact on their chastity and fertility. For a married woman, sexuality and fertility are the means of retaining her worth and thus regarded important for health care seeking. Her productivity is valued when her own young children and the old parents-in-law are dependant upon her. Any illness causing a lowered productivity of the woman gains attention and investment on health care by her family. In the old age it is her social role that gains the most importance in a woman's life, as witnessed in the narrative given in section 7.22.5.

Similar physical symptoms acquire a different meaning at different stages of the life cycle. During young age, menstrual bleeding needs to be profuse enough to signal a woman's fertility but at an older age, the same bleeding becomes a hindrance in fulfillment of her social roles. Breasts need to be fuller at the pre-marital and sexually active stages but should be barely visible among the post-menopausal; thus those who still have prominent breasts in the post-menopausal stage consider this as an abnormality (see oral history Section 7.22.6).

The decisions to obtain treatment and choose a provider lie in the hands of a woman's husband economically and in the hands of her mother-in-law, socially. It is only in the old age when she becomes an elder and can decide for herself but even at this age, economic dependence on her sons is a considerable constraint. Mobility restrictions are severe in post-menstrual and all pre-menopausal ages. Menopause, however, brings greater freedom of mobility and possession of social capital.

The cultural construction of reproductive illnesses can be broadly grouped into bleeding problems in relation to her monthly cycles and quantity and colour of her vaginal discharge and association with pain in back and lower abdomen. The fertility performance exposes her to risks of problems during pregnancy, childbirth and puerperium and constitutes a major share of all her reproductive health needs. Management of infertility and excessive fertility is sought with an overall preference for four children or more. Greater numbers of children produced than the actually desired

ones acts as a safeguard against high child mortality. Postmenopausal women experience discomfort due to uterine prolapse for which treatment is neglected due to having no options with a *''dai''* and feelings of embarrassment for undergoing a naked examination by a modern medical care personnel, including a doctor or an LHV.

The significant others or the TMG is constituted by the woman's mother, mother-in-law and peers and includes saints, *Pir* and *'dais'*in addition to those who are suffering presently or have suffered a similar illness in the past. Parallels are drawn between experiences and differences sought out to justify differential treatment.

Individual autonomy and status is gained by age, by having sons and having an exposure to the men's world due to circumstances which would exceptionally give a woman a chance to overcome mobility restrictions and come out of the conventional gender role. A repeated exposure to illness cure seeking from providers gives women the knowledge and comparison of options. This provides them a greater authority over their health care decisions.

The provider interaction is mostly rated with regard to patient- provider reciprocal understanding on meaning of the symptoms and causes of illness. Thus, a saint at the shrine, the *'Pir'* and *''dai''* are the more favored options. The *'dai'* is especially preferred for intimate examination and the fact that she puts the ease and interest of the patient first. She is flexible in getting remuneration (monetary or in kind; lump sum or in installments), is readily available and comes to the woman's home and helps manage her household responsibilities together with the emotional support. Her procedure and devices are empowering in contrast to the modern providers who generally do not pay any heed to women's comfort or concerns. Reliance on traditional providers is also an action to tilt the power balance in the woman's favour as far as patient-provider hierarchy is concerned.

Individual experiences are narrated and re-narrated at visits of friends and relatives to the sick. These oral traditions are spread throughout the female networks of relatives and

neighbors; and to some extent among peers in school-going girls. The cultural construction of illness and health is thus, maintained, modified or changed and also influences the subsequent decisions. These processes are cyclical, reinforcing and self-perpetuating until an external factor operates to change this equilibrium. This externality has to be at a universal level to be effective (e.g. tetanus toxoid vaccination to pregnant women) or is actively sought by the women themselves (as in case of fertility regulation).

10.11 Conclusion

In the study of decision-making processes for female reproductive health, it has been found that traditions and religion construct the female ideals of perfection in her body and in her roles as a daughter, a mother and a wife. The virtues of docility, chastity and self-annihilation in servitude to one's husband and children are upheld. These constructions frame the woman's response to a reproductive illness. The gender roles are maintained by early age socialization, stories of suffering and stoicism of *'paak bibis'* (female heroes of Islamic history) and an explicit resistance meted out to the deviants. The conflicts in their lives are tackled by fatalism and trance behaviors. The power dynamics among females are more important than between males and females, as regards young age care-seeking patterns for reproductive illness. However, on sexual issues, the balance of power is between the husband and the wife but strongly influenced by the value judgment of the mother-in-law and comparison with peers.

Decision-making processes are composed of actions that include symptom labelling shaped by beliefs and cultural values. The decision to seek care or not is initiated by the perceived impact on gender roles. Significant others include mothers, husbands, mother-in-law and individuals with similar illness experience. Provider choices always start with a *Pir Sahib* (faith healer), *Siani* (wise woman) and a shrine visit. As a secondary option, a Lady Health Visitor or Lady Health Worker is consulted. The reliance on traditional healers is facilitated by perceived self-empowerment in the process. Hospital care is sought only for life threatening and debilitating issues. Treatment failure by modern

medical providers usually causes reversion to faith healers. In addition, individual status and autonomy enables women to negotiate with significant others.

This study has confirmed the over–riding influence of cultural beliefs on recognition of a reproductive illness, establishing illness causality and individual inference of severity in a particular illness. The fulfilment of biological (reproductive) and gender (productive and social) roles is held superior to woman's subjective feelings of sexual satisfaction, suffering and self-attainment. Decision-making processes are found to be context and situation specific as asserted by previous studies; however, the present study has added the life cycle stage as a 'context'. Use of a life cycle approach has given a deeper understanding of concepts of sexuality, fertility, infertility and illness than if these areas were studied individually. The value of children in the Potowar culture becomes more obvious by illustrative accounts of the infertile women and the inspection of gains in status and decision-making authority accomplished by becoming married, getting pregnant, after delivering an alive offspring, after fulfilling one's fertility goals (i.e. desired number of sons) and entering menopause. It is found that female autonomy in matters of sexuality is an important aspect of overall decision-making processes in reproductive health.

Decision-making processes in female reproductive health have been found to be a product of beliefs, values, religious prescriptions, female ideals of virtue and homophily among the patient and the provider. However, self esteem and self-confidence among women by virtue of their education status, awareness gained through radio and television, opportunities to independently manage a household and enter male domains; and exposure to a diverse range of providers confers upon them a greater decision-making power in matters of their reproductive health. Programmes to improve female reproductive health need cognizance of anthropological insights. Mere availability of modern health care services is not sufficient to induce a change for improvement. The significant others (TMG) and traditional providers heavily relied upon can be involved in the strategies to reach and inform women. The cultural factors determining female role

models and ideals are the fundamentals on which a reproductive health program can be based.

Religion, rituals and local authoritative knowledge of reproductive health are the instruments of culture driving decision-making processes. Culture however, is not stagnant; it is changing at a very imperceptible level, evident from inter-generational differences. Future research is required to study the agents and mechanism of change in a given culture of reproductive health decisions.

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Annexes

Socio-Economic and Census Survey
Page 1

S. No.	Sex		Age	Marital Status					Relation to the head of HH	Religion		Ethnic group	Education						Land holdings (yes/No) If yes in kanals
	M	F		Single	Once	More	Divorce	Widow		Main	Sect		Nil	1-5	6-8	9-10	13-14	15-16	

								S. No.
							Yes	Tractor
							No	
							Poultry	Live Stock
							Goats	
							Cow	
							Buffalo	
							Oxen	
							Donkey	
							Kacha	House
							Pacca	
							Hand pump	Water Source
							Sanitation Facility	
							Electricity	
							Mobile Phone	
							TV	
							Radio	
							Refrigerator	
							Transport (car, bicycle, rickshaw,,)	
							(Husband/ Son)	Occupation
							Formal	Occupation (self)
							Informal	
							Daily	Income
							Monthly	
							Yearly	
							Nuclear	Nature of Residence
							Joint	
							Extended	

Interview Guide for Semi-Structured Interviews

I. PROFILE OF RESPONDENT

1. Name .....

2. Age (years) : Adolescent ≤ 20 years ☐ Youth 21-24 ☐ Adult ≥ 25 years ☐

3. Marital status : Married ☐ Divorced☐ Widow☐

4. No. of children alive: M ☐/F ☐
   No. of children dead ☐
   No. of still births ☐
   No. of abortions ☐

5. Occupation of respondent.....
6. a. If yes- monthly income? .....
6.b. How much of it she keeps/spends for herself?.....

7. Occupation of husband .....

8. Monthly income (in Pak Ruppees) ☐

9. Material possessions

TV ☐ Telephone/Mobile ☐ Refrigerator ☐

10. a. Does she have land on her name? Yes☐ No ☐

11. b. Does she have any other property in her name? Yes☐ No ☐

12. Level of Education (years of schooling/formal education)
Self ☐ Did she have her say in ending her schooling ? Yes☐ No ☐
Spouse ☐

13. Type of family : Nuclear ☐ Extended(Co-habiting with MIL) ☐ Joint ☐

14. No. of people living in the household ☐

15. No. of siblings: self ☐ husband ☐

16. Sibling order: self ☐ husband ☐

17. Does it make any difference to be elder or younger in the family? Yes ☐ N0 ☐

II. AUTONOMY

1. Permission needed to go to the market

Can go alone Yes ☐ No ☐

2. Permission needed to go to health centre
Can go alone Yes ☐ No ☐

3.Permission needed to go to natal home
Can go alone Yes ☐ No ☐

4. Is your opinion sought in important matters of family? Yes □ No □

5. Can you give opinion if you feel like it? Yes □ No □
Is your advice respected? Yes □ No □

III. DECISION MAKING

Who decides about

1. What to cook ? Self □ Husband□ Joint □ MIL□

2. Major purchases(land/jewelry) ? Self □ Husband□ Joint □ MIL □

3. Seeking care for own illness: Self □ Husband □ Joint □ MIL□

4. Seeking care for child illness ? Self□ Husband□ Joint □ MIL □

5. Remember being opposed by ---------- on a decision to----------

IV. MARRIAGE

1. Which is the most suitable age for the marriage of a girl (in years)?
2. What was your age at marriage?
3. What was your husband's age at marriage?
4. What kind of a wife, parents want for their son?
5. What kind of a husband, parents want for their daughter?
6. Did your parents ask your opinion about the selection of spouse ?

7. If no, why not?
8. Are you married with in family? Within biradari? What was your relationship to your husband before Cousins □ or not □
9. If yes, Maternal side □ Paternal side□
   First cousin □ Second cousin□
10. Have you met your husband before marriage? If yes, how often?
11. What is your opinion about married life? .....Why do you think so- explain?
12. Do your parents live in the same village as yourself?
13. How frequently do you visit your natal house?
14. How frequently do you talk to them?
15. When you go to see your parents, from whom do you seek permission?
16. Who accompanies you?
17. Who takes charge of work at home when you are away?
18. After marriage how soon should the first conception take place?
19. Did you conceive within a year or later?
20. If later, what was the reaction of the family?
21. How did you know you had conceived?

V. PREGNANCY AND CHILD BIRTH CARE

The total number of pregnancies you have ever had?
Note: Ask the whole series of questions for each pregnancy

First pregnancy

1. Whom did you consult about pregnancy care?
2. Did you go for check up?
3. Where did you deliver? Home/ Hospital
4. How much did you pay for delivery? Travel plus fee
5. Did you have any medical problem during pregnancy or delivery?
6. Why did that problem arose?
7. What did you do about that?

Second pregnancy and so on (Repeat questions)

VI. MENSTRUATION

1. At what age did you have your first periods?
2. Did you know about it before hand?
3. Who explained /told you about it and what?
4. Did they tell any special precautions during those days?
5. Why do some times women have heavy or very light menstrual flow or pain during menses or stop or spotting ?
6. Is this a disease?
7. What can be done about it?
8. Did you ever have such a problem?
9. Whom did you consult?
10. Was it cured?

VII. SEXUALITY :

1. What do you think makes a female attractive ?
2. What do you think makes a man attractive ?
3. How many times do you think one should have sex in a week? Explain your answer.
4. Do you think your husband is satisfied with sexual relationship with you?
5. Did he ever complain about any thing?
6. Are you satisfied with your sexual life? Do you think it could have been better? How?
7. Did you ever talk about it with him?
8. If you have any problem with sexual relations whom do you consult?
9. How many times do you think one should have sex in a week? Explain your answer.
10. If you have any problem with sexual relations whom do you consult?
11. Do you continue sexual relations with your husband when you are sick?
12. Have you ever refused him if you do not feel like it ?

13. How did you refuse?
14. What was his reaction?

VIII. FAMILY SIZE

1. What family size do you prefer for yourself? Reasons
2. What family size does your husband prefer? Reasons
3. What family size does your MIL prefer? Reasons
4. Have you and your husband ever used any method of family planning? Describe with later first in reverse order. In detail about each method?
5. Who referred you? From where obtained? Cost ? Any side effects or problems? Reasons for those problems? How those problems were solved?
6. In case of an unwanted pregnancy, would you prefer to induce abortion or give birth and why?
7. Have you ever had an induced abortion? If yes
8. Who was the provider? Who referred you there? Method adopted ? Any health problem after wards?

IX. HEALTH

1. How do you define health?
2. Have you ever been sick ? What kind of sickness?
3. Were you severely sick ever?
4. Tell more about it?
5. What do you do not like about illness?
6. Who takes care of yourself during your illness?
7. Who takes care of children during your illness?
8. How do you think our bodies work? How disease occurs
9. Network (information and care seeking)
10. Name at least 5 friends with whom you meet at least once a week to discuss common interest issues?
    Name ----- Friend/ Cousin/ SIL/Neighbour
11. If you have any health problem whom do you consult first?
12. If you have a female health problem whom do you consult first?

X.CHOICE OF PROVIDER AND FEMALE REPRODUCTIVE HEALTH NEEDS:

Provider consulted	Reproductive Health Condition and Complaints																			
	Vaccination during pregnancy TT	Preg. Problem Vomitting	Backache	Preg. Checkup	Delivery	Post natal	FP By method	Menstrual irregularity	Dysmenorrhea	Menorrhagia	Vaginal discharge	Pain lower abdomen	Dyspareunia	Abortion	Infertility	UV Prolapse	Frigidity	PMS	Menopausal symptoms	Breast condition
Self																				
Other family counsel																				
Dai																				
Village Maulvi sahib																				
LHV- BHU																				
Dai- BHU																				
Dr- BHU																				
Private Dr																				
Private LHV																				
Private Hospital																				
Public Hospital Fateh Jang																				
Public Hospital Rawalpindi																				
Private clinic – other city																				
Private hospital – other city																				
CMH- Employer facility																				
Chemist																				

XI. PROVIDER CHARACTERISTICS

1. Who referred you to this person and why?
2. Cost : how much is the fee? Can you afford?
3. Is provider sensitive? Yes / No, explain.
4. Does provider keeps confidentiality? Yes/ No, explain
5. Travel time to provider ?Less than 30 minutes 30 minutes to 60 minutes More than 60 minutes ?
6. Waiting time: what is your feeling about it? Is it acceptable or too long
7. How do you measure professional competence?
8. How do you rate his /her quality of care?
9. Can you trust this provider with confidential information?
10. Utilization : Do you use the same provider every time get sick ?
11. Is the provider generally helpful or not?
12. Can understand fully your problem?
13. Are you fully satisfied with his/her management?
14. How do you rate cleanliness of facility; good or bad?
15. Are operating times of the provider convenient?
16. Are all drugs/medicine usually available?
17. Are you satisfied with the diagnosis and treatment offered?

XII. ILLNESS HISTORY

1. When was the last time, you felt sick?
2. What was the problem?
3. Give detailed history----
4. How did you know you were sick?
5. What do you think caused that illness?
6. Who pays for your treatment when you are sick?
7. What did you feel when sick: guilty, concerned, afraid- explain

8. Did you knew about that illness before : some one had it ....., heard about it from others.....; saw it on TV.....;was on radio.....; read about it.....

Illness Narrative: Part 1

1. When did you experience your health problem or difficulty for the first time?
2. What happened then? and then? and then?
3. I would like to know more about your experience. Could you tell me when you realized you had this health problem?
4. Can you tell me what happened when you had this HP(Health problem)?
5. Did some thing else happened when you had this HP? (Repeat as necessary to draw out contagious experiences and events).
6.If you went to see a helper or healer of any kind, tell me more about your visit and what happened afterwards.
7. If you went to see a doctor, tell me about your visit and what happened afterwards.
8. Did you have any tests or treatment for your HP? The relevance of this question depends on the type of health problem.

Part II. Prototype Narrative

9. In the past, have you ever had a health problem that you consider similar to your current HP? (If yes, ask next Q)
10. In what way is the past health problem similar to or different from your current HP?
11. Did a person in your family ever experience a health problem similar to yours? (if yes, ask next)
12. In what ways do you consider your HP to be similar or different from this other persons HP?
13. Did a person in your social environment (friend/work/acquaintance) experience a HP similar to yours? If yes, ask next Q.
14. In what ways do you consider your HP to be similar or different from this other person's health problem?
15. Have you ever seen, read or heard on TV, radio, in a magazine or on the internet of a person who had the same health problem as you? If yes, ask next.
16. In what ways is that person's problem similar to or different from yours?

Part III. Explanatory Model Narrative

17. Do you have any term or expression that describes your HP?
18. According to you, what caused your HP? List primary causes.
19. Are there any other causes that you think played a role? List secondary causes.
20. Why did your health problem start when it did?
21. What happened inside your body that could explain your health problem?
23. Have you ever considered that you might have (introduce popular symptom or illness label)?
24. What does (Popular label) mean to you?
25. What usually happens to people who have (popular label)?
26. What is the best treatment for people who have (Popular label)?
27. How do other people react to someone who has had (Popular label)?
28. Is your HP somehow linked or related to specific events that occurred in your life?
29. Can you tell me more about the events and how they are linked to your HP?

Part IV. Services and response to treatment

30. During your visit to the doctor (healer) for your HP; what did he/she tell you that your problem was?
31. Did your doctor/healer give you any treatment; medicines &treatment or recommendations to follow?
32. How are you dealing with each of these recommendations (repeat for each)
33. Are you able to follow that treatment (or recommendation or medicine)?
34. What made that treatment work well?
35. What made that treatment difficult to follow or work poorly?
36. What treatment did you expect to receive for your HP that you did not receive?
37. What other therapy, treatment, help or care would you like to receive?
38. Do you think you were cured? If yes why, if no why?
39. Will you go to same provider again if such problem occurred again? If no, where will you go and why?