WOMEN WITHOUT VOICE: CHILDBEARING WOMEN OF RURAL AREAS

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ABSTRACT

Healthcare in Pakistan is identified as one of the most daunting tasks. Discrimination with women is a common practice in Pakistan which starts with their birth and continues all their life. Women from rural areas are more prone to this discrimination than their urban counterparts. All these things along with the fact that reproductive health and related issues in Pakistani society are hitched with socio-religious belief system, and therefore are not discussed openly, make this exploratory research all the more important. The heavy dependency of women on men, particularly of rural settings makes them more vulnerable. So, they confront with maltreatments, neglects and exploitations. The study aims at exploring the process, condition, socio-economic and religious causes, and impact of problems and vulnerability of childbearing women in a village called 'Kot Pindi Das' about 12km away from Lahore. The study analyses the primary data collected through unstructured interviews, participant observation, and Participatory Rural Appraisal (PRA) methods to document the phenomenon in detail, and results in suggesting preventive, regulating, and rehabilitating measures to address the problem.

Keywords: *Childbearing women, Pre and post natal healthcare, Nutrition, Morbidity, Mortality, Lady Health Visitor, Midwife, Vasectomy, Tubectomy, Basic Health Unit*

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INTRODUCTION

Childbearing women are those who are in the process of giving birth to child or have recently given birth. Such women particularly of rural areas have been confronting various social, cultural economic and health problems. Health-care is one of the most challenging problems in Pakistan, the fifth most populous country of the world (Mussadaq, 2011). High population growth rate, maternal mortality and low-weight of babies at birth, across Pakistan are the biggest health indicators (Haq, 2004, p. 51). Women suffer from nutritional and micro nutritional deficiencies that contribute to higher rates of morbidity and mortality (IUCN, 2012, p. 37).

Women health is associated with her social status and it goes without saying that women are mistreated and discriminated. The discrimination starts since their birth and continues all their life. As far as Indian conditions are concerned, "Parents can now detect the sex of a fetus within the first trimester, and upon learning that the sex of the unborn child is female, many women choose or are forced to abort. Although the evidence is not fully available, one study showed that 7,997 of 8000 fetuses aborted were female" (Jaising,1995, p. 51) Whether it is a distribution of food in a household or a matter of education, decision of marriage or a decision of having a child, women are not taken into account. When a girl is unmarried, she is heavily dependent on her father or male elders of the family. She is not allowed to take important decisions without their consent. Girls are often married in their teen-age and in many cases their husbands are quite aged. Other measures of female autonomy commonly used in past studies include household type (conjugal versus joint or stem), the age difference between husband and wife (Cain, Khanam & Nahar, 1979). A male enjoys the authority within the household. After the marriage females are also under the domination of their in-laws and dependent on husbands. A Woman does not have say even in fertility matters. When she is living with her in-laws or in a

combined family system, she has to take permission from her mother-in-law or elders for most of the matters. "A wife is always expected to submit to her husband's authority. When a couple lives with the husband's parents, as it is often the case, the woman is under the control of the most senior woman for the household" (Hakeem,1994, p.729) She always has to have a companion from her family member when she gets outside the boundaries of her house. She is generally not allowed to move outside alone.

When a woman gets pregnant, everyone in family desires baby boy and so does she. It is a fact that son is considered a security asset for woman with which she attains a better status in her in-laws, "Within the family, a son is conditioned to be dominant and protective of the family interests and its good" (Hakeem, 1994, p. 729) If a baby girl is born, family feels low because they think that daughter is a liability and she will have to proceed to her husband's house. In our social system, many couples usually keep on increasing their family size in search of 'son' and at times women are forced to abort a female child when there are already some daughters, which badly affect their health and mental condition. "If a girl child is lucky enough to be born, she experiences discrimination in her infancy. Girl children are fed less and for shorter periods and are not given food like butter or milk, which are reserved for boys. … While boys are sent to school, girls often stay home to look after young siblings and to help in household chores. Even those girls who do receive some education must, at the same time, do washing and cleaning, as these are taboo chores for males" (Jaising, 1995, p. 51). In some households when a female child is born a woman has to face discourteous behavior within her family (in-laws), and in some cases they are not given proper care and food. Mother and daughter both face biased attitude by other family members and sometimes face domestic violence also.

There are certain established values in Pakistan and one of them is bifurcation of sexes through veil (*Purdah)* which plays a role while accessing health care services, "*Purdah* is a practice for females,

usually by veiling or keeping them at a distance from men outside the immediate family. According to set norms this preserves honor *(izzat)* of women and protects them from the sexual advances of men. Needless to say, it prevents women from having the opportunity to respond to those advances. The codes do not apply on pre-pubescent girls or to women beyond reproductive age." (Khan, 1995, p. 42)

By and large it is not permissible for a rural woman to go to a male doctor during her pregnancy due to religious and social norms or even visiting hospitals or clinics where male staff is available. She is supposed to be in company of a female family member when she access any health service. To avoid the compulsion of companion, transportation and costly treatments of private doctors family generally prefers *Dai* (traditional midwife), who handles the case within four walls of the house. A midwife is mostly an illiterate woman, who takes training either from her mother or a senior *Dai*, charges nominal fees and manages delivery of a child. They are found in almost every village and even in urban settings. "Lack of access is one of the major failures of health system. Access to water, sanitation, health facilities, doctors and transport is limited. In Pakistan, 49 percent of extremely poor patients have to travel over six kilometers for medical consultation. Also on average 54 percent of poor people go to private practitioners, compared to 13.3 going to government hospitals and 8 percent to government dispensaries. The availability of health services including health provider, is another factor that determines the accessibility of healthcare for the poor" (Haq, 2004, p. 33) The private practitioners operating in rural areas are mostly unqualified and untrained like dispensers, midwives, lady health workers and *hakeems*.

In fact the poor women in rural areas work hard to make their both ends meet. They do the household chores, take care of their children, help their husbands in fields and even do labor outside if need arises. Notwithstanding they do not have say in most decision makings and their consent is not considered necessary for the size

of their family or gap between two children. Their low socio-economic status makes them more vulnerable to health problems during their pregnancy. Deaths and sickness from reproductive matters are high particularly among the women in villages. In Pakistan reproductive problems are more severe for such women since mostly they are illiterate, poor and powerless.

Objectives of the Survey

The following are the main objectives of the study.

- To highlight mistreatments and neglects faced by the childbearing women of the area under study.
- To draw attention of the stakeholders towards the issue of Childbearing women.
- To shed light on the established traditions and practices of the society not compatible with women's rights.
- To evaluate the role of traditional, public and private institutions regarding women's health care.
- To suggest some recommendations to improve the condition of childbearing women.

HYPOTHESIS

Heavy dependency of Childbearing women particularly of rural settings makes them more vulnerable.

RESEARCH DESIGN

This is an exploratory study in which the phenomenon has been observed and studied in the field. 'Descriptive study' is opted which helps to understand the process, condition, causes and effects of the problem under study. To know the Role of Health Sectors for childbearing women in a rural area of Punjab, a village 'Kot Pindi Das' about 12km away from Lahore was chosen. The

researchers spent two months, visiting the area understudy almost on daily basis. The primary data was collected from feelings, observations, and unstructured interviews. After consulting experts of Punjab Rural Support Program (PRSP), few villages of rural Punjab were taken into consideration but finally village "Kot Pindi Das" of district Sheikhupura was selected.

It is a 'qualitative research' and largely depends on primary sources. So besides eight women and some relevant persons from health services were selected for interviews through 'Stratified' and 'Snowball' sampling method. The 'semi-structured' interview schedule was used for interviews. The different terminologies and information have been triangulated by discussing it with the qualified doctors. For the analysis of data 'Content Analyses' have been undertaken in which data was coded and broken into categories and sub-categories.

FINDINGS OF THE SURVEY

Public, Private and Traditional Healthcare

Lady Health Visitors (LHVs) were quite familiar because people of the area considered that they are 'lady doctors' though they have been given basic training about woman health and birth related matters. For them LHVs who work in the governmental health sectors are educated and trained persons. The women who are from poor household prefer the traditional midwife and women from better households go to doctors in cities for treatment. However Lady Health visitors were often seen unoccupied because of less nominal patients. They are not very regular to their duty because of transport and accommodation problem. The LHVs who are working in the village come from Sheikhupura. They mostly come late at work and often use to take lifts from others, which are also not considered inappropriate in rural areas.

Qaisra reported in her interview, "When there is any delivery in our clinic, it sometimes takes a lot of time. Either I have to stay in

the clinic all the night or I take lift from this clinic's owner. But people see it negatively, even my husband does not like my late coming but my work has its own pressures, I cannot ignore my patients when they need me. Then I take off next day when I go back home late consequently many patients go back disappointed. I will either leave this job or I will try to convince my husband to shift to Kot Pindi Das."

It was noted that transport is the main problem for them. The LHVs travel all the way on local busses which were always stuffed with people and it consumed lot of time. The conveyance issue was reported by all the female staff working in governmental and private health sectors. Moreover few lady health workers reported that a private vehicle or rickshaws are not allowed to enter the village because it reduces the number of bus passengers. The *Nazim's* uncle is the in charge of bus stand. The LHV stated about conveyance problem, "Huh! Renting a private Vehicle! The *Nazim* would never let it happen". A rickshaw or a taxi is not allowed to enter in this village because in charge of the main bus stand is *Nazim's* uncle and it could affect his business. Bus waiting at Qilla Sattar Shah requires 25 to 45 minutes and then there is a long distance towards civil dispensary which has to be covered on foot. Sometimes we take lift from Uncle (Senior Technician at Civil dispensary) to reach dispensary".

It is evident that lack of transportation facilities was one of the reasons of irregularity and unavailability of Lady Doctors and Lady Health Visitors. The female health workers can work in the villages but behavior of people on the roads and busses was also teasing which is affecting their self-confidence. The LHVs of Kot Pindi Das do not possess any certificate. Two things were observed as a part of their day-to-day practice. Firstly they blame traditional midwives for ill-health of child bearing women and secondly rebuking female patients was a part of their duty. At governmental sectors they had a typical behavior because of the reason that they do not have stock of medicine and any other facilities like

ultrasound machine, nebulizer etc. The main reason for their inefficiency and crude behaviors is that they are more interested in making money by referring patients to their private clinics.

People from health care services reported that few men and women are addicted to 'avil' injection which is mixed with one or two other injections. Certain people in villages have a strong obsession of injections. They do not feel cured without injections as they are reluctant to take medicines. An MBBS doctor of village stated, "People feel cured with injection. They dissent to take other medicine. They are even satisfied with injection full of water….They seriously need health education!"

It was also noted that the woman, who were literate and vigilant knew the importance of trained LHV however, illiterate and ignorant women were not aware of the role of education and training, thus they were inclined towards *Dai*. The MBBS doctor of the village reported that all his children were delivered by a family *Dai* because social norms are more important than health of a rural woman. It is pertinent to note that an educated woman had her children delivery from a traditional midwife because of her mother-in-law and husband compelled her. So a woman herself cannot take decision at her own because she is powerless.

It was seen that the LHVs were not in favor of traditional midwives, *Peer* and *Hakeem.* Though illegal abortions were taking place yet it was not considered righteous act in the religion. Women who are pregnant after illicit affairs or due to a female child approach the LHVs and traditional midwives for abortions. In this way they can make a good business by doing this illegal job discretely.

In Kot Pindi Das neither lady doctors were available nor male doctors. The government is unable to supply medicines and proper equipment to Basic Health Unit and Civil Dispensary; this was the main reason why people of the village rarely visit it. Women became victim of quacks because of non-availability of qualified

doctors in the area. At times women also could not afford delivery charges by private doctors or LHVs that why they were more inclined towards traditional midwives.

Traditional midwives were considered reliable in Kot Pindi Das and people felt that they could manage delivery of a child. They preferred them because of their experience and at the same time they were affordable. They not only avoid the public clinics and hospitals due to the presence of male doctors but also due to transportation problems, expensive tests and treatments.

One of the important reasons of approaching a traditional midwife was her familiarly within the family. At times traditional midwives had experience of delivering children of two generations that was why people trust them. Women were hesitant to go to clinics and hospitals because they do not have exposure. Secondly in rural areas it is a social practice too, a child-bearing is supposed to be kept in veil and not to be taken to hospitals and clinics where there is presence of male workers. Woman from poor households preferred traditional midwives as they were affordable for them and they did not have to travel a long way for delivery. In Kot Pindi Das it was also observed that a few women were going through severe infections because of the usage of unsterilized equipment during the delivery and traditional ways of treatments by midwives.

In Kot Pindi Das Midwives were believers of superstitions. Bano during body mapping stated, "A woman who was suffering from '*Athra*' is a 'Shani-Aurat' (cursed women), other woman should stay away from her, one should not use her washroom, wear her clothes and restrain even from her shadow". People believed in superstitions and some of the superstitions were harmful. It was affecting the self-confidence of a women and making them stigmatized individuals of society. "Dais" strongly believed in superstitions like "*Athra*" and "*Shani Aurat*", women also learnt from them. One of the sources of such myths was these traditional

midwives. Women consult midwives during their pregnancies and spend nine months according to their advices. But the people from Medical Sciences had different views; A Lady Health Visitor Qaisra reported in her interview, "If a woman who has "*Athra*"-A contagious disease then we are the ones who treat them, we should get this disease first. I am totally fine, I have two kids and I treat such women on daily basis"

Two kinds of midwives can be seen in the rural areas. One is experienced who has proper training from any institute and the other one is untrained midwife who does not know even the names of medicines yet they are working in the village. There are midwives who work in public health sector and get training but most of them are untrained. They work in different clinics for getting a "Certificate" which enables them to practice openly. The traditional midwives also found difficulty in learning the names of medicines, injections and drips for that they needed assistance from the Lady Health Visitors. They also worked with different local LHVs for the sake of learning the names of medicines but remained frustrated as LHVs took them their competitors.

The job of a traditional midwife had its own boons because women in rural areas keep getting pregnant again and again. So there are many cases which bring money for them. And if a baby boy is born they get gifts and sweets as a good will. Some traditional midwives were earning more than LHVs in the village or even more a doctor.

Apart from transport, the scarcity of doctors in Kot Pindi Das was also there because of residence problem. Another problem was financial because the doctors working in rural areas could not charge good fee from poor patients. An expensive doctor was unaffordable for the people of the village. This would be an exception in Kot Pindi Das, if an MBBS doctor comes to serve the people it must be just for the sake of humanity. The doctors of governmental health sectors remained absent and the technicians unoccupied as there was inadequate supply of medicines and

equipments by the government. Thus people are forced to go to private dispensaries, clinics and peers for their treatment. Senior technician of BHU said, "Our Doctor is on leave because he is going abroad and it is good, there is nothing to do in BHU, and he is just putting rust on his self here. We do not get enough supply of medicines from this government. A poor person needs treatment and free medicine, which we cannot provide *them*. Government has given us nebulizer and a computer but unfortunately we do not have electricity connection".

There is a section of people who strongly believe in *'Peers'* thus some peers were found in Kot Pindi Das. *'Peer'* is normally a person respected among his followers and they show different gestures to pay respect to him like kissing his hand, bowing before him, help him wearing his shoes etc. Some people were found wearing *'Taveeze'* around their neck or arms, given by *'Peer'*. They believe that *'Taveeze'* can cure diseases and solve their problems. There are some Quranic verses and numbers written inside the *'Taveeze'*. People go to *'Peer'* when they are totally glum for a last hope. '*Peers*' give them hopes and demand for money to resolve their problem. An MBBS doctor stated, "Ignorant people go to Peers because a drowning man catches at a straw. They go to them when they are hopeless."

There were three *hakeems* in the village that do the cure of the diseases with herbs. Men mostly visit them for sexual problems and women visit them for the cure of bareness (infertility) and *Lukeria* (vaginal discharge) problems. Hakeem Sarfraz reported that their treatment is lengthy because they do not have any laboratory where they can perform tests. Once they get to know about the disease, they have many effective cures. Their treatment needs time and patience which people do not have these days. Government should provide them laboratory for tests and training.

Table No. 1: Age of Respondents and Their Number of Children of the Area Understudy i.e., Kot Pindi Das

Name	Age	Age of Marriage	No. of Children	No. of Children Died	No of Miscarriages	Pregnancy
Fehmida Rehmania	46	16	4	8	0	No
Uzma Rehmania	30	17	4	4	0	Yes
Fozia Changar	24	18	1	0	0	Yes
Aneesa Rana	35	16	3	1	0	Yes
Shahnaz Chauhdry Kumbo	28	25	2	0	0	No
Shabana Rana	24	20	0	0	2	Yes
Parveen Changar	26	17	3	2	0	Yes
Shahnaz Kumbo	20	23	2	0	0	No

Source: Survey Data

Table No. 1 shows age of respondents when they got married and their current age. It also shows the number of children died and number of miscarriages. Most of the women at the time of interviews were pregnant. The women interviewed, were between 20-35 years and most of them got married in their teen-ages.

Table No. 2: Level of Education, their Profession, Husband's Profession and Delivery Preferences of the Respondents.

Name	Literate	Education	Profession	Husband's Profession	Delivery Preferences
Fehmida *Rehmania*	No	Never been to school	Runs a "*Bhatti*" at house/helping husband in his business	Cooks food at different occasions	Traditional Midwife
Uzma *Rehmania*	No	Never been to school	Housewife	Works at Brick Kiln	Traditional Midwife
Fozia *Changar*	No	Never been to school	Housewife	Works in corporation	Hospital in city
Aneesa *Rana*	Yes	Graduate	Teacher	Teacher	Hospital in city
Shahnaz *Chauhdry Kumbo*	Yes	Middle pass 8 class	Housewife	Landlord	Hospital in city
Shabana *Rana*	Yes	Middle pass 8 class	Housewife	Works in hospital	Hospital in city
Parveen *Changar*	No	Never been to school	Kiln worker	Sells vegetables	Traditional Midwife

Source: Survey Data

The data discloses the education, level of education, their professions, profession of husbands and preferences of delivery of the respondents. It was noted that educated spouses prefer hospitals for delivery, whereas uneducated spouses are more inclined towards traditional midwives.

Table No. 3: Transport Facilities and Health Care of Child Bearing Women

Name	Transportation	Accompanied by Whom When Visit Any Hospital & Clinic	Pre-natal Care	Post-natal Care	Ultra-Sounds During Delivery	Regular Intakes: Iron & Multivitamins
Fehmida *Rehmania*	On foot	Husband	No	No	Never	No
Uzma Rehmania	On foot	Sisters-in-law	No	No	Never	No
Fozia *Changar*	By local transport	Husband/sisters-in-law /mother-in-law	Yes	Yes	After every two months	Yes
Aneesa *Rana*	Rent a care	Husband/ sisters	Yes	Yes	After every two months	Yes
Shahnaz *Chauhdry kumbo*	By own car	Mother-in-law /sisters-in-law	Yes	Yes	Every three months	Yes
Shabana Asif *Rana*	By own car	Sisters-in-law	Yes	-	After every two months	Yes
Parveen *Changar*	By bicycle/on foot	Neighboring women	No	No	Never	No
Shahnaz *kumbo*	Rent a car	Mother-in-law	Yes	Yes	After every two months	Yes

Source: Survey Data

Table No. 3 shows the mode of transportation used for approaching health services and also who accompanied the childbearing women. It was noted that childbearing women do not approach health services independently. The data shows that the gap between two children. Out of eight respondents mostly (62.5%) had gaps of 1-2 years, it badly affects health of women. Majority of the women did not have the recommended gap between two children.

Fehmida *Rehmania's* son was handicapped and a liability on his mother. She got pregnant twelve times in her married life and her eight children died after birth. The only son of Parveen was wearing *'Taveeze'* as well as some coins around his neck. It was of

golden color and purpose of the *'Taveeze'* was to save her son from 'evil eye'. The two coins of five Rupees were given by the 'uncle' (Parveen's brother) of the child to save him from 'evil eye' and for good health. The child also had pierce in the middle of his right ear and black thread in it. It was for fulfilling the promise (*Mannat*) made at a local Shrine (*Dargah*) by the parents, prayed to have a 'son'. People commit different kind of promises (*Mannats*) there that if God who fulfills their wish then they in return will do something unusual to thank Him. It was observed that the people sitting in '*Dargah*' were addicted of smoking, Hashish and Opium (*bhang*).

In the village many banners of hospitals and clinics were placed. And in fact, there was no qualified doctor and reliable laboratory available. For example a board was showing 'Gynecologist Health Clinic', run not only by a lady doctor but it also offered the facilities like tests of hepatitis, diabetes and pregnancy. When the clinic was visited, the researchers did not find any of the things, written on the board. There was only one LHV available who was working just on the basis of experience which she got by working with a gynecologist in Lahore.

WOMEN HEALTH VULNERABILITIES IN KOT PINDI DAS

The study shows that most of the respondents got married in their teenage. Five of eight were pregnant at the time when they were interviewed. The women taken in the sample gave child birth from 2-12 times. There were 1-4 children per household and still they were hoping more children because they were in their 20's and 30's. Child mortality was high in most households, and still they had confidence in traditional health services. A midwife ('*Dai*') reported, " mortality rate is high because of one disease in which children of a woman die after few days, months or years of birth, this disease is infectious…it can even spread with a shadow… Pregnant women should restrain from those women who are suffering from '*Athra*'….There is no medication for *Athra* except for '*mannat*' or '*Dum*'".

The main health problems in the respondents were malnutrition and over work resulted in low blood pressure, general weakness like body pains or muscular spasm and iron deficiency. Though lady health workers make visits house to house to distribute iron tablets but due to ignorance, lack of health awareness, illiteracy, women do not bother to take the tablets on regular basis. It was observed that women were underweight. As Uzma *Rehmania* was quite weak and pale because she had poor household and hostile relations with her in-laws. She got pregnant nine times in her ten years of marriage which obviously had adverse effects on her health. Although Fehmida *Rehmania* was healthy according to her own statement but she looked ten years older than her actual age. Comparatively women of well-off families, like the ones from *Kumbo Biraderi,* had better health.

It was observed that some of the women were increasing their family size partly on their own will as they consider it a sign of being 'Young', because they have doubt that their husbands may not got another marriage. Many women in the village did not want to increase their family size but they are under the pressure of their husbands and in-laws.

The literacy rate was low in poor households; parents prefer that girls do domestic chores like cooking, washing clothes, housekeeping and looking after livestock. There is a difference between the choice of health service between literate and illiterate woman. Education is directly proportional to the health service choices. Due to financial constraints, they are not able to approach the qualified doctors because of the long distance from their village to city hospitals. Many people die in case of emergency as they have to cover 28 KM to reach a hospital in city. These conditions compel them to depend on *Peer*, *hakeem*, quacks and midwives.

Some women are educated but they are unable to materialize their desire due to pressure from their in-laws or husbands. It was noted that the women who have tough work and less to eat have higher

child mortality rate. Long distance and transport problems are the main obstacles for a pregnant woman particularly of poor families to approach the health services in city hospitals as money was involved in it. There were very few women in the village whose family had their own vehicle and could move easily to the city. Fozia *Changar* had choice of moving through local busses during the pregnancy as her family could not afford to rent a car. So what they did was that she spent eight and half months in the village and then moved to a relative's house in city just a few days before the delivery. This way the poor woman managed her delivery at city hospital. Otherwise it could be a difficult position for her to bear expenses of hospital, transportation and accommodation.

It was also observed that a woman could not move alone and always needed a male or a female companion especially when she intended to visit any clinic or hospital. These factors directly create hurdles in regular checkups, ultra sounds and other kind of health care which are needed before and after the delivery. Parveen *Changar* reported during 'mobility mapping' exercise that she had ultrasound once, when she got pregnant for the first time. She went to hospital with a few neighboring women as they were also going for ultrasound. It was difficult for her to go to the clinics or hospitals alone as she was hesitant to deal with doctors. Her husband was not willing to take her to doctor for checkups before the delivery. She was nine months pregnant at that time and '*Dai*' had told her that her delivery date was very close. She would call the *Dai* when time of the delivery would come. The *Da*i would charge Rs.1000 to Rs.1500 for the delivery. After few days, when the researchers visited her again, she already had given birth to a baby-girl. The newly born was sleeping in room and her siblings between the ages of 3-6 years were taking care of her. Parveen came from the job of brick kiln, whereas her husband was found doing comparatively more comfortable job. He stays at home and sells vegetables outside the house.

The women who are from better households get pre-natal and post-natal care at home and get regular checkups but those who are from poor household keep working in brick kiln and lands even in the first week of delivery. Some cases were found when women gave births at their working places. Women of the village were also not familiar with vaccinations and intake of nutritious food during their pregnancy. To counter this weakness, they were suggested to take tablets of iron and other vitamins but many did not follow it. Whatever a woman eats during her pregnancy it affects the health of child as well as the woman. Doctors always recommend the women to have a balanced and nutritious diet. The poor women often do not get much to eat, especially the expensive things like meat, eggs, milk, rice, fruits etc. They eat simple bread (*Roti)* with pickle or any seasonal vegetable. On the other, hand the women from better households take milk, meat, fruits etc. They are also given things like *'Panjeeri'* which has a lot of sugar, nuts and oil and considered very powerful, however, it only contains bulk of calories which increases the weight of a woman. It was also observed that if a girl was born then in-laws and the husband did not take care of her in terms of providing a nutritious food. Everybody around a pregnant woman including her family, in-laws and husband expect a 'son'. They are disappointed with the birth of baby girl and considered it a burden. Many thought that daughters are liabilities because they have to take care of their expenses and honor. It is an integral part of the culture that a girl should not have any interaction with any male outside the family. Marrying a girl is also a big financial burden on parents where they have to spend on dowry and other marriage arrangements. They think that the burden that comes along with daughter and it does not end even after her marriage. Because there are many rituals which put financial burdens on parents even after her marriage. For instance, there is a ritual that the expenses of the 'first delivery' of a woman should be borne by her parents. They also have to take care of their daughter and the new born baby for the first forty days after delivery. After that the female's parents have to give gifts, toys, and

clothes for new born baby as well as for the in-laws. This ritual is called *'Wayam' or 'Jamana'*.

Though five children of Uzma *Rehmania* have already died and four are alive. According to her family, she was suffering from a disease called *'Athra'* in which a child dies in mother's womb or after the delivery. She got pregnant nine times in her ten years of marriage. She had almost one year gap between all her children. Shabana *Rana* had two miscarriages in the first two years of her marriage and she was six months pregnant again. So, she also got pregnant three times in three years of her marriage. She also reported that she was suffering from *'Athra'* disease.

Parveen *Changar* had about 1 to 2 year gap between her 6 pregnancies. She had 3 kids alive and 2 dead and was pregnant again. Shahnaz *Kumbo* had one year and eight months old son and she was carrying an eight days old daughter in her hands, so it was evident that she had almost one and half year gap. Shahnaz *Chauhdry Kumbo* who was a wife of a land lord had, about two and half year gap between her both children. Fozia *Changar* also had about three year gap between her two children. She was looked after by her in-laws and husband as they were supportive during her pregnancy. She was not forced to undertake household chores. Her husband used to bring fruits and other eatables for her. Her in-laws and husband did not mind if she would have a daughter which was indeed an exceptional case.

Anees *Rana*, who was a teacher and considerably vigilant had eighteen year old daughter and two sons of 14 and 7 years old respectively. However, she had lost one son and was pregnant again. She is suffering from 'Hepatitis C'. She came to know about one month back when she had a proper check up from a doctor in a city. She also was very conscious about her diet, she restrained from all kind of things which are not good for health and she was quite positive about her cure. It should be kept in mind that most of these

women were in their 20's or 30's; it means that they have probability to get pregnant again.

The general attitude of the people towards health problems of unmarried girls was quite suspicious. It is a fact that an unmarried girl had to face obstacles while accessing health care especially if she has any gynae problem. A mother of unmarried 18 year girl (who was suffering from severe infection) reported to LHV, "I can't allow you to check my daughter. She is unmarried (virgin). You people do strange kind of tests. What is the matter with my daughter? Her brothers ask me daily. Doctors have told us to bring ultrasound reports and ultrasound is only for married women. What is the problem? We never had such kind of pains or infection in our times."

The use of contraception among spouses was also investigated in the field and it was noted that people by and large do not use contraception because they considered it illicit in Islam. Though religion was the dominating factor but some social and cultural factors were also observed. An LHV, at family planning clinic reported that people used to throw stones at their vehicles when they started Family Planning Clinic 10 years back. They were against Family Planning Clinic in the village but the trend has changed now. We try to motivate people in different ways. We tell them that there is no use of so many children if you cannot afford to teach them 'Quran'. Still many people do not have regard for us.

After investigating, it was evident that males do not use condoms because they were not comfortable and satisfied while using it. So they said straight "No" for the use of condoms for the sake of pleasure. If the size of the family is increasing and they want to stop it, the woman has to sacrifice and chose different traditional ways like placing coil, tubectomy etc.

A woman reported while getting herself checked by an LHV of Civil Dispensary, "My husband will marry another girl and I will be homeless. I don't know what to do, today my mother-in-law

gave me warning that she will throw me out of house and get her son married to another girl because I am a barren. Although doctor (LHV) said my tests are normal yet my husband will never agree for his fertility test."

In the village LHVs are called 'doctors' by the inhabitants. Two women patients at civil dispensary were quite worried as one of them had 'tubectomy' and was in severe pain. The LHV was scolding her for choosing untrained and unqualified person. She replied with tears in her eyes, "Doctor *Sahiba*! We are poor and illiterate, how would we know who is qualified and who is not? I thought if private doctor (LHV) would take more money, so she would give a better treatment. I gave her sixteen hundred rupees and that was the only money I had. But see, I have got pain and infection due to tubectomy done by the doctor (LHV). My husband gives a damn….he does not care…. I can't spend more money on it now. I don't have!"

Some women got pregnant after the treatment by local untrained midwives and Lady Health Workers. There was a 'Family Planning Clinic' in the village but it was considered as a sign of ignominy. Contraceptive pills were generally not used by the woman of Kot Pindi Das because they found it difficult to take medicine daily. The day they forgot taking medicine, there was a chance of getting pregnant. It was learnt that these contraceptive pills also affect the health of women. Few women reported that they felt nausea and have high blood pressure after taking these contraceptive tablets. Mostly Muslims in the village were not inclined of using contraception. On the other hand it was noted that condoms were more in use by the Christian males to control their family size. Few male Christians had vasectomy to save their wives from risks of getting pregnant again even after having a coil in uterus or tubectomy.

A woman, who had five children reported during 'Body Mapping', "Never! My husband has beard and he offers prayer five times a

day. We both are against contraception. Children are God's gift. It's His will and we cannot go against God's will. Those people who stop their pregnancies with use of contraception are sinners…"

Men in rural areas are dominating and authoritative and women are just their subjects. Vasectomy is considered an offence in the villages. They feel that their masculinity will reduce if they get it done. The first choice for the spouses was to use condom yet not so popular in Kot Pindi Das especially among Muslims who were not inclined to control family size. Second choice is that a woman takes measures with the consent of her husband and gets herself operated. A woman can avoid pregnancy after placing coil in her uterus or by tubectomy. However men are not willing for vasectomy. After investigating some Christian households, it was observed that a few Christian males were willing for vasectomy. Fozia Christian *Changar* reported during PRA exercise, "My husband is very caring; he says that we will have two kids only. We already have son and if God gives us daughter this time, we will name her "Jennifer", we will not try for third child. My husband is also willing to have vasectomy as he does not want me to suffer risk and pain." This seemed to be an exceptional case. Out of all respondent women only one woman reported that her husband is willing for vasectomy for family planning.

CONCLUSION

Discrimination with women is also a common practice in Pakistan, and if a woman belongs to a marginalized family of rural area, she is more prone to this treatment than her urban counterpart. Childbearing women are especially vulnerable to healthcare neglect because of the socio-religious and economic stigmas attached with them during and after their pregnancies. Most of the practices, which create problems for child-bearing women in rural areas, are so deeply embedded in socio-economic and religious fabric of the society. Notwithstanding very weak public healthcare infrastructure, lack of medicines, non-availability of medical

equipments, absence, on permanent basis, of paramedical staff and doctors at BHUs and no monitoring from government side push the women to depend on traditional health care treatments which are dangerous to their health and well being. So the hypothesis cannot be rejected that 'heavy dependency of childbearing women in rural settings makes them more vulnerable'. Therefore, a three-pronged strategy is suggested to address the problem.

SUGGESTIONS AND RECOMMENDATIONS

Following is the detailed scheme having preventive, regulating and rehabilitating measures to address the problem.

1. Preventive Measures

a) Education

Education makes people vigilant and aware about their own rights and health. We live in a society where even men are not aware of their own right then what can be expected in case of women. Women are normally not provided education which limits their exposure and knowledge. It has been proved that educated societies have small family sizes, less mortality rate and more contraception usage. Example of the Kerala state in India can be seen where education of females particularly in rural areas led them for empowerment.

b) Empowerment of women

Special importance should be given to women for social, political and economic empowerment. This way a woman will have more say in household decision making and family size planning. There will be reduced rates of unintended births.

c) Awareness

There is immediate need to create awareness among the rural women about birth problems, balanced diet, and vaccination. Women should also be taught about pre-natal and post-natal care.

d) Role of Media

For creating awareness among the people in rural areas media can play a great role because television can be seen in the rural houses largely. They watch television at their houses, neighbors, food shops, tea or at barber shops. When media play its role not only the women will get awareness but the whole family including husband will know about important things regarding women health and rights.

e) Role of Society

Society can play a vital role in spreading awareness. People in rural areas strongly believe in myths and which suffocate women at times. People can be educated about scientific and rational approach towards women health issues. There are many religious and social taboos which are believed in the rural areas like trusting in fake *Peers* who give false hopes to people and loot them. An educated *Imam-e-Masjid* can play an effective role to educate people about true spirit of religion and make them aware.

f) Community Participation

Community should help itself by spreading awareness. A committee should be organized among educated people of the area, which should work on the problems faced by people while monitoring public and private health care facilities. It should also keep check on the governmental health services and report to the authorities by highlighting the flaws.

g) Role of People's Representative

Role of people's representatives is very important. Gaps in the elections of local bodies have multiplied many difficulties. When people choose their representative, they are answerable to them. People can always reject the elected individuals in the next elections if they are unable to address the problems of their area efficiently. Noted people like *Nazim* and councilors of the village should play

their role effectively and meaningfully. They should keep check on the negligence of public health sector like BHU, Civil dispensary etc. They should also control the persons who are prescribing medicines without proper authority and give high potency injections. It is the duty of *Nazim* to provide his people with fair and accessible health system.

REGULATING MEASURES

a) **The Role of Government**

Government has to play its role efficiently by providing the facilities for its people. It should revise strategy and make proper system by involving local community. The government should provide staff, medicines and equipments to all public Health Care Centers for the health care of women.

b) **Accessible Qualified Doctors**

First of all the doctors appointed to public health care center should be made available for the people. Proper monitoring should be done by surprise visits. Long leaves and absence of the doctors and taking away of medicine and equipments be discouraged. Other doctors, practicing privately in the village should be monitored and their qualification should be checked. Unqualified dispensers or quakes who practice openly in the villages should not be allowed.

c) Availability of Medicines and Doctors

All the available public health care centers and dispensaries in the village should properly be equipped. Medicines and equipments like nebulizer, oxygen cylinder, gluco meters, blood pressure apparatus, ultrasound machines, ECG machines should be made available. The equipments which are out of order should be replaced or repaired.

d) **Proper Labor Room**

Labor Rooms are available in the public health centers but they are hardly in operation due to unavailability of female doctors,

paramedical staff and equipments. These labor rooms should be equipped and presence of female staff can make it more useful.

e) **Local Doctors**

Absentees from duty are noted in the area under study. It is suggested that the doctors should be appointed from the local community or from the adjusted areas. It will reduce the number of absentees and comfort level of the community with the doctor will also increase.

f) **Extra Incentives to Doctors Working in Villages**

Those doctors who work in villages should be given extra incentives as compared to those who work in cities. More female doctors should be appointed to the villages with attractive pays and benefits. They should also be provided with other facilities like residence and conveyance.

g) **Transport or Conveyance**

The most important problem, seen among the female paramedical staff, was the problem of conveyance. Government should start public vehicles especially for the pick and drop of Lady Health workers, Lady Health Visitors, Midwives and other staff to the villages where they do their duty.

h) **Refresher Courses and Trainings**

The paramedical staff should be given special workshops on their communication skills and polite behavior towards the community. In this way patients will feel comfort to visit public health care facilities. Like this the new doctors and paramedical staff should also be given trainings before sending them to the field.

i) **Local Government System**

Due to absence of local government system, there is increase in mismanagement. This should be brought back so that the *Zilla Nazim* and DCO can play a role to run the affairs smoothly. It

should have regular basis election. Long gaps in elections of local bodies make things worse.

j) **Helpline**

Modern techniques like telecommunication should be brought into consideration for effective management. There should be a helpline number on which people can complain about the negligence or absence of doctors or paramedical staff to government authorities. It would improve the working of BHUs.

k) **Role of Anti-Quackery**

A mechanism of anti-quackery should also undertake in the villages. They should fine and arrest the quacks that are practicing in the village and making people fool.

REHABILITATING MEASURE

a) **Handling of Maltreated Cases**

The cases which have already been mistreated by the untrained and uneducated local quacks should be given importance. There should be facility within the village where these people should be admitted and taken care of. In this regard existence of helpline will have the great importance.

b) **Improvement in Existing Public Health Sector**

The public health sector, which are already existing in the village but not working efficiently in real sense because of unavailability of staff, medicines and equipment's, should be mended. Proper monitoring system should be placed by government involving local people and use of helpline for feedback. It is seen that vast places are occupied for public health centers but they lack the facilities. The number of problems of childbearing can be resolved if Basic Health Unit and Civil Dispensary start working properly.

c) **Training of Mothers**

It is very important to give trainings to the mothers about ante-natal care, post-natal care, vaccinations etc. Women in the villages are ignorant of these precaution measures. This kind of workshop by NGOs in collaboration with local community on 'Mother Training' can bring a positive change in the health of childbearing women.

d) **Curbing Malnutrition**

As one can see that a large number of women are suffering from malnutrition, the centers like BHU, RHU and Civil Dispensary should facilitate women for checkups and provide them nutritious things in the form of iron tablets, candies, milk and biscuits. The Government should take befitting action against the quacks. Many actions and policies were announced to curb the problems that child bearing women have been facing yet no desired results are achieved. However, such measures and solutions can only work if government applies them in true spirit. Moreover, other stakeholders like local leaders, community chiefs, NGOs and local bodies should come forward and join hands to address the problem of child bearing women. With such concentrated efforts one can not only ensure good health of women but also control rapid population growth.

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