Gender and Reproductive Health: a need for reconceptualisation

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This thesis is dedicated to my father, Mumtaz Ahmed, a great believer of gender equality and social justice. His love of reason saw the quest for knowledge as a crucial tool to achieve justice.

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Abstract

This thesis is a conceptual and empirical exploration of the links between women's gendered position and their reproductive health in Pakistan.

A growing body of literature seeks to identify the relationship between gender inequality and women's reproductive health, most commonly their contraceptive use and fertility. However, to-date findings have been mixed and we lack a coherent picture of how these two aspects of women's well-being are related. This thesis illustrates that the focus on female autonomy, which is central to much of the discourse concerning gender and reproductive health in South Asia, is inappropriate to this cultural setting. An alternative framework for conceptualizing and measuring women's gendered position is presented in an attempt to further our understanding of the determinants of reproductive health.

The study uses an integrated analysis of quantitative and qualitative data. The Pakistan Fertility and Family Planning Survey (1996-97) data show important socio-demographic and contextual differentials in women's mobility, decision-making, control over financial resources, communication with husband, exposure to information and health knowledge. Relationships between different measures of women's gendered position and reproductive health outcomes are shown to be varied, with only joint decision-making, communication with husband, and health knowledge having positive associations with both contraceptive and antenatal care use.

A detailed ethnographic study of a Punjabi village reveals kinship structures based on an ideology of *akhathe* (jointness), and social networks and inter-personal relationships as the primary route to resources of all kinds. Women's interests are intricately linked with their family's well-being. They aspire to be *mazboot* (strongly connected) members of their families rather than autonomous individuals. The qualitative data inform the interpretation of the quantitative associations and suggest ways in which measures of women's gendered position can be refined. Both fertility control and pregnancy are shown to be highly gendered processes. However, an unexpectedly high contraceptive use rate, and the emergence of antenatal care use, are found in the absence of accompanying shifts in gender ideology.

In such a context, the 'centrality' approach is suggested as a valid and sensitive way of conceptualising women's gendered position in Pakistan. This approach incorporates the kinship and social structures and suggests women's *mazbooti* as a more acceptable and realisable goal for improving women's reproductive health and well being.

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Chapter 1

Gender and reproductive health: a need for reconceptualisation

1.1 Introduction

Contemporary understanding of reproductive health envisages women 'empowered' with better education, employment opportunities, income, suitable social and political status, and enjoying full benefits of human and reproductive rights. Thus empowered, women would achieve family sizes compatible with their personal goals and those of the social and economic context in which they live (United Nations 1994). The International Conference on Population and Development (ICPD) 1994 endorsed this concept as the appropriate underpinning of the current international policy and 181 countries, including Pakistan, consented.

Currently there is little evidence that Pakistan, the focus of this research, has managed to translate these ambitious goals into concrete action. The complexity of the holistic concept of reproductive health and a lack of understanding of the multiple dimensions of gender relations have hampered the development of specific policy prescriptions that will implement the ICPD goals. Without clarity of objectives, interventions with specific targets will remain impossible to design.

I postulate that an important factor dragging change is that the concept of the right of women to decide their lives, as envisaged in Cairo, is in direct clash with the cultural values regarding normative behaviour of women in Pakistan. The concept advanced by ICPD (1994) is rooted in an individualistic stance, which while laudable, is an alien concept in this social context. Here, customs and socialisation processes not only promote dependency on interpersonal relationships, dependency is a key element of the cultural constitution of female identity (Shah 1986a). There is thus a gap between the rhetoric of 'autonomous decision-making' and the reality of the lives of Pakistani women.

Until very recently, women's 'status' was described using education and employment as referents. Education was assumed to provide the necessary knowledge and skills and employment the economic clout required for women to look after their interests. A new innovation has been the development of more direct measures of women's social position. These include, amongst others, direct measures of mobility, access to and control over material resources, and decision-making in different spheres. Survey analysis of these 'direct indicators' have highlighted not only the complex multidimensionality of the concept of women's position, but also the fact that in some contexts, particularly Pakistan, education and employment do not necessarily bring the postulated changes in other areas of women's lives. One such example is the relationship between education and decision-

making. Instead of a hypothesised positive correlation, education appears to have no effect on women's decision-making powers in Pakistan (Sathar and Kazi 1997). Similarly, women's employment outside the home is often a reflection of economic poverty rather than a symbol of liberation, and any improvements in socio-economic status result first in the withdrawal of women from the labour force (Kazi and Raza 1991; Sathar and Kazi 1997). Furthermore, the practice of *purdah*, with its associated mobility restrictions, is more prevalent amongst the rich and educated (Sathar and Kazi 1997).

These counter-intuitive findings highlight the importance of the socio-cultural context in which broad international policy prescriptions have to be implemented. The Cairo concept of reproductive health is largely rooted in western feminism. An underlying theme of this agenda is that women should be allowed to make independent autonomous decisions, and be 'in control of their own lives'(Jejeebhoy 1995). I feel this idea is culturally incongruous in a context where there is no locally translated term for the word 'autonomy' and those that come closest to it, such as '*azadi*' have negative connotations at the individual level.

I argue that although women's right to a broad range of social, cultural and human resources is inalienable, a vision of exercising those rights via autonomous independent action is problematic. Policies based on such a conceptualisation are likely to translate into a situation that places women in opposition to their families, their socio-cultural context, and even themselves. Pakistan is a communal society in which both women's and men's lives and interests are closely entwined with their families (Ahmed 1997). The need therefore is to explore how women's gendered position can best be conceptualised in this context in order to take into account the multitude of relationships that define and locate women within their families and the larger social context in which they live.

The broader goal of this research is to contribute to our understanding of which aspects of women's social situation and gender context, and at what level, are important determinants of their reproductive health. A key argument I advance is that different aspects of a woman's social position act in different directions and at different levels (individual, societal) to shape women's health. The specific objective is to identify which of these aspects are positively related with contraceptive use and utilisation of antenatal services. The Pakistan Fertility and Family Planning Survey (PFFPS) data were analysed. Complementary qualitative data were collected to provide an in depth understanding of the relationships identified in the survey analysis. The findings of the study will inform the mainstreaming of gender in reproductive health policies and programme content in Pakistan in a manner that is in the spirit of ICPD but grounded in the Pakistani context.

The review of the literature is divided into the following sections:

Part 1: Reproductive health: Evolution of the concept from population control to a broad human rights approach.

Part 2: From Women to Gender; the theoretical underpinning of the concept of gender. Why the concept evolved from Women in Development (WID) to Gender and Development (GAD).

Part 3: A gendered social relations analysis of Pakistani macro and microstructures.

Part 4: Measuring women's gendered position: The limitations of using education and employment as proxy indicators of women's gendered position in Pakistan.

Part 5: Conceptual and empirical evidence of the relationships between different dimensions of women's gendered position and contraceptive use and antenatal care services utilisation.

1.2 Reproductive health: Evolution from population control to reproductive health

Population policy has undergone many changes as lessons learned from experience (and modified by political forces) have been incorporated into policy and action. Neo-Malthusian concerns dominated the 50's and 60's, with their inherent belief that too many people reproducing too rapidly neutralises economic growth, exacerbates poverty, overstretches social services, destroys the environment and fuels conflict (Malthus 1972). Consequently, the focus was on contraceptive technology and family planning programmes (Miller and Rosenfield 1996). At the same time, at least in some quarters, there was an emerging understanding of the circular relationship between poverty, development, social position of women in society and human fertility. At the 1974 Bucharest conference, Southern countries tried to focus attention on issues such as lack of social justice and an unjust economic order as the root causes of 'uncontrolled' population growth. With the theme 'development is the best contraceptive', they argued for equitable socio-economic development as the most effective route to curbing population growth. However, in the face of stiff resistance from the northern countries, little was accomplished in terms of a productive population policy (Finkle and Crane 1975).

By the 1980's, family planning activities had expanded greatly as most governments now acknowledged the detrimental effects of rapid population growth (Miller and Rosenfield 1996). Nevertheless, there was widespread dissatisfaction with contraceptive delivery systems, which had led to some reduction in fertility, but were obviously not addressing women's overall health needs as understood by the women clients themselves (Graham and Campbell 1991). Concurrently, ethical violations of China's one-child policy, and India's enforced sterilisation programmes highlighted dangers of 'population control' as the metaphor with its inherent understanding that 'normalises coercive policies' (Lane 1994, pg. 1308). Demographically driven population policies gave national welfare and fertility limitation more importance than the desires or rights of the individual (Lane 1994).

A theme that thus remained missing in all earlier policies is the role of the individual woman and man: what are their reproductive desires and social needs, what say do they have over their bodies and fertility? The idea of women's reproductive self–determination first originated as early as the mid-nineteenth century, when the Owenite socialists in England advocated women's rights to reproductive choice as a basis for women's personal and political emancipation (Correa and Petchesky 1994). It re-emerged a couple of decades ago as women's organisations at the national and international level, led by feminists, began to voice their interests and present an alternative to the traditional instrumental approach of population control. Their point of departure is that human reproduction takes place through women's bodies, but women have no control over this process. In all the diverse cultures of the world, women lack the autonomy to make decisions about their own bodies, their sexuality and fertility. The root cause of this subjugation, as they see it, lies in the social constructions that place women in a position subordinate to men (Correa and Reichmann 1994; Sen, Germain and Chen 1994).

Coincident with these changes, but running parallel, has been an increasing recognition in the development arena that women have been excluded from mainstream economic and social life and are likely to receive fewer benefits from whatever the development process has to offer. As a consequence, the UN Decade for Women (1975-85) promoted a strategy that aimed to improve the status of women by enhancing their access to economic opportunities, social services, education, credit, health and other resources that might improve their well-being. Women's issues were inserted into the policy agenda of most national governments and international organisations. However, despite some very positive developments in bringing about practical improvements in women's lives, such initiatives did little to alter their basic position in society (Doyal 1998). This led a growing number of observers to question the appropriateness of these approaches as a means for meeting women's long term needs (Kabeer 1994).

As a result of these concerns, albeit from diverse positions, the Population Council, WHO, IWHC, the Ford Foundation and academic researchers conceptualised a new 'reproductive health' approach to replace the limited 'population control' approach. This concept, largely the result of feminist critique, places 'women at its centre'. *Individual choice* and freedom to make *independent decisions* free of coercion is the cornerstone of its philosophy. A holistic approach, reproductive health approach merges health, population, and social development concerns by highlighting their circular and inter-dependent relationships. It appreciates that although reproductive health, (which includes but is not limited to, maternal morbidity and mortality, malnutrition, sexually transmitted diseases and sexual violence) is an individual woman's bio-medical outcome, it is embedded in the larger social, economic and political contexts.

1.2.1 The International Conference on Population and Development

The International Conference on Population and Development (ICPD), 1994 endorsed this concept as the appropriate underpinning of the current international population policy. There are three major points of the Cairo agenda. First, a primary emphasis is placed on women as responsible agents of change. This individually centred conceptualisation of population envisages women 'empowered' with better education, employment opportunities, income, suitable social and political status and enjoying full benefits of human and reproductive rights. Secondly, it infused an individualistic perspective into population policy with the understanding that individuals should not be coerced into lowering their fertility. Instead of population programmes determining women's behaviour, individual women are seen as determining the success of population programmes. The third element is that family planning services should be one of the many components of a comprehensive set of services (United Nations 1994).

The ICPD concept of reproductive health is very broad. It covers a range of issues from maternal mortality, unsafe abortion, and sexually transmitted diseases to contraceptive services (Miller and Rosenfield 1996). However, the most important contribution of ICPD has been a recognition of the fact that a key factor underlying poor reproductive health is the complex web of gender relations and power structures that bar women from participating in crucial decisions that affect their lives (ICPD 1994).

This conceptualisation of reproductive health has potentially major implications for policy and programme action at national and local levels. The emphasis on gender equality and empowerment of women, with its attendant consorts of individual choice and freedom, strikes at the core of patriarchy, that almost inviolable aspect of social organisation of large parts of the contemporary world (Evans 1977; Miller and Rosenfield 1996). Any attempt to modify this 'sacrosanct' norm is bound to meet resistance (Aslam 1995).

Currently, there is little evidence that Pakistan has managed to translate these ambitious goals into concrete action. I postulate that an important factor inhibiting change is the incongruity of the individualistic stance and concepts advanced by ICPD with the socio-cultural milieu of Pakistan. While laudable, the notion of a woman as an independent individual separate from society is an alien concept in a context characterised by dependency on interpersonal relationships (Shah 1986a). There is thus a large gap between the rhetoric of 'autonomous decision-making' in international policy forums and the reality of the lives of Pakistani women.

Gender equality and the empowerment of women is thus one of the most contentious issues of the ICPD agenda (Miller and Rosenfield 1996). However, as a concept, gender is a complex domain, difficult to articulate and even more so to translate into practice. I address these issues next.

1.2. 2 Why Gender? From Women to Gender

Gender as a concept initially emerged in the social development domain. To understand fully its meaning and implications, it is essential to trace its evolution from a women's needs perspective to how it is currently understood.

Nowadays women's role in the development process is widely acknowledged and incorporated into policy agendas of most national and international organisations (Doyal 1998). The United Nations Decade for Women (1976-85) provided the crucial impetus that started this process. Since then a number of initiatives have been developed with the stated objective to improve the 'status of women' (Doyal 1998). Although diverse in their origins and implementation strategies, most have been based on the idea that something needs to be done 'for women' considering they have been marginalized from the development process for so long (Razavi and Miller 1995). A concern with this perspective was that it continued to view women as passive victims who need special help if their circumstances are to be improved (Kabeer 1994). What appeared to be missing was an understanding of the social structures and power distributions which act to restrict women's access to social and economic resources in the first place; resources that men have easy access to and which enable them to promote their own well-being (Kabeer 1994). Gender as a concept addresses this issue. A feminist product, it addresses the social divisions between the sexes and the power plays that form the structures that marginalize women (Correa and Petchesky 1994). Before proceeding to describe the intellectual underpinnings of gender, I will trace the main trends in the ways women's issues have been conceptualised in the development context. This will help us understand the thematic drift from women to gender.

1.2.3 From Women in Development to Gender and Development

Since the 1950's a diversity of social development interventions have been formulated for women. The first of these was the 'welfare approach' (Razavi and Miller 1995; Kabeer 1994). As the name suggests, the focus of this development policy was welfare assistance for dependent and vulnerable groups, usually believed to be women and children. Moreover, normative values about men as bread winning head of households meant that mainstream development efforts for market-oriented productive activity were targeted at men, further exacerbating the dependency connotations regarding women (Moser 1991; Kabeer 1994).

It soon became apparent to women development workers and academics that the Third World development projects were negatively impacting women (Razavi and Miller 1995). They challenged the trickle-down theories of modernisation when it was observed that for example, higher aggregate level of agricultural production, one of the aims of development, did not necessarily lower malnutrition amongst women and the girl-children (Jacobson 1993). This dissatisfaction resulted in the development of a number of alternative approaches to address women's needs. Together they have been categorised as the 'Women in Development approach' (WID) (Moser 1991). WID's primary position was that the origin of women's subordinate position is the result of their exclusion from the marketplace. Rejecting welfare assistance, the WID position linked efficiency issues with development. The approach argued for increasing women's access to education, technology and credit with the justification that efficient use should be made of all human resources. Implicit in the demand for access to economic opportunities was that once women were economically productive, their status vis-à-vis men will improve (Razavi and Miller 1995).

WID is thus associated with a wide range of activities such as improved educational and employment opportunities; equality in social and political participation and increased health and welfare services for women. The policy has brought considerable benefits for women. Across the world, fertility rates have fallen by a third, maternal mortality rates have been halved and female literacy has increased from 54% of the male to 74% (UNDP 1995).

However, the WID focus on investing in women's productivity in terms of economic returns resulted in a number of compromises. For one, rejection of the welfare approach meant that some real needs were neglected (Goetz and Sen Gupta 1996). There was also a tendency to exaggerate women's contribution to development. Whilst this gave women a high profile, inherent in it was a danger that women would be expected to compensate for provision of services that are the responsibility of the state (Goetz and Sen Gupta 1996).

Despite the compromises, WID received only cursory treatment from the largely male development specialists and bureaucrats (Moser 1993). Most WID demands for productive employment were met with small-scale income generating projects in nutrition or traditional handicrafts. Even when successful, they did little to overcome women's economic marginalization (Kabeer 1994).

Researchers soon realised that the problem with focusing on women in isolation from the rest of their lives ignored the essentially *relational* nature of their subordination (Kabeer 1994). Emphasising women's productivity alone ignores the impact of the broad range of social divisions and social relations that constrain women's choices and opportunities in the first place. Moreover, the approach fails to recognise socio-economic class differences amongst women. Influenced by feminist

epistemology, which emphasises the importance of power, conflict and gender structures in understanding women's subordination, there has been a gradual drift from 'Women in Development ' to 'Gender and Development', so far largely limited to academic circles and policy statements (Kabeer 1994; Doyal 1998).

1.2.4 Gender: theoretical roots

The theoretical starting point of 'gender' as an analytical concept is that humanity inhabits a socio-political environment of its own making, an idea common to all theorists from Rousseau and Marx to de Beauvoir (Di Stefano 1990). One such construct has been the division of society along what is called the 'fault line of gender' (Moore 1988; Papanek 1990). There is no denying that women and men are biologically different, most obviously in terms of their reproductive systems, with their associated anatomical and hormonal variations that ascribe individuals to a particular sex. But this is only a part of the social 'set of criteria by which we all learn to distinguish 'femaleness' from 'maleness' (Doyal 1998). For, on top of the biological difference, but quite distinct from it, is a set of characteristics that defines 'femaleness' and 'maleness' (Goetz and Sen Gupta 1996). This set of criteria, a creation of society, is what is referred to as 'gender'. Although gender and sex tend to be used interchangeably, gender is a more inclusive term. Moreover, unlike biological sex, gender is not a timeless universal but constituted within historical and social contexts, with an astonishingly wide-ranging cross-cultural variability (Standing 1991; DiStephano 1990).

Gender shapes the lives of both women and men in fundamental ways. A pervasive force, it 'structures all aspects of life' (Greenhalgh 1995, pg. 24). Gender values are inculcated in children from an early age and are thought to form a basis for personality (Rubin 1975). It is therefore deeply rooted in women and men's consciousness, determining their sense of selfhood and identity, cutting across class and other social divisions. The most obvious illustration of gender is the divide between the 'public' world of employment and politics and the 'private' world of the home and family. The normative concepts of 'femaleness' and 'maleness' ensures that in most parts of the world (although not all), women see their most important role as that of a mother and home-maker, while men see themselves as breadwinners and protectors of their families (Doyal 1998).

One important consequence of gender is the justification of patterns of inequality between the two sexes. Gender systems are hierarchical, and to the detriment of, largely, women. Most things 'feminine' tend to be devalued and in large parts of the world, women have less access to a variety of economic, social, and political resources compared to men (DiStephano and Lorber 1998). Masculine attributes, roles and behaviour are considered superior and given greater social and economic rewards. Both women and men perpetuate the disadvantaged position of women (Adams 1994). Furthermore,

this ideological construction is presented as biologically determined or divinely ordained, thus rationalising the exclusion of women from the main sources of power, privilege and prestige (Kabeer 1994). However, it is important to be mindful of the fact that women and men's gender experiences are not monolithic, but complex and vary not just by context, but with in a single context by life-cycle stage, class and other social divisions including ethnicity and caste (Annandale and Clark 1996).

1.2.5 Gender and social relations analysis

Starting from the premise that gender was socio-cultural in origin rather than physiological, a number of alternative approaches to women and development have evolved in recent years. Gender as a concept has been used in such a number of different ways in different disciplines that it is difficult to generalise. For the purpose of this thesis, the framework called the 'social relations analysis' will be discussed. I use this framework because its holistic approach to understanding gender also fits in with the holistic approach of reproductive health as discussed earlier.

According to social relations analysis, gender relations refer specifically to those dimensions of social relations that create differences in the positioning of men and women in social processes. It is through gender relations that men are given a greater capacity than women to mobilise a variety of cultural roles and material resources in pursuit of their own interests. The central focus here is the social structures, processes, and relations that give rise to women's disadvantaged position in a given society. As such, ending women's subordination is viewed as more than a matter of reallocating economic resources. It involves a reorientation of value systems and redistribution of power. Thus, rather than down playing the 'political ' dimension of gender, social relations analysis brings it to the core (Razavi and Miller 1995).

Social relations analysis demands a significant understanding of societal structures; political, economic and socio-cultural. With its focus on understanding the broad set of social relations, it aims to use the 'social relations lens' to understand why and how resources, material, human and social are unequally distributed between the two sexes. It begins from the premise that we need to first understand, in–depth, the inter-related range of relations through which needs are met, 'the social relations of everyday life' (Pearson, Whitehead and Young 1981, pg.10). This ensemble of relations governs the processes of production and reproduction, distribution and consumption. And in order to fully understand the whole process in all its holistic form, other types of social differentiation should also be taken into consideration. These include class, ethnicity, age, and caste (Razavi and Miller1995). This analysis also draws attention to the social relations embedded in a range of institutions through which social groups acquire resources.

The social relations analysis thus addresses the whole gamut of forces at both the macro and micro levels that cross-interact to create inequalities between women and men. More importantly, this approach addresses the 'togetherness' or 'social connectedness' of a husband and wife who live under the same roof and share a life (Kabeer 1992). This aspect at the individual level is important because as Amartya Sen states ' conflicts of interest between men and women are unlike other conflicts, such as class conflicts. A worker and a capitalist do not typically live together under the same roof, sharing concerns and experiences and acting jointly. This aspect of 'togetherness' gives gender some very special characteristics' (Sen 1990, pg. 147).

Social relations analysis is a useful tool for my study question because I am interested in reproductive health. The process of reproduction, by its very nature, is not an individual matter. At the very basic level, it involves at least two people, and maybe the site of conflict as well as co-operation. It may also involve other family members and according to some, fertility should even be considered a collective property of the whole society (Greenhalgh 1994; Kumar and Vlassoff 1997). All the actors in this process are located in a society's institutional structures that determine the boundaries of their behaviour (Greenhalgh 1994). Social relations analysis will enable me to address the multitude of social relations that structure gender ideology in Pakistan. The fact that social relations analysis incorporates the togetherness of women and men as they share a social space is of particular use in Pakistan, which as we shall see later in the chapter, is a context characterised by a kinship system in which the interests of women and men are closely interconnected.

In summary, this section has set out the main trends in the conceptualisation of women's issues in the context of development. The historical account illustrates the shift in policy discourse from welfare to WID and from there to GAD. The theoretical underpinning of gender as socially constructed expectations of female and male behaviour and associated inequalities have also been described. The social relations analysis approach to analysing gender was discussed as well as its suitability for understanding the gamut of forces that affect women's reproductive health. In the next section I will concentrate on Pakistan, the focus of the research.

1.3 A 'social relations analysis' of gender in Pakistan: a synopsis of the literature

I apply the 'social relations' lens to understand the ideology, structure and processes of gender in Pakistan. The objective of this section is to describe the context in which international policies such as those of ICPD are meant to be implemented. I highlight the key features of the Pakistani socio-political and cultural context that are overlooked in the generality of international policy prescriptions. I also want to emphasise the strength of these structures and how resistant they can be to ideas that have essentially been foisted upon them.

There is a paucity of theoretical and empirical research related to gender and social relations in Pakistan. However, as I have worked in the Federal Ministry of Health and have been closely related in the policy-making process regarding gender and reproductive health, I share my personal observations as well. A reading of the limited political and social literature from a critical 'social relations' perspective makes clear how the socio-political systems interact with the dominant religion, Islam, to produce a gender system portrayed as not only divinely ordained, but *natural* (Shaheed 1986, also see Feldman and Clark (1996) for a discussion of the use of religion to control women). The macro-level forces of the state act symbiotically with the micro-level forces in the community and household to maintain a structure of unequal social relations. I will discuss each in turn for the macro-level structures provide the framework within which micro-level gender ideology is anchored.

1.3.1 The macro-level structures

Pakistan as a nation state was created as a result of Indian Muslims claim of a separate nationhood in their own right. Thus, Islam the religion is its ideological identifier. Historians tend to portray the creation of Pakistan as the culmination of a natural process that started when Islam was introduced in the Indian sub-continent by Mohammed Bin Qasim a thousand years ago. Pakistan inclines towards the Arab world in an effort to embrace and demonstrate its Islamic identity, rejecting its Hindu past (Iqbal 1986).

However, this past has played an important role in the contemporary structure of social relations and gender ideologies. Islam was adopted in the 8th century A.D. Although the doctrine has a degree of flexibility on the issues of women rights, the social and political context in which it was adopted played a key role in determining its limited expression (Obermeyer 1994). The existing Hindu culture, in line with its norms, neither granted nor institutionalised the Islamic prescriptions, limited as they are, with regard to rights of women to education, property, or approval of a marital partner. At the same time, aspects such as practice of *purdah* were avidly accepted and incorporated into the way of life because they were consistent with the existing belief system (Shah 1986a).

The contemporary gender system in Pakistan is the result of patriarchal oriented interpretation of Islam in a highly patriarchal South Asian society. Maulana Maudidi a religious scholar expresses a widely held understanding of gender systems of this society when he states that a man is the active and woman the passive partner in the system of nature. According to him, men's superiority is due to the fact that men possess natural qualities of dominance, power and authority, and in order to maintain the family system and save it from confusion, someone must be entrusted with the necessary authority. He then goes on state that such a person can only be man, for women's mental and physical

state is unstable (because of the cyclic fluctuations associated with menstruation and pregnancy). Women cannot therefore be expected to use authority with wisdom and discretion (Maudidi 1979). Moreover, according to Maudidi, although Islam does not allow any distinction between men and women in the acquisition of knowledge, it does recognise a difference in the type of education. From the Islamic point of view, the right sort of education for women is that which prepares her to become a good wife, good mother and good housekeeper (Maudidi 1979).

The contemporary socio-political system interacts with religion to further accentuate the gender gap. Feudalism is still the dominant political structure that dons the cover of democracy under external pressure. Feudalism attains its legitimacy from the hierarchical class structure, in turn further strengthening it (Hafeez 1998). Feudalism in Pakistan consists not just of a class of society who derive their income from landed property, but also a culture, a way of life that is a model of success and prosperity. It has thus created and perpetuated a 'status-centric' societal norm. A 'status-centric' societal orientation is characterised by an inviolable right to power and resources for those already in high status, simply by virtue of their station. Status-centric orientation breeds a natural consort, affiliation orientation, which is a means to access resources controlled by a few feudals. In this context, the achievement orientation is relatively unimportant. The power of one's background matters more than the power of one's efforts (Hafeez 1998). At this point a reader familiar with South Asian social dynamics is bound to ask 'So how different is Feudalism from the Hindu caste system? The difference is small, as the ideology underlying feudalism is similar to the Hindu caste system, with its unquestioning acceptance of one's social station in life. One difference is that, unlike the caste system, social mobility is possible in the Pakistani brand of feudalism. All social classes, the upper, middle, lower, and the poor aspire to acquire land and its associated symbols of feudal power. Those who manage, the so-called neo-feudals emulate old money, exploiting and oppressing those from their own social class (Hafeez 1998).

The feudal classes, in collusion with the military and the bureaucracy (who often hail from a feudal background), have established a system of governance that is authoritarian. Democracy in the spirit of by the people for the people never took root in Pakistan (Bhardwaj 1998). Authoritarian regimes reject public consent, but they need to draw upon an unquestioning traditional support base. This is managed through people's religiosity (Hossain 1995). Thus, religious parties are given an importance disproportionate to their size (Bahadur 1998). Despite major differences in philosophies, both the feudals and religious leaders share a common theme: a gender system that values the masculine over the feminine. Together the religio-political structures have given the existing system of unequal gender relations not only a legal cover, but divine ordination (Shaheed 1991).

Thus at the macro-level, the state exhibits high levels of gender discrimination which is manifest in diverse ways. Although the constitution guarantees women a right to participate in the political process as well as vote, in reality, notwithstanding a twice-elected woman prime minister, women's presence is token. Women's vote is essentially an extra vote for the men (Hafeez 1981). The laws of the land discriminate against women. Women are considered legal minors, denied a voice in the courts of law (two women witnesses are considered the equivalent of one male witness) and the victims of honour killings that the state, albeit indirectly, accepts (Dawn 1999). The Hudood Ordinances are the basis of arbitrating women's sexuality. This ordinance does not differentiate between rape and adultery; the burden of proof falls upon the raped women to verify that the sexual act was not consensual (Qureshi 1999).

This devaluation is starkly reflected in the resources directed to women. Essential services that are the responsibility of the state, such as education and health are woefully inadequate. Of the approximately 11,000 health facilities nationwide, only 28% in Sind, 16% in Balochistan and 50% in Punjab report actually having provided family planning services (HMIS 1998). Similarly, female adult literacy rates at 22% compared to 48% amongst males reflect a systematic bias in access to education. Only 4% of the administrators and managers and 21% of the professional and technical workers are women (UNDP 1999). When the country had a democratically elected parliament, 2% of the seats were held by women (UNDP 1999).

The formal position of the state is to promote gender equality and gender equality in the social sector is one of the five pillars of the Second Social Action Programme 1998-2003 (UNFPA 1998). However, a critical reading of policy documents (Min. of Women Development 1998) suggest that donor pressure rather than any internally felt need is the basis for this position. Donors play a crucial role in the development of broad gender policy objectives such as those as outlined in the National Program of Action for the empowerment of women in Pakistan (Min. of Women's Development 1998) although they are presented as locally originated ideas. Moreover, based on personal observations and communication, these policy objectives are unlikely to be translated into practical processes because of the deep ambivalence by the mostly male bureaucrats.

There is little in the way of civil society action or lobbying to challenge the state and religious forces that perpetuate these stark gender inequalities. There are a few NGO's but they work in a rather hostile environment. Few are addressing the issue of gender in any meaningful way.

1.3.2 Gender relations at the micro-level

At the micro-level, gender is played out in a very complex way. Operative at this level are the more fluid social and relational resources such as rights, obligations and claims between women and men. Women and men share space in the form of 'social connection' rather than 'social division' (Razavi and Miller 1995). In assigning women and men to different responsibilities, activities and spheres, the gender division also makes it essential for them to engage in relationships of co-operation and exchange. However, this interdependence is not symmetrical. By and large, the structure of social relations is based on a gender ideology that devalues women (Kabeer 1994).

1.3.2.1 The family structure in Pakistan

The family is the smallest social unit in which gender roles and relations are played out. The family is thus also the turf, which has polarised studies of class and gender. Studies of economics (largely the neo-classical economists) and class tend to treat the family as a simple unity; they ignore the internal differences and portray it as a homogenous resource-sharing unit headed by an altruistic male. At the other end are the gender-focused studies, largely by feminists who tend to stress the divisions between members, treating women and men as individuals with distinct interests while underplaying their common household membership (Razavi and Miller 1995). Neither position conveys the complexities and subtleties of the family and kinship system in Pakistan.

Family formation patterns create the structures within which individuals, both women and men operate. The key feature of social organisation of Pakistan, as reported by both the ethnographic as well as the lay literature is a strong and pervasive orientation to family life and family values. Integral to this is the mutually exclusive but complementary roles of men and women (Shah 1986a). The widely held view of a Pakistani family is a joint family consisting of a male head of household, his wife, their grown sons with their wives and an array of children, all living together in harmony. The reality may be quite different (Lyon and Fischer 1997). Pakistan is a large and culturally diverse country. There are differences in family structures, not just in the major regions, but in rural / urban areas and in different socio-economic classes (Donnan 1997a). The description of an all-powerful male head of household may be reflective of a reality in 'tribal' households such as in rural Balochistan or NWFP where the ideology of male authority may have a practical force (Ahmed 1997). In Punjab, senior males seem less likely and less able to make or enforce life and death decisions (Mumtaz 1987).

As in many Asian societies, family formation in Pakistan is patrilineal (Ahmed 1997). We take marriage as the starting point of family formation. Marriages are largely arranged, first or second

cousin marriages are the most desirable (Hussain 1999). In general, the terms of exchange at marriage favour the grooms party. An obvious demonstration of this is the dowry, an aspect of gift exchange in which the amounts involved have risen dramatically in favour of the groom (Shah 1986b). Marriage in Islam is an obligation and a contract, but the Hindu influence of marriage as sacrosanct is deep-seated and ingrained. Referring to the husband as a *'Majazi Khuda'* or God on earth, hence to be worshipped and obeyed at all costs, is a partial, humorously represented reflection of this behaviour (Hafeez 1981, pg. 216).

Marriage is an important milestone in both women's and men's lives; more so for women as it involves moving from their paternal home to the marital home. Since endogamy is the preferred form of marriage (66% of marriages are between cousins) (Hussain 1999; Jejeebhoy and Sathar 2001), the marital home may not be an unfamiliar place. Despite the familiarity with marital home for a large proportion of women, as a new bride they occupy a structurally weak position, possibly the weakest of any part of their lives. It is this stage that women come closest to the feminine ideal of subordination and dependence (Winkvist and Akhter 2000). A young wife spends most of her time with other women of the household, who can be sharply critical of her (Shah 1986b). Thus, at this stage of her life, the more practical hierarchies are not the gender hierarchies, but those with other senior women, usually the mother-in-law (Sathar 1996).

The next critical milestone is motherhood. Reproduction of the patrilineal lineage is probably the most important step a woman needs to undertake in order to prove her worth to her husband's family as well as consolidate her own identity and status as the new family member (Winkvist and Akhter 2000; Donnan 1988). This crucially requires giving birth to one or more sons. Fertility is high at about 5.3 children and son-preference widespread (Sathar and Casterline 1998; Arnold 1997). Any reluctance or failing on her part to perform this crucial function may lead not only to violence, but real prospect of divorce or having to put up with additional marriage (Winkvist and Akhter 2000; Donnan 1988). The reproductive years of a woman coincide with her life-cycle stage characterised by structures that ensure maximal dependency upon and control by older women, particularly the mother-in-law and the husband. With the passage of time, women gradually expand their sphere of influence so much so that older women in some instances may acquire greater weight in household decision-making exceeding that of younger men (Sathar 1996).

A major aspect of gender construction in the framework of patriarchy is women as economic dependants and men as the economic providers. This social norm is, in turn, the basis of a rigidly laid down sexual division of labour, which broadly speaking allocates *'indoor'* work to women and *'outdoor'* work to men. Both sexes accept this division without question and present it as an ideology of complementarity rather than inequality (York 1997). As normative providers, a role supported by

the religious text, men are under tremendous pressure to provide for their families. It is a matter of shame if a man cannot provide for his family. In this context, women's work is rendered invisible because of the shame attached to it. Women themselves actively collude with this ideology by allowing men a disproportionate degree of credit for the economic support of the household by devaluing their own contribution (Ayub 1994; Sathar and Kazi 1997). There is an inherent conflict in these norms. While women, on the one hand, are obviously discouraged from working, there is a large demand for their services in the 'outside' sphere. The most obvious example is the demand for female doctors and teachers because the norms of *purdah* insist women receive medical and educational services from women only (Mumtaz 2000).

Women are dependent on men for not only economic security but also social status and recognition. Depending on their life-cycle stage, women remain under protective guardianship of successive male kin at different stages of their lives; father, brother, husbands and later sons. The primary source of recognition of women and men in Pakistan is as members of a certain family, *biradari*[1] and ethnic group (Shah 1986a; York 1997). At the family level, women derive their identity as daughters, sisters, wives, and mothers of men. Thus 'women do not exist as individuals in the western sense of the word' (Shah 1986a, pg. 14)

When describing the family and household structure in Pakistan, the public-domestic dichotomy is convenient. At the same time, any analysis of this model can lead to results that may be superficial and even misleading. Although this framework is particularly suitable in the South Asian context, there remains a tension between the 'inside' and the 'outside'. On one dimension, this tension can be manifested in very physical terms such as a domestic courtyard, which is usually a 'inside space' becoming an 'outside ' space by virtue of a presence of a strange male (York 1997). More importantly, women can negotiate the meaning of this space, stretching the boundaries as the situation may demand. For example, the mid-seventies saw a dramatic increase in male labour migration to the cities or overseas; in most cases the migrants travelled alone, leaving behind what was termed a 'female–headed household'. The women took over responsibility of activities that were traditionally the domain of men; managing agricultural activity, marketing the produce, banking and so on. These activities brought them in close contact with a range of people, mostly men they would never otherwise meet. The women negotiated the norms of 'inside' and 'outside' work, while the community viewed them as enterprising young women coping in their husbands absence (Donnan, 1997b).

Shaw (1997) also argues that it is not invariably the men who mediate between domestic units and the wider institutional structures, irrespective of how this relationship might be construed and presented.

[1] A *biradari* is a loosely defined clan of related people that form a social, economic and even political group.

Women, particularly the older women and mothers of sons, play a critical role in the power dynamics. According to Young (1997), women manipulate and influence relationships in the public domain, which is otherwise nominally controlled by men. These findings hint at the roles women play beyond the domestic domain, but there is little detailed analysis of the processes involved. An exploration of these processes through which women make their voice heard would be useful in gaining an understanding of how women in Pakistan exert their agency.

1.3.3 The *purdah* system

One of the most obvious manifestations of gender in Pakistan is the institution of *purdah*. The precise meaning and characteristics of *purdah* are a matter of dispute and varying interpretations (Shah 1986a). Although *purdah* has a strong religious essence, its variability across Muslim societies is conspicuous. Within single cultures, there are sharp differences of opinion about its interpretation. For example in Pakistan, one opinion is represented by Maulana Maudidi, who states that the Koran and Sunnah ordain the seclusion of women and restrictions on their mobility (Maudidi 1979). A contrasting view is provided by S.A. Ali who believes *purdah* is simply a custom that was borrowed by Muslims from a pre-Islamic period (Ali 1976).

The word *purdah* literally means 'curtain' or 'veil' (White 1992, pg. 22). Specifically, it refers to the covering of the face and head in the presence of men who are not a part of the woman's natal home and with older male member of the husband's family. It also refers to a range of behaviours and practices that separate women from men. The restrictions range from patterns of speech to physical space (Papanek 1973; Donnan 1988). It has also been described variously as

'an institution that controls and governs women's lives....a rather complex set of rules that governs all interactions between the genders' (Shaheed 1989)

'a system of social control that emphasises the separation of women from men and the seclusion of women from the world outside the home' (Kibria 1995 in Bangladesh)[2].

According to White (1992), ideologically, the institution of *purdah* plays a significant part in sustaining separate spheres imagery. According to her, the power of *purdah* is the power of myth, not in the sense of being unreal or untrue, but as a symbolic expression of relations between men and women, with simultaneous ideological and material dimension. It reifies the differences, the 'otherness' (White 1992, pg. 22). This 'otherness', according to White (1992), is an expression

[2] I draw on the literature from other parts of South Asia because there is a paucity of literature from Pakistan. However, there are broad similarities between Pakistan and other parts of South Asia.

of the fear and distrust by men of women's perceived powers of sexuality and fertility.

Purdah has also been seen as a mechanism of social control by defining the limits of appropriate behaviour of women (Kabeer 1991; Kibria 1995). It legitimates and facilitates the use of female family labour and sexuality while also restricting women's control of what they produce (White 1992). It is thus used as a tool to restrict women to the 'inside' private sphere, limiting them to unpaid, unproductive work such as processing crops or the reproductive task of maintaining their families (White 1992; Kibria 1995). However, the other side of this social contract is that men protect women. Thus *purdah* has also been termed as a 'symbolic shelter' (Papanek 1973).

In Pakistan, class, socio-economic status, and age influence the behavioural practices associated with *purdah*. Poor women especially cannot afford to adhere to *purdah* and the associated norms of seclusion as they need to go outside in need of work (Sathar and Kazi 1997). They make a token concession to the practice by covering their heads with a '*duppata*'[3] or a '*chador*'[4]. In the rural areas, women from large land-owning families and those educated adhere to the practice more tenaciously (Sathar and Kazi 1997) while educated urban women tend to dispense with the practice altogether (Shah 1986a). Older women are less likely to observe *purdah*, while younger women are under the most pressure (Donnan 1988; Sathar and Kazi 1997). For a large part of the population, adherence to *purdah* restrictions is often more symbolic rather than real, particularly in Punjab and Sind. There is some evidence that women make use of the anonymity provided by covering the head and face to travel as indicated by the greater mobility of women who practice *purdah* (in the literal sense of covering their heads with a *chador*) (Sathar and Kazi 1997). Nonetheless, most women do not or cannot go to public places or take part in public events thus reflecting the practice in its more implicit form.

The institution of *purdah* has its cultural roots deeply embedded notions of the *izzat* or honour. The concept of honour is a complex, multifaceted value system that is difficult to define. The honour belongs to men, and then the family, but women symbolise it (Khan 1999). Women's sexual chastity is the most important dimension of honour. The word '*izzat*' connotes different things; it ranges from a girl's virginity, a woman's protection from forbidden sexual contact, to the good reputation of the family (Khan 1999; Donnan 1988). *Izzat* is most often violated by any suspicion that a woman has sexual contact (consensual or not) with a male forbidden to her (Khan 1999). A paramount consideration for a good marriage is that the girl remain chaste, and does not behave in ways which compromise her honour and reputation as a virtuous women; the same applies after marriage to keep *izzat* intact (Khan 1999). Indeed any woman venturing out on her own, outside prescribed *purdah* limits, is perceived to be risking violation of her *izzat* by forbidden men.

[3] '*Duppata*' is a 2 x1/2 m long scarf made of a flimsy chiffon like material.
[4] '*Chador*' is a 2x1 m long piece of cloth made of cotton material.

Closely interwoven with the concept of *izzat* is women's mobility. The *purdah* culture holds seclusion to be the highest ideal for women for it epitomises women's sexual chastity and therefore the family's '*izzat*' (Khan 1999). Sex-role socialisation ensures most women internalise these notions and few question it (Mumtaz 2000). A woman world is thus primarily restricted to her household or the fields in the vicinity of the household (Donnan 1988; York 1997) and any movement beyond the immediate confines is chaperoned (Donnan 1997a).

This discussion of gender in Pakistan thus brings into focus the wide range of factors that interact in complex ways to affect women's gendered position. I will now discuss how resilient the gendered rules, beliefs, customs, and practices are as gauged from the limited impact education and employment has had on improving the gendered position of women in Pakistan.

1.4 Women's gendered position in Pakistan: the complexities

Until very recently, women's gendered position in the demographic literature was described using education and employment as referents. Education was assumed to provide the necessary knowledge and skills and employment the economic clout required for women to look after their interests. More recently, direct measures of mobility, access to and control over material resources, and decision-making in different spheres have been used (Sathar and Kazi 1997). Survey analyses of these 'direct indicators' indicate that that education and employment do not bring the postulated changes in Pakistan.

1.4.1 Women's education

Education has been conventionally used as an indicator of women's gendered position as it was hypothesised to enhance women's knowledge, decision-making powers, confidence in interacting with the outside world, closeness to husband and children and economic and social reliance. Education, apart from imparting cognitive skills, is also believed to have powerful indirect effects on value systems and outlooks. These include a shift away from fatalism to reasoning, greater sense of alternative lifestyles, new ideas, greater self–reliance and even questioning of traditional authority figures (Sathar and Mason 1993; Jejeebhoy 1995; Basu 1996).

However, survey analysis using direct measures of women's gendered position in Pakistan suggests their education has little effect on decision-making powers, employment opportunities or mobility (Sathar and Kazi 1997). A 10-district survey of rural Punjab found that irrespective of women's educational status, men were the main decision-makers on important household purchases and that

over three-quarters of women with greater than six years of education believed that men *should* make such important decisions (Sathar and Kazi 1997). Similarly, almost 90% of the women needed permission to go to the next village irrespective of educational status.

These findings mirrored survey work elsewhere in South Asia (Vlassoff 1996; Kumar and Vlassoff 1997; Balk 1994). Jeffery and Jeffery's work revealed that in Northern India, education of women did not in any way have an influence on four key areas of women's lives; the choice of a marriage partner and timing of marriage; household arrangements in the affinal village; control over economic resources and fertility (Jeffery and Jeffery 1996a).

The observed relationships between education, mobility and labour force participation may in part be explained by the force of class and *purdah*. In situations where the levels of education are generally low, as in Pakistan, education is an indicator of economic status since attending school places direct and indirect burdens on households (Mahmud 1997). Educated women from wealthy homes marry wealthy husbands (Zafar 1991). Wealth and higher social class enable the women to practice *purdah* (Sathar and Kazi 1997).

Furthermore, it seems the prevailing mode of education for Pakistan women, is not geared to challenge traditional values with respect to women's status; rather it reinforces gender differences and role distinctions (Hina 1997). The curriculum is not geared to teach women to understand and analyse the social, political and economic systems that govern their lives and oppress them. Instead education is used to enhance a woman's ability to fulfil society's idealised expectations of her and as a tool to attract educated, economically well placed husbands (Hina 1997; Zafar 1991).

1.4.2 Women's employment

Similarly, the use of employment as a proxy variable for women's position is based on the premise that economic dependency is a major factor in structuring inequalities between women and men in market based economies. Support for this hypothesis range across the political spectrum, from Marxism to the World Bank (Standing 1991).

The potential of monetary wages to alter gender relations is believed to lie in its positive effect on women's decision-making power; the leverage it provides in intra-household bargaining; and its reinforcement of their claims on consumption of resources within the household, so they are materially better off (Cheevy 1996; Sood 1991; Joekes 1985). Employment outside the home may also expose women to new ideas, and new attitudes about their own roles (García 1995). At the same time, there is sufficient counter-evidence that not every woman is able to translate her employment

into more power or 'autonomy' (Greenhalgh 1991; Safilios-Rothschild 1990; Sharma 1990). Findings from Pakistan suggest this may well be the case for the majority of working Pakistani women.

The relationship between employment and direct measures of women's position in Pakistan is neither direct, nor consistently inverse, but complex and contradictory. Sathar and Kazi (1997) found that irrespective of their wage contributions, rural Punjabi women's role in major economic 'outside' decisions was limited. Only 5% of economically active women had a major say in large household purchases and only 7% in sale and purchase of livestock.

However, amongst women whose income contributed to greater than 20% of the total household income, nearly 13% were major decision-makers on sale and purchase of livestock indicating that a large fractional contribution can have an impact. However, the absolute proportions are extremely small and women's decision-making authority in relation to men remains limited.

The transformatory potential of employment appears to depend not only upon the type of work, type of remuneration, but more importantly, why women entered it. However, according to Kabeer (1995), the most critical issue is the specific socio-cultural context in which the women are situated. The pre-existing gender relations and what is considered permissible ultimately determine the effect of the employment opportunity (Kabeer 1995).

In Pakistan, as in much of South Asia, women do not traditionally enter the formal labour force (Kazi and Sathar 1986; Sathar and Desai 1996; White 1992). They are proud of their economic and non-economic dependence on men (Basu 1996). When they do act against this norm, it may reflect a distress sale: a symptom of deteriorating rather than improving quality of life (Amin 1995). This is either a breakdown of the male support system or increasing land poverty (Bilquees 1988; Kazi and Kazi 1988). This situation is compounded by the fact that notwithstanding class differences in women's access to labour markets, a combination of lack of skills, an economic and cultural agenda that upholds prior right of men to scarce employment opportunities and unsuitability of employment for particular subgroups of women, all act to force them into informal, unskilled, low prestige jobs (Standing 1991). Add to this a general devaluation of women who work outside the home, a real risk of harassment and violence, low pays and lack of benefits, all of which act as a powerful deterrent to women's desire to work outside the home. Withdrawal of women from the labour force remains one of the most important symbols of high economic and social status (Sathar and Kazi 1997).

Another dimension of this situation is that man's role as a provider is undermined when women are contributing to the household income. Studies from India and Bangladesh show women routinely hand over their income to the male head of the household; they do so to defuse the destabilising

implications of their independent wages and to reconstitute as far as possible the model of the male as the authority, breadwinner, and decision-maker (Kabeer 1995; Standing 1991).

To summarise, the evidence suggests that although education and employment may have some important positive implications for women, the broader structures of constraint imposed by gender relations remain untouched. In fact, women themselves go to considerable lengths to defuse the possible challenge that their ability or earning capacity might pose to gender hierarchies. The situation is complicated because the effects of education and employment on women's gendered position are to a large extent determined by the larger context in which the women are located. As Jejeebhoy states 'uneducated women often have relatively little autonomy and highly educated women tend to have the most. What happens in between varies by cultures and the extent of gender stratification. In other words the norms of patriarchy play an important role in conditioning the impact of education on changes in women's autonomy' (Jejeebhoy 1995, pg36).

1.5 Conceptualising women's gendered position in Pakistan

The discussion above highlights the importance of taking into account the specificities of context when attempting to conceptualise women's gendered position. Although gender is nearly a universal and ubiquitous feature of all cultures, there are large variations in the degree to which differences between women and men are appreciated. Moreover, these differences may have important implications for women's reproductive health. It is therefore important to understand how women's gendered position can be conceptualised in the Pakistani context in order to develop specific policy prescriptions that are in the spirit of ICPD, but grounded in the Pakistani context. There are three aspects to this:

1. A need to reconceptualise women's gendered position in a context characterised by interconnectedness of social relationships and interests between women and men.
2. Understanding how women's gendered position constrains their access to various social, human and material resources *relative* to men.

3. The role of wider societal level gender ideologies on individual behaviour and how the two interact to affect women's reproductive health, (more specifically contraceptive use and antenatal care use.

1.5.1 A need to reconceptualise women's gendered position in Pakistan

The first step towards conceptualising women's gendered position is to understand what different authors mean when they try to address women's gendered position. The concept of women's 'status' or 'position' is extremely confused (Mason 1987; 1993). I would like to clarify at this stage that I use the term 'women's gendered position' as a generic term without any values attached to it. It can be taken to mean the same as the 'social construct of a female person'.

A number of terms have been employed by different researchers to describe a woman's gendered position. These include 'women's status' (Mason 1986), 'women's autonomy' (Dyson and Moore 1983; Jejeebhoy 1995), 'women's situation', women's position (Mason 1987) and 'female empowerment' (Kishore 2000; Schuler and Hashemi 1994). Alternative terms, such as 'gender inequality' (Morgan and Niraula 1995), 'female dependency' and 'male dominance' are frequently used inter-changeably. To add to the confusion, single terms are given alternative meanings. Thus, while Mason refers to 'women's status' as 'woman's versus man's average position across a variety of social, economic and political hierarchies' (Mason 1987), others refer to it as specifically the relative prestige, that is the respect and esteem accorded to women by virtue of their gender (Epstein 1982). Women's autonomy has been described as 'the ability-technical, social and psychological-to obtain information and to use it as the basis for making decisions about one's private concerns and those of one's intimates' (Dyson and Moore 1983). Jejeebhoy understands women's autonomy to consist of those characteristics that men acquire simply by virtue of their gender. These include decision-making authority within the home, economic and social autonomy and self reliance, emotional autonomy, the ability to forge close conjugal bonds and physical autonomy in interacting with the outside world (Jejeebhoy 1995). 'Women's position' has been variously employed to mean the degree of women's control over resources compared to men; their autonomy from men's control; or other aspects of their privilege or oppression that arise from society's institutions (Mason 1987). Others use the term 'gender inequality' to reflects the 'social position' of women vis-à-vis men. Gender inequality confers differential wealth, power and prestige to women and men and is maintained by denying access to some or handicapping individuals in the pursuit of high-status positions. Discussions related to the 'women's empowerment' describe it as 'women's increased control over their lives, bodies and environment' (Kishore 2000).

The diversity of terms reflects on the one hand, confusion surrounding the concept and on the other hand, the complexity of the issues involved. One explanation for the confusion could be that gender ideologies vary across cultures and definitions of women's gendered position in one setting may be inappropriate in another. Cultures vary, as do constructs of personhood. A concept developed in one context may not be applicable in another.

Most of the definitions described above hinge upon a woman's ability and right to make her own decisions about how she will conduct her life. The focus on 'women's need to be in control of their own lives' (Jejeebhoy 1995, pg. 7) is located in the historical development in consciousness and thinking regarding authority and equality that took place in the West during the past two centuries. This enhanced consciousness extended not just to socio-economic class differences, but also to relations between women and men. Feminists led the on-going struggle for equality between women and men. Feminism, as a school of thought in the tradition of modernity, can be considered a branch of liberal and liberal egalitarian philosophies with their emphasis on the rights of the individual (Evans 1977). It can be credited for developing the concept of a woman's right to her body, her right to make individual decisions and have the final say in issues related to her life (Correa and Petchesky 1994; Sen, Germain and Chen 1994; Sen 1996).

This transformation, is however, still largely a Western development. Nonetheless, its influence has translated into a theme that permeates the entire international reproductive health agenda, including the ICPD prescriptions; that women should be allowed to make independent autonomous decisions. The dictionary (Oxford 1990) defines 'autonomy' as right to self-rule and at the individual female level this meaning is extended to the 'right of the woman to rule her own life' (Basu 1996). The focus on 'autonomy' is based on two implicit assumptions:

1. To be 'autonomous' is to be modern and progressive.
2. An individual is an 'autonomous' unit, separate from society.

These two assumptions are believed to have universal applicability by policy-makers and researchers alike and hence the development of indicators of women's gendered position, all of which are, more or less, based on a theme of 'autonomy'.

However, in recent years, a number of scholars have begun to question these assumptions and with them, the notion of women's autonomy. Ogden cautions against conflating western notions of personhood as an individual separate from society to other cultures (Ogden 1996). Strathern argues that conceptions of the 'individual' and the 'person' vary across cultures and the application of western notions of personhood to analysis of other cultures is fraught with pitfalls (Strathern 1988).

Empirical research from South Asia too throws doubt on the notion of 'women's autonomy' with its focus on individuality, as a valid conceptualisation of women's gendered position in this setting. Jeffery and Jeffery (1989, pg. 17-18) argue, based on their work in Northern India, that 'women's autonomy' as a concept is culturally incongruous in South Asia. They found no local terms equivalent to 'autonomy' and those that came closest to it had negative connotations at the individual level.

Similarly, White (1992) argues that in the context of Bangladesh, where women's lives involve a complex intrication of social relationships that are interconnected with all other aspects of social life, a focus on autonomy and independence is inappropriate. She challenges the notion that women in South Asia are isolated and live in private spheres only. While accepting that women are not, in any way, the structural or ideological equal of men, autonomy is not what they desire. Rather, women in Bangladesh desire to be *central* members of their families (White 1992).

These findings raise the question of the appropriateness and validity of conceptualising women's gendered position in Pakistan in terms of autonomy. Pakistan is a context where all individuals, women and men derive their self-identify in reference to the family, *biradari*, or a tribe (Shah 1986a; Ahmed 1997). Kinship ties and relationships, both with immediate family members and wider network of kin are very important (Donnan 1988). These relationships take on another dimension for women, with their limited opportunities and choices.

Furthermore, measures that have been developed from the 'autonomy' perspective show no relationships with women's reproductive health outcomes. For example, Sathar and Kazi (1997) defining woman's autonomy as 'control over their own lives' found no association between economic 'autonomy' and contraceptive uptake. Similarly, Fikree et al. (2001) found no relationship between two dimensions of 'women's autonomy' and use of a modern contraceptive method in urban Sind.

Rather than rejecting gender systems as unimportant for women's reproductive health, these findings point to the possibility that the measures being used may not have been well conceptualised in this context. There is thus a need to explore how women's gendered position can be appropriately conceptualised in Pakistan. I argue that although women's right to a broad range of social, cultural and human resources is inalienable, a vision of exercising these rights via autonomous independent action is problematic. Policies based on such a conceptualisation are unlikely to be operationalised into a reality because of their incongruity with the socio-cultural context. White's (1992) notion of 'centrality' rather than 'autonomy' suggests an alternative approach to the problem that maybe more sensitive to the social and kinship structures in Pakistan. It is therefore worth exploring how useful the centrality approach may be in conceptualising women's gendered position in Pakistan.

1.5.2 Understanding gender relations between women and men

The demographic literature has, in general, focused on women in isolation from men (Cornwall and White 2000; Riley 1997). But reproduction is not just a biological phenomenon in which women give birth (Townsend 1997). Men are not just important for the biological aspect of reproduction, but biological reproduction itself is an important aspect of social reproduction, in which structures of

relationships, such as the family and larger social groups, are reproduced (Bourdieu and Passeron 1990). Reproduction is therefore a deeply engendered and a power-related issue (Greenhalgh 1995). Men constitute one full half of society, usually the more powerful half, and are thus in a stronger position to enforce their desires. It is therefore important to understand men's gendered position, what social institutions enforce their gendered behaviour and how notions of masculinity affect women's reproductive health and well-being in general. It is also important to understand men's perceptions of fertility control and issues related to reproduction.

1.5.3 The effect of wider societal gender systems

Another feature of the traditional demographic literature has been a focus on individual-level determinants of fertility. These studies are based on the assumption that individuals make independent decisions regarding their fertility and tend to neglect the wider societal level forces. They neglect societal values, which in turn are embedded in economic, political and legal structures (Greenhalgh 1994).

According to Greenhalgh (1994; 1995) the role of larger culture, and importantly gender systems in reproduction cannot be overemphasised. Given fertility's place in the creation and perpetuation of families and kin groups, communities and nation-states, it is an emotive issue in which the decision to procreate is not just located in individuals, but the family and the community (Greenhalgh 1994). This is particularly relevant in a kinship system such as Pakistan's, which as discussed above, is characterised by the interconnectedness of individuals, both women and men. These individuals in turn are embedded in a family, *biradari*[5] and ethnic group (Shah 1986a; York 1997). Empirical evidence from other South Asian countries with similar kinship structures provides support for the hypothesis that an individual's use of contraception is strongly influenced by community level variables (Kamal 1995).

To summarise, this section argues that in order to understand how gender systems affect women's reproductive health, it is essential to first understand how women's gendered position can be conceptualised in this specific socio-cultural context. I question the applicability of the concept of autonomy, to Pakistani women and highlight the importance of situating women within their relationships to their husbands, families and wider communities.

In the next section, I will review the theoretical and empirical literature in order to assess the current state of knowledge regarding the relationship between gender systems and women's reproductive health.

[5] A *biradari* is a loosely defined clan of related people that forma social, economic and even political group.

1.6 What is the relationship between gender and reproductive health[6]?

As discussed in chapter two, reproductive health in the present study is operationalised through the application of two measures, use of contraception and antenatal care services. While not direct measures of health per se, both have potentially close links to women's reproductive health. Furthermore, uptake of these services may reflect proactive behaviour by which women are able to translate their desires into action, and may therefore be subject to variation with prevailing gender systems.

The following discussion draws primarily on the demographic literature, and is heavily dominated by a focus on fertility control. This essentially reflects the dominant thrust of the population policies of the time, which, after ICPD, are somewhat obsolete (Miller and Rosenfield 1996). However, the literature is well developed and provides both a theoretical basis and some empirical evidence of how gender systems may affect women's reproductive health.

1.6.1 Theoretical underpinning of the relationship between gender and fertility

The idea that women's social position has important consequences for demographic outcomes is not new (Notestein 1953; Mason 1986; Caldwell 1982; Cain 1984). The potential importance of society's gender organisation for demographic change (especially for fertility and mortality) was mentioned in the 1950's but became more widely recognised in the 1980's when researchers such as Dyson and Moore (Dyson and Moore 1983; Caldwell 1982; Cain 1984; 1993) first described how patriarchal family systems act to maintain high fertility. A number of relationships have been postulated through which women's social position can affect fertility (Mason 1988; 1993). They range from the most straightforward, namely that an increase in women's 'autonomy' or 'control of resources' leads to a lowering of fertility, to the possibility that there is no relationship, or even that fertility decline is itself an essential pre-requisite for any improvements in women's social position. One postulated pathway is that women's 'autonomy' is an intervening variable that in turn is determined by other exogenous social or economic factors. The model with the greatest empirical support is one in which women's pre-existing position *conditions* the impact of other factors on the change in fertility. This model posits that it is not change in women's position per se that triggers a change in fertility, but rather the extent of the impact of other forces on fertility is modified by the nature of women's position in a society (Mason 1993).

[6] I would also like to reiterate here that this research shall focus on how gender relationships between women and men act to affect *women's reproductive health*. Contemporary understanding of reproductive health also includes men's health, but I shall not address it.

There are a number of hypotheses in the literature regarding possible routes of causation between women's gendered position and fertility. For the objective of this research, I shall concentrate on those aspects of reproduction over which individuals possibly have a choice. I divide these volitional aspects into two:

1. The desire to control fertility.
2. The ability to act on the desire.

Table 1.1 outlines some of the interrelated aspects through which women's gendered position is postulated to influence fertility.

Table 1.1: Fertility determinants potentially influenced by women's gendered position

1. Desire to control fertility :
• **Demand for children**
a) Value of children
b) Costs of children
c) Gender preferences for children
• **Supply of children**
a) Women's age at first marriage
b) Breast feeding.
1. Ability to act on the desire :
• **Fertility regulation and decision-making regarding**
a) Use of contraception
b) Other factors entering into fertility decisions

1.6.1.1 Demand for children

The desire to control fertility is likely to be influenced by the various forces that produce a demand for children. It is hypothesised that patriarchal systems (which is the most common social system in South Asia) promote increased demand for children through a number of pathways. One postulate is that since these systems are characterised by women's economic and social dependency on men, women in turn are dependent on the maternal role for legitimacy, risk insurance against divorce and old age security (Cain 1982; 1993). Patriarchal societies are also characterised by women's seclusion, limited access to resources and son-preference (Cain 1984; 1993). Together these are postulated to promote high fertility as women desire to achieve the required number of sons and through them,

access to familial resources, prestige and respect within the family and broader community (Mason 1987; 1988). Patriarchal systems thus promote fertility by increasing the value of children, reducing their costs (to men at least) and promoting the need for a pre-determined number of sons. A logical conclusion to this argument is that structures that are more egalitarian would facilitate fertility decline by altering the routes through which women can access familial resources and prestige.

1.6.1.2 Supply of children

Patriarchal societies are also characterised by early and universal marriage. This is understood as a strategy meant to control sexuality of unmarried females (Mason 1984; 1987). Early marriage leads to early initiation of sexual activity, one of Bongaarts proximate determinants of fertility (Bongaarts 1978). The seclusion of women, their limited opportunities for independent income, and the fact that their labour belongs to the husband's family are all postulated to lead to an early marriage (Mason 1987). These same factors also possibly act to further reduce the costs of children. Therefore, it is premised, that a more conjugally oriented family system, women's education and their economic independence would facilitate fertility decline by leading to later age at marriage (Mason 1987; 1988; Cain 1984; 1993).

1.6.2 Effect of women's gendered position on fertility regulation and associated decision-making

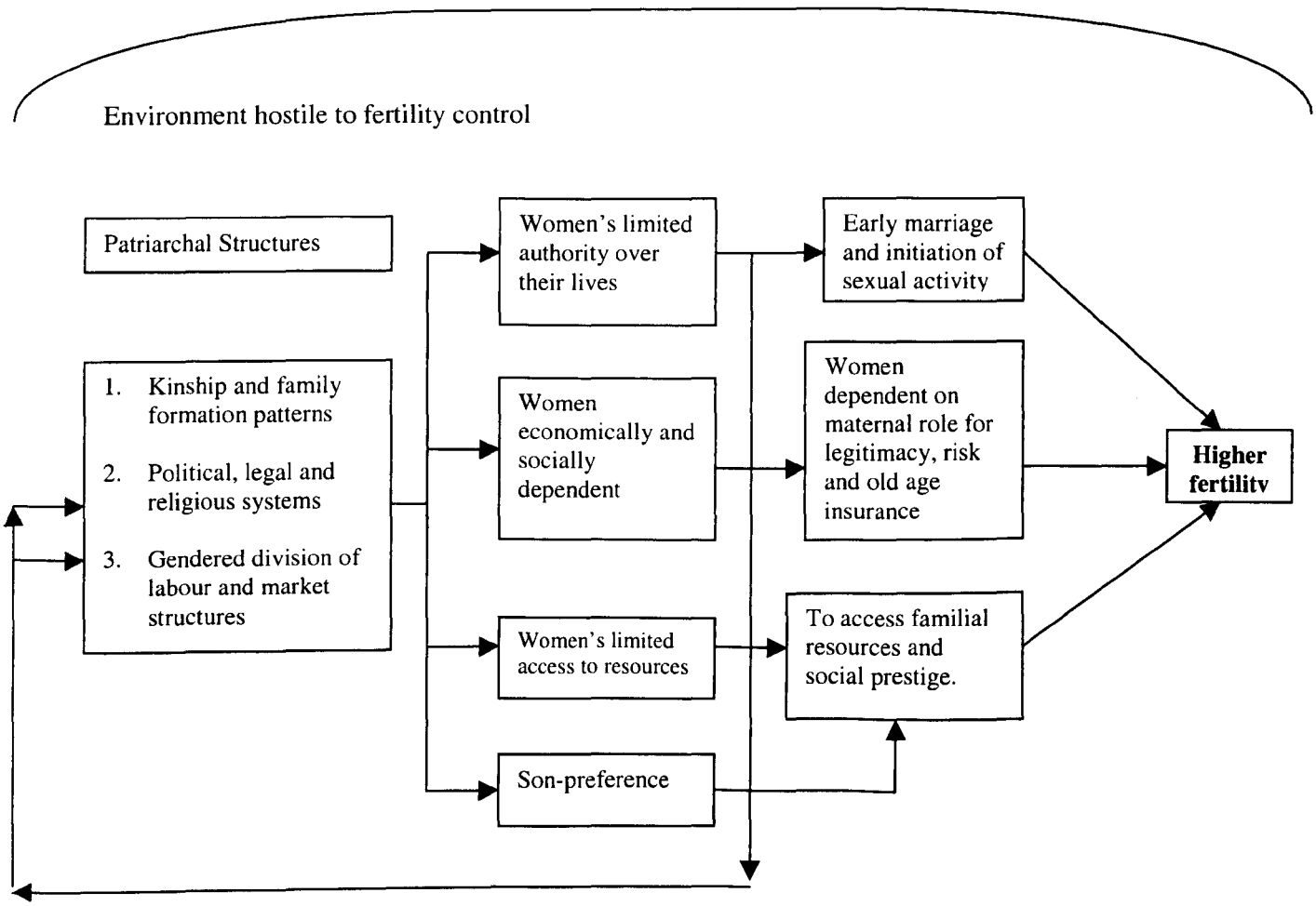
Uptake of contraception is an outcome of a complex interplay of a number of factors. A key factor argued to intervene between women's gendered position and use of contraception is their ability or willingness to engage in innovative behaviour (Caldwell 1986). Since in patriarchal systems women have limited say regarding their fertility, it is argued that if they have greater autonomy, they will have greater access to education and better educated women will not only engage in innovative behaviour, but will typically have more knowledge of contraceptive methods or how to acquire them. They will be more familiar with modern institutions, and have a greater likelihood of rejecting a fatalistic attitude towards life (Jejeebhoy 1995).

A better social position of women may also influence contraceptive use by determining the egalitarianism of the husband-wife relationship. Equality of spouses is linked with the likelihood of their communicating about fertility control, which in turn is argued to influence the use of contraception (Mason 1987). The other main hypothesis is that a more egalitarian relationship between the sexes is likely to increase the weight given to the wife's health and well being in fertility decisions. Egalitarian couples are likely to worry about the health consequences for the wife of having an additional child, whereas men in male dominated families are likely to decide about additional

children in terms of their own needs and interests. Finally, in some cultures, gender systems influence contraceptive use by influencing the extent to which couples abide by a sexual double standard. Where such a double standard exists, making it acceptable for husbands but not wives to have pre-or extra-marital sexual relations, men may worry that use of female contraceptive methods will free their wives to violate this norm (Mason 1987).

Figure 1.1 graphically presents the hypothesis outlined above.

Figure 1.1 Gender and fertility: Some postulated relationships



These hypothesis, although conceptually sound, have little empirical support as the review of the literature below reveals.

1.6.3 The relationship between women's gendered position and fertility: the empirical evidence

I will first review the literature that used proxy indicators of women's gendered position before proceeding onto the literature that uses more direct measures.

1.6.3.1 The association between proxy indicators of women's gendered position and fertility

A number of different measures have been used to represent women's gendered position. They include women's education, their labour force participation, male/female mortality ratios, marriage patterns and spousal age-gap (Miller 1981; Malhotra 1995; Sathar 1996). Of all these, women's education has received the most empirical attention because it was believed to be a key factor affecting fertility (Caldwell 1986). The argument is as follows: education makes women economically independent (through employment) and improves their access to and control over resources. Education enhances women's ability to rely on themselves, rather than their husbands or children for social status and acceptance. Educated women have more knowledge, this includes knowledge of contraceptive methods, where to obtain them and how to use them effectively. Schooling will also enhance women's ability or their willingness to engage in innovative behaviour. They will have greater interaction with the outside world and be more familiar with modern institutions, including health services (Jejeebhoy 1995). All these features of education are believed to reduce the demand for children as well as enhance women's ability to act on their desires to contracept.

In general, women's schooling has been found to have a strong statistical relationship with fertility. However, the relationship is not straightforward or unidirectional (Sathar, Crook, Callum and Kazi 1988; Sathar and Mason 1993; Cleland and Jejeebhoy 1996; Jejeebhoy 1995). In countries where fertility has not declined appreciably, such as Pakistan and Nepal, schooling appears to have a negative monotonic relationship with fertility. However in Bangladesh, India and Sri Lanka, where the fertility transition is well underway, there is no appreciable difference in the fertility rates of women with or without schooling (Cleland and Jejeebhoy 1996; Cleland, Kamal and Slogget 1996). These findings remain significant after controlling for urban-rural residence, region, age and socio-economic status. Specifically in Pakistan, where the high fertility rates have, until very recently, remained resistant to change, the association between education and contraceptive uptake becomes significant only after completion of primary education (Sathar 1996). Fikree et al. (2001) found that women who are 'literate' are significantly more likely to use a method compared to illiterate women ($OR=1.7$, $p<0.05$).

An important feature of gender inequality is the wider social context. Women's gendered position at the individual and household level occurs within a larger gender system of stratification (Mason 1986; 1995; Federici and Mason 1993). Thus education of women and its effect on fertility is not just an individual matter, but reflects the gender values of the larger community in which the women live. In other words, the overall levels of schooling in a society may constitute as powerful an influence on reproductive patterns of individuals as their own length of schooling. This is strikingly brought out in India, which is characterised by high interstate differences in fertility for each educational category. In areas such as Uttar Pradesh and Bihar, characterised by high gender inequality, women with no education have on average two births more than their counterparts in Tamil Nadu, which is characterised by more gender equal norms (Cleland and Jejeebhoy 1996). One interpretation is that if a woman has only a few years of education, its impact on a couple's reproductive levels in a setting such as Uttar Pradesh is minimal. The results suggest that the contextual effects may be as important as the individual effect.

An important contextual factor that mediates the effect of education on contraceptive uptake is the programmatic context of service delivery. There is evidence that a large part of the Bangladesh fertility decline is due to a strong family planning programme rather than any significant changes in the educational status of women (Cleland, Kamal and Slogget 1996). Bangladesh is not unique in this regard. Fertility transition in Indonesia was also characterised by little divergence between educational strata. There is also supporting evidence from multi-country studies that socio-economic differentiation of fertility is greatest in countries where family planning services are not widely available or vigorously promoted, and least in settings where programmes are strong (Entwisle and Moore 1985).

As discussed above, women's education was hypothesised to reduce fertility by promoting innovative behaviour, enabling women to actualise their desires and in general making them more independent. However, Jeffery & Jeffery's (1996a) work in Northern India does not support this hypothesis. They found that while women's education was considered prestigious, it did not change the reality of women's everyday living in any significant way. A woman's education did not enhance her economic potential (although it improved her chances of marriage to a desirable groom), increase her say in the choice of marriage partner, post marital residential arrangements or control over economic resources of the household (except if they lived in a nuclear family). More importantly, there was no association between the fertility experiences of educated women and those with no formal schooling. Without an exception, women never made a fertility decision on their own. The most common situation was where the husband and wife jointly made the decision to take up contraception (Jeffery and Jeffery 1996a). These findings are corroborated by other researchers who found that uptake of contraception was determined, not by a woman's education, but by having achieved a desired number of children,

more importantly the sex composition of the family (Kumar and Vlassoff 1997). Furthermore the approval regarding the completed family size and hence the decision to contracept was not that of the women, but of the husband and even the whole family (Kumar and Vlassoff 1997; Vlassoff 1996). The relationship between education and contraceptive uptake is thus not as straight forward as it is often maintained. In fact, it is possible for fertility to decline and women's education levels to increase without concomitant changes in other dimensions of women's lives. Vlassoff (1994a, 1996) goes as far as to say that education and fertility decline are two independent processes.

As stated earlier, another proxy indicator of women's gendered position is employment. The presumed relationship between employment and fertility is based on the economic explanations of fertility with the assumption that as women become economically productive, the value of their time and the fact that they have alternative routes to social identity and prestige increases the opportunity costs of child-bearing (Mason 1993; Sathar, Crook, Callum and Kazi 1988). However, the empirical evidence is far from consistent.

For one, the effect of employment varies by the nature of employment, and circumstances of entry into employment. Kazi and Sathar (1993) found that social class is an important determinant of the effect of employment on their fertility. Social class determined educational opportunities, with women from the upper classes being mostly college educated and employed in professional jobs. Their total fertility of 2.1 was significantly lower than the national TFR of 5.3. However, greater proportions of women were employed in low paying, low prestige work. The fact that these women had higher fertility than even the non-working women led to the conclusion that economic needs of a large family had pushed them into employment (Kazi and Sathar 1993). Whether they took up contraception after joining the labour force was not explored.

The wider social context also has an important effect on the relationship between women's work for wages and their fertility. Malhotra and Kishore (1995) using female labour force participation, female to male mortality ratios, endogamy vs. exogamy and proportion of literate women as indicators of gender stratification in India found that high female labour force participation was positively associated with low fertility. But this effect did not work in isolation: socio-economic development was as important as the gender context for women's employment to significantly affect fertility (Malhotra and Kishore 1995). Sathar and Desai (1996), while not addressing fertility directly, argue that the affect of women's work is determined more by the gendered inequalities in labour markets, gendered rules regarding the type of work women can do and social inequalities such as unequitable land distribution patterns. In other words, pre-existing class divisions, gender inequalities and rigidity of prescribed forms of behaviour force women into jobs that do not have the potential to alter women's lives or increase their well-being.

Some earlier studies used spousal age gap as a proxy indicator of women's gendered position. Most found that large gaps between the ages of husband and wife were positively related to total fertility (Cain 1984). Age at marriage has also received considerable attention, although it is not clear, whether it is itself, an indicator of women's gendered position or the result of other indicators such as education and employment. The links to fertility are however, inverse: women who marry later are exposed to a shorter period of childbearing (Sathar 1996; Mason 1984; 1987).

In sum, despite a strong theoretical grounding and a large well-developed literature, empirical evidence is far from conclusive. Although the education–fertility relationship is more consistent, the employment–fertility relationship is often positive or zero rather than the expected negative. Taken together these studies do not provide consistent support for the hypotheses described above. Furthermore, the pathways via which these proxy measures act on women's gendered position to ultimately affect fertility are not clearly described by this literature.

One explanation for the lack of any consistent relationships between women's education, their employment and fertility could be that these are proxy indicators of a complex multidimensional concept, which in turn is composed of a number of dynamic characteristics. According to Mason (1995), the proxy variables, education and employment, are conceptually distant from the dimensions of gender stratification that they are hypothesised to measure. Furthermore, they may be the effect rather than the cause of women's low social position (Balk, 1994). Research suggests that using direct measures of women's gendered position may be a more valid approach to the problem (Kishore 1995; Durrant and Sathar 2000).

I next review the more recent literature that incorporates direct measures of women's gendered position.

1.6.3.2 The association between direct measures of women's gendered position and fertility (and contraceptive use)

Some of the dimensions of women's gendered position identified and measured in recent studies in South Asia include (but are not limited to) women's freedom of movement, participation in decision-making, access to financial and non-financial resources, gender attitudes, freedom from fear and coercion, equality in relationships with partners, and the practice of *purdah* (Sathar and Kazi 1997; Balk 1994; Schuler and Hashemi 1994; Durrant and Sathar 2000). According to Durrant and Sathar (2000), it is essential to decompose women's gendered position because, not only will it enable researchers to develop more valid measures of women's gendered position, but also to decipher the pathways through which they are operating to ultimately affect the outcome we are interested in.

Sathar and Kazi (1997) analysed the relationship between some direct measures of women's autonomy and contraceptive use in a 10-district survey of rural Punjab in Pakistan. Five aspects of women's 'autonomy' were measured: mobility, economic autonomy, freedom to purchase, taking 'inside' household decisions, and 'outside' decisions. Contrary to expectations, mobility, economic autonomy and taking outside decisions were not significantly related to contraceptive use, while freedom to purchase and making inside household decisions were. One possible explanation is that the numbers involved are small, since only 1,036 women were interviewed and contraceptive prevalence rate in this sample was 23%. The findings are nonetheless intriguing.

Another survey also from Punjab (both rural and urban) used a similar strategy to study the association between women's autonomy and contraceptive use (Population Council 1997). Women's autonomy was measured by whether they could, independently, move within the village, travel to the health centre and decide on their own to:

- Spend a part of the household income
- Send children to school.
- Seek treatment for a sick child
- Purchase a *shalwar/kameez*[7] for herself.

Overall, it was seen that a larger fraction of contraceptive users were more mobile, had greater authority in deciding how to spend household income, whether their children should attend school and seek treatment for a sick child. At the same time, women with 'low autonomy' had greater unmet need. In other words, these women had the desire to control their fertility, but could not act upon it (Population Council 1997).

Fikree et al. (2001) investigating what social, religious and cultural aspects of Pakistani society may constrain a couple's adoption of family planning addressed two aspects of a woman's gendered position. These included women's ability to travel alone to six different locations and their levels of involvement in decision-making in routine household decisions. Both indicators were found to have no relationships with contraceptive use. However, women whose mothers-in-law reported having discussed the issue of contraceptive use with them were significantly more likely to use a method compared to women whose mothers-in-law do not report any such discussions (OR=3.6, $p<0.01$). The other important determinant of use was a belief that Islam allows family planing.

[7] *Shalwar /Kameez* is the standard mode of dress in Pakistan amongst both women and men. It consists of loose pants and a long shirt.

These three studies from the different regions (two of which are from Punjab) of Pakistan present quite contrary findings. Studies from other parts of South Asia demonstrate similar complexities. Balk (1994) analysed the relationship between direct measures of women's gendered position and their fertility in 218 villages located in two districts of Bangladesh (one reputedly more traditional and patriarchal than the other). Four aspects of women's 'status' at the individual level were measured: women's mobility, their domestic authority, the household leniency towards them, and their gender-role attitudes. Modelling showed that mobility, leniency and working outside the home were associated with low fertility. Thus, where women were able to move around without permission from family members, their fertility was lower, with stronger relationships occurring in villages located in the more liberal of the two districts. Overall, it was seen that measures of women's status explained as much variance in fertility as all other socio-economic predictors combined. She concluded that positive changes in women's status might directly influence their demand for children (Balk 1994).

Using qualitative methods, Morgan and Niraula (1995) examined the impact of women's freedom of movement and say in household decisions on fertility desires and use of contraception in two villages in Nepal chosen for their differing gender systems. Strong community and individual level effects were observed for both dependent variables. Women in the relatively egalitarian village were more likely to say they wanted no more children than were women in more patriarchal terai (plains) village. Contraceptive use was also higher in the hill village compared to the terai village (Morgan and Niraula 1995). Similar results were reported from Bangladesh. Using the DHS 1989 data, Cleland, Kamal and Slogget (1996) found that women whose self-reported mobility and decision making was high were twice as likely to use a modern method of contraception compared to those with low mobility or decision making ability.

A number of programmes aimed at enhancing women's literacy and income-generating capacity have been established in Bangladesh. This provided a fortuitous natural experiment enabling researchers to study the effect of financial credit on women's empowerment and contraceptive use. Schuler and Hashemi (1994) operationalised empowerment as a complex variable consisting of mobility, economic security, small purchases, larger purchases, major decisions, subjection to domination and violence, political/legal awareness and participation in non-family groups. It was found that membership in any of the programmes contributed to women's empowerment. Grameen Bank membership also had a strong effect on contraceptive use (60% of Grameen Bank members were users), while BRAC membership did not (47% of BRAC members were users compared to 43% in the group that did not belong to any organisation) (Schuler and Hashemi 1994). Unfortunately, the authors combine a number of distinct measures of gender stratification into a single scale, thereby obscuring whether some aspects of gender stratification are more important than others.

The same authors also analysed the impact of enrolment in Self-Employed Women's Association (SEWA) on the lives of the very poor women in Ahmedabad, India. SEWA provides a distinct model for provision of micro-credit and poverty alleviation in addition to its stated goal of empowerment of women (Schuler, Hashemi and Pandit 1995). Their analysis suggests that SEWA membership leads to a development of a sense of self-efficacy, hope, a sense of dignity in work and an erosion of their feeling of vulnerability. This is believed to be the result of the economic security they achieve, which in turn leads to an increase in their 'status' and greater involvement in decision-making in the household. However, it is not entirely clear whether empowerment is translating into reproductive empowerment because there were still conflicts and pressures within the family to produce sons and the women remained ambiguous regarding the use of contraceptives, fearing unknown side-effects (Schuler, Hashemi and Pandit 1995).

In contrast to these cross-sectional surveys, Vlassoff (1990) carried out a longitudinal study to address the same question in Northern India. Over a 12-year period from 1975-1987, the study villages underwent rapid economic development. As agricultural output changed from basic subsistence farming to cash crop farming, the village became relatively prosperous. Men became managers who supervised the work of hired labourers. Women's lives changed too. They no longer had to work in the fields, or carry water over long distances. Instead, they enjoyed more education, leisure, and economic security. To analyse the relationship between women's gendered position and fertility, women's 'status' was measured using three direct measures; control over resources, decision making power and isolation. Over the 12-year period, as prosperity grew, women's lives became more conservative. Women started adopting the traditional beliefs of the upper castes regarding seclusion, reduced control over resources and decision making. The relationships between indicators of women's gendered position and fertility desires were difficult to interpret. In 1975, a strong desire for sons was related to lower women's 'status', but in 1987, the opposite appeared true. The authors conclude that a strong family planning programme should be credited for creating lower fertility goals rather than any changes in women's status (Vlassoff 1990).

The studies thus provide inconsistent and contradictory findings between the direct measures of women's gendered position and demand for children on the one hand, and the ability to act on their desire to control their fertility on the other hand. One explanation for the inconsistency of findings could be diversity in samples. Some samples are limited to rural areas alone, others to urban areas alone while some incorporate both areas. The study design also seems to affect the conclusions. Survey-based studies and qualitative studies frequently highlight different things and come to different conclusions.

However, a striking finding is that most authors use more or less the same set of indicators to measure women's gendered position in different contexts, albeit all in South Asia. The focus on women's independent unaccompanied mobility and final decision-making illustrates the extent to which the theme of 'autonomy' has permeated the gender discourse. Few researchers question the applicability of these measures in the South Asian context despite the fact that in some contexts, notably Pakistan, there are no significant relationships between measures of women's 'autonomy' and contraceptive use. Moreover, a rereading of the same literature shows that good husband wife communication (Population Council 1997), a nuclear family system (which encourages conjugal intimacy when compared to a joint family system) (Sathar and Kazi 1997) and families that are lenient towards the women (Balk 1994) are associated with lower fertility and higher contraceptive use. These findings all point to the need for a reconceptualisation of women's gendered position in Pakistan.

Table 1.2: Summary of the literature addressing direct measures of women's gendered position and fertility (or contraceptive use) in South Asia

Authors	Title/Location	Study design	Sample size	Direct measures of women's gendered position used	Outcome measure	Major findings
Sathar and Kazi, 1997	Women's autonomy, livelihood and fertility: A study of rural Punjab, Pakistan	Survey	1,036	• Mobility • Economic autonomy • Freedom to make a purchase • Household 'inside' decision making • Outside decision making	Contraceptive use Fertility (CEB)	1. Mobility, economic autonomy and outside decision-making not associated with contraceptive use 2. Freedom to make purchases and inside decision making positively related to contraceptive use.
Population Council, Pakistan. 1997	The gap between reproductive intentions and behaviour: A study of Punjabi men and women, 1997. (Rural and urban Punjab)	Survey + Qualitative methods	1,295	Women can decide on their own to • Spend a part of the household income • Whether children can attend school • Treatment for a sick child • Purchase a shalwar/kameez for herself. • Travel	Contraceptive use	A larger fraction of users report they can independently travel to a health facility, decide how to spend household income, whether children should attend school and, treatment of a sick child.

Authors	Title/Location	Study design	Sample size	Direct measures of women's gendered position used	Outcome measure	Major findings
Fikree et al. (2001)	What influences contraceptive use among young women in urban squatter settlements of Karachi, Pakistan	Survey	1,020	• Women's mobility • Women's decision-making	Use of modern contraceptive methods	Women's mobility and decision-making have no relationship with contraceptive use.
Balk, D 1994	Individual and community aspects of women's status and fertility in rural Bangladesh.	Survey	7,433	• Women's mobility • Domestic authority • Household's leniency towards them • Their gender role attitudes	Children ever born	Mobility, leniency, and work outside the home were positively associated with low fertility.
Morgan, and Niraula 1994	Gender inequality and fertility in two Nepali villages.	Quasi-anthropological	655	• Mobility • Household related decision-making	Contraceptive use	Mobility and decision-making positively associated with contraceptive use.
Cleland, Kamal and Slogget, 1996	Links between fertility regulation and the schooling and autonomy of women in Bangladesh.	DHS survey	10, 907	• Mobility • Decision making	Contraceptive use	Women who reported high mobility & decision making were twice as likely to use a modern method of contraception compared to those with low mobility or decision making ability.

Authors	Title/Location	Study design	Sample size	Direct measures of women's gendered position used	Outcome measure	Major findings
Schuler and Hashemi, 1994	Credit Programmes, women's empowerment and contraceptive use in rural Bangladesh	Survey	1,305	• Membership in Grameen Bank, and BRAC	Contraceptive use	Grameen Bank membership had strong effect on contraceptive use (60%) but BRAC membership did not (47%) compared to (43%) in the comparison group
Schuler and Hashemi, 1995	Beyond credit: SEWA's approach to women's empowerment and influence on women's reproductive lives in urban India	Semi-structured interviews	50	Day to Day problems and periodic crisis employed women face because of their poverty and because they are women in a gender biased society	Reproductive decision making and child bearing experiences	SEWA members are relatively empowered socially and economically. Numbers too small to make conclusions, but evidence suggests that saving, investment and family planning coexist as elements of an empowered life strategy.
Vlassoff 1990	Progress and Stagnation: Changes in fertility and women's position in an Indian village	Longitudinal study (2 surveys 12 years apart)	153 (1975) 171 (1987)	• Control over resources • Decision making powers • Isolation	Desired number of children	Travel frequency, communication with husband (isolation) and decision regarding purchase of a sari (control over resources) related to desired fertility. Education, work, approval of dowry, girls consent regarding choice of husband and marriage distance not related to desired fertility.

1.7 The relationship between women's gendered position and antenatal care: the empirical evidence

The link between women's gendered position and health care use including antenatal care utilisation, in South Asia has received considerably less systematic research attention than fertility and contraceptive use. Emerging evidence suggests marked inequalities between males and females in health-services related options and outcomes (Okojie 1994; Vlassoff 1994b). Social and cultural forces overwhelm the supposed biological advantage of women (Doyal 1998). There are three issues here: the production of vulnerability to ill-health, access to health services and disadvantages within the health care system. Applying the gender perspective to all these aspects reveals a complexity of factors that together affect women's health. Poor reproductive health indicators are, on the one hand, a reflection of social and gender norms that put women at high risk of reproductive health problems in the first place (Okojie 1994). The situation is complicated because the same cluster of social and gender norms that operate to produce greater risks in women's reproductive health (social and economic dependency, limited decision making authority and limited access to material resources) also appear to be associated with a lower likelihood of accessing and utilising health services (Standing 1997; Obermeyer 1993). Then there is a paucity of health services in terms of magnitude and mix of services. Once in the system, women are treated in a manner different from men (Timyan and Griffey 1993; Vlassoff 1994b)[8]. Only recently have researchers started to recognise that perceptions of health, health needs and health may differ between women and men and the implications of these differences are just starting to emerge.

Before proceeding further, it is worthwhile to separate the literature that addresses availability of health services from that addressing potential clients demand for such services. We will review each in turn.

1.7.1 Provision of antenatal services

In Pakistan, as in other developing countries, the provision of adequate health services to prevent maternal mortality and morbidity is constrained by the lack of infrastructure, equipment and trained personnel (Midhet, Becker and Berendes 1998). In part this reflects the very low levels of expenditure on health overall, which has been exacerbated by structural adjustment policies. However, it is compounded by the fact that until recently, women's health problems received inadequate attention by policy makers. The largely male policy

[8] While I recognise that gendered roles may also severely compromise men's reproductive health, my focus here is on women's reproductive health outcomes.

makers, including professionals, have failed to appreciate the nature and extent of women's health problems, both in the design and delivery of services (Standing 1997; Okojie 1994; De Brouwere, Tonglet and Lerberghe 1998). In Pakistan today, the government is responsible for delivery of reproductive health and family planning services from their approximately 11,000-health facilities nation-wide (HMIS 1998). However, it is clear that the quantity and quality of these services are not commensurate with the wide network of service centres. According to the HMIS data, only 28% of the facilities in Sind, 16% in Balochistan and 50% in Punjab report actually having provided maternal health services (HMIS 1998). Their actual impact on women's health is low, as can be gauged by statistics such as a Maternal Mortality Rates that range from 300 - 700 per 100,000 live births and a life expectancy of 63 years (UNDP 1995).

1.7.2 Utilisation of antenatal services

However, even availability of quality services does not necessarily translate into utilisation of services (Dujardin 1995). Important determinants of access to health services can be divided into geographical, financial and social access. Gender roles and behavioural expectations are intertwined in all three aspects. In a context characterised by limited mobility for women, geographical access has been identified as a major limitation. It is not just the practical problem of traversing large distances, but the 'social distance' is equally, if not more important. Khan (1999) notes that women's access to services within their villages was least restricted because mobility within the village, for activities that called for little or no interaction between the sexes, posed little threat to anyone's honour. Women in Pakistan stated that they did not use antenatal services because it is a *'sharam ki baat'* (a shameful matter) as it is not a tradition in their village; you can only go to the health centre if your mother-in-law or husband takes you because otherwise it looks bad (Winkvist and Akhter 1997). Another aspect of the institution of *purdah* is the gender of health care providers. Women cannot use services manned by male health care providers (Winkvist and Akhter 1997; Tinker 1998; Okojie 1994; Vlassoff 1994b). Cost considerations are also related with gender inequality. There is evidence in the literature that households in South Asia spend less on health care for women and girls (Das Gupta 1987). Since men make the decisions and control the purse strings, women cannot pay for health care, or even the transportation costs to facilities that are far away (Okojie 1994).

The social aspect of access and utilisation of antenatal services is complex. The decision to use a health service is one aspect of a sequence of remedial actions that individuals undertake to rectify perceived ill-health (Christman 1977). It starts with symptom definition, where

upon a strategy for treatment is devised (Christakis and Kleinmann 1994). If a symptom is not conceptualised as a problem, then logically no action is taken. A number of studies report that pregnancy is seen as a natural process for which medical care is regarded as unnecessary (Okojie 1994; Gertler 1993). It appears that the notion of risk during pregnancy and childbirth that is at the heart of the Safe Motherhood Initiative and ICPD does not necessarily correspond to local conceptions of pregnancy. Ethnographic fieldwork in Pakistan suggests a discrepancy. Winkvist and Akhter (1997) found that not one of the pregnant women in a village in Punjab had antenatal care because 'they had not been sick, so they felt no reason to go' (pg. 1488). The basic premise of modern management of pregnancy and childbirth, that it is a medical process where risks can be minimised by proper intervention is not an attitude commonly expressed by women in Pakistan. For them pregnancy and birth are not defined as health issues, but are understood as natural reproductive events not requiring routine medical care (Winkvist and Akhter 1997).

Previous research has also established that symptoms, once recognised, will not necessarily be identified in bio-medical terms nor will their recognition necessarily result in health action of the variety that 'scientific medicine' deems most appropriate. Treatment choice involves a myriad of factors related to illness type, causation, the range and accessibility of therapeutic options available and their perceived efficacy (Helman 1995; Kleinmann 1980). In the realm of pregnancy and birth, the motivation to use preventive health care requires that pregnancy and birth be conceived as health conditions with potential risks, that problems emerging in the course of pregnancy be perceived as manageable and they be classified as belonging to the realm of modern health care providers. There is evidence in the literature that although such a sequence may be the norm in some contexts, it is by no means universal (Obermeyer 1993). The course of action taken is closely linked to profoundly held ideas about risk and to the alternatives that are available for the management of the problem. Like much of the developing world, medical pluralism, or the existence of several distinct therapeutic systems is a feature of health care in Pakistan. And women in Pakistan view modern medicine not as a system in itself, but rather as a selection of therapies to be used in parallel with those of the *'hakim*[9]*'* to restore humoral balance of the body. They constantly shift between traditional and modern health services during pregnancy and at the time of birth. It appears the reasons for alternating between the two may be less the result of commitment to one type of care than the outcome of a pragmatic weighting of alternatives (Winkvist and Akhter 1997).

[9] A *hakim* is a practitioner of traditional medicine. Traditional medicine in Pakistan is based in the *Yunani* (Greek) schools.

1.7.3 The empirical evidence for association between women's gendered position and antenatal care use

While a number of studies have examined the predictors of antenatal care use/maternal care use (Bhatia 1995; Gertler 1993; Obermeyer 1991), few have looked at how women's gendered position affects utilisation. An analysis of determinants of maternal care in India is one of the few studies that explicitly measured women's 'autonomy' and its association with antenatal care, its timing, and source. 'Autonomy' was measured as a complex variable that included economic and financial decision making, mobility, communication with the husband on sensitive matters and her involvement in important household matters (Bhatia and Cleland 1995). This indicator failed to emerge as a strong predictor of use of antenatal or delivery services. However, it was significantly related to choice of private rather than public sector care. This was explained in terms that more 'autonomous women' can seek better quality health care. Women's education and socio-economic status were strongly related to the probability of using antenatal care and use of the private sector (Bhatia and Cleland 1995). However, both education and socio-economic status are correlated. Unfortunately the authors combined a number of distinct measures of women's gendered position into a single scale, it is not possible to determine from their presented findings the effect of different dimensions on women's ability and desire to use antenatal care.

Winkvist and Akhter (1997), using ethnographic methods, found that women's perceptions of their health are conceived in terms of their ability to fulfil their gender roles. Their ability to produce sons and perform household and agricultural work emerged as the major factors in the perceptions of their personal health and their confidence about receiving health care, support and attentions. If they were able to fulfil their expected role in society, that meant they were leading a healthy life. Only women who had sons discussed health as an issue: women without children or those who had daughters only did not perceive their health was a topic that warranted attention. In a context characterised by a concept that 'sons are a gift from God', women who only have daughters were considered incomplete and not deserving of nutritional or health resources (Winkvist and Akhter 2000).

In summary, while there is an emerging understanding of the role of gender in perceptions of health, health needs and health care, supporting empirical evidence is minimal and further information is greatly needed. There is a need to explore women's perceptions of pregnancy and child-birth and how they fit in with the medical model of risk, what individual level dimensions of women's gendered position are positively associated with their desire and ability to use antenatal services, and what contextual level norms modify these associations.

1.8 Research questions and objectives

In sum, the literature serves to highlight the importance of the distinctiveness of the socio-cultural context of Pakistan, in which the international policy prescriptions such as ICPD are meant to be implemented. A gendered social relations analysis demonstrates how a wide range of forces, from the state and societal level to the family/individual level interact in complex ways to determine the gendered position of women. Based on the evidence presented, I argue that the current conceptualisation of women's interests in the framework of 'autonomy' is premised on an insufficient understanding of the social and cultural context of Pakistan. In a milieu characterised by interdependency and interconnectedness of interests such as Pakistan, a more valid conceptualisation of the gendered position of women may be one based on the notion of centrality (White 1992).

The review of existing literature demonstrates that women's gendered position is illusive, multidimensional and difficult to measure. Different aspects of this concept not only vary at the individual level, but their meaning and impact varies by the larger social context in which the women are situated. Macrostructures at the societal level modify individual behaviour and are in turn modified by it. Collectively the literature supports the need to decompose the different aspects of women's gendered position and to look at the effects of each aspect on the outcomes independently. I postulate that women's gendered position, as measured, amongst others, by their degree of mobility, decision making and access to resources not only vary at the individual level, but are conditioned according to the prevailing climate of gender norms of the wider society in which they live.

The literature also supports the assertion that different aspects of women's gendered position act in different directions, for contraceptive uptake at least. There is insufficient evidence to comment on utilisation of antenatal care services. However, it seems reasonable to postulate that the relationship between women's gendered position and contraceptive use on the one hand and antenatal care utilisation on the other are likely to differ. For example, the literature reviewed above suggests contraceptive uptake reflects two separate aspects; firstly a desire to control fertility and secondly an ability to act on the desire. Societal ideals of family size and son-preference influence the desire to take up contraception, while religiosity, availability of health services, an overall acceptance of women's social and geographical access of health services determine their ability to act on their desire. Antenatal care utilisation on the other hand, depends upon perceptions of risk during pregnancy, and its manageability in the realm of modern medicine. However, this recognition or desire by the women alone is insufficient. In order to physically access services the husband or mother-in-law too has to acknowledge

the risk and need for modern medical care during pregnancy. Then there is the societal level acceptance of pregnant women seeking health care services and of-course, the availability of culturally appropriate services.

So, with the broader goal of contributing to our understanding of which aspects of women's gendered position, and at what level, are important determinants of their reproductive health, and how such knowledge can be used to inform strategies and policies relating to gender and reproductive health, the objectives of this research are:

1. **Conceptual objectives**

1.1 To develop a conceptual framework for understanding different dimensions of women's gendered position from a 'centrality' perspective. Both individual and societal level factors will be incorporated to situate individual level behaviour in its wider social context.

1.2 To identify the strengths and limitations of a 'centrality' approach to understanding women's gendered position in Pakistan.

2. **Empirical objectives**

2.1 To demonstrate how different dimensions of women's gendered position vary by social, economic and demographic characteristics (including age, number of sons, education, occupation, socio-economic class, household structure, blood relationship with husband, rural /urban residence, and province).

2.2 To identify which direct measures of women's gendered position are associated with contraceptive uptake and antenatal care use.

2.3 To understand how gendered roles, processes and structures create individual and contextual norms and behaviours that promote or restrain women's ability to achieve good reproductive health.

2.3.1 To explore women's and men's perceptions of their gender roles and relationships and how and to what extent they are modulated by the larger community. To identify similarities and differences between current understanding of 'gender' and 'autonomy'.

2.3.2 To explore whether women can or cannot manoeuvre gender norms to stretch the boundaries to make space for themselves? To identify whether there is room for negotiation and what women level, family or societal level charascterisitcs enable woman to be 'central' members of the context in which they are situated.

2.3.3 To seek what are the women's understanding of their reproductive health, their perceptions of fertility control, contraceptive use, pregnancy, and utilisation of health care services. To identify what individual level characteristics of women's gendered position enables them to operationalise their desire and ability to use antenatal services and what contextual level norms modify these associations. To identify the barriers that exist between women's desires regarding their well-being and their ability to implement them.

Chapter 2

Methods and Data

A major challenge of this research is to explore the relationship between gender systems and women's reproductive health. The issue is complicated because not only are gender systems elusive, multidimensional and difficult to capture, they are embedded in and difficult to extricate from the social, economical and political forces of society. In this chapter, I discuss the strengths of combining quantitative and qualitative research methods to address these complexities, and how the data for the present study were collected and analysed.

2.1 Integration of quantitative and qualitative research methods in the study of gender and reproductive health

A combination of quantitative and qualitative research methods was used because the mixed method paradigm, by providing complementary perspectives, is particularly suited to the study question. Quantitative survey data allowed an exploration of variations in some direct measures of women's gendered position, and their relationships with contraceptive use and antenatal care. The main merit and utility of survey data is that they identify the existence of associations, which may indicate causal relationships. Quantitative findings that persist over time and within a large sample lend substance to the plausibility of relationships identified (Lin 1998). The numbers produced, backed by tests of significance make general inference possible and their decisive arguments have a motivating effect on policy makers. But, quantitative data can improve understanding of only some of the issues related to gender systems and their relationships with reproductive health. The complexities of these relationships are simply too difficult to disentangle in a survey questionnaire. This limitation was offset in the present study by the use of qualitative research methods. Qualitative research methods, with their flexibility and an interpretative approach, enabled me to capture the intangible issues of power, status and resource distribution. It helped to clarify the mechanisms that underlie the causal relations identified by the quantitative data (Lin 1998). By allowing an exploration of the social and cultural constructions of gender, qualitative data added a 'thick description' and richness to the bare-bones findings of the survey. Qualitative data also illuminated themes of variability and deviance between normatively constituted gender roles and the actual reality. More importantly, they enabled contextualisation of individual gendered behaviour, action, and belief. The qualitative data challenged some of the

conclusions based on survey data, and the complexities revealed cautioned us against taking findings at face value.

2.2 Quantitative component

The quantitative data are drawn from the Pakistan Fertility and Family Planning Survey (PFFPS). The PFFPS was conducted by the National Institute of Population Studies in collaboration with the London School of Hygiene and Tropical Medicine. The survey was conducted during 1996-97 with the objective of assessing trends in fertility, child mortality, contraceptive practice, attitudes towards family planning and family size, contact with health services and unmet need for fertility regulation. In addition, the survey provides valuable data on some direct measures of women's gendered position.

The universe consisted of all urban and rural areas of Punjab, Sindh, NWFP, Balochistan and the federal territory of Islamabad. A sampling frame was drawn using a two-stage sample design, with area units at the first stage and households at the second. Using a standard stratification scheme, the universe was stratified into rural and urban areas. The urban sector was further stratified into major urban and other urban[1]. The blocks within the urban sub-strata were further stratified into high, medium and low-income areas. In the rural sector, villages were stratified by province and district. In the next step, 120 blocks in the urban sample and 175 villages, *dehs* and *mouzas* were selected in the rural sample. Thus, there were 295 area units or Primary Sampling Units (PSUs) (Hakim, Cleland and Bhatti 1998).

A household listing of all the sampled PSUs was undertaken. From these, 22 households were selected randomly from each urban PSU and 31 from each rural PSU. A total of 8,002 households were selected; 2,640 from urban areas and 5,362 from rural areas. Households in more populous provinces (particularly Punjab) were under-sampled, while households in Balochistan were over-sampled. These unequal probabilities have been corrected by weighting households according to the sample design. Weighting factors for every cluster were obtained from Federal Bureau of Statistics and applied to obtain representative estimates at the national, provincial and urban-rural levels. Weights were standardised so that the weighted totals were approximately equal to the unweighted total.

[1] The major urban areas included Karachi, Lahore, Peshawer, Rawalpindi, Quetta, Hyderabad, Faisalabad, Multan , Gujranwalla, Sialkot and Sargodha. All other cites and towns are considered 'other urban'.

The PFFPS used three main data collection instruments and a community proforma. The household schedule listed all household members, their demographic characteristics and socio-economic status of the household. From this, women aged 15-49 years were identified and the woman's questionnaire used to collect information on their socio-demographic characteristics, marriage, reproductive histories, use of contraception, pregnancy, fertility preferences and some direct measures of their gendered social position. The instruments were prepared in English and then translated into the four major languages spoken in the country (Urdu, Sindhi, Pushto and Balochi). Data quality was controlled through extensive training of interviewers, supervisory level checks of all questionnaires and revisits to 10 percent of the households per PSU (Hakim, Cleland and Bhatti 1998).

Successful interviews were conducted with 7,325 households, in which 7,848 ever-married women aged 15-49 were interviewed. The analysis for contraceptive use is based on 7,582 currently married women while analysis for antenatal utilisation is based a sub-sample of 3,982 women who had given birth since January 1994. This database thus provided an opportunity to explore several dimensions of a woman's gendered position and their relationships with contraceptive and antenatal care use in a nationally representative sample of women.

Survey data were analysed to explore

1. Variations in the different dimensions of women's gendered position by age, education, socio-economic class, household structure, parity, rural/urban residence and province.
2. The relationships between the direct measures of women's gendered position and contraceptive uptake and antenatal care use.

2.2.1 Operationalization of the indicators of women's gendered position

The PFFPS survey included a small number of questions postulated to capture those aspects of a woman's gendered position that presumably affect fertility control in Pakistan. Of these, women's mobility, decision-making in three domestic domains and control over their monetary income were directly asked from the women. Based on insights obtained from qualitative data, three additional indicators, communication with husband, exposure to sources of information and reproductive health knowledge were 'created' by combining a series of questions from the survey. The scoring and further categorisation of these measures is also based on insights obtained in the qualitative work.

Here I describe the conceptualisation and operationalization of the key variables in the quantitative analysis.

2.2.1.1 Women's mobility

An interest in women's seclusion and restricted mobility is central to much of the discourse concerning gender and health in South Asia (Dyson and Moore 1983; Balk 1994; Durrant and Sathar 2000). Women's restricted mobility is viewed as crucial barrier to their ability to geographically access family planning and antenatal services (Khan 1999; Sathar and Kazi 1997; Fikree et al. 2001; Bloom et al. 2001). In this thesis, an unrestricted independent mobility is postulated to promote health by enabling women to travel to service outlets to access healthcare. The issue, however, is not so straightforward for women's mobility in Pakistan is embedded in the ideology of '*purdah*' and '*honour*' (Khan 1999). Seclusion is the normative ideal in Pakistan. While this has never been absolute (Donnan 1997a), in general women's movement outside the home is a reflection of economic necessity rather than any notion of 'liberty' (Sathar and Kazi 1997). Poverty interacts with *purdah* to assign women's mobility a doubly negative connotation. An added layer of complication is the relative freedom of movement of the urban middle class women, who have dispensed with the practice of *purdah* altogether. Although small in number, their visibility in urban areas reflects the importance of the wider social context and society's acceptance of women travelling alone. All these complexities indicate that women's mobility is an important aspect of their gendered identity and should be addressed when measuring a woman's gendered position.

The PFFPS included three questions aimed at capturing women's mobility. Two questions were directly related to their recent mobility. They were asked *'In the last four weeks have you been outside this village/neighbourhood for any purpose in the company of another adult'* and *'In the last four weeks have you been outside this village/neighbourhood for any purpose without the company of any adult?'* The third question was a hypothetical question *'If you needed to go to a health clinic or hospital, could you go by yourself or would you need to be accompanied by someone else*?' The first question asks respondent if they had travelled in company. Those who answered 'No' to this question consist of two groups of women: one who had not travelled at all and those who had travelled alone. However the subsequent question asked about travelling alone and addressed the women who had travelled without company. All three types of mobility are analysed.

2.2.1.2 Decision-making

A concern with aspects of women's empowerment revolving around decision-making is common in the gender and feminist discourse. Women's exclusion from decision-making processes is believed to be the underlying cause of their limited access to material and social resources. This exclusion also keeps women out of the major sources of power and prestige (Kabeer 1994). Women's level of involvement in decision-making is therefore considered an important aspect of their gendered identity and has been a central concern in prior research on women's gendered position (Sathar and Kazi 1997; Fikree et al. 2001). Particularly in light of the nature of our outcome variables, contraceptive use and antenatal care use, which involves making a conscious choice, I consider women's involvement in decision-making an important dimension of women's gendered position and therefore it explore further.

However, survey questions related to decision making are problematic. Decisions are difficult to access. They are usually made through a complex process and may involve diverse negotiations. The process involves co-operation and consensus, compromise and persuasion and there may not be a single final decision-maker. Even the people involved themselves often have very different views of what takes place.

The PFFPS asked a series of questions related to women's participation in three types of household decisions', treatment of a sick child; purchase of food and purchase of clothing for the woman herself. For each domain, the women were asked '*When a child is sick/ food has to be bought/ you need new clothes for yourself, who usually participates in the decision about treatment / what to buy?'* and *'Who usually takes final decision about treatment/what to buy?'*. In each case, every family member who participated in the decision-making process was identified and then the individual who made the final decision was also named.

The questions are based on the hypothesis that women who have a greater involvement in household decision-making will be in a better position to exert influence over their reproductive behaviour.

However, an exploration of the distribution of responses showed that the majority of the women participated in each decision: 91% in child treatment; 85% in food purchases; and 88% in clothes purchases. The numbers of women who made the final decision were much smaller, but a focus on final decision-making alone may lead to loss of information regarding aspects of co-operation and consensus that are important to an understanding of the decisionmaking process. The issue was solved by combining the two questions (for each

decision-making domain) to create four categories that reflect a continuum of participation in the decision-making process. This ranges from a complete exclusion from the decision-making process, followed by participation, but not making the final decision, making the final decision jointly with the husband and finally the woman makes the final decision alone. The resultant variable is coded as an ordinal variable as shown below.

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1 = Women did not participate in the decision at all.

2 = Women participated in the decision-making process, but did not make the final decision

3 = Women participated in the decision-making process and made the final decision jointly with the husband.

4 = Women made the final decision and husband was not involved.

2.2.1.3 Access to financial resources

Women's economic dependency is understood as a major factor in structuring inequalities between women and men (for extensive reviews see Kabeer 1994; Standing 1991). Therefore, Mason (1986) suggests that a woman's *control* over financial resources should be one of the most important aspects that should be addressed when attempting to measure a woman's gendered position. Moreover, access to and utilisation of antenatal services and even contraceptive use involve financial outlays. A woman's ability to financially secure these services for herself is an important determinant of access.

The PFFPS asked two questions aimed at capturing women's access to monetary income and her control over her wages. These are (1) *As you know, some women take up jobs for which they are paid in cash or kind. Are you currently doing any of these jobs or any other work for money? (2) Do you keep all the money, some or none of the money specially at your disposal.*

The two questions were combined to develop an ordinal variable that contains the following four categories.

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1 = Women do not have an independent income.

2 = Women have an independent income and keep all the money.

3 = Women have an independent income and keep some of it.

4 = Women have an independent income but give it all away.

2.2.1.4 Communication with husband

Some researchers (notably Jejeebhoy 1995) consider the husband-wife bond as an indicator of women's 'status' in South Asia because this is a context in which conjugal intimacy is discouraged (Dyson and Moore 1983). Husband-wife communication is also considered an important factor in determining fertility desires and contraceptive use (Mehmood and Ringheim 1997). Since Pakistan too is a context in which conjugal intimacy is discouraged (Sathar and Kazi 1997), I decided to explore if the husband-wife bond is a valid and important measure of a woman's gendered position.

To measure the quality of a husband-wife bond, an index of 'communication with husband' was developed. The PFFPS survey had asked respondents whether they discussed family planning related issues with their husbands. The survey also included two questions that can assess a woman's knowledge of her husband's attitudes: (i) Whether her husband approves of couples using a method to avoid a pregnancy and (ii) Whether her husband's desired family size is the same as hers or different. A woman's ability to report her husband's opinions about these issues is assumed to reflect greater communication between the couple than an inability to report such opinions. Assuming linearity, I have assigned a value of 0 if the woman reports no discussion of the issues or cannot report her husband's opinions and desires to a maximum of 2 if they discuss the issues more frequently. The index of communication was developed by summation of the following.

Dimension of communication	**Score**
Discussion with husband about family planning in the past year	
• No	0
• Once or twice	1
• More often	2
Does her husband approve or disapprove of family planning	
• Approve/Disapprove	1
• Don't know	0
Does her husband want the same number, fewer or more children than her	
• Same/more / fewer	1
• Don't know	0
Communication index range	**0-4**

2.2.1.5 Information and Knowledge

Information and knowledge of family planning and utility of antenatal care are pre-requisites of contraceptive and antenatal care use. However, Pakistan is a context in which information and knowledge of reproductive health matters is considered shameful and a culture of silence surrounds these matters (Khawer & Rauf 1997). Young women in particular are 'protected' from reproductive and sex related information. In addition, flow of information of all types is enwrapped in class and gender relations. Therefore, knowledge in its broadest sense can be considered a dimension of woman' gendered position. I develop two indicators to measure information and knowledge.

1. Exposure to Information Index.
2. Health knowledge Index

2.2.1.5.1 Exposure to Information Index

This index measures the extent to which women are exposed to the larger 'outside' world, through the radio, TV, newspapers and letters. Assuming linearity, I assigned a value 0 for no exposure to a radio, TV or newspaper to a maximum of 3 for a daily exposure to the same. The use of the same scale for reading a letter or newspaper may seem low in a context of low literacy levels, but it is also important not to overstate its importance either. However, writing a letter is assigned a value of 3 for writing is an additional ability. The index of exposure to information was developed by summation of the following scores.

Listens to a radio	
• Daily	3
• At least once a week	2
• Once in a while	1
• Never	0
Watches TV	
• Daily	3
• at least once a week	2
• Once in a while	1
• Never	0
Read or write a letter with understanding	
• Yes	3
• No	0
Reads the newspaper	
• Daily	3
• At least once a week	2
• Once in a while	1
• Never	0
Exposure index	**0 - 12**

2.2.1.5.2 Reproductive health knowledge index

A health knowledge index was developed by scoring dimensions that reflect reproductive health related knowledge base. Assuming linearity, a minimum of 0 was assigned if the woman could not answer the question to a maximum of 3 for a correct answer or knew of all the four contraceptive methods (pill, condom, IUCD and injections). The index of reproductive health knowledge was developed by summation of the following.

Knowledge of when during the menstrual cycle women have the greatest chance of becoming pregnant	
• Correctly stated	3
• Incorrectly stated or does not know	0
Knowledge of the Pill, condom, IUCD and injections as contraceptives	
• Knows all 4	3
• Knows 2-3	2
• Knows only1	1
• Knows of none	0
Knowledge of where to obtain the Pill, condom, IUCD and injections	
• Knows all 4	3
• Knows 2-3	2
• Knows only 1	1
• Knows of none	0
Knowledge about whether contraceptives can have side effects	
• Yes / No	1
• Don't know	0
Health knowledge index	**0 - 10**

2.2.2 Reproductive health indicators

Reproductive health, in all its holistic concept, is a complex notion. However, two of its important aspects are contraceptive uptake and utilisation of antenatal services. The two are viewed as products of purposive behaviour based on knowledge, desire and ability to act on the desire, all within the reproductive health framework.

2.2.2.1 Contraceptive uptake

Of the 7,582 currently married women between the ages of 15 and 49, 1,486 reported that they or their husband were currently using a method of contraception. Both modern and traditional methods of contraception are included in the analysis. Contraceptive use is employed as a dichotomous variable. Women are coded 1 if they or their husband currently use any method of contraception, 0 otherwise.

2.2.2.2 Antenatal care use

The antenatal use sample is composed of the 3,982 women who gave birth to a child after January 1994, that is within the three years prior to the survey. Antenatal care is measured as a dichotomous variable. Women are coded 1 if they utilised antenatal care during their last pregnancy, 0 otherwise.

2.2.3 Background characteristics

2.2.3.1 Education and employment of women

As discussed previously, education and employment have been used as proxy indicators of women's gendered position. Because the purpose of the study is to examine direct measures of women's gendered position, we include measures of women's schooling and whether they work outside the home as background variables. Women's education is coded as an ordinal variable consisting of no education, primary education only (that is up to five years of schooling), secondary education (up to 10 years) and greater than secondary (higher secondary school and university). Similarly, based on women's identification of the type of work they do, women's occupation is categorised as a nominal variable consisting of homemakers, professionals, services industry workers, agricultural workers and cottage industry workers. The services industry includes women who work as maids, cooks and other similar services. The cottage industry is a mix of occupations, largely home-based that require specific skills such as tailoring, spinning and material handling, as well as unskilled labour.

2.2.3.2 Household socio-economic status

A direct measure of family income or wealth is complex, particularly in contexts such as rural areas of Pakistan. However, qualitative work shows that socio-economic hierarchies are based on land-ownership and caste (*zaat*), (in the rural areas). Therefore, consumption patterns can be considered a valid reflection of the socio-economic hierarchy in both rural and urban areas.

The socio-economic indicator of the household was developed as a complex variable reflecting lifestyle purchase and consumption patterns meaningful in the Pakistan context. Type of housing, sanitation facilities, source of drinking water, availability of electricity and ownership of specific electrical items and modes of transport are used. Based on my previous knowledge of Pakistan and the qualitative work, I assigned a value between 0 and 10 to each item, a higher value reflecting more purchasing power. Some items, such as ownership of a

air-conditioner or a car are assigned much higher values for ownership of these assets reflects consumption patterns that cannot be compared to those who only own a radio or a bicycle on a linear scale. The resultant score was further categorised into five classes. Again, the cut-off points are based on previous knowledge and the qualitative work.

Housing was divided into *katcha* and *pucca* based on construction materials used. *Katcha* refers to a dwelling constructed with natural unprocessed materials such as wood, clay or dung. *Pucca* housing is made of processed materials such as concrete and cement. If the roof was made of *katcha* material, it was given a score of 1; 2 for *pucca* materials. Similar scoring was used for flooring materials. Water supply, sanitation facilities and ownership of consumable durables were scored as follows.

Dimensions of SE status	Score
Construction material of house	
Roofing material	
Katcha	1
Pucca	2
Flooring material	
Katcha	1
Pucca	2
Source of drinking water	
Rain and surface water	0
Public well	1
Public tap	2
Private well	3
Piped water	4
Sanitation facilities	
No facility	0
Pit latrine	1
Flush latrine	2
Availability of electricity	
Yes	1
No	0
Ownership of electrical items/consumable durables.	
Air conditioner	7
Room cooler	4
Refrigerator	4
TV	3
Washing machine	3
Telephone	4
Radio	1
Ownership of transport	
Car / van / tractor	10
Motor cycle	5
Bicycle	1

A socio-economic indicator of the household was developed by summing up the scores of dwelling, ownership of electrical items and ownership of modes of transport. The scores were categorised as follows.

Socio-economic category	Score
Very poor	0-5
Poor	6-8
Lower middle	9-12
Upper middle	13-20
Rich	21-46

2.2.3.3 Household structure

Households are divided into nuclear families, vertically joint or horizontally joint based on number of generations living together as reported in terms of relationship to the head of household. Households consisting of, usually, a male head of household, his wife and their unmarried children (including adopted children) are coded as nuclear. Households that contain three generations or the presence of married children are coded as vertically joint. Households consisting of married brothers living together or other relationships (uncles or cousins including non-relations) are coded as horizontally joint. This variable reflects age and gender hierarchies that operate when a large number of family members live together.

2.2.3.4 Blood relationship between spouses

Endogamy is common in Pakistan and initial exploration of the PFFPS data-set show that 67% of the respondents are married to individuals to whom they are related by blood. Assuming endogamy is an important measure of kinship rules, it is important to explore its effects. The variable is coded 1 if the couple is related, 0 otherwise.

2.2.3.5 Total number of surviving sons

Pakistan is characterised by high level of son-preference for it is the only form of old age social insurance (Sathar and Kazi 1997). Since daughters do not provide this security (Winkvist and Akhter 2000), and preliminary analysis indicated that addition of daughters did not affect the results significantly, only the total number of living sons will be analysed in this thesis. The variable is coded as 0 if a woman has no sons, 1 if she has one or two sons and 2 if more than three sons.

2.2.3.6 Province and rural-urban residence

It has been shown that although value systems of individuals are important, the larger social milieu has a strong manipulative effect on enforcing gender norms (Balk 1994). Pakistan is a large heterogeneous country made up of four provinces, Punjab, Sind, Northwest Frontier Province (NWFP), and Balochistan. Although these provinces are administrative units, they are largely based on distinct ethnic and linguistic groups albeit with some variability within each province. Furthermore, there are significant differences between the different ethnic groups, particularly regarding the degree to which gendered rules are implemented in practice (Donnan and Selier 1997). An additional layer of complexity is the rural-urban divide that

cuts across all the provinces. The urban areas are more developed with greater availability of health and educational services. These can have an independent effect on both gender context as well as contraceptive and antenatal care use.

2.2.3.7 Religiosity

As discussed in the previous chapter, religion plays an important role in sanctifying gender roles. It is also vitally important in shaping attitudes towards contraceptive use (Kamal 1995). The PFFPS survey asked a series of questions regarding religiosity. In view of the rise of militant Islam in Pakistan in the past few years, during which *maulvis*[2] have tended to use the mosque as a platform for the spread of ideas against family planning, only the question *'Have you heard anything against family planning from a 'Maulvi Sahib'?* is used in this thesis. It is coded 1 if the respondent had heard the *Maulvi Sahib* preach against family planning and 0 if she had not.

2.2.3.8 Availability of health services

Access to high quality services is an important variable that should be controlled for given that the objective of this research is to study the relationships between women's gendered position and their use of reproductive health services. Numerous studies from Pakistan reveal that large segments of the population, mostly concentrated in the rural areas, face considerable difficulty in obtaining low-cost, high quality family planning and antenatal services (Mehmood *et al.* 1992; NIPS 1992). The PFFPS survey asked a general question *'Have you visited a health facility or clinic for any reason in the last 12 months*?' It is coded 1 if the respondent answered yes, 0 otherwise. A positive answer is assumed to indicate geographical, social and financial access to health services, for any purpose. A limitation of the indicator is that it does not capture the quality of the health services.

2.2.3.9 Neighbours' opinion regarding contraceptive use

Social and cultural unacceptability of contraceptive use, as perceived by women, has been identified as a major barrier to use in Pakistan (Casterline and Sathar 2001). The PFFPS survey measured this aspect by asking *'Do most of your female friends and neighbours approve or disapprove of couples using a method to avoid pregnancy?'*. Based on qualitative

[2] *Maulvi Sahib* is a religious leader who leads prayer in the mosque, conducts marriages and is in general considered an authority on Islam.

findings, this question is considered the most appropriate indicator of larger social and cultural acceptability of contraceptive use. It is coded 1 if yes, 0 otherwise.

2.2.4 Data analysis

The PFFPS data is a stratified, cluster based data that is weighted by province and rural urban areas. The statistical package, Stata 6.0 (Stata 1999) statistical package has a set of commands, the 'svy' commands that take into account the lack of independence of individual observations within clusters although inter-cluster independence is assumed.

2.2.4.1. In the first phase, bivariate analysis was done to explore how the direct measures of women's gendered position varied by age, number of sons, woman's education and employment status, socio-economic status, structure of the household, and blood-relationship with husband. Similar analysis was carried out for contraceptive use and antenatal care utilisation. The F-statistic was calculated to measure the significance of the overall associations obtained.

2.2.4.2 Multivariate analysis was then carried. In the first phase, the relationships between the socio-demographic characteristics and the six dimensions of women's gendered position were explored. In the second phase, the relationships between the six dimensions of women's gendered position and contraceptive and antenatal care use were explored. Logistic regression methods were used where the outcome was a categorical variable (dichotomous or polytomous) and linear regression where it was continuous. The models were developed in a sequential step-wise manner to first assess the effect of single variables and then the effects of different combinations of factors. Since the data are clustered, pseudo-maximum likelihood estimators are obtained.

Wald statistics were used to test whether individual coefficients differed significantly from zero. The likelihood ratio tests (LRT) were used to test the significance of the coefficients to the overall model. The LRT test was carried out on unweighted data since STATA does not have the ability to conduct this test on weighted data.

2.3 Limitations of survey methods for studying gender systems and reproductive health

A single round multi-objective household survey such as the PFFPS can measure only some aspects of the issues related to gender systems and their relationships with reproductive

health. Limited resources and insufficient evidence of the utility of the measures acted to restrict the number of questions that could be included in a multi-objective survey such as the PFFPS.

In addition, a problem commonly identified in surveys in developing countries is the 'conspiracy of courtesy' which leads the respondents to give what is assumed to be the required answer (Gill 1993). This is particularly critical in the realm of gender where the respondent may give normative answers rather than what they really do. Presence of other family members, particularly the mother-in-law, further increases the danger of obtaining the 'right answers'. Questions aimed at capturing decision-making are, for example, particularly problematic in surveys because decisions are, by their nature, difficult to access. They are usually made through a complex process and may involve diverse negotiations (White 1992), not all of which can be categorised into neat divisions or be shared with a stranger filling a form.

Although the PFFPS has data which allowed a quantification of some dimensions of a woman's gendered position, particularly its variation according to a range of socio-demographic characteristics, the construct is too complex to be understood using traditional quantitative approaches alone. Quantitative methods are also of limited use for unravelling behaviours and activities women and men carry out to manoeuvre around gendered restrictions. I turn to the qualitative data to make up for these shortcomings.

2.4 The qualitative component

2.4.1 Study site

The qualitative data were collected from a small village, called Jatti[3], in District Attock, Northern Pakistan. Appreciating that there is no such thing as a representative village, we purposively selected Jatti because it met certain pre-defined criteria. It is small, well defined and reasonably remote but still accessible by an all-weather metalled road. More importantly we had access to it through a colleague. Ghulam Farooq works as a medical technician in a Basic Health Unit and is familiar with research activities carried out by my institution, the Health Services Academy. In many ways this turned out to be an ideal situation. Ghulam Farooq is not one of the Raja landlords, but at the same time he is well respected as a 'doctor'. This enabled us to enter the poorest and the most marginalised households in the village,

[3] Names have been changed to protect privacy.

while at the same time providing protection from the not-so desirable elements of the village. His *biradari* practically adopted my research assistants and me; the help and care we received from them was invaluable.

I lived in the village for five full months from January to May 2001. Two research assistants, a man and a woman were hired and trained. The male research assistant was hired to access men and discuss sensitive issues they may feel uncomfortable discussing with women. Contrary to prior expectations, I had no difficulty hiring a female research assistant willing to live in a remote village. Afshan turned out to be my biggest asset as she was from the same region, spoke the same dialect (*patwari*) and was familiar with the ways of the villagers. Both research assistants had just graduated from the Department of Anthropology, Quaid-e-Azam University, Islamabad. They were given a one-week training that oriented them to gender theory, reproductive health, and the research objectives.

The villagers were intrigued by our presence. On the one hand they warmly welcomed us into their homes. At the same time, rumours that we were Indian spies, and later income tax spies, dogged us. The Indian spy story died a quick death but the income tax rumour remained. Income tax was a particularly sensitive topic in Pakistan those days. The government had conducted a number of surveys to broaden its income tax base and identify tax evaders. Although we were meticulous in informing the villagers of our research and its objectives, the villagers, particularly the land owning Rajas, remained sceptical of our intentions right till the end. The villagers also wanted to know what benefit would they get out of this research, an issue with its own ethical dilemmas that I will not touch upon here.

2.4.2 Objectives

The objectives of this component were to

1. Explore:

    1.1 The emic definitions of femininity/masculinity, female/male roles, and how these form the basis of the relationships between women and men.

    1.2 Life cycle variations in these roles.

    1.3 How gender roles and relations facilitate and constraint men and women's access to different types resources.

    1.4 If women and men contest normatively prescribed gender roles. Whether women/?men can or cannot manoeuvre around the gender norms or stretch

the boundaries to make space for themselves. If yes, how do they do so, (overtly /covertly)?

This information will be used to examine the relevance of autonomy to the conceptualisation of women's gendered position in Pakistan.

2. To 'unpack' and understand in greater depth the contextual meaning of the variables measured by the PFFPS survey. This includes

    2.1 Assessing whether the survey questions are sensitive enough to capture the different dimensions of women's gendered position or are they 'ambiguous' in this cultural context?

    2.2 Identifying the differences in the meanings attached to these measures by Pakistani women and men and how they differ from the meanings given by researchers from the 'autonomy' perspective.

    2.3 Identifying other dimensions of women's gendered position of relevance in understanding the concept but are not addressed in the survey.

3. Understand women's and men's view and perspectives on contraceptive use and utilisation of antenatal services. This includes:

    3.1 Understanding women and men's perception of fertility control, contraceptive use, pregnancy, and antenatal care use, particularly from the perspective of the importance of women's roles as wives and mothers.

    3.2 Identifying what individual level characteristics of women's gendered position enable them to operationalise their desire and ability to use antenatal services and what contextual level norms modify these associations. What is the role of men's gendered role in the women's use of contraception and antenatal care use.

    3.3 Identifying the barriers between women's desires regarding contraceptive use and antenatal care and the ability to implement them? How do they do things they are not supposed to do? What areas (in the context of their use of contraceptives and antenatal services) are they willing to accede in order to gain in other areas (not necessarily related to health).

    3.4 Identifying and understanding the influence of other socio-cultural and economic forces on patterns of contraceptive and antenatal care use and how they are inter-related with the gender order.

This information will be used to understand and describe the links between gender norms and values and contraceptive uptake and antenatal care use.

2.4.3 Data and methods

The data collection process was divided into four sequential phases, each phase increasing in depth and focus. In practice the phases overlapped and did not strictly follow the linear pattern envisaged. Each phase informed the next, both in terms of research questions and refinement of methods. The original plans were modified as and when required.

2.4.3.1 Phase 1. The objective of this phase was primarily to introduce ourselves, build rapport with the villagers and collect general information about the village in terms of its history, economic and political structures, kinship networks and religious and power structures. Two social mapping exercises were conducted, one each with women and men. The essence of social mapping is that informants are asked to draw maps and indicate locations of relevant data while the interviewers try to play a passive supportive role. This methodology is most useful for producing an emic perspective of their geography and history, socio-economic and possibly power structures, depicting information that outsiders cannot see by direct observation. As a participatory research method, the local informants are treated as knowledgeable experts instead of passive respondents to framed questions.

The participants of these exercises were largely members of our host, Ghulam Farooq's, larger extended family and their neighbours who belonged to the kammi[4] caste. The exercises produced a map of the village and general information about the main *zaats* (castes), land ownership patterns, occupational groups, existing health care services, and schools. The major benefit of the group discussion situation was instantaneous correction of erroneous information and production of a consensus solution. While this validated the data, the heterogeneous group situation also acted to denude the data of values attached to contentious issues like *zaats*, occupational classes and land ownership. The participants did not want to say things that might show their village in a bad light. Furthermore, the Kammis, as I found out later, normally do not speak out openly in front of *zaats* believed to be on a higher social plane than the Kammi *zaat*. These issues are discussed in detail in chapter 5.

[4] The Kammi caste are the landless and hence the powerless member of the community. The issues are discussed further in chapter 5.

Plate 2.1 **Women's social mapping exercise**

Soon after completing the group mapping exercises, we received feedback from the villagers that we should visit them individually instead of asking them to collect as was done for these exercises. So, the original plan of introducing ourselves to the community by conducting general group discussions with older women and men was abandoned in favour of house to house visits. The next two weeks were spent visiting each and every household in the village. A positive outcome of this exercise was that we came to know of every single woman and family in the village. This was very helpful in identifying women who met the criteria for selection into the second phase of the study.

2.4.3.2 Phase 2. The objective of this phase was to start focusing on the research questions and identifying normative values attached to male and female roles and gender relations. Specifically we aimed to understand this by exploring:

1. Types of work women and men do. Is there an overlap?
2. Places women can go/cannot go to, places where men can go/cannot go? Is there an overlap?
3. Areas in which women are the main decision-makers, and those in which men are the main decision-makers. Is there an overlap?

The primary method used at this stage was observation and, to an extent, participation and informal interviews. Participant observation is a method of data collection in which the researcher observes the people as they go about their everyday lives and participates in their

activities (Bernard 1995). Underlying the use of the method is the belief that knowledge about a community is different from understanding it, and that the latter can only be determined and obtained by actually living in it. Observations made by an outsider may uncover behaviour that the participants are unaware of and in the process reveal discrepancies between subjective meaning and practice (Mays and Pope 1995). The method is particularly suited to my research question since gender is not only a sensitive topic, but a theme that permeates all aspects of life (Greenhalgh 1994). Respondents did not give concrete answers, rather insights were acquired over a period of time by observing people as they went about their daily lives.

We lived in the village for five months. This sustained and regular contact enabled us to build rapport with the people, win their confidence and understand norms and values beyond respondent self-representation. We collected fodder from far-away fields, harvested wheat, applied mud on floors, attended weddings and dressed up brides. We participated in the village social life, welcoming back Hajis after their pilgrimage to Mecca and condoling the death of a cow (struck by lightening). Despite all this, our involvement in the villagers' life did not really amount to participation. We were too obviously different. Our clothes, mannerisms and inability to apply mud properly were constant reminders that we were not one of them. Nonetheless, the immersion enabled us to win the confidence of men and very importantly, the elder women. Initially we found that we were only interacting with the elderly women. During our home visits, they would sit and chat with us, while the daughters-in-law, our primary targets, either worked away or sat and smiled without saying a word. Being able to talk to this group of women alone without arousing suspicion was the real sign of our acceptance, which we achieved after about eight weeks in the village. Our constant presence also, hopefully, reduced respondent reactivity. All in all, living amongst the villagers and sharing their lives turned out to be the most powerful tool for understanding gender roles, processes and structures and how they shaped, restricted and promoted women's reproductive health. A total of 171 observation episodes were noted, but this is just the tip of the information amassed.

2.4.3.3. Phase 3. Phase 3 merged imperceptibly with phase 2 on the one hand and phase 4 on the other hand. This was largely because of the differential rate at which we developed rapport with different target respondents, their receptivity, availability and the fact that we could not spend too much time with one person or family without them tiring of our presence. But I will describe them separately for clarity purposes.

Phase 3 became much more focused as we explored, in greater depth, the emic perspective and contextual meaning of the variables measured by the PFFPS survey and their implications

for contraceptive use and utilisation of antenatal services. The objective of this phase was to

1. Explore how do women and men make decisions in response to specific events (treatment of a sick child, purchase of food and clothing), role of the quality of relationships between couples and other family members in women's participation in decision-making.
2. Explore the emic understanding of women's mobility? What does *purdah* mean for women and men and that to what extent do they adhere to its ideals?
3. Describe the views and experiences regarding family planning and contraceptive use, pregnancy and use of antenatal care services.
4. Identify the role of other social and economic forces that may influence fertility control and antenatal care use.

In-depth interviews and focus group discussions were the main methods used in this phase.

1. In-depth interviews

An interview is a basic technique of data collection in which verbal conversations and statements between the participant and researcher are documented. Since gender is implicit in practically all aspects of life, it was more productive and informative to ask informants for concrete examples i.e. key event witnessing of a complicated pregnancy (Gittelsohn 1994). By narrating information about specific events, key event witnessing brought forth attitudes and beliefs 'spontaneously' as explanations were offered for certain actions taken or events that resulted from the actions (Pelto 1994).

A total of 35 interviews were conducted, including 15 women, 15 husbands and 5 mothers-in-law. Women were purposively selected on the basis of experiences that we believed might illuminate gender influences on reproductive health. These included complications during previous pregnancies or childbirth (2), women with female children only (1), women with sons only (2), women using contraceptives (4), women perceived to be powerful/happily married/lucky (2), childless women (2), and women who were simply very forthcoming and willing to share their stories with us (2).

Realising the importance of *biradaris*[5], a deliberate effort was made to include women from all the four *biradaris* to get a more comprehensive picture. By this stage, with the exception of three women, we knew every single woman in the village, not only by name,

[5] A *biradari* is a group of households related by blood. The issue is discussed in detail in chapter 5.

but also their life experiences and we selected them according to the criteria described above. Interviews were unstructured but guided by the framework of the research question as one of the objectives was to 'unpack' and understand in greater depth the measures used in the PFFPS survey. An interview guideline was used, but mainly as a point of reference and respondents were free to talk about any other issue in addition to the questions asked. Repeated interviews were conducted with some respondents to gain clarity when needed. The interviews were recorded on audiocassettes, translated, and transcribed verbatim.

2. Focus group discussions

Focus groups are discussions about a particular topic by a group of people who are quite homogenous (Bernard 1995). This method, grounded as it is in group dynamics, may lead to disclosure of 'rich information' previously not available (Liefooghe 1995). In addition, focus group discussions, by virtue of the homogeneity of the group, promote candid discussion and openness with the group encouraging other members to analyse issues (Fern 2001).

We conducted six focus group discussions, four with women and two with men. Realising women's limited cross-*biradari* interaction, separate focus group discussions were conducted with women in each *biradari*. Ignoring the *biradari* divide would have risked the possibility of a non-discussion as not only was the inter-*biradari* chasm very wide for women, their sensitivity of the class differentials would have hindered candid discussions. So, one focus group discussion was conducted each with the young women of Farooq's *biradari*[6], young women of the Malik *biradari*, older women of the Raja *biradari* and older women of the Kammi *biradari*. The *biradari* boundaries are not so rigid for men. One focus group discussion was conducted with older men and one with younger men, less than 40 years of age. The *biradari* composition in these discussions was heterogeneous, but the Raja's were underrepresented.

Collecting people together for a group discussion was a difficult task. After a number of planned discussions were cancelled because too few participants turned up, I started using 'natural gatherings' as an opportunity for a focus group discussion and this worked like magic. Six to ten women, sitting together in a social situation (such as a visit to welcome a Haji back from pilgrimage) were primed to participate in any discussion. I would just direct the discussion after getting their permission. Very rich information regarding gender values was obtained in these discussions.

[6] See chapter 5 for details of the different *biradaris* in the village.

2.4.3.4 Phase 4. The final phase was a very focused and in-depth exploration of the issues identified in the earlier phases. In addition, we explored

1. Contestation of normatively prescribed gender roles. Whether women and men manoeuvred around the gender norms, overtly or covertly and what characteristics, at individual, family, and community level, prevented or promoted this manoeuvring.
2. Power structures: The focus was on both gender-related power structures between women and men and between women. Life-cycle variations were addressed.
3. Barriers between women's desire to use contraceptives and antenatal care services and the ability to implement them. What areas (particularly in the context of their use of contraceptives and utilisation of antenatal services) are they willing to accede in order to gain in other areas (not necessarily related to health)?

In this phase, with its aim of a sharp focus and deep exploration, we conducted five very detailed case studies. Yin and Dhameja (1997) classify case studies as a research strategy that enables focus on a few individuals, but in much greater depth than is possible with any other technique. By studying in-depth a few cases, we were able to understand the complex interactions, tactic processes and often hidden beliefs, values and behaviours that underlie normatively presented gender structures and relations.

The five case studies were selected from the informants interviewed in phase 3. By this stage, we had developed good interpersonal relationships with some respondents and this played a large role in the selection of the cases. They were friendly, an important issue if we were going to spend large periods of time with them. They were willing to share very sensitive aspects of their lives and equally important, their husbands and larger families were willing to put up with our continuous presence in their homes. The case studies included a woman with a history of complicated pregnancies (Salma), a mother of two sons (Nadia), a woman whose marital family was of lower socio-economic status than her natal family (Sameena), a woman who managed to by-pass patrilocal residential norms (Chayya) and a working woman who was the primary source of cash household income (Fozia).

Data were collected using

1. **Participant/observation**. We spent long periods of time observing the case study women and men as they went about their daily lives. To observe their mobility, we accompanied them to far-away fields to collect fodder, their places of work and on their visits to relatives. We observed women's role in deciding whether a cattle sale should go through

or not and how food purchases are made. We managed to observe who had physical control of the money and who decided how it should be spent.

2. **Unstructured but directed interviews**. Repeated interviews over a period of time enabled us to put together information about different events and episodes over a lifetime that directly or indirectly provided the information we were seeking. To heed all perspectives, the informants' husbands, mothers-in-law, and other family members including in-residence *nands* (husbands sister), *jeyths* (husband's brother) and *jethanis* (their wives) were also interviewed.

3. **Detailed genealogies of the cases**. The location of women and men in *biradari* networks were delineated. This will enable us to explore roles women play in connecting families.

2.4.4 Data recording

Data were collected in *patwari,* the local dialect. The interviews and focus group discussions were recorded on audiocassettes. They were translated and transcribed verbatim by native patwari speakers. Observation notes were recorded as field notes, either in journals or directly in Microsoft Word. I double checked each interview transcript by listening to the audio-tape and verifying the translation (I understand and speak *patwari*). This was important because the transcribers were not familiar with the research context. Furthermore, listening to the tapes enabled me to reflect on the flavour and richness of the local language, how use of particular words and the manner in which they were threaded to convey a message. Pauses, hesitations, laughter all conveyed something. The field notes were discussed in daily meetings with the research assistants and clarifications and corrections made on the spot.

2.4.5 Data analysis

Qualitative data analysis was an on going process. It started in the field with a reading, and correction of notes made by the two research assistants. The ensuing discussions generated interesting ideas which were recorded as analytic notes and memos. This early analytic activity also provided information that formed the basis of further data collection, producing the characteristic funnel structure as the study became progressively more focused.

The main data analysis was carried out later according to the grounded theory procedure outlined by Strauss and Corbin (Strauss & Corbin 1990). The transcripts were read and

reviewed several times manually. The following activities were carried out, but not necessarily in the strict chronology described. The process was to an extent, iterative.

1. **Open coding**. In this process the data (a sentence, paragraph, discrete incident, idea or event) was broken down to understand what it is and what it represents.
2. **Axial coding**: This was a 'set of procedures whereby the data were put back together in new ways after open coding, by making connections between categories' (pg. 96). The focus was on understanding categories in terms of the conditions that give rise to them, the context in which they are embedded and how they relate to other categories.
3. The last stage involved a process of **reflecting** on the data and categories. This phase is similar to the phase Spradley refers to as discovering **cultural themes** (Spradley 1979). A cultural theme is defined as 'a postulate or position, declared or implied and usually controlling the behaviour of stimulating activity, which is tacitly approved or openly promoted in a society' (Spradley 1979, pg.185).

The themes discussed in chapters 6 and 7 were not necessarily voiced by all the participants. Opinions were never uniform and divergences are identified throughout the analysis.

2.4.6 Data validity

The issue of validity is always a concern in research. Defined as the 'truth' and interpreted as the extent to which an account accurately represents the social phenomena to which it refers, it is a controversial concept (Hammersley 1990). Hammersley suggests validity of qualitative data be assessed in terms of plausibility and credibility of the findings and the effects of likely sources of error and then by making a judgement (Hammersley 1990). This position recognises that while we can never be absolutely certain about the validity of any knowledge claim, we can still make reasonable judgements based on the plausibility and credibility of the findings.

2.4.6.1 Procedural reactivity

Procedural reactivity refers to the effect of the research process on the behaviour of the participants in ways that threaten the validity of the findings (Hammersley 1990). The information obtained, either from observation, interview responses or even accounts given by one participant to another in a focus group was assessed in terms of procedural reactivity. Insights into gender ideology were largely acquired as respondents narrated information about certain events and from there expressed attitudes and belief systems. Gender values emerged

'spontaneously' as explanations were offered for certain actions taken or events that resulted from the action taken. An example of how gender values emerged spontaneously despite the effect of the presence of the researcher on respondent behaviour is as follows. Women in the village were very particular to emphasise that they never 'go out of their homes'. In one interesting interaction, the mother was, at the early stages of the fieldwork, quite suspicious of our motives and kept signing to her daughter not to say anything. To keep the interaction moving, I asked them where to shop for local handicrafts. Both women proceeded to give me minute details on how to reach the nearby town, in essence indicating they travel to the market on a regular basis. Thus, their mobility patterns emerged indirectly despite obvious procedural reactivity. Nonetheless, the issue persisted and we remained alert to it.

For a start, informants' narratives were based on their memories, with an intrinsic potential for recall error. There was a clear gender difference in recall of women's reproductive health events. Women were very lucid and could describe their pregnancy experiences in minute details. Their husbands were often vague, forgetting major aspects of their wife's pregnancies (the attendant at delivery for example). I judged the validity according to the plausibility of the details, which more often than not, came from the women.

Secondly, lived experiences, values and sometimes aspirations shape the narrator's representation of accounts. Not everything can be shared with a stranger and some respondents did not want to show their village or family in a bad light or were trying to portray themselves as richer or on a higher social plane than they really were. Triangulation, both respondent and methods triangulation, provided an invaluable means to assess the accuracy of the stories told. Repeated discussions with different family members, living amongst them and with the passage of time, knowing who had a tendency to stretch the facts and who did not, enabled me to develop a reasonably valid picture.

Thirdly, and most important, was trying to understand which of the many versions of an event narrated by the same person but in *different contexts* and to *different audiences* was the 'truth'. Does the truth vary in different contexts and yet the person narrating it believes every version to be valid? Reality can have different dimensions, and the context and audience determine the social acceptability of the various versions. An example of variations in truth is Nadia's narratives. Nadia's marital family was pressuring her to have another child. We observed interactions in which the pressure was applied and she also confirmed this state of affairs in an in-depth interview, stating that she and her husband did not want another child, but were expected to have one. A few weeks later, she had her IUCD removed and was pregnant by the end of the fieldwork. Yet, when explaining the removal of her IUCD to a

friend, she identified excessive bleeding as the reason for removal of the IUCD. She did not mention any problems with her IUCD in our interview and did not tell her friend that she was trying to conceive and that too under pressure from the family. The question arises: which version is the truth and how many more versions were there that we are not aware of? Which version were we given? How did our personal attributes affect which version we were given.

The context in which the information is relayed to the researcher is also important. We managed to interview most respondents, women, men and older women without the presence of other family members. The fact that we were allowed to sit alone and interview the young daughters-in-laws is evidence of the rapport and trust we developed with the villagers. We reciprocated their trust with complete confidentiality. The names of the village and respondents have been changed in this thesis.

Peer debriefing and respondent validation was used to assess the quality of the data. Peer debriefing with colleagues is a process in which researchers discuss and reflect upon the findings with local and international peers. We regularly discussed our findings with colleagues in Islamabad to assess their plausibility and credibility. Respondent validation was also used. This is a process in which the research findings are presented to the respondents and their judgement about its validity assessed (Hammersley 1990). Some take this as the litmus test for assessing data quality (Lincoln and Guba 1985). However, it assumes the participants both recognise the relevant facts about their situation and behaviour and are willing to admit to such facts. These features were absent in this particular situation and respondent validation did not quite work out. This is because gender is a deeply rooted force, embedded in the consciousness and determining our sense of selfhood and identity. It is also a contentious, power-related issue. When we shared some of our observations with the villagers, the men in particular did not appreciate the links we made between gendered ideology, behaviour and women's reproductive health. Some felt women really had no problems and that we were giving them ideas, an aspect viewed with alarm.

2.4.6.2 Researcher reactivity

Much has been written about the role of the researcher in ethnography. Obtaining ethnographic information is more than applying the methods, rather the insights are generated through an inductive process in which the researcher interacts with and shares the social world of the people under study. This is achieved by first-hand contact with people as they live out their daily lives. An important implication of this is the effects of the personal and social characteristics of the researcher on the behaviour observed. Although the standard

textbooks advise that the researcher should seek to minimise her/his effect on the behaviour of the people being studied (Hammersley 1990), in practice it is difficult if not impossible to do so. The type of questions we asked reflected our values as well, which try as we might to avoid, are sometimes too deeply embedded. Our values are an aspect of our socialisation that we could not always identify or control. In one instance, my research assistant was discussing a woman's ability to visit her natal family without her mother-in-law's prior approval. This was an ideal opportunity to discover how women manoeuvre around mobility restrictions, but the interviewer's phrasing of the next question reflected a built-in disapproval of women who manoeuvre around the mobility restrictions. The respondent quickly picked up on the disapproval and an opportunity for some interesting information was lost.

As a woman and a doctor, I had reasonably easy access to the village women. I could easily discuss reproductive health related issues and from there gender roles, behaviours and ideology. But at the same time, the same characteristics probably affected women's responses to my questions. Stories are mediated by power relationships. Women may have given answers they felt they should give to a doctor based in western biomedicine or what they may perceive as 'modern' behaviour. My social class and personal attributes may have influenced some explanations for a striking finding in the thesis is an absence of Islam as an explanation for women's and men's roles and behaviours. Also the accounts women gave are filtered through my personal experiences and this may also be a reason for lack of Islamic perspective.

2.5 Limitations of the data

2.5.1 Lack of male perspective. A major limitation of the qualitative data is a lack of depth from the male perspective. Although a male research assistant was hired specifically for the task of accessing the male perspective, we found it difficult to develop rapport with men. The male perspective remained weak because

i) Men were difficult to access. In contrast to women, who were available at home, men would be out to work, visiting friends or travelling.

ii) As a woman (of Pakistani origin), my interaction with the men tended to be misconstrued because it was inconsistent with *purdah* norms. Interaction with men, mostly after focus-group discussions, led to some unwanted familiarity and attention that forced me to withdraw into the female space.

As a result, male perspective of gender issues is based only on in-depth interviews, focus group discussions and women's narratives of their husbands and other men's behaviour. Direct observation and participation in men's day-to-day lives, a method that produced some very rich data about women's lives, is missing. The male research assistant did try to socialise with men in their local hangouts, but this led to offers of 'women' and 'drugs'. He rejected the offers and as a result was excluded from networks that might have produced interesting information about masculinity and men's sexual practices outside marriage.

2.5.2 Limited to one setting. The qualitative data are collected from one setting only. Since gender systems are characteristics of a society (Mason 1995), there is minimal variation in gender ideology at the societal level. A comparison of two locales with differing gender systems (or at least differentials in the extent of gender inequities) might have been a better design to understand societal level factors.

2.5.3 Sensitivity of the subject. Certain topics could not be discussed in greater depth because they were sensitive areas. One such topic was the finding that men in childless marriages were not free to remarry because of the pressure exerted by their wives families and in some case by their own families. This would have been an interesting area to explore women's social resources, but it would have been very insensitive to ask the men why had they not remarried or their brothers for not giving them the necessary permission.

2.6 Ethics

Ethical clearance was obtained from the LSHTM Ethics Committee. The ethical case was based on

a) All the fieldwork will be conducted on a voluntary and informed basis.
b) Confidentially will be respected. Names and identifying details of the respondents will not be included in the recording or the writing up of the research.
c) The participating communities will be provided a feedback after data collection and some analysis has been done.
d) The research conclusions and findings will be made available to the Ministry of Health, Ministry of Population Welfare, UN agencies and NGO's (such as the Marie Stopes International) involved in reproductive health actives in Pakistan. The findings will be published and dispersed so that they will be utilised to inform reproductive health policy in Pakistan.

Chapter 3

Levels and differentials of the direct measures of women's gendered position

The overall objectives of the quantitative data analysis are to:

1. Demonstrate how the different dimensions of women's gendered position vary between different sub-groups of women (according to age, education, type of household, number of sons, work for wages, socio-economic status, province, and rural/urban areas).
2. Explore the associations between these measures and (i) contraceptive and (ii) antenatal care use.

This chapter addresses the first objective while chapter 4 focuses on the second. The form of the chapter is as follows. First, the variations in the six measures of women's gendered position across a range of socio-demographic variables are described. The results are then brought together to discuss the emerging complexities and identify areas that need further exploration.

Findings

3.1 Differentials and levels of the direct measures of women's gendered position

Bivariate and multivariate statistical analyses were carried out to demonstrate how six dimensions of women's gendered position vary according to a range of background socio-demographic characteristics. The six dimensions are:

1. Women's mobility.
2. Women's involvement in decision-making regarding treatment of a sick child, food purchases and clothes purchases.
3. Women's work for wages and control over their income.
4. Husband-wife communication index.
5. Women's exposure to sources of information.
6. Women's health knowledge.

3.1.1 Women's mobility

Three measures of women's mobility were addressed based on the following questions directed to the women in the survey

1) In the last four weeks have you been outside this village/neighbourhood for any purpose in the company of another adult?
2) In the last four weeks have you been outside this village/neighbourhood for any purpose without the company of any adult?
3) If you needed to go to a health clinic or hospital, could you go by yourself or would you need to be accompanied by someone else?

Bivariate analysis

On the whole, the survey data suggest women's mobility in Pakistan is limited, particularly mobility without the company of other adults. Forty eight percent of the women reported that they had travelled in the company of an adult outside the village/neighbourhood in the past four weeks, 18% had travelled alone and 28% said they could travel alone to the health centre if the need arose.

Table A1.1 (Appendix 1) shows the results of bivariate analyses of the associations between various socio-demographic characteristics and the three measures of mobility. Accompanied mobility is positively associated with women's education, a higher socio-economic class, living in a horizontally joint household, residence in the provinces of Balochistan and NWFP and in major urban areas. Unaccompanied mobility and postulated ability to travel alone to a health centre are positively associated with age, women's education, number of living sons, exogamous marriage, living in a nuclear household, higher socio-economic class, residence in Punjab and in major urban areas.

Women's occupation has a complex relationship with their mobility. Working women might be expected to be more mobile than homemakers, but this assumption is not supported by the data. Professional women and homemakers are most likely to report having travelled with company. The professional women are also more likely to report having travelled alone and that they can travel alone to a health centre if a need arose. The majority of women who work in the services or

agricultural industry are even less likely to travel than homemakers. Their employment outside the home is not translated into their increased mobility beyond the village or neighbourhood, whether accompanied or unaccompanied. For example, 93% of women in the agricultural sector and 79% in the services sector work away from home, indicating they leave their homes on a regular basis. Yet, only 22% of the former and 36% of the latter report travel alone outside the village or neighbourhood (results not shown). They were equally unable to go to a health centre if the need arose. Apparently, these women can go to work, which is most likely to be within the village or neighbourhood, but this freedom of travel does not extend to travelling alone outside the village. The fact that they perceive they cannot travel alone to a health centre is interesting for it indicates that in Pakistan, women's employment and income generating ability clearly does not necessarily imply an ability to access health centres alone.

The large variations in the proportions of women answering positively to all three mobility questions in different provinces demonstrates the importance of the wider social context in modulating women's mobility. Women in Balochistan and NWFP are most likely to report accompanied mobility (77% and 79% respectively), while women in Punjab and Sind are less likely to (39% and 48% respectively). In contrast, women in Punjab are more likely to report unaccompanied travel and that they can travel alone to a health centre if necessary followed by women in Sind and NWFP. Women in Balochistan are the least likely to travel without company with only 5% reporting they had travelled alone or can travel alone to a health centre.

Another layer of variation in context is rural-urban location. Overall, women in major urban areas are the most likely to report accompanied mobility, unaccompanied mobility and that they can travel to a health centre alone if the need arises. Although there is little difference in the proportions of women who travel outside the neighbourhood with company or alone between women living in other urban areas and rural areas, women in other urban areas are more likely to report that they can travel alone to a health centre (29% vs. 19%). While this could be reflecting greater access to services in other urban areas, a clearer example of the extent to which context modulates individual behaviour is demonstrated by the mobility of professional women. This small group of women are quite mobile in that over 55% had travelled alone and 72% state they can travel alone to a health facility. Nevertheless, the greater mobility of professional women varies by their residence in rural or urban communities. Seventy eight percent of these women resident in urban areas had travelled alone, while only 35% resident in the rural areas had done so.

Multivariate analysis

In order to investigate further and to estimate the net effect of each background characteristic, a series of multivariate logistic regression models were run for each of the three measures of mobility. Binomial logistic regression was used[1]. The outcome variable was coded 1 if the woman reported: that she had travelled in the company of an adult (Model 1), that she had travelled alone (Model 2); and that she could travel alone to a health centre if the need arose (Model 3). The three series of models are presented together in Table 3.1 in order to compare and contrast the predictors of accompanied and unaccompanied mobility.

Age is a significant predictor of *unaccompanied* mobility. Women aged 40-49 have odds of reporting unaccompanied mobility nearly six times higher than women aged 15-19 (OR=5.77, $p<0.001$). The pattern is similar for women who state they can travel to the health centre if the need arose, although the size of the odds ratios is smaller. However, age is not a significant predictor of women's *accompanied* mobility, indicating women of all ages had travelled with adult company to a similar extent.

The number of living sons a woman has is a predictor of unaccompanied mobility as well as the ability to travel alone to a health centre if the need arose, but not of accompanied mobility. Controlled for age, mothers of sons have odds of reporting unaccompanied mobility 1.5 times higher than women with no sons. Thus, the data support the assertion that both age and sons, essentially life cycle related characteristics, independently enable women to overcome gender-related mobility restrictions.

In contrast, the acquired characteristics, education and employment, are not as strongly associated with an increase in reports of travel without company. Education is a significant predictor for accompanied mobility, but not of unaccompanied mobility. As seen in Table 3.1, women with secondary or greater than secondary education are more likely to have travelled outside the village or neighbourhood in the company of another adult than women with no education (OR=1.52, $p<0.05$).

[1] For details of regression methods, see Appendix 4.

However, women with greater than secondary education report they can travel alone to a health centre if the need arose more commonly than women with no education (Column 3, Table 3.1). This points to the possibility that highly educated women feel they can travel alone if the need arose, although routinely they do not travel alone.

Employment has a complex relationship with both accompanied and unaccompanied mobility. Women working in the services and agricultural industry are less likely to have travelled accompanied compared to housewives. However, Model 2 indicates that these women are no more likely to have travelled alone. The only exception are the professional women who have odds of reporting unaccompanied mobility four times higher than non-workers. They are also more likely to report they can travel to a health centre if the need arises compared to the non-workers (OR=5.3, $p<0.001$). In sum, for the majority of women, work for wages controlled for socio-economic status, does not translate into increased mobility outside the village, whether it is accompanied or unaccompanied. It does not even translate into a perception that they can travel to a health centre if the need arose.

Socio-economic status is an independent predictor of accompanied mobility. However, only 'rich' women report significantly greater accompanied mobility than the baseline category 'poor'. In contrast, there is no significant variation in women's unaccompanied mobility by socio-economic class, indicating women of all socio-economic groups are equally likely or unlikely to travel without company.

Type of marriage is an independent predictor of unaccompanied mobility. Women who are married to men to whom they are not related by blood are significantly more likely to report both having travelled without company and that they can travel alone to a health centre if the need arose (OR=1.27, $p<0.05$). The type of household structure is significant only in Model 3. Women living in vertically joint households are significantly less likely to travel alone to a health centre if the need arose compared to women who live in nuclear households (OR=0.70, $p<0.00$).

The role of the wider social context in determining women's mobility is demonstrated by the large differentials in coefficients of province in Model 2 (for unaccompanied mobility). The largest after age, these coefficients demonstrate the importance of the context in modulating women's mobility, particularly unaccompanied mobility. Women in Punjab, Sind and NWFP have odds of reporting travel without company three to four times higher than women in

Balochistan. At the same time, women in these provinces, particularly Punjab and Sind are significantly less likely to travel accompanied compared to women in Balochistan (OR=0.17, $p<0.00$ and OR=0.22, $p<0.01$). Women in Punjab are also more likely to state they can travel to a health centre if the need arose compared to women in Balochistan.

The rural-urban context is also a significant determinant of women's mobility. Women in major urban areas are more likely to report travel without company. They are also more likely to state they can travel alone to health centre if the need arose compared to women in rural areas. There are no significant differences between 'other urban' and rural areas in any of the three different types of women's mobility patterns.

In sum, the quantitative data support the assertion that life-cycle related characteristics, such as age and number of sons, are associated with increased travel without company, while acquired characteristics, such as education or employment do not unequivocally translate into increased unaccompanied mobility. The wider social context, in terms of rural-urban and provincial area, also plays an important role in modulating woman's mobility. Furthermore, the diverse patterns of association seen for accompanied mobility and unaccompanied mobility suggest that these two indicators are capturing distinct forms of female behaviour rather than measuring actions on a continuum of increasing 'freedom of movement' (from no movement, through accompanied movement, to unaccompanied movement) as I suspect was postulated during the original framing of the questions.

Table 3.1 Binomial logistic regression models of the predictors of the three measures of mobility, currently married women (15-49), PFFPS 1996-97[1]

	Dependent variables		
	Travelled in company of an adult (Model 1)	**Travelled alone (Model 2)**	**Can travel alone to a health centre (Model 3)**
	Odds ratio	Odds ratio	Odds ratio
Independent variables[2]			
Women's age			
15-19		1.0	1.0
20-29	NS	2.14**	2.09
30-39		3.98***	4.03***
40-49		5.77***	4.44***
Women's education			
None	1.0		1.0
Primary	0.99	NS	1.20
Secondary	1.52*		1.27
Above secondary	1.71		2.35*
No. of living sons			
0			1.0
1-2	NS	1.53**	1.46**
3+		1.38	1.62***
Occupation			
Homemaker	1.0	1.0	1.0
Professional	0.94	4.3***	5.25***
Agricultural	0.44*	0.65	0.51
Services	0.71	0.71	0.70
Cottage industry	0.65**	1.46	1.22
Type of marriage			
Husband–wife related	NS	1.0	1.0
Husband-wife not related		1.27*	1.27*
Household structure			
Nuclear			1.0
Vertically joint	NS	NS	0.70***
Horizontally joint			0.51
SE status			
Very poor	1.12		
Poor	1.0		
Lower middle	1.17	NS	NS
Upper middle	1.30		
Rich	1.60*		
Province			
NWFP	0.86	3.69***	2.00*
Punjab	0.17***	4.34***	5.16***
Sind	0.22**	3.38***	1.97*
Balochistan	1.0	1.0	1.0
Rural/urban residence			
Major urban	1.12	1.72**	2.19***
Other urban	0.87	0.91	1.23
Rural	1.0	1.0	1.0

[1] N (weighted) = 7577.

[2] Variables retained in the final model on basis of Likelihood Ratio Test on unweighted data (α =0.05).

*** p<0.001, ** p <0.01, * p<0.05.

3.1.2 Women's involvement in decision-making

Women's involvement in decision-making was measured in the three following domains

1. Treatment of a sick child
2. Purchase of food
3. Purchase of personal clothing

Women's level of involvement in the decisionmaking process is categorised as an ordinal variable ranging from complete exclusion from the decision-making process to participation but not making the final decision, then making the final decision jointly with husband and the women making the final decision alone.

Bivariate analysis

Overall, large proportions of women report that they participate in the decision-making process under question (90% for child health related decisions, 85% for food purchase and 88% for clothes purchase). However, only about 30% of women report themselves as the final decision-makers regarding treatment of a sick child and food purchases and about 50% regarding clothes purchases. Furthermore, amongst the women who make the final decisions, the majority do so jointly with their husbands.

Tables A1.2, A1.3 and A1.4 in Appendix 1 show the bivariate relationships between women's decision-making regarding child's health, food purchase and clothes purchases and their background characteristics. Despite concerns discussed in chapter 2 regarding collection of such illusive information, a distinct pattern emerges in the responses women gave to the three questions. It therefore seems reasonable to analyse responses to these questions further.

Women's age, their education, number of living sons, employment in a professional capacity, living in a nuclear household, and a higher socio-economic status are all positively associated with making the final decision jointly with their husbands in all the three decision-making domains. More importantly, there is a distinct trend between each of these variables and the level of involvement in the decision-making process in all three domains. With increasing age, education, number of living sons, and improving socio-economic status, there is a decline in the

proportion of women who are completely excluded from the decision making process and in the proportion of women who report participation without making the final decision.

At the same time, the proportions of women who report making the final decisions jointly with their husbands increases as does the proportion of women who make the final decisions alone. In other words, increasing age, education, number of sons and socio-economic status leads to greater involvement in the decision-making processes with a greater probability of making the final decisions. It is worth noting that the women who work for wages, particularly in the agricultural and services industry, are more likely to report complete exclusion from the decision-making process, or only participation without making the final decisions compared to housewives (in all three domains). Furthermore, they are less likely to report making the final decisions jointly with their husbands or alone, particularly in the food purchase domain.

Overall, only a small proportion of women make the final decisions *alone* in all three domains. The only exception are the rich and professional women, who are more likely to report making the final decisions alone, particularly regarding food purchases.

Women's role in the decision-making process also varies by province and rural-urban residence. The proportion of women completely excluded from the decision-making process (in all three domains) is the lowest in Punjab and highest in Balochistan, with Sind and NWFP falling in between. At the same time, the proportion of women who make the final decision jointly with their husbands is the largest in Punjab and smallest in Balochistan.

The rural-urban trend is similar to the pattern discussed above. In all three domains, proportions of women completely excluded from the decision-making process is the smallest in major urban areas and largest in rural areas with women in other urban areas falling in between. At the same time, the proportion of women who make the final decisions jointly with their husbands is the largest in major urban areas and least in rural areas. Although the general trend is the same for all three domains, a much higher proportion of women report making the final decisions alone for clothes purchases compared to food purchases or treatment of a sick child.

Multivariate analysis

Several of the above factors are obviously related. In order to investigate the effect of each socio-demographic predictor on woman's level of involvement in the decision-making processes, regression analysis was carried out. Multinomial regression methods[2] are used because the dependent variable is polytomous. In addition, these methods allow each category of outcome to be analysed separately. This separation is important for our understanding of types of decision-making patterns that are more relevant in the Pakistani context, particularly the differences between joint and final decision-making. The outcome variables are the four categories reflecting the differing levels of involvement. Women who do not participate in the decisions at all are the reference category. The three models are presented in Tables 3.2, 3.3 and 3.4.

In all three models, the most significant predictors of women's level of involvement in decision-making are her age, and province. Age emerges as the single-most important predictor of the level of women's involvement in making decisions regarding child treatment, food purchases and clothes purchases. With increasing age, there is a gradual shift with women less likely to be simple participants and more likely to be the final decision-makers, both jointly with their husbands and alone. The pattern comes out particularly sharply in child-health related decisions, although the trend is the same in all three domains. The odds that women aged 40-49 report making the final decision regarding treatment of a sick child is 32 times greater than be non-participants (compared to women aged 15-19).

The second most important predictor of women's level of involvement in decision-making is the context in which the women are located. Across all three decision-making domains, women in Punjab are the most likely to make the final decisions jointly with their husbands and make the final decisions alone than be non-participants (compared to women in Balochistan). Women in Punjab are particularly more likely to make the final decisions alone in child-health and food purchase domains than be non-participants. This trend is followed by Sind and NWFP. Although there are minor variations in the size of the coefficients, women in Sind and NWFP are similar in their patterns of involvement in decision-making in the three domestic domains. In other words, women in Sind and NWFP are more or less equally likely to participate but not make the final

[2] For details of multinomial regression methods, see Appendix 4.

decision, make the final decisions jointly with husband and make the final decisions alone than be non-participants (compared to women in Balochistan). It is worth noting that the large size of the coefficients, particularly of Punjab, is not because large proportions of women in Punjab are making the final decisions, but because an extremely small proportion of women in Balochistan (around 5%) are involved at all in the decision-making processes. Nonetheless, the findings support the assertion that the Punjab context allows a greater involvement of women in these three domestic domains, followed by Sind and NWFP together. In contrast, the Balochistan context sees women largely excluded from decision-making in these three domestic domains.

The rural-urban context is also important. Women in major urban areas have odds of making final decisions alone regarding food and clothes purchases two times higher than be non-participants (compared to women in rural areas). However, during the model-building process, the size of the coefficients reduced to mostly non-significant levels once province was added to the model indicating province is a more important contextual determinant of women's level of involvement in decision-making than rural-urban area.

Household structure is also an important predictor of the level of women's involvement in decision-making, particularly of food purchases and to a smaller extent, of child health and clothes purchases. Women living in joint families, (both vertically and horizontally joint)[3], are significantly *less* likely to make the final decisions regarding food purchases, either jointly with their husbands or alone than be non-participants (compared to women living in nuclear families). They are even less likely to simply participate without making the final decisions than be non-participants (compared to women living in nuclear families). In other words, women who live in joint household are significantly more likely to be completely excluded from decision-making regarding food purchases. The patterns are similar for child-health decision-making based on the size of the coefficients, but they are not significant.

The effect of the number of living sons on a woman's involvement in decision-making varies by the domain under consideration. The variable is not significant in the child-health model (based on the Wald statistic and Likelihood Ratio Test on unweighted data) and was therefore not

[3] Vertically joint families consist of two or more generations living together, while horizontally joint families consist of brothers or other relatives living together. See chapter 2 for details.

included in the model. It is significant in the food and clothes purchase models (Table 3.3 & Table 3.4), but its effect varies between the two domains. Women with sons are more likely to make the final decisions regarding food purchases jointly with their husbands and even alone than be non-participants (compared to women who have no sons). In contrast, the pattern is more complex in the clothes purchase model, which shows women with sons are less likely to participate without making the final decision than be a non-participant (compared to women with no sons). In other words, they are more likely not to participate compared to women with no sons. This counter intuitive finding is difficult to explain.

The effect of women's education on their involvement in decision-making also varies by the domain under consideration. For child-health related decisions, the level of women's education is important. Only women with a secondary education are more likely to make the final decision, jointly or alone, than be non-participants (compared to women with no education). Similarly educated women are more likely to make final decisions (jointly with husband or alone) regarding clothes purchases than be non-participants (compared to women with no education). However, women's education does not have similar associations with their level of involvement in food purchase decisions. Only those with *greater* than secondary education are significantly more likely to make the final decisions in this domain, that too jointly with their husbands, than be non-participants (compared to women with no education).

Tables 3.2, 3.3 and 3.4 show that women's employment (including in a professional capacity) does not lead to a greater involvement in the decision-making process in these three domains in Pakistan. In fact, women who work in the agricultural industry are less likely to participate or make the final decisions than be non-participants (compared to homemakers). Closely related is women's socio-economic status. While there is little variation in the women's involvement in decision-making by socio-economic status, rich women are more likely to be the final decision-makers in the child-health and food purchase domains than be non-participants (compared to the poor women).

To summarise, age and structure of the household are the most important individual level predictors of the extent to which a woman is involved in decisions in the three domestic domains addressed in the survey. The context, as captured by province, is an equally important determinant, indicating how important the wider social context is in determining individual level behaviour within the household. Women's education too is significant, but the effects become

apparent only at higher levels of education. Women's employment on the other hand fails to make any impact on their involvement in decision-making in these domestic domains at least.

Table 3.2 Multinomial logistic regression model of socio-demographic predictors of women's level of involvement in decision making process regarding treatment of a sick child, currently married women (15-49), PFFPS 1996-97[1]

Dependent variable	Compared to reference category of women who did not participate in the decisions at all		
	Women participated but did not make the final decision	Women made the final decision, but jointly with husband	Women made the final decision alone
	Odds ratio	Odds ratio	Odds ratio
Predictors[2]			
Women's age			
15-19	1.0	1.0	1.0
20-29	1.21	3.05**	11.2**
30-39	1.61	6.51***	23.8***
40-49	2.24**	7.63***	32.2***
Women's education			
None	1.0	1.0	1.0
Primary	1.48	1.61	1.66
Secondary	2.19*	3.46*	3.77**
Above secondary	2.60	4.32*	2.38
Women's occupation			
Homemaker	1.0	1.0	1.0
Professional	0.82	1.71	2.67
Services	1.20	0.57	1.05
Agriculture	0.94	0.77	0.35*
Cottage industry	0.97	0.90	1.01
Household structure			
Nuclear	1.0	1.0	1.0
Vertically joint	0.97	0.59**	0.76
Horizontally joint	0.78	0.66	0.80
SE status			
Very poor	1.17	0.88	0.71
Poor	1.0	1.0	1.0
Lower middle	1.29	1.25	1.32
Upper middle	0.86	0.85	0.47
Rich	1.85	2.42	3.10*
Province			
NWFP	6.79***	6.88***	8.89***
Punjab	6.93***	19.3***	19.72***
Sind	4.01***	7.75***	8.33***
Balochistan	1.0	1.0	1.0
Rural/urban residence			
Urban	0.61	1.16	1.5
Other urban	0.78	0.97	1.07
Rural	1.0	1.0	1.0

[1] N (weighted) = 6566.

[2] Variables retained in the final model on basis of Likelihood Ratio Test on unweighted data (α =0.05).

*** p<0.00, ** p <0.01, * p<0.05.

Table 3.3 Multinomial logistic regression model of the socio-demographic predictors of women's level of involvement in decision-making regarding food purchases, currently married women (15-49), PFFPS 1996-97[1]

Dependent variable	Compared to reference category of women who did not participate in the decisions at all		
	Women participated but did not make the final decision	Women made the final decision, but jointly with husband	Women made the final decision alone
	Odds ratio	Odds ratio	Odds ratio
Predictors[2]			
Women's age			
15-19	1.0	1.0	1.0
20-29	1.39	1.87	2.87*
30-39	1.46	3.56**	5.88**
40-49	1.49	3.90**	8.27***
Women's education			
None	1.0	1.0	1.0
Primary	0.99	1.10	1.22
Secondary	1.38	1.57	1.63
Above secondary	1.73	2.60*	1.62
Women's occupation			
Homemaker	1.0	1.0	1.0
Professional	0.64	0.79	1.03
Services	2.15	0.88	1.07
Agriculture	0.70*	0.29**	0.27**
Cottage industry	1.16	0.92	1.27
No. of living sons			
None	1.0	1.0	1.0
1-2	1.20	1.52*	1.62*
>3	1.30	1.63*	1.32
Household structure			
Nuclear	1.0	1.0	1.0
Vertically joint	0.58***	0.28***	0.39***
Horizontally joint	0.51***	0.34***	0.34***
SE status			
Very poor	1.13	0.97	0.62
Poor	1.0	1.0	1.0
Lower middle	1.06	1.03	0.80
Upper middle	1.10	0.94	0.65
Rich	1.46	2.65	2.48
Province			
NWFP	5.71***	6.79***	6.94***
Punjab	6.42***	6.93***	22.7***
Sind	3.66***	4.02***	8.83***
Balochistan	1.0	1.0	1.0
Rural/urban residence			
Major urban	0.64	1.50	1.96*
Other urban	1.03	0.90	1.23
Rural	1.0	1.0	1.0

[1] N (weighted) = 7577.

[2] Variables retained in the final model on basis of Likelihood Ratio Test on unweighted data (α =0.05).

*** p<0.00, ** p <0.01, * p<0.05.

Table 3.4 Multinomial logistic regression model of the socio-demographic predicators of levels of women's involvement in decision-making regarding clothes purchases, currently married women (15-49), PFFPS 1996-97[1]

Dependent variable	Compared to reference category of women who did not participate in the decisions at all		
	Women participated but did not make the final decision	Women made the final decision, but jointly with husband	Women made the final decision alone
	Odds ratio	Odds ratio	Odds ratio
Predictors[2]			
Women's age			
15-19	1.0	1.0	1.0
20-29	1.36	2.53***	3.09***
30-39	1.52*	3.54***	5.60***
40-49	1.70*	3.83***	7.45***
Women's education			
None	1.0	1.0	1.0
Primary	0.98	1.34	1.60**
Secondary	1.34	2.37**	2.22***
Above secondary	1.67	3.81**	3.98***
Women's occupation			
Homemaker	1.0	1.0	1.0
Professional	0.42	0.41	0.63
Services	0.81	0.68	0.58
Agriculture	0.59	0.51*	0.47*
Cottage industry	0.91	0.89	1.27
No. of living sons			
None	1.0	1.0	1.0
1-2	0.73*	0.98	0.97
>3	0.66*	0.86	0.79
Household structure			
Nuclear	1.0	1.0	1.0
Vertically joint	0.75	0.61***	0.65***
Horizontally joint	0.64*	0.59	0.48**
SE status			
Very poor	1.07	0.90	0.57**
Poor	1.0	1.0	1.0
Lower middle	0.99	1.19	1.07
Upper middle	1.02	1.49	0.91
Rich	0.98	1.69	1.13
Province			
NWFP	5.83***	5.54***	1.61
Punjab	4.38**	14.7***	3.57***
Sind	4.11**	7.05***	1.96
Balochistan	1.0	1.0	1.0
Rural/urban residence			
Urban	0.63	1.13	1.98*
Other urban	1.01	1.22	1.53*
Rural	1.0	1.0	1.0

[1] N (weighted) = 7577.

[2] Variables retained in the final model on basis of Likelihood Ratio Test on unweighted data (α =0.05).

*** p<0.001, ** p <0.01, * p<0.05.

3.1.3 Access to financial resources

Access to financial resources is addressed in the present analysis by analysing women's participation in work for wages and their retention of the money earned (keep all, some or none).

Bivariate analysis

Table A1.5, Appendix 1 demonstrates the bivariate relationships between women's access to financial resources (not working, working and keeping all their money, some or giving all away) and socio-demographic characteristics. The most striking finding is the very high level of economic dependency. Over 80% of women report that they do not work for wages. This group consists largely of homemakers, but also includes a small number of women who work in home-based family enterprises for which they are not paid.

On the whole, there is little variation in the proportion of women who work for wages by age, type of marriage, numbers of surviving sons, husband's occupation or household structure or rural urban residence. The variable husbands occupation is analysed only for this dimension of women's gendered position because in a context of normative male provision and female dependency, there may be a relationship with women's work for wages. Poorer women, women with no formal education and those living in Sind province are more likely to work for wages while educated women, women whose husbands work in the agricultural industry and women who live in Balochistan and NWFP are less likely to work for wages.

Amongst working women, there is little variation in the socio-demographic characteristics of women who keep all their money, those who give some away and those who give all away. Nonetheless, there are some variations such as the finding that the very poor are more likely to give away all their wages (51%) compared to the rich (28%) (results not shown). This would be expected since in poor households, women's wages are likely to be a critical addition. Highly educated women (above secondary education) are also more likely to keep all their wages than give all away.

As several of these variables are obviously correlated, multivariate logistic regression was employed to separate the effect of each independent variable. Two sets of models were run, one for women's work for wages and one for their control over their income.

Multivariate analysis

Women's work for wages

Table 3.5 shows the results of a binomial logistic regression model with women's current work for wages (yes or no) as the outcome variable. Women's education, husband's occupation, household socio-economic status and province are significant predictors of women's employment. The relationship between women's education and their employment is very interesting. It follows a J-shaped curve. Women with no formal education and those with greater than secondary education are the most likely to work for wages, while those with primary or secondary education are less likely. However, it is worth noting that only 6% of women have received a college education and amongst them, only 19% work for wages. The coefficients of this group of women are also of borderline significance (p=0.058).

Husband's occupation is a significant variable in the final model, but there is, with one exception, no relationship between husbands occupation and the women's work for wages. The exception is husbands work in the agricultural industry. Women whose husbands work in the agricultural industry have odds of working that are twice those of women whose husbands work as labourers. Since this is controlled for socio-economic status of the household, one explanation for the finding could be that land ownership in Pakistan is very skewed, with a few feudals owning most of the agricultural lands. Consequently, a majority of the people work on these farms as tenants or hired labour. In both cases, in view of very small wages, all family members tend to work.

The socio-economic status of the household is an important predictor of women's work for wages. Women who belong to the very poor and poor households are most likely to work. With improving socio-economic status, the coefficients become negative (test of trend $p<0.05$). The major conclusion from Table 3.5 is that poverty is a strong predictor of women's work for wages.

The wider social context is also important. Women in Punjab and Sind are more likely to work for wages compared to women in Balochistan and NWFP. During the model-building process, addition of the variable province to the model reduced the coefficients of education, particularly of women with greater than secondary education, indicating that the two are related.

Control over income

This analysis is limited to the 1,457 women (weighted) who report working for wages. Table 3.6 shows the results of a binomial logistic regression model with women's control over their income as the outcome variable. It is categorised as 1= women keep all their money or some of it, and 0 = women give all their money away. The lack of variability between whether women keep all / some of their money or give it all away by various background characteristics and a small sample size has resulted in a parsimonious model with only three significant covariates, husband's occupation, household socio-economic status and province.

Table 3.6 shows that with one exception, women's control over their income has no relationship with their husband's occupation. Irrespective of husband's occupation, women are equally likely to keep their money / give some away or give all away. However, women whose husband's work in the agricultural industry are more likely to give all their wages away. One explanation for this could be that where the whole family works on large feudally owned lands, the wages of the family labour may be paid to the heads of the households, which in most cases are men.

The very poor women are more likely to give away all their wages compared to the poor. This would be expected since their wages are probably essential for household survival. What is more interesting is that rich and upper middle-class women are as likely to keep their money or give it all away as the poor women. Since the wages of the rich women are probably not essential for household survival, this suggests that other social and possibly gender-related norms are responsible for these women's behaviours.

The pattern of women's control over income by province is interesting. Women in Punjab and Sind are less likely to keep the money they earn compared to women in Balochistan. The obvious conclusion would be that women in Balochistan have greater control over the income they earn. However, it may not be valid to draw any conclusions because there are only 23 women in the sample who work for wages in Balochistan. These 23 women may be a very select group of women, perhaps abandoned or their husband's are not in employment.

To summarise, the data suggest that Pakistan is a context in which poverty is the primary force pushing women to work for wages. Controlled for household socio-economic status, only women with no formal education or women with greater than secondary education work for wages.

Punjab and Sind are contexts in which, controlled for socio-economic status, women are more likely to work compared to Balochistan.

Women's control over their income shows minimal variation and only three socio-demographic characteristics predict whether a woman will keep her wages or give all away. Poor women, women whose husbands work in the agricultural industry and women living in Punjab and Sind are significantly more likely to give away all their wages. Overall, women are equally likely to keep all their money, some or give all away irrespective of their age, education, type of employment, type of marriage and household structure.

Table 3.5 Binomial logistic regression model of the socio-demographic predictors of women's work for wages, currently married women (15-49), PFFPS 1996-97[1]

	Dependent variable: women's work.	
	Odds Ratio	**95% CI**
Predictors[2]		
Education		
None	1.0	-
Primary	0.65*	0.47, 0.90
Secondary	0.77	0.48, 1.24
Above secondary	1.69*	0.66, 1.53
Husbands Occupation		
Professional	1.00	0.66, 1.52
Services	1.38	0.90, 2.10
Agriculture	1.92**	1.37, 2.67
Labourer	1. 0[rc]	-
Others	1.00	0.42, 2.58
Socio-economic status		
Very poor	1.15	0.81, 1.64
Poor	1. 0	-
Lower middle class	0.63**	0.48, 0.82
Upper middle class	0.30**	0.18, 0.50
Rich	0.32**	0.15, 0.75
Province		
NWFP	1.00	0.51, 1.98
Punjab	5.63**	2.73, 11.6
Sind	9.39**	4.72, 18.7
Balochistan	1. 0	-

[1] N (weighted) = 7577.

[2] Variables retained in the final model on basis of Likelihood Ratio Test on unweighted data (α =0.05).

*** p<0.001, ** p <0.01, * p<0.05.

Table 3.6 Binomial logistic regression model of the socio-demographic predictors of women's control over their income, currently married women (15-49), PFFPS 1996-97[1]

	Dependent variable: women's control over their income	
	Odds ratio	**95% CI**
Predictors[2]		
Husbands Occupation		
Professional (labourer)	0.93	0.58, 1.47
Services	0.72	0.50, 1.04
Agriculture	0.46***	0.34, 0.62
Labourer	1.00[rc]	-
Others	0.88	0.33, 2.37
Socio-economic status		
Very poor	0.51***	0.39, 0.68
Poor	1.00[rc]	-
Lower middle class	1.16	0.83, 1.61
Upper middle class	1.22	0.68, 2.20
Rich	0.59	0.31, 1.13
Province		
NWFP	0.54	0.26, 1.11
Punjab	0.54**	0.32, 0.92
Sind	0.48**	0.29, 0.80
Balochistan	1.00[rc]	-

[1] Analysis limited to 1,457 women who work for wages.
[2] Variables retained in the final model on basis of Likelihood Ratio Test on unweighted data (α =0.05).
*** p<0.001, ** p <0.01, * p<0.05.

3.1.4 Communication with husband

The 'communication with husband' index is based on women's report of whether they discussed family planning issues with their husbands in the past one year, their husband's approval of couples using a method to avoid a pregnancy and whether the husband's desired family size is the same as hers. The index score ranges from 0-4 (see chapter 2).

Overall, women's communication with their husbands is rather limited with a mean score of 2.2 (range 0-4). Bivariate analysis show that the score improves slightly with increasing age, education, number of living sons and the socio-economic status of the household (See Table A1.6, Appendix 1).

Table 3.7 shows the results of a linear regression model carried out to identify socio-demographic characteristics predictive of husband-wife communication. Linear regression was carried out because the outcome variable, the communication index score, is a continuous variable. The final model suggests age, woman's education, marriage to a non-relative, women's occupation, her household socio-economic status, household structure, and province are all significant predictors of communication with husband as measured in this study.

Women's communication with their husbands peaks in the age group 20-29, then tapers off. The likely explanation for this pattern relates to the fact that the communication index is based on questions regarding the couple's discussion about family planning and desired family size. Young couples in the early stages of their family building careers may not discuss these issues at any great length. Couples are most likely to discuss family size and related issues when women are in the peak of their reproductive careers. Communication then seems to taper off in the 30-39 years age group. The older women in the 40-49 age group, who are at the end of their child-bearing years discuss these issues even less than women aged 15-19, presumably because it is no longer a relevant issue for them.

The number of living sons is positively associated with the communication index. This finding indicates that once a couple have sons, they are more likely to discuss family planning issues compared to couples who do not have a living son.

Women's education is an important predictor of communication with husband index. Increasing education leads to better communication and the trend starts with as little as primary education
The type of marriage is also important. Couples not related by blood have better communication than couples who are related by blood ties. Women living in joint families, have lower communication index scores than couples who live as a nuclear family. Interestingly, women who live in vertically joint families are the least likely to communicate with their husbands pointing to the possibility that the presence of parents-in-law acts a barrier to greater inter-spousal communication.

The household socio-economic status has a positive relationship with communication index. The very poor women have the worst scores. Improving socio-economic status is associated with higher scores, which taper off slightly in the rich. Employment, for most women, has no

relationship with their communication index scores, with the exception of women who work in the agricultural industry. They have significantly lower scores compared to the homemakers.

The larger social context is an important predictor of the communication index. Women in NWFP, Punjab and Sind all report greater communication with their husbands compared to women in Balochistan.

To summarise, husband-wife communication is positively associated with

1. Age.
2. Number of sons.
3. Woman's education.
4. Nuclear household.
5. Marriage to a non-related individual.
6. Higher socio-economic status.
7. Provinces of NWFP, Punjab and Sind.

Table 3.7 Linear regression model of the socio-demographic determinants of wife-husband communication index score, currently married women (15-49), PFFPS 1996-97[1]

	Dependent variable: Communication index	
	Beta-coefficient	**95% confidence limits**
Predictors		
Women's age		
15-19	rc	-
20-29	0.17**	0.07, 0.27
30-39	0.10	-0.01, 0.21
40-49	- 0.10	- 0.22, - 0.16
No of living sons		
None	rc	-
1-2	0.43***	0.36, 0.49
3+	0.68***	0.60, 0.76
Women's education		
None	rc	-
Primary	0.27***	0.17, 0.36
Secondary	0.49***	0.30, 0.51
Above secondary	0.55***	0.35, 0.73
Type of marriage		
Husband –wife related	rc	-
Husband-wife not related	0.16***	0.06, 0.17
Women's occupation		
Homemaker	rc	-
Professional	0.15	- 0.05, 0.35
Agricultural	- 0.39***	-0.54, - 0.24
Services	0.01	- 0.09, 0.12
Cottage industry	0.08	- 0.01, 0.18
Household structure		
Nuclear	rc	-
Vertically joint	- 0.15***	- 0.20, -0.09
Horizontally joint	- 0.06	-0.16, 0.04
SE status		
Very poor	- 0.27***	- 0.33, -0.20
Poor	rc	-
Lower middle	0.23***	0.16, 0.29
Upper middle	0.34***	0.23, 0.43
Rich	0.23***	0.08, 0.36
Province		
NWFP	0.47***	0.39, 0.55
Punjab	0.32***	0.24, 0.40
Sind	0.16***	0.08, 0.23
Balochistan	rc	-

[1] N (weighted) = 7577.
*** p<0.001, ** p <0.01, * p<0.05.
rc = reference category.

3.1.5 Exposure to information

The 'exposure to information index' is based on women's report of whether and how frequently they listen to the radio, watch TV, read the newspaper and if they can read and write a letter. The index score ranges from 0-12 (see chapter 2).

Overall, Pakistani women's exposure to information is rather limited with a mean score of 3.45. Nearly 30% of the women never listen to the radio, watch TV, read the papers or communicate via letters. On the other end of the scale, about 10% are regularly exposed to the outside world through the radio, TV and newspapers. However, a breakdown of the exposure index indicates that 60% of the women occasionally watch TV and 50% listen to the radio. In Pakistan TV ownership rates (44% of households own a TV) are relatively high compared to other poor countries (Mitra, Al-Sabir, Saha and Kumar 2001).

Table 3.8 shows the results of a linear regression model with the exposure to index score as the outcome variable. Education emerges as the most important determinant of exposure to information. Bivariate analysis showed that women with no education have a mean exposure score of 1.99 that jumps to 6.82 for women with primary education and over 8 for those with secondary or greater than secondary education (Table A1.7, Appendix 1). The trend remains the same in the final multivariate model after adjusting for a range of potential confounders. The importance of education can be gauged from the fact that education alone explained nearly 60% of the variation in the model (R-squared=0.59). However, it is worth noting that over 75% of the women had received no formal education and only 9% had received secondary education, so only a small proportion of women are exposed to information through an ability to read. In other words, the effect of education on exposure to information is large, but not very important on a population-wide basis.

Socio-economic status is also an independent predictor of exposure to information. Access to a television (and electricity) are functions of socio-economic status. The very poor group's lack of exposure to the larger world could just as likely be constrained by lack of access to the medium through which the information exposure takes place as by gender norms and rules. Poor men are possibly equally likely to have as little exposure as poor women.

Women's occupation lost significance and is not included in the final model. The bivariate analysis show homemakers have larger exposure to information scores than women who

work, the only exception being the small numbers of professional women (Table A1.7, Appendix 1). The likely explanation for this loss of significance is that the type of work most women do, such as working as agricultural workers or in the services industry does not translate into increased TV viewing, listening to a radio or an ability to read the newspaper. The number of sons is significant in the final model, but it seems women with sons are less likely to be exposed to sources of information than women with no sons. The number of sons is related to women's age, which lost significance when the variable 'total number of living sons' was added to the model, indicating the two are related. Bivariate analysis also show that older women (40-49) are less likely to be exposed to sources of information (Table A1.7, Appendix 1). Together these two findings lend support to the assertion that watching TV, listening to the radio and ability to read maybe a cohort effect with younger women (with exception of the very young, 15-19) more likely to watch TV, listen to the radio and be able to read.

Women's exposure to the outside world varies by province and rural - urban areas. Women in Sind, and NWFP have significantly higher levels of exposure to information, followed by women in Punjab (compared to women in Balochistan). Similarly, women in urban areas have a higher exposure than rural areas. Again, as discussed above, one explanation for Balochistan's very low levels could be the limited availability of electricity, TV and radios. Only 52% of the households in Balochistan have electricity and 22% a television compared to Punjab (the most developed province) in which 80 % of households have electricity and 44% a TV. However, this pattern remains true after controlling for socio-economic status and education, suggesting that women's access to TV or the radio are possibly also restricted by gender norms and behaviours.

To summarise, exposure to information is positively associated with

1. Women's education.
2. High socio-economic status.
3. No sons.
4. Provinces of Sind, NWFP and Punjab (in that order).
5. Major urban area.

Table 3.8 Linear regression model of the socio-demographic predictors of exposure to information index score, currently married women (15-49), PFFPS 1996-97[1]

	Dependent variable: Exposure to Information	
	Beta coefficient	**95% confidence interval**
Predictors		
Education		
None	rc	-
Primary	4.11***	3.97, 4.26
Secondary	5.37***	5.21, 5.54
Above secondary	4.95***	4.73, 5.18
No. of living sons		
None	rc	-
1-2	- 0.21***	-0.31, -0.10
>3	- 0.19**	-0.31, -0.08
SE status		
Very poor	- 1.14***	-1.25, -1.02
Poor	rc	-
Lower middle	1.63***	1.52, 1.75
Upper middle	2.10***	1.94, 2.28
Rich	1.03***	0.70, 1.26
Province		
NWFP	0.86***	0.64, 1.07
Punjab	0.38***	0.18, 0.58
Sind	0.99***	0.77, 1.20
Balochistan	1.0	-
Area		
Major urban	0.45***	- 0.60, -0.30
Other urban	0.04	-0.17, 0.09
Rural	rc	-

[1] N (weighted) = 7577.
rc= Reference category.
*** p<0.001, ** p <0.01, * p<0.05.

3.1.6 Reproductive health knowledge

The reproductive health knowledge index is based on women's knowledge of the pill, condom, IUCD and injections, where to obtain them, whether contraceptive methods have side-effects and when during the menstrual cycle a woman has the greatest chance of becoming pregnant. The index score ranges from 0-10 (see chapter 2).

Overall, women scored reasonably well on our measure of reproductive health knowledge, with a mean score of 5.24 (on a scale of 0-10). The past decade has seen concerted efforts to inform the population about family planning through health education media campaigns. Forty six percent of

the women had heard about family planning messages on TV and one in three women had heard a family planning message on the radio.

Table 3.9 displays the results of a linear regression model with knowledge index as the dependent variable. Overall, the predictors of knowledge index are similar to those of the exposure to information index. Education is important. Even five years of primary education significantly increases women's knowledge of reproductive health issues compared to women with no formal education, while women with greater than secondary education have the highest scores. Closely related, socio-economic status has an independent and linear relationship with health knowledge score. The 'very poor' score the least and the 'rich' the most. Both, sources of exposure to information (e.g. a TV) and education are direct functions of economic resources.

Age also emerges as a significant predictor of reproductive health knowledge. The youngest group of women (15-19) have the lowest scores, which then increase with age. This trend reflects the tradition of not discussing sex, sexuality and related reproductive health matters with young women (Khawer and Rauf 1997), despite the fact that in this sample the young women are married women. It could also be a perceived lack of need for family planning information since they have few children at this stage of family formation. Type of marriage, household structure and the number of sons are significant predictors of health knowledge. Women married to men who are not related by blood and those who live in nuclear families have significantly better knowledge scores. Women with sons have better scores than women with no sons. A likely explanation for this is that once a woman has given birth to sons, preferably two, she can consider taking a break from childbearing (or limiting childbearing) and thus would be more likely to seek knowledge of contraceptive methods.

The knowledge of reproductive health matters varies by province and rural-urban area. Women in NWFP have the highest scores followed by women in Punjab and Sind (compared to women in Balochistan). Women in major urban areas have higher reproductive health knowledge scores compared to women in rural areas.

To summarise, women's health knowledge is positively related with

1. Age.
2. Education.
3. Socio-economic status.

4. Living in a nuclear household.
5. Marriage to a non-related individual.
6. Residence in NWFP, followed by Punjab and Sind.

Table 3.9 Linear regression model of the socio-demographic predictors of health knowledge index score, currently married women (15-49), PFFPS 1996-97[1]

	Dependent variable: health knowledge score	
	Beta coefficient	**95% confidence interval**
Predictors		
Age		
15-19	rc	-
20-29	0.86***	0.65, 1.07
30-39	1.10***	0.87, 1.33
40-49	0.88***	0.63, 1.13
Education		
None	rc	-
Primary	0.79***	0.62, 0.96
Secondary	0.73***	0.53, 0.93
Above secondary	1.12***	0.85, 1.39
Type of marriage		
Husband-wife related	rc	-
Husband-wife not related	0.14*	0.03, 0.25
No. of living sons		
None	rc	-
1-2	0.57***	0.43, 0.70
>3	0.58***	0.42, 0.74
Household structure		
Vertically joint (nuclear)	- 0.34***	- 0.45, - 0.23
Horizontally joint	- 0.30**	- 0.50, -0.10
SE status		
Very poor	- 0.83***	- 0.97, - 0.69
Poor	rc	-
Lower middle	0.67***	0.53, 0.81
Upper middle	0.85***	0.65,1.05
Rich	0.79***	0.51, 1.06
Province		
NWFP	2.68***	2.42, 2.95
Punjab	2.05***	1.82, 2.29
Sind	1.97***	1.72, 2.22
Balochistan	rc	-
Area		
Major urban	2.64**	1.14, 3.25
Other urban	0.12	-0.04, 0.29
Rural	rc	-

[1] N (weighted) =7577.
rc = Reference category.
*** p<0.00, ** p <0.01, * p<0.05.

3.2 Relationships between the direct measures of women's gendered position

So far, the data analysis has addressed the levels and differentials of the six indicators believed to represent the different dimensions of a woman's gendered position. The question that now arises is how are the six measures related to each other. It is important to address the relationships between the six measures because some of the measures may be lying on the same causal pathway. Based on plausibility of relationships, the following measures are postulated to be related:

1. Women's mobility and health knowledge.
2. Women's mobility and exposure to information.
3. Women's involvement in decision-making and communication index
4. Women's access to financial resources and their level of involvement in decision-making

3.2.1 Women's mobility, health knowledge index and exposure to information index

Women's mobility is postulated to directly promote health since it implies women can travel to service outlets to access healthcare (Thaddeus and Maine 1990; Okojie 1994). In addition, women's mobility is also believed to indirectly affect health via exposure to information and health knowledge. To address the latter, the relationships between the three type of women's mobility and exposure to information index and health knowledge index are explored. Linear regression is used because exposure to information and health knowledge are linear scores. Table 3.10 shows the relationships of the three types of mobility with health knowledge and exposure to information index. Controlled for a range of potential cofounders, only accompanied mobility is significantly associated with exposure to information. In contrast, health knowledge is associated with accompanied, unaccompanied and hypothesised unaccompanied mobility. The data thus support the assertion that women's mobility per se and not necessarily unaccompanied mobility is associated with an improvement in health knowledge. The weaker relationship with exposure to information may be a function of the measure because the index is based on watching TV and listening to the radio, activities usually carried out at home.

Table 3.10 Linear regression model of the relationships between patterns of mobility, health knowledge index and exposure to information index, currently married women (15-49), PFFPS 1996-97[1]

	Travelled in company of an adult	Travelled alone	Can travel alone to a health centre
Exposure to information index	0.20*	-0.23	-0.17
Health knowledge index	0.26*	0.33*	0.33*

[1] N (weighted) = 7577

Note: All relationships above are controlled for woman's age, education, number of sons, type of marriage, household structure, woman's work, household socio-economic status, province and area.

*** p<0.00, ** p <0.01, * p<0.05

3.2.2 Husband-wife communication and women's level of involvement in decision-making

It is hypothesised that women who have good interpersonal relationships with their husbands, as measured by the communication index, may be more involved in making routine household decisions. To address this hypothesis, the relationships between the communication index and women's levels of involvement in child-health, food and clothes purchases decision-making were explored. Multinomial regression methods[4] are used because the dependent variable, involvement in decision-making is polytomous. Table 3.11 presents the logistic regression odds ratios of the relationships between the couple communication index scores and the level of women's involvement in decisionmaking in all three domains. Women who do not participate at all are the reference category.

[4] For details of multinomial regression methods, see Appendix 4.

A woman with a high communication index score of four is significantly more likely to be a final, but joint, decision-maker regarding child-health, food and clothes purchases than be a non-participant (compared to women who scored zero). The data thus support the assertion that women who have good communication with their husbands are significantly more likely to participate and make the final decisions jointly. Interestingly there is no relationship between the communication score and women making the final decision alone.

However, the fact that the communication index is based on discussions about family planning only, the positive relationship between it and joint decision-making in domestic domains indicates that both are functions of a husband-wife bond rather than one measure leading to the other.

Table 3.11 Multinomial logistic regression models of the relationships between the communication index and women's level of participation in decisionmaking, currently married women (15-49), PFFPS 1996-97

	With reference to women who do not participate at all[1]								
	Child-health			Food purchases			Clothes purchases		
	1	2	3	1	2	3	1	2	3
Communication index score[2]									
1	0.87	0.75	0.58	1.08	1.09	0.92	0.70	1.12	0.72
2	0.82	0.81	0.52*	1.18	1.70	1.08	0.70	1.43	0.93
3	1.04	1.38	0.65	1.41	2.31**	1.04	0.84	2.26**	0.89
4	1.90*	2.30*	1.18	2.07*	3.56***	1.30	1.25	3.11***	0.99

Note: All relationships above are controlled for woman's age, education, number of sons, type of marriage, household structure, woman's work, household socio-economic status, province and area.

[1] Women's level of involvement:

1= Women participated but did not make the final decision.

2= Women made the final decision but jointly with husband.

3= Women made the final decision alone.

[2] With reference to communication score of zero.

*** p<0.001, ** p <0.01, * p<0.05.

3.2.3 Women's access to financial resources and their level of involvement in decision-making

It is hypothesised that if women have access to independent wages, and a control over their wages, it will have a positive effect on their household decision-making (Joekes 1985). To address this postulate, the relationships between women's access to financial resources (through waged work and a control over their wages) and women's levels of involvement in child-health, food and clothes purchases decision-making were explored. Multinomial regression methods[5] are used because the dependent variable, involvement in decision-making, is polytomous. Table 3.12 presents the logistic regression odds ratios of the relationships between the work for wages and control over their wages and the level of women's involvement in decisionmaking in all three domains. Women who do not participate at all are the reference category.

Women's work for wages has, on the whole, no relationship with women's level of involvement on decision-making in all three domains. The only exception are women who work in the agricultural industry. This group of women are significantly less likely to make the final decisions alone than be non-participants in all three domains (compared to homemakers).

Similarly, there is no relationship between women's control over their wages and their level of participation in routine household decision-making. However, women who give all their money away are significantly less likely to be involved at all in the decisionmaking process regarding clothes purchases than women who keep all their wages. This does suggest that if women keep their money they are more likely to decide on their personal expenditures, like purchase of personal clothing.

[5] For details of multinomial regression methods, see Appendix 4.

Table 3.12 Multinomial logistic regression models of the relationships between women's access to financial resources and their participation in decisionmaking, currently married women (15-49), PFFPS 1996-97

	With reference to women who do not participate at all[1]								
	Child-health			Food purchases			Clothes purchases		
	1	2	3	1	2	3	1	2	3
Women work for wages									
Homemakers	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Professional	0.68	1.28	2.55	0.78	1.01	1.37	0.43	0.34	0.66
Services	1.12	0.65	0.95	1.70*	0.78	0.85	0.71	0.63	0.51
Agriculture	0.91	0.77	0.32*	0.70	0.31*	0.26*	0.58	0.51*	0.41*
Cottage industry	0.81	0.75	0.82	0.95	1.10	1.08	0.67	0.77	0.87
Women's control over their wages[2]									
Keep all their money	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Keep some of their money	0.84	0.76	1.01	1.06	0.61	1.19	0.75	0.64	1.04
Give all money away	0.69	0.98	0.82	0.70	0.52	0.61	0.31**	0.25**	0.36*

Note: All relationships above are controlled for woman's age, education, number of sons, type of marriage, household structure, woman's work, household socio-economic status, province and area.

[1] Women's level of involvement:

1= Women participated but did not make the final decision.

2= Women made the final decision but jointly with husband.

3= Women made the final decision alone.

[2] With reference to women who keep all their wages.

*** p<0.001, ** p <0.01, * p<0.05.

3.3 Summary and discussion

This chapter addressed the relationships between the six measures of women's gendered position and background socio-demographic characteristics. The diversity of the findings makes it difficult to summarise, but Table 3.13 highlights some of the most salient patterns seen.

Three aspects of women's gendered position are highlighted by the results presented in this chapter. These are

1. Variability
2. Multidimensionality
3. The complex and sometimes counterintuitive relationships between the six measures and socio-demographic characteristics.

The large amount of variability in the levels and differentials of the six measures indicate that women's gendered position is a fluid concept that varies according to a range of socio-economic, demographic and contextual factors. These large variations in socio-demographic predictors also indicate that the six measures are conceptually distinct, supporting the notion that woman's gendered position is a multidimensional concept. At the same time, despite their distinctiveness, some of them are inter-related. The positive relationships between, for example, a woman's mobility and health knowledge, demonstrates that one dimension of a woman's gendered position may affect another or that they are both part of a nexus of factors.

An important finding in the chapter is that the relationships between the six measures of women's gendered position and their socio-demographic characteristics do not always operate in ways postulated in the demographic literature. For example, women's unrestricted, independent mobility is postulated to directly promote health since it implies women can travel to service outlets to access healthcare (Khan 1999). It would be expected that educated women and women who work for wages would have the initiative and confidence to travel without company. Instead, the data contradict this assertion and show that education and employment (with the exception of professional women) are not associated with unaccompanied mobility. Rather, educated women, who also tend to belong to well-off households, are more likely to travel *with company*. Only life cycle related characteristics that are known to confer traditional status such as age and number of sons are associated with unaccompanied mobility.

Table 3.13 Salient patterns of the relationships between the six dimensions of women's gendered position and socio-demographic characteristics

Measure	Age	No. of sons	Education	Work for wages	Married to non-relative	Living in nuclear HH	Socio-economic status	Living in Punjab (ref: Balochistan)	Living in major urban (ref:rural)
Women's mobility									
• Travelled alone	+	+	0	-[1]	+	+	0	+	+
• Travelled with company	0	0	+	-	0	0	+[2]	–	0
Decision-making[3]									
• Makes final decisions jointly	+	+	+[4]	-[5]	0	+	0	+	0
• Makes final decisions alone	+	+	0	-	0	+	0	+	+
Control over income									
• Works for wages	0	0	- +[6]	NA	0	0	-	+	0
• Keeps all her income	0	0	0	NA	0	0	-[7]	-	0
Communication index	+	+	+	-	+	+	+[8]	+	0
Exposure to information index	0	-	+	0	0	0	+[8]	+	+
Health knowledge index	+	+	+	0	+	+	+[8]	+	+

Notes

1. Except for professional women
2. Only rich women more likely to travel with company
3. Only food purchase decisions
ref: women who do not participate at all
4. Relationship positive only after secondary education
5. Only agricultural workers less likely (homemakers)
6. Women with primary education are less likely to work and women with greater than secondary education more likely to work (ref: no education)
7. Very poor women less likely to keep all their money
8. Except the very poor women, who have lower scores than the homemakers

Key: + = Positive association 0= No association - = Negative association

These findings agree with previous research on women's mobility patterns in Pakistan. Sathar and Kazi (1997) found that educated women and women belonging to the large land owning class are more likely to observe seclusion practices and travel with company compared to poorer women. They also found that unaccompanied mobility was more common in older women and women who live in nuclear households

Women's mobility in Pakistan is closely related to the ideology of *'purdah' and 'izzat'* (honor) with seclusion as the normative ideal (Khan 1999). The findings of this chapter show that education and a higher socio-economic status, both positive attributes, act not to increase women's *unaccompanied* mobility, but *accompanied* mobility for this behaviour is within the norms of *purdah* in its more implicit form. These complexities indicate that a focus on unaccompanied mobility may be misplaced in this context. Accompanied mobility appears to be the more socially acceptable and common type of mobility behaviour. Moreover, the diverse patterns of association seen for accompanied mobility and unaccompanied mobility suggest that these two indicators are capturing distinct forms of female behaviour rather than measuring actions on a continuum of increasing 'freedom of movement' (from no movement, through accompanied movement, to unaccompanied movement). The fact that health knowledge index scores are comparable between women who travel accompanied or alone supports this observation and indicates that it is mobility per se rather than unaccompanied mobility is more important from a health perspective.

The second dimension of women's gendered position analysed above is their level of involvement in decision-making in three domestic domains. Age emerges as the most important predictor of the level of women's involvement in decision-making in all three domains, followed by province or in other words, the wider socio-cultural context in which the women live. Across all three decision-making domains, women in Punjab are the most likely to make the final decisions jointly with their husbands and make the final decisions alone than be non-participants (compared to women in Balochistan). Women's education is positively associated with decision-making, but only for child health and clothes purchases and its effect becomes apparent only after secondary level education. Women's employment on the other hand has no relationship with the level of their involvement in decision-making.

These findings agree with previous research on women's decision-making patterns in Pakistan. Sathar and Kazi (1997) too found that older women and those living in nuclear households are

more likely to be the major decision-makers regarding purchase of food, and to a smaller extent, children's schooling. The study also found that education does confer greater decision-making status, and it that varies by domain under consideration. Women's work for wages had no effect on their ability to become a major decision-maker.

A concern with decision-making is central to the gender and reproductive health discourse because women's exclusion from the decision-making processes is considered a major barrier to their ability to access health care (Vlassoff 1994; Okojie 1994). It is hypothesised that if women make the *final* decision in routine household matters, they will be able to make the final decisions regarding contraceptive and antenatal care use. But, decision-making is a complex process, characterised by co-operation and consensus, negotiations and persuasion. In some instances the people involved themselves have different views on what took place and cannot clearly state who made the final decision. In a framework of such complexities, is a focus on final-decisionmaker appropriate? The data show that a much larger proportion of women make the final decisions *jointly* with their husbands than alone and an even larger proportion participate in the process without making the final decision. Moreover, the positive relationships between couple communication and women's involvement as a joint decision-maker hint at the manner in which decisions are made in this context. A focus on final-decision-making also tends to miss the fact that a woman can influence a decision without necessarily identifying herself as the final decision-maker.

The third dimension of women's gendered position analysed is women's access to an independent income and their control over it. The data show that Pakistan is a context in which poverty is the primary force pushing women to work for wages. Only women with no formal education or a very small number of women with greater than secondary education work for wages. Moreover, whether women keep all their money, keep some or give all away varies minimally by their socio-demographic characteristics. Only the very poor women, women whose husbands work in the agricultural industry and women who live in Punjab and Sind are significantly more likely to give away all their wages.

These findings agree with previous research from Pakistan (Sathar and Kazi 1997). In recent years, researchers from a wide range of backgrounds have sought to understand how women's participation in paid employment alters their roles, rights and responsibilities and relations with men (see for example Kabeer 1997; Standing 1991; Creevy 1996). The research, mostly from

South Asia, has produced a variety of conclusions but the general consensus among the recent studies is that 'even when [women] enter into contractual terms of waged employment, their pattern of life does not undergo a radical change' (Hossain, Jahan and Sobhan 1990, pg. 180)

The findings in this chapter suggest that Pakistan is a context in which women's work for wages does not alter the fundamentals of the gender order. Women's work for wages does not lead to an increased participation in household decision-making or greater mobility. Nor does women's control over their wages fit into patterns commonly hypothesised. For example, rich women are as likely to give away their wages as the poor women. While the poor women's behaviour can be understood in terms of economic imperatives of survival, the relationships are not so clear in the richer households. It is the women's behaviour in the richer households that points to a need to further explore what gender values underlie access to and control over financial resources in this context. Issues that therefore need to be addressed further include what are the emic perceptions of women's work for wages and control over their income and whether a focus on earning an independent income and keeping all of it is valid in this cultural context.

The fourth measure, the communication index is an important measure of the husband-wife interpersonal relationship. Number of sons, woman's education, a nuclear household, marriage to a non-related individual, a higher socio-economic status and residence in provinces of NWFP, Punjab and Sind are all positively associated with the communication index.

Research in Pakistan is increasingly addressing the issue of husband-wife communication, but usually only as a predictor of desired fertility or contraceptive use (Mahmood and Ringheim 1996; 1997; Mason and Smith 2000). Only recently have Sathar and Kazi (1997) and Fikree et al. (2001) addressed it as an aspect of women's gendered position. In view of the positive associations between the communication index and woman's education and number of sons, it seems reasonable to explore the measure further.

Women's education has long been considered a key to contraceptive use and more recently to improve women's reproductive health (Sathar and Mason 1993). However, the exact manner in which education operates is not clear (Jeffery and Basu 1996). I used more direct measures, exposure to information and health knowledge, for they are sensitive to other sources of information besides formal schooling. The most important finding is that socio-economic class is

a crucial predictor of both indicators, suggesting access to information and knowledge is enmeshed in class and gender divisions.

This discussion, besides highlighting the complexities of the concept of women's gendered position, also raises a number of questions regarding the relationships between these dimensions and reproductive health. For example, there is a need to

1. Explore the relationships between the different types of mobility and women's ability to use contraceptive or antenatal care services. What type of female mobility facilitates access to healthcare services and is unaccompanied mobility essential for women to seek reproductive health services?
2. Explore the relationships between women's level of involvement in decision-making in domestic domains and contraceptive and antenatal care use. Does making decisions in the domestic domain lead to making decisions in the reproductive health domain? More importantly, is a focus on final decision-making appropriate in this context?
3. Understand the relationships between women's control over their wages and their ability to use contraceptive and antenatal care services. Is a woman's control over financial resources an essential pre-requisite for their use of health services?
4. Understand the relationships between couple communication and contraceptive and antenatal care and further explore how the gender context modulates couple communication.
5. Explore the relationships between exposure to information and health knowledge index and contraceptive and antenatal care use. To what extend is health knowledge operationalised into use of health services?

These issues are explored in depth using survey data in chapter four and qualitative data in chapters six and seven.

Chapter 4

Measures of women's gendered position and reproductive health

This chapter examines the relationship between the six quantitative measures of women's gendered position and (i) contraceptive use and (ii) utilisation of antenatal services. The chapter is organised as follows. First, the socio-demographic predictors of contraceptive use and antenatal care are identified. Second, the relationship between each of the six measures of women's gendered position and contraceptive and antenatal use is examined. Finally, the results of the individual measures are brought together to compare the different directions in which the measures act on contraceptive use on the one hand and antenatal care use on the other hand.

4.1 Contraceptive use

4.1.1 Levels and socio-demographic differentials of contraceptive use

Overall, 24% of the respondents reported current use of any contraceptive method. Table 4.1 presents the percentage distribution of the methods used. Female sterilisation is the most common method, followed by withdrawal and condom.

Table 4.1 Distribution of contraceptive method use, currently married women (15-49), PFFPS 1996-97

Contraceptive method use	No of women	Percentage
Female sterilisation	368	24.7
Withdrawal	290	19.5
Condom	226	15.2
IUCD	215	14.5
Pill	131	8.8
Injectable	131	8.8
Periodic abstinence	89	6.0
Others	32	2.2
Vaginal methods	2	0.1
Male sterilisation	2	0.1
Total users	**1,486**	

Only reversible methods (both modern and traditional) will be used in this analysis because we do not have the information of when the sterilisation procedure was carried out. It is plausible that when the decision to undergo sterilisation was made, the indicators of women's

gendered position, such as mobility, and importantly, access to financial resources (especially work for wages) may have been different.

Bivariate analysis

Contraceptive use is positively associated, at the individual level, with age, number of surviving sons, number of surviving daughters, woman's education, household socio-economic status, woman's work in a professional capacity, marriage to a non-related individual, living in a nuclear household, woman's desire to avoid or delay another birth, and husband's desire to avoid another birth (as reported by the woman) (see Table A2.1, Appendix 2).

Contraceptive use is also positively associated with residence in an urban area, a woman's report that her neighbours and friends approve of family planning and the fact that the woman had visited a health facility in the past one year. Contraceptive use differs between provinces with highest use reported from Punjab (27%), followed by Sind (23%), NWFP (19%) and finally Balochistan (7%).

Multivariate analysis

As a number of factors described above are obviously correlated, multivariate analysis was carried out to examine the effect of each factor separately. Binomial logistic regression was used[1]. The outcome variable was coded 1 if the woman reported current use of a reversible contraceptive method, 0 otherwise. An important points worth noting is that non-Muslims were not asked about whether they had heard the *maulvi*[2] preach against family planning. Consequently, 340 observations (5% of the total sample) could not be used for the contraceptive use models.

Table 4.2 shows that the total number of surviving sons is a strong predictor of contraceptive use. Women with 1-2 sons have odds of contraceptive use four times greater than women with no sons (OR=4.06, $p<0.00$). During the model-building process, the age group 20-29 years lost significance with the addition of this variable, indicating younger women use contraceptives only if they have the requisite number of sons.

[1] For details of regression methods, see Appendix 4.
[2] The *maulvi* is the religious leader responsible for leading the prayers in a mosque, teaching Koran and officiating at marriages.

However, once surviving daughters were added to the model, age lost significance, indicating that number of children, and not age per se, determines contraceptive use.

Husband's desire for more children, as reported by the wife, is also an important predictor of contraceptive use. A woman has significantly higher odds of using a method when her husband does not want any more children, compared to a woman whose husband wants more children. In contrast, women's desire to avoid another birth does not translate into contraceptive use. During the model-building process, there was a positive association between women's desire to stop childbearing and contraceptive use, but it lost significance once husband's desire was added to the model. This suggests that if there are differences regarding family size, the husband's preference takes priority.

Women's education is an independent predictor of contraceptive use. Educated women, even those with just a primary education, are more likely to take up contraception compared to women with no formal education (OR=2.14 $p<0.00$). In contrast, husband's education is not an important determinant of contraceptive use and is not included in the model. However, household socio-economic status is important. With improving socio-economic status, contraceptive use rates have a positive upward trend (test of trend, $z=19.9$ $p<0.00$).

There is no association between women's employment and contraception. Although women working in the professions and cottage industry have a higher odds of using a method compared to housewives, the differences are not significant at $\alpha=0.05$. Women working in the services industry have a significantly lower odds of use. On the whole, this variable had borderline significance in the final model, but was included since the role of women's employment in Pakistan is of particular interest.

The role of the wider social climate is demonstrated by the significance of province and more importantly, whether friends and neighbours approve of contraceptive use (as reported by the respondent). Women who report that their friends and neighbours approve of contraceptive use have odds of contraceptive use that are three times greater than the odds of use amongst women who state that their neighbours disapprove such behaviour. Surprisingly, women who reported that they had heard the local *maulvi* talk against family planning still went ahead and used contraceptives (OR= 1.27, $p<0.05$), and were actually more likely to use than those who had not heard such messages from the *maulvi*.

Table 4.2 Estimated logistic regression odd ratios of current contraceptive use by background socio-demographic characteristics, currently married women aged (15-49), PFFPS 1996-97[1]

Dependent variable: current contraceptive use	Odds Ratio	95% confidence interval
Independent variable[2]		
Women's education		
None	1.00	-
Primary	2.14***	1.64, 2.79
Secondary	2.64***	1.80, 3.87
Above secondary	1.90***	1.19, 3.08
No. of living sons		
None	1.00	-
1-2	4.06***	2.74, 6.00
3+	5.39***	3.20, 9.06
No. of living daughters		
None	1.00	-
1-2	2.18***	1.44, 3.30
3+	2.05***	1.40, 3.00
Type of marriage		
Husband-wife not related	1.00	
Husband-wife related	0.80*	0.64, 0.99
Husband's desire for more children		
Desires more children	1.00	-
Does not desire more children	1.86***	1.42, 2.44
Woman's desire for more children		
Desires more children	1.00	-
Does not desire more children	0.96	0.69, 1.36
Woman's occupation		
Homemaker	1.00	-
Professional	1.27	0.57, 2.80
Services	0.67	0.38, 1.18
Agricultural	0.58*	0.33, 1.00
Labourer	1.31	0.79, 2.20
SE status		
Very poor	1.15	0.77, 1.73
Poor	1.00	-
Lower middle	1.72***	1.37, 2.17
Upper middle	2.17***	1.49, 3.16
Rich	2.32**	1.30, 4.14
Access to health services		
Did not visit a health centre	1.00	-
Visited a health centre	0.86	0.67, 1.10
Province		
Balochistan	1.00	-
NWFP	1.49	0.88, 2.51
Punjab	2.14**	1.25, 3.66
Sind	1.29	0.72, 2.33
Neighbours/friends approval of FP		
Disapprove	1.00	-
Approve	3.29***	2.18, 4.97
Don't know	1.06	0.69, 1.66
Heard *maulvi* preach against FP		
Yes	1.27*	1.01, 1.62
No	1.00	-

[1] N (weighted) = 6809.

[2] Variables retained in the final model on basis of Likelihood Ratio Test on unweighted data (α =0.05).

* p<0.05, ** p<0.01, *** p<0.001.

4.1.2 Direct measures of women's gendered position and contraceptive use

This section examines the relationship between the six measures of women's gendered position and contraceptive use.

4.1.2.1 Women's mobility and contraceptive use

A bivariate analysis of the three measures of women's mobility and contraceptive use show that unaccompanied mobility, both actual and hypothetical, is positively associated with contraceptive use (see Table A2.2, Appendix 2). Twenty eight percent of women who had traveled alone outside the village or neighborhood reported current use of a contraceptive method compared to 17 % among those who had not. In other words, women who can and do travel alone for any purpose are more likely to use a contraceptive method. In contrast there is no significant difference in contraceptive use rates of women who had traveled in the company of an adult compared to women who had not (both 19%).

There is obviously a need to control for the socio-demographic factors known to independently affect contraceptive use. Binomial logistic regression[3] methods were used with contraceptive use as the outcome variable. Table 4.3 shows the relationships with accompanied mobility (Model series 1), unaccompanied mobility (Model series 2) and hypothetical unaccompanied mobility (Model series 3) with contraceptive use controlled for various combinations of confounders. The three models are presented together to compare and contrast the three measures.

On the whole, women who reported travelling alone or that they can travel alone to a health centre have a greater probability of using contraception compared to women who did not. Adjusting for various combinations of potential confounders reduces the size of the odds ratios, but they retain significance. However, when all potential confounders are adjusted for simultaneously, only hypothetical unaccompanied mobility remains significant (Model series 3), while actual unaccompanied mobility demonstrates a weak and borderline relationship with contraceptive use (OR 1.29, p=0.07).

There is, however, no association between women's accompanied mobility outside the village/neighbourhood and contraceptive use. This remained true after adjusting for various

[3] For details of regression methods, see Appendix 4.

combinations of potential confounders. In other words, contraceptive use rates are the same for women who had travelled with company as for women who reported no such activity.

In sum, the data suggest that women's actual unaccompanied mobility has a weakly positive relationship with contraceptive use. The relationship is stronger with their postulated ability to travel unaccompanied.

Table 4.3 Estimated logistic regression odds ratios of the relationship between the three measures of women's mobility and contraceptive use, currently married women (15-49), PFFPS 1996-97

	Travelled with company (Model series 1)	**Travelled alone (Model series 2)**	**Can travel alone to a health centre (Model series 3)**
Uncontrolled	1.02	2.09***	2.42***
Adjusted for desired and achieved fertility[1]	1.09	1.65***	1.82***
Adjusted for socio-economic characteristics[2]	0.88	1.80***	2.09***
Adjusted for wider societal characteristics[3]	0.99	2.06***	2.33***
Adjusted for all potential confounders together[4]	0.87	1.29	1.40**

[1] Controlled for total number of surviving sons, total number of surviving daughters, woman's desire and her husband's desire for more children.

[2] Controlled for woman's education, socio-economic status, occupation, marriage to a relative and visited a health centre in the past one year.

[3] Controlled for province, neighbours/friends approval of family planning and heard the local *maulvi* preach against family planning.

[4] N (weighted) = 6809.

* p<0.05, ** p<0.01, *** p<0.001.

4.1.2.2 Women's decision-making patterns and contraceptive use

A bivariate analysis of the relationship between women's involvement in decision-making regarding treatment of a sick child, food purchases and clothes purchases and contraceptive use show that:

1. Contraceptive use increases with increasing levels of women's involvement in decision-making in all the three domains.
2. Contraceptive use is higher amongst women who make the final decisions jointly with their husbands compared to women to make the final decisions alone. For example, 31% of women who reported making food purchase decisions jointly with their husband's are users compared to 23% amongst those who make the final decisions alone (Table A2.2, Appendix 2).

To adjust for potential cofounders, multivariate logistic regression is used. Contraceptive use is the outcome variable. Tables 4.4, 4.5, and 4.6 show the relationship between women's involvement in decision-making regarding treatment of a sick child, food purchases and clothes purchases and contraceptive use, unadjusted and adjusted for various combinations of potential cofounders. The most striking feature, in all the three spheres, is the positive relationship between increasing levels of women's involvement in the decision-making process and contraceptive uptake. Women who are not involved in the decisions at all have the lowest contraceptive use rates, followed by women who participated but did not make the final decision. The highest use rates are amongst women who make decisions jointly with their husbands, followed by women who make the decisions alone.

Adjusting for individual and societal level confounders reduces the size of the odds ratios, but they remain significant indicating the extent of a woman's involvement in the decision-making sphere has a positive relationship with contraceptive use. A more interesting finding is that once all the potential confounders are adjusted for simultaneously, women who make the final decisions *jointly* with their husbands are significantly more likely to report use of a contraceptive method while women who make the final decisions alone are no different from those who do not participate at all in the decision-making process (in all the three domains).

Table 4.4 Estimated logistic regression odds ratios of the relationship between the women's involvement in decision making regarding treatment of a sick child and contraceptive use, currently married women (15-49), PFFPS 1996-97

	Does not participate	Participates, but does not make the final decisions	Makes the final decision jointly with husband	Makes the final decision alone
Uncontrolled	1.0	1.75**	3.13***	2.49***
Adjusted for desired and achieved fertility[1]	1.0	1.80**	2.84***	1.95*
Adjusted for socio-economic characteristics[2]	1.0	1.66**	2.42***	1.94**
Adjusted for wider societal characteristics[3]	1.0	1.71**	2.96**	2.29***
Adjusted for all potential confounders together[4]	1.0	1.52*	1.77*	1.27

[1] Controlled for total number of surviving sons, total number of surviving daughters, woman's desire and her husband's desire for more children.

[2] Controlled for woman's education, socio-economic status, occupation, marriage to a relative and had visited a health centre in the past one year.

[3] Controlled for province, neighbours'/friends' approval of family planning and heard the local *maulvi* preach against family planning.

[4] N (weighted) = 5911.

* $p<0.05$, ** $p<0.01$, *** $p<0.001$.

Table 4.5 Estimated logistic regression odds ratios of the relationship between the women's involvement in decision making regarding food purchases and contraceptive use, currently married women (15-49), PFFPS 1996-97

	Does not participate	Participates, but does not make the final decision	Makes the final decision jointly with husband	Makes the final decision alone
Uncontrolled	1.0	1.65**	3.97***	2.74***
Adjusted for desired and achieved fertility[1]	1.0	1.35*	2.81***	1.79*
Adjusted for socio-economic characteristics[2]	1.0	1.61***	3.40***	2.21***
Adjusted for wider societal characteristics[3]	1.0	1.51**	3.53***	2.46***
Adjusted for all potential confounders together[4]	1.0	1.11	1.90**	1.13

[1] Controlled for total number of surviving sons, total number of surviving daughters, woman's desire and her husband's desire for more children.

[2] Controlled for woman's education, socio-economic status, occupation, marriage to a relative and had visited a health centre in the past one year.

[3] Controlled for province, neighbour's/friends' approval of family planning and heard the local *maulvi* preach against family planning.

[4] N (weighted) = 6809.

* $p<0.05$, ** $p<0.01$, *** $p<0.001$.

Table 4.6 Estimated logistic regression odds ratios of the relationship between the women's involvement in decision making regarding clothes purchase and contraceptive use, currently married women (15-49), PFFPS 1996-97

	Does not participate	Participates, but did not make the final decision	Makes the final decision jointly with husband	Makes the final decision alone
Uncontrolled	1.0	1.23	2.92***	2.55**
Adjusted for desired and achieved fertility[1]	1.0	1.22	2.75***	2.02***
Adjusted for socio-economic characteristics[2]	1.0	1.22	2.36***	1.96***
Adjusted for wider societal characteristics[3]	1.0	1.20	2.84***	2.46**
Adjusted for all potential confounders together[4]	1.0	1.10	1.91**	1.33

[1] Controlled for total number of surviving sons, total number of surviving daughters, woman's desire and her husband's desire for more children.

[2] Controlled for woman's education, socio-economic status, occupation, marriage to a relative and had visited a health centre in the past one year.

[3] Controlled for province, neighbours/friends approval of family planning and heard the local *maulvi* preach against family planning.

[4] N (weighted) = 6809.

* $p<0.05$, ** $p<0.01$, *** $p<0.001$.

4.1.2.3 Women's control over their wages and contraceptive use

Women's economic dependency is measured using women's paid employment and their control over their wages.

Women's work for wages

A bivariate analysis of the relationship between women's work for wages and contraceptive use show that 15 % of women who work for wages use a reversible contraceptive method compared to 20% amongst homemakers (results not shown). Amongst women who work for wages, 17% of those who keep all their wages report current use of a method compared to 11% of women who give all their wages away (Table A2.2, Appendix2).

To adjust for potential confounders, binomial logistic regression methods were used with contraceptive use (a reversible method) as the outcome variable. Table 4.7 shows the relationships with work for wages (Model series 1) and control over wages (Model series 2).

Uncontrolled, there is no significant difference in contraceptive use between women who work for wages and the homemakers (OR=0.78, p=0.12). This remains true after adjusting for various combinations of potential confounders confirming that woman's work for wages does not increase their probability of contraceptive use. Rather, the size of the odds ratios show that working women are less likely to use contraceptives. Further exploration by type of work showed that professional women were no more likely to use a contraceptive method compared to homemakers (results not shown).

Women's control over income

This analysis is limited to 1,457 women (weighted) who work for wages. Control over income was measured by whether women kept all their wages, gave some or all of it away. As seen in column 2 of Table 4.7, the size of the odds ratios suggests women who kept all or some of their money were more likely to use contraceptives compared to women who gave all of it away, although the differences are not statistically significant at α=0.05.

During the model building process, adjusting for age disclosed that women who gave all their money away were significantly less likely to use family planning methods (OR=0.60, p=0.04). When total number of surviving sons was added to the model, women who gave away all their money were even less likely to use contraceptives (OR=0.57, p=0.02). These

results, (not shown) indicate that part of the contraceptive use amongst this group of women was due to their age and number of sons. Once these were controlled for, women who gave away all their money were even less likely to use contraception. However, addition of the variables measuring husband and wife fertility desires rendered the coefficients insignificant in the final model.

The fact that addition of age and total number of sons to the model changed the coefficients indicates that patterns of control over income are related to these two variables. Since age and number of sons, essentially life cycle related events confer traditional status, it can be concluded that control over income is also related to increasing age and number of sons.

Interestingly, considering women's work is largely the result of economic need, socio-economic status did not emerge as an important confounder. This could be due to the lack of economic heterogeneity in the subsample of working women. The majority of them are either poor or very poor. However, I adjusted for it to control for any residual confounding. Household structure or marriage to a blood relative also did not emerge as important confounders.

The wider societal level variables of province, rural/urban area, whether neighbors approve of family planning and if the respondent had heard the local *maulvi* preach against family planning were not important confounders of the relationship between control over income and contraceptive use.

To summarise, there is no significant difference in contraceptive use between women who work for wages and homemakers (who by definition have no independent income). Furthermore, among those who earn a wage, there is no conclusive evidence that women who give away all their money are any less likely to use contraceptives than women who keep all their money.

Table 4.7 Estimated logistic regression odds ratios of the relationship between women's work for wages and control over their income and contraceptive use, currently married women (15-49), PFFPS 1996-97

	Model series 1		Model series 2		
	Women work for wages[1]		Control over income[2]		
	Women do not work for wages	Women work for wages	Keeps all the money	Keeps some money	Gives all the money away
Uncontrolled	1.0	0.78	1.0	0.87	0.63
Adjusted for age, desired and achieved fertility[3]	1.0	0.68*	1.0	1.03	0.60
Adjusted for socio-economic characteristics[4]	1.0	0.64	1.0	0.90	0.77
Adjusted for wider societal characteristics[5]	1.0	0.79	1.0	0.80	0.57
Adjusted for all potential confounders together	1.0	0.88	1.0	1.04	0.68

[1] N (weighted) = 6809.
[2] Analysis limited to 1457 women who work for wages.
[3] Controlled for age, total number of surviving sons, total number of surviving daughters, woman's desire and her husband's desire for more children.
[4] Controlled for woman's education, socio-economic status and whether she had visited a health centre in the last one year.
[5] Controlled for province, area, neighbours/friends approval of family planning and heard the local *maulvi* preach against family planning.
* p<0.05, ** p<0.01, *** p<0.001.

4.1.2.4 Couple communication and contraceptive use

Bivariate analysis shows a positive linear relationship between increasing couple communication index score and contraceptive use (Table A2.2, Appendix 2). Forty seven percent of couples who had a score of four (range 0-4) report current use of a method compared to one percent amongst those who scored a zero.

To adjust for potential confounders, binomial logistic regression was carried out with contraceptive use as the outcome variable (Table 4.8). The size and significance of the coefficients indicate couple communication is a very important aspect of fertility control. It also indicates contraceptive use is a joint husband-wife decision.

The large odds ratios could either be due to a very powerful relationship between good husband-wife communication and contraceptive use or because couples who desire to control their fertility (and are doing so) are more likely to discuss family planning issues.

Table 4.8 Estimated logistic regression odds ratios of the relationship between communication index scores and contraceptive use, currently married women (15-49), PFFPS 1996-97

	Communication index score			
	0/1	2	3	4
Uncontrolled	1.0	4.96***	14.7***	33.7***
Adjusted for desired and achieved fertility, son preference[1]	1.0	4.3***	11.7***	24.3***
Adjusted for socio-economic characteristics[2]	1.0	4.30***	12.0***	26.4***
Adjusted for wider societal level characteristics[3]	1.0	4.50***	13.4***	35.0***
Adjusted for all potential confounders[4]	1.0	3.59**	8.7***	19.2***

[1] Controlled for age, total number of surviving sons, total number of surviving daughters, woman's desire and her husbands desire for more children.

[2] Controlled for woman's education, socio-economic status, marriage to a relative and visited a health centre in last one year.

[3] Controlled for province, neighbours/friends approval of family planning and having heard the local *maulvi* preach against family planning.

[4] N (weighted) = 6809.

* $p<0.05$, ** $p<0.01$, *** $p<0.001$.

4.1.2.5 Exposure to information and contraceptive use

Bivariate analysis shows a positive linear relationship between exposure to information index score and contraceptive use (Table A2.2, Appendix 2). Thirty eight percent of women who had a score greater than nine (range 0-12) report current use of a method compared to 10% amongst those who scored a zero.

Table 4.9 shows the relationship between exposure index scores and contraceptive use. Overall, exposure to information, as measured by watching TV, listening to the radio and reading the newspaper, is positively associated with contraceptive use. Adjusting for desired

and achieved fertility increases the size of the odds ratios indicating that once these predictors of fertility are controlled for, exposure to information via the written word is a powerful independent predictor of contraceptive use (those who could read and write scored the highest). Moreover, the association remains significant even after controlling for woman's education, indicating that exposure to information that occurs outside the formal educational system can have an impact on contraceptive use. Similarly, the socioeconomic status is an important determinant of exposure to information. Controlling for it results in a large drop in the size of the coefficients, demonstrating that the poorer women are disadvantaged because they do not have access to TV or other sources of information. However, even having controlled for a wide range of confounders, women with the highest exposure score are 74% more likely to be using contraception that those with lower scores.

Table 4.9 Estimated odds ratios of the relationship between exposure to information index and contraceptive use, currently married women (15-49), PFFPS 1996-97

	Exposure to information index score[1]			
	0	**1**	**2**	**3**
Uncontrolled	1.0	1.87**	3.31***	4.90***
Adjusted for desired and achieved fertility[2].	1.0	1.76*	3.17***	6.45***
Adjusted for socio-economic characteristics[3]	1.0	1.31	1.59**	1.86**
Adjusted for wider societal level characteristics[4].	1.0	1.67***	2.43***	3.26***
Adjusted for all potential confounders[5]	1.0	1.25	1.24	1.74*

[1]The index scores were categorised as 0=0, 1-4=1, 5-8=2, 9-12=3 after analysing each score separately.

[2]Controlled for total number of surviving sons, total number of surviving daughters, woman's desire and her husband's desire for more children.

[3] Controlled for woman's education, socio-economic status, marriage to a relative and visit to a health centre.

[4] Controlled for province, neighbours'/friends' approval of family planning and having heard the local *maulvi* preach against family planning.

[5] N (weighted) = 6809.

* p<0.05, ** p<0.01, *** p<0.001.

4.1.2.6 Health knowledge and contraceptive use

Bivariate analysis shows a positive linear relationship between health knowledge index score and contraceptive use (Table A2.2, Appendix 2). Forty five percent of women who score greater than eight (range 0-10) reported current use of a method compared to one percent amongst those who score a zero.

Table 4.10 demonstrates the relationship between health knowledge index score and contraceptive use. As expected, contraceptive use is positively associated with health knowledge index scores since the index itself is based on knowledge of family planning methods.

Table 4.10 Estimated odds ratios of the relationship between health knowledge index score and contraceptive use, currently married women (15-49), PFFPS 1996-97

	Knowledge Index score[1]		
	0/1	**2**	**3**
Uncontrolled	1.0	4.81***	13.0***
Adjusted for desired and achieved fertility, son preference[2].	1.0	3.80***	9.82***
Adjusted for socio-economic characteristics[3]	1.0	4.0***	9.15***
Adjusted for wider societal level characteristics[4].	1.0	4.05***	8.86***
Adjusted for all potential confounders[5]	1.0	3.10***	5.65***

[1] The index scores were categorised as 0-4=1, 5-7=2, 8-10=3 after analysing each score separately.

[2] Controlled for age, total number of surviving sons, total number of surviving daughters, woman's desire and her husband's desire for more children.

[3] Controlled for woman's education, socio-economic status, marriage to a relative and whether the woman had visited a health facility in last one year.

[4] Controlled for province, area, neighbours/friends approval of family planning and having read or heard the local *maulvi* preach against family planning.

[5] N (weighted) = 6805.

* p<0.05, ** p<0.01, *** p<0.001.

4.1.2.7 The combined effect of women's gendered position measures and socio-demographic characteristics on contraceptive use

Table 4.11 shows the results of the combined effect of the six indicators of women's gendered position and background socio-demographic characteristics on contraceptive use.

Of the six indicators of women's gendered position, only three, the communication index score, health knowledge index score and women's participation in food purchase decisions are statistically significant in the final model. The last variable is included because the Wald test is significant, although it lost significance on the basis of the Likelihood Ratio Test on unweighted data.

Women with a communication index score of four have odds of contraceptive use that are nearly 30 times greater than odds of use in women with a score of zero. Taken together with the significance of the variable indicating husband's desire for more births, it can be concluded that the husband's involvement in fertility decisions is an important determinant of contraceptive use. In addition, neighbours' approval of contraceptive use, as reported by the woman, also has a positive effect on use. In contrast, women's desire for more children does not appear to have an important determining effect on contraceptive use. One conclusion from this model is that control over fertility decisions is located not with the woman, but her husband. Furthermore, the importance of the neighbours approval of contraceptive use indicates that the larger social climate regarding acceptability of contraceptive use has an important bearing on use by a particular woman.

The model also shows a positive relationship between health knowledge and contraceptive use. Since health knowledge index is controlled for education, it indicates that familiarity with contraception, independent of formal schooling, is an independent and important determinant of use. However, woman's education remains a significant, if somewhat weaker, factor determining use.

Interestingly, all the three measures of women's mobility, two measures of decision-making, control over resources and exposure to information index lost significance and are not present in the final model. As discussed earlier the relationships between these measures and contraceptive use adjusted for socio-demographic characteristics only are quite weak if significant at all, and none of the odds ratios are larger than two. It is possible that when large number of variables were introduced in this more complex model, the power detect small differences is greatly reduced. Nonetheless, the socio-demographic predictors of

contraceptive use retained significance suggesting that these indicators of women's gendered position may really have no relationship with contraceptive use.

This model also does not contain the variable measuring visit to a health centre in the past one year and having heard the *maulvi* preach against family planning because they lost significance. Poor access to high quality family planning services has repeatedly been identified as a major barrier to use (Rosen and Conley 1996; Mahmood et al. 1992; Rukanuddin and Hardee-Cleaveland 1992). Similarly, religious proscriptions against family planning are commonly cited as reasons for non-use (Hashmi et al. 1993; Shah and Shah 1984). One inference of their lack of significance could be that if a woman has sufficient health knowledge about the methods and their availability and the couple can discuss these issues, then barriers like easy availability or religious proscriptions can somehow be manoeuvred around.

Table 4.11 Estimated logistic regression odd ratios of current contraceptive use by indicators of women's gendered position and background socio-demographic characteristics, currently married women aged (15-49), PFFPS 1996-97[1]

Dependent variable: current contraceptive use	Odds Ratio	95% confidence interval
Independent variables[2]		
Communication index score		
0/1	1.0	-
2	2.77**	1.54, 4.97
3	6.07***	3.70, 9.97
4	10.8***	6.17, 18.9
Health knowledge index score		
0-4	1.0	-
5-7	2.01***	1.50, 2.71
8-10	3.50***	2.32, 5.29
Food Purchase decision		
Not involved	1.0	
Participates, does not make final decision	0.94	0.67, 1.30
Makes final decision jointly with husband	1.46*	1.01, 2.10
Makes final decision alone	0.98	0.63, 1.53
Women's education		
None	1.00	-
Primary	2.03***	1.56, 2.63
Secondary	2.21***	1.50, 3.26
Above secondary	1.50	0.92, 2.46
No. of living sons		
None	1.00	-
1-2	3.11***	1.90, 5.06
3+	3.96***	2.49, 6.29
No. of living daughters		
None	1.00	-
1-2	2.04**	1.34, 3.10
3+	1.93**	1.30, 2.87
Husband's desire for more children		
Desires more children	1.00	-
Does not desire more children	1.61**	1.23, 2.12
DNK	2.04	0.84, 4.94
Woman's desire for more children		
Desires more children	1.00	-
Does not desire more children	1.00	0.70, 1.41
DNK	0.47**	0.30, 0.75
SE status		
Very poor	0.97	0.69, 1.36
Poor	1.00	-
Lower middle	1.40*	1.07, 1.83
Upper middle	1.93*	1.34, 2.79
Rich	1.85	0.99, 3.44
Neighbours/friends approval of FP		
Disapprove	1.00	-
Approve	2.18**	1.41, 3.37
Don't know	1.46	0.95, 2.25

[1] N (weighted) = 6808.

[2] Variables retained in the final model on basis of Likelihood Ratio Test on unweighted data (α =0.05).

* p<0.05, ** p<0.01, *** p<0.001.

For the objective of this thesis, the relationships between the direct measures of women's gendered position and contraceptive use are more important. These can be summarized as follows. A woman's probability of contraceptive use is positively associated with

1. A perception that she can travel to a health centre if the need arose and weakly with actual unaccompanied mobility.
2. Making final decisions jointly with her husband about routine domestic matters.
3. A high communication index score.
4. A high exposure to information score.
5. A high knowledge index score.

4.2 Antenatal care use

4.2.1 Levels and socio-demographic predictors of antenatal care use

Overall, 35% of the women who had a birth in the three years prior to the survey had at least one antenatal care visit. Table 4.12 presents sources of antenatal care used by type of service provider.

Table 4.12 Antenatal care use by type of service provider, PFFPS 1996-97

Antenatal care use (Type of provider)	No. of women	Percentage
Doctor	1025	74.6
Nurse/Midwife	125	9.1
Traditional Birth Attendant	127	9.2
Lady Health Visitor	44	3.2
Family Welfare Worker	21	1.5
Others	17	1.2
Village-based Family Planning Worker	10	0.7
Did not know identity	5	0.4
Total users	**1,374**	

Bivariate analysis

Antenatal care use is positively associated with women's education, employment in a professional capacity, a higher socioeconomic status and living in a joint household. Women's education is a very important determinant as 96% of women with greater than secondary education had used antenatal care compared to 26% of women with no formal education. The household socioeconomic status is another important determinant as 78% of women in the upper middle class category used the services compared to 20% amongst poor women (Table A2.3, Appendix 2).

In contrast to patterns of contraceptive use, age, number of surviving sons and total parity are negatively associated with use of antenatal services. Younger women, particularly the 20-29 years group, are most likely to use the services, while higher parity women are less likely to do the same. The sex of the surviving children does not predict use (results not shown). Since

a number of these characteristics are obviously correlated, logistic regression analysis was carried out to tease apart the effect of each variable on antenatal care use.

Multivariate findings

Table 4.13 displays the results of a binomial logistic regression model. Antenatal care use is the outcome variable.

Education emerges as the strongest predictor of antenatal care use. Women with secondary education have odds of antenatal care use that are five times greater than the odds of use by women with no formal education (OR=4.9, $p<0.001$). This strong relationship is controlled for socio-economic status, which itself is an important independent predictor of ANC use. The very poor women are the least likely to use ANC services and the upper middle-class the most likely (OR =2.13, $p<0.005$) (compared to the poor).

Women's work has a negative relationship with antenatal care use. Housewives are the most likely to use antenatal services and working women less so, although, with the exception of women working in the services industry, the differences are not significant.

Unexpectedly in a context of son preference, women with three or more sons are less likely to use ANC services compared to women with no sons (OR= 0.66, $p<0.01$). Women's age lost significance in the model, but it is reasonable to assume that number of living sons is related to age. Therefore, one possible explanation for the relationship between number of sons and use of ANC services could be that older and multiparous women are less likely to seek antenatal care services compared to younger primiparous women. Qualitative findings support this assertion (chapter 7).

Accessibility of services is important. Women who report having visited a health centre in the past one year for any reason have odds of antenatal care use that are nearly twice those of women who report no such visits (OR=1.93, $p<0.00$). In urban areas, where health facilities are more easy to access, women's odds of using antenatal care services are nearly three times those of women in rural areas (OR= 2.77, $p<0.00$). Availability of health services in Pakistan also varies by province (Midhet, Becker and Berendes 1998) and there are large differentials in women's use of ANC by province. Nearly 52% of women in Sind report ANC use compared to around 30% in NWFP and Punjab receptively (results not shown).

Table 4.13 Estimated logistic regression odd ratios of antenatal care use by background socio-demographic characteristics, currently married women aged (15-49), PFFPS 1996-97[1]

Dependent variable: antenatal care use	Odds ratio	95% confidence interval
Independent variables[2]		
Women's education		
None	1.0	-
Primary	2.38***	1.63, 3.46
Secondary	4.90***	3.06, 7.83
Above secondary	20.0***	6.03, 66.7
Husband's education		
None	1.0	
Primary	1.01	0.74, 1.39
Secondary	1.4*	1.04, 1.90
Above secondary	1.7**	1.08, 2.33
SE status		
Very poor	0.73	0.51, 1.03
Poor	1	
Lower middle	1.14	0.82, 1.60
Upper middle	2.13**	1.33, 3.40
Rich	1.92*	1.17, 3.18
Women's occupation		
Homemaker	1	
Professional	0.50	0.21, 1.19
Services	0.35*	0.18, 1.68
Agriculture	0.69	0.42, 1.14
Cottage industry	0.83	0.54, 1.27
No. of living sons		
0	1.0	
1-2	0.89	0.69, 1.16
3+	0.67**	0.50, 0.90
Province		
NWFP	1.06	0.64, 1.78
Punjab	0.75	0.48, 1.17
Sind	1.77*	1.06, 2.97
Balochistan [r]	1.0	
Rural/urban area		
Urban	2.77***	1.79, 4.30
Other urban	1.57**	1.16, 2.15
Rural	1.0	
Access to health services		
Visited a health centre in past 1 year	1.93***	1.41, 2.65
Did not visit	1.0	

[1] N (weighted) = 3813.

[2] Variables retained in the final model on basis of Likelihood Ratio Test on unweighted data (α =0.05).

* p<0.05, ** p<0.01, *** p<0.001.

4.2.2 Direct measures of women's gendered position and antenatal care use

This section examines the relationship between the six measures of women's gendered position and antenatal care use.

4.2.2.1 Women's mobility and use of ANC services

Table 4.14 shows the results of three series of binomial logistic regression models of the relationship between the three measures of mobility and antenatal care use controlled for combinations of potential confounders believed to reflect socio-economic, other social and societal level characteristics, and then all combined. Antenatal care use is the dependent variable. The three series of models are presented together to compare and contrast the three measures.

Overall, women who had travelled in the company of another adult are significantly more likely to use antenatal services than women who reported no such movement. The relationship retains significance after controlling for women's education, socio-economic status, occupation, province and rural / urban area. Thus, women who had travelled in the company of an adult have odds of using ANC services 28% higher than those who report no such movement. Surprisingly, household structure, marriage to a relative or numbers of sons are not important confounders of this relationship.

There is no relationship between women's unaccompanied mobility and antenatal care use. This finding contrasts with the positive, if somewhat weak relationship between unaccompanied mobility and contraceptive use. Apparently, women's ability to travel *alone* does not translate into an ability to use antenatal services.

Table 4.14 Estimated logistic regression odds ratios of the relationship between the three measures of women's mobility and antenatal care use, currently married women (15-49), PFFPS 1996-97

	Travelled with company Model series 1	Travelled alone Model series 2	Can travel alone to a health centre Model series 3
Uncontrolled	1.57***	1.50	1.36
Adjusted for socio-economic characteristics[1]	1.37**	1.10	1.0
Adjusted for social characteristics[2]	1.53***	1.53*	1.49**
Adjusted for wider societal level characteristics[3]	1.51**	1.23	1.22
Adjusted for all potential confounders together[4]	1.28*	1.13	1.19

[1] Controlled for women's education, husband's education, socio-economic status and occupation.

[2] Controlled for age, number of sons, and household structure.

[3] Controlled for province, area and having visited a health centre in the past one year.

[4] N (weighted) =3813.

* p<0.05, ** p<0.01, *** p<0.001.

4.2.2.2 Decision-making and utilisation of antenatal services

As discussed earlier, the three decision-making variables are based on the premise that women who are effectively involved in these decisions can also make decisions regarding their own health. Although this premise is supported by findings for contraceptive use, it does not hold true for antenatal care use.

Tables Table 4.15, 4.16, and 4.17, show the odds ratios of antenatal care use with different levels of involvement in decision-making in the three domains, first uncontrolled and then adjusted for various combinations of potential confounders. Once all the potential confounders are adjusted for simultaneously, the odds ratios fall to insignificant levels in all three domains. The data thus support the assertion that there is no relationship between

women's level of involvement in domestic decision-making and antenatal care use. This finding contrasts with the positive relationship seen earlier between levels of involvement in decision-making and contraceptive use. However, despite the lack of an association, a large proportion of women (around 85%) participate in the decision making process, even if few of them actually make the final decision. Apparently, participation or even making the final decisions in these domestic domains is neither necessary nor sufficient for women to seek antenatal services.

Table 4.15 Estimated logistic regression odd ratios of the relationship between levels of involvement in decision-making regarding treatment of a sick child and antenatal care use, currently married women (15-49), PFFPS 1996-97

	Does not participate	Participates, but did not make the final decision[5]	Makes the final decision jointly with husband	Makes the final decision alone
Uncontrolled	0.83	1.0	1.65**	1.70*
Adjusted for socio-economic characteristics[1]	0.91	1.0	1.15	1.19
Adjusted for social characteristics[2]	0.81	1.0	1.78***	1.83*
Adjusted for wider societal level characteristics[3]	0.84	1.0	1.26	1.47
Adjusted for all potential confounders together[4]	0.87	1.0	1.10	1.24

[1] Controlled for woman's education, husband's education, women's occupation and socio-economic status.

[2] Controlled for age, number of living sons and household structure.

[3] Controlled for province, area and having visited a health centre in past one year.

[4] N (weighted) =3745.

[5] Reference variable.

* $p<0.05$, ** $p<0.01$, *** $p<0.001$.

Table 4.16 Estimated logistic regression odd ratios of the relationship between levels of involvement in decision-making regarding food purchases and antenatal care use, currently married women (15-49), PFFPS 1996-97

	Does not participate	Participates, but did not make the final decision[5]	Makes the final decision jointly with husband	Makes the final decision alone
Uncontrolled	0.89	1.0	1.39	1.62*
Adjusted for socio-economic characteristics[1]	0.87	1.0	1.02	1.29
Adjusted for social characteristics[2]	0.87	1.0	1.60*	1.86**
Adjusted for wider societal level characteristics[3]	0.88	1.0	1.11	1.29
Adjusted for all potential confounders together[4]	0.87	1.0	1.09	1.36

[1] Controlled for women's education, husbands education, woman's occupation and socio-economic status.

[2] Controlled for age, number of living sons, and household structure.

[3] Controlled for province, area and having visited a health centre in the past one year.

[4] N (weighted) = 3813.

[5] Reference variable.

* $p<0.05$, ** $p<0.01$, *** $p<0.001$.

Table 4.17 Estimated logistic regression odds ratios of the relationship between levels of involvement in decision-making regarding clothes purchases and antenatal care use, currently married women (15-49), PFFPS 1996-97

	Does not participate	Participates, but did not make the final decision[5]	Makes the final decision jointly with husband	Makes the final decision alone
Uncontrolled	1.0	1.0	2.26***	2.16***
Adjusted for socio-economic characteristics[1]	0.92	1.0	1.37	1.31
Adjusted for social characteristics[2]	0.98	1.0	2.32***	2.32***
Adjusted for wider societal level characteristics[3]	0.93	1.0	1.80**	1.53**
Adjusted for all potential confounders together[4]	0.9	1.0	1.38	1.27

[1] Controlled for women's education, husbands education, woman's occupation and socio-economic status.

[2] Controlled for age, number of living sons, and household structure.

[3] Controlled for province, area and having visited a health centre in the past one year.

[4] N (weighted) = 3813.

[5] Reference variable.

* $p<0.05$, ** $p<0.01$, *** $p<0.001$.

4.2.2.3 Control over wages and use of antenatal services

Use of antenatal services obviously involves financial outlays. So it would be reasonable to assume that women with independent monetary resources over which they have some control will, at least, be more likely to be able to overcome the financial barrier to seeking antenatal care than those with no such control. Multivariate analyses does not, however, support this assumption. Table 4.18 shows the odds ratios of antenatal care use and women's work (model series 1) and control over their income (model series 2), first unadjusted, and then adjusted for various combinations of potential confounders.

Model series 1 show that women who work for wages are significantly less likely to use ANC services compared to homemakers (who by definition who do not have an independent source of income). The size of the odds ratios changes somewhat after adjusting for various individual and societal level characteristics, but the differential remains significant.

Analysis of control over income and use of antenatal care is limited to a sub-sample of 714 women who worked for wages. The size of the odd ratios in model series 2 suggest that women who keep all their money are more likely to use ANC services compared to women who give all away although the differences are not significant at α=0.05. Adjusting for important confounders changed the size of the coefficients, but the differential remains insignificant. Women who give away all their money are as likely to use ANC as women who keep all their money.

Since control over their income and use of antenatal services might be expected to vary by type of household structure, age or number of sons, it is interesting to note none of these emerged as important confounders. Thus, traditional life cycle related characteristics, which appear to confer a certain status on women, tend not to factor in the use of ANC services.

In sum, the data show women who work are less likely to use ANC services compared to women who do not. Amongst women who have an independent income, there is no significant difference in the odds of ANC use between women who keep all their money and those who give all away.

Table 4.18 Estimated logistic regression odds ratios of the relationship women's work and control over their income and antenatal care use, currently married women (15-49), PFFPS 1996-97

	Women working for wages[1] Model series 1		Control over income[2] Model series 2		
	Women do not work for wages	**Women work for wages**	**Keeps all the money**	**Keeps some money**	**Gives all the money away**
Uncontrolled	1.0	0.53***	1.0	0.49	0.72
Adjusted for socio-economic characteristics[3]	1.0	0.63**	1.0	0.52	0.95
Adjusted for social characteristics[4]	1.0	0.54***	1.0	0.52	0.74
Adjusted for wider societal level characteristics[5]	1.0	0.58***	1.0	0.50	0.70
Adjusted for all potential confounders together[5]	1.0	0.61**	1.0	0.50	0.87

[1] N (weighted) =3813.

[2] N (weighted) =714 women who work for wages and had a pregnancy in the three years prior to the survey.

[3] Controlled for women's education, husband's education and socio-economic status.

[4] Controlled for age, number of living sons and household structure.

[5] Controlled for province, area and having visited a health centre in the past one year.

* p<0.05, ** p<0.01, *** p<0.001.

4.2.2.4 Communication index and antenatal care use

Table 4.19 shows the relationship of the communication index scores with antenatal care use. An increase in communication index score is positively associated with antenatal care use. Adjusting for combinations of potential confounders changes the size of the odds ratios, but the differential remains significant. Once all the potential confounders are adjusted for

simultaneously, women who score a maximum of four have odds of antenatal use that are two times greater than the odds of use in women who score zero.

The communication index is based on a discussion of family planning matters only, but the positive relationship with antenatal care use gives some reassurance that it capturing broader aspects of interpersonal communication and maybe a reasonable proxy for interpersonal relationship as well. As seen Chapter 3, this is a very complex dimension of women's gendered position. Only a small fraction of its variability can be explained by the background factors measured in the survey. This is not surprising, since inter-personal relationship is a fluid and subjective measure, very difficult to capture in a survey.

Table 4.19 Estimated logistic regression odds ratios of the relationship between the communication index and antenatal care use, currently married women (15-49), PFFPS 1996-97

	Communication index score				
	0	**1**	**2**	**3**	**4**
Uncontrolled	1.0	2.0***	2.36***	3.78***	4.72***
Adjusted for socio-economic characterisitcs[1]	1.0	1.68*	1.68*	2.16***	2.45***
Adjusted for social characteristics[2]	1.0	2.04**	2.57***	4.30***	5.76***
Adjusted for wider societal level characteristics[3]	1.0	1.45	1.51*	2.52***	2.82***
Adjusted for all potential confounders together[4]	1.0	1.42	1.40	2.06**	2.36***

[1] Controlled for woman's education, husband's education, socio-economic status and woman's occupation.

[2] Controlled for age, number of living sons, and household structure.

[3] Controlled for province, area and having visited a health centre in the past one year.

[4] N (weighted) = 3813.

* p<0.05, ** p<0.01, *** p<0.001.

4.2.2.5 Exposure index and antenatal care use

Overall, exposure to information is positively associated with antenatal care use. Table 4.20 shows the relationship between exposure to information scores and antenatal care use, adjusted for various combinations of potential confounders. Controlling for women's education greatly reduced the size of the coefficients, indicating the strong relationship between education and exposure to sources of information. The score of five differentiates women who read a newspaper from women who do not (a score of greater than nine indicates daily reading of the newspaper, which was uncommon and small numbers may be the reason for the lack of significance). Overall, the results show that women with a score of greater than five (category 2) are significantly more likely to use antenatal services than women who score zero. The obvious conclusion is that women who can read are more likely to use antenatal care. This is consistent with the finding that woman's education is a very important determinant of antenatal care use (Table 4.13). However, these results are controlled for education, indicating that an ability to read even in the absence of formal education has an effect on antenatal care use.

Table 4.20 also shows that a score of less than five has no relationship with antenatal care use. Since these are women who watch TV or listen to the radio only, apparently watching a TV or listening to the radio has no impact on antenatal care use behaviour. This can be explained by the fact that there are no health education campaigns about antenatal care use. The current health education media campaign tends to focus on family planning and immunisation only. These findings indicate that the focus of the messages is also important.

Table 4.20 Estimated odd ratios of the relationship between the exposure index and antenatal care use, currently married women (15-49), PFFPS 1996-97

	Exposure index scores[1]			
	0	1	2	3
Uncontrolled	1.0	1.67**	6.1***	11.3***
Adjusted for socio-economic charascteristics[2]	1.0	1.30	2.12**	1.77*
Adjusted for social characteristics[3]	1.0	1.69	6.01**	10.8***
Adjusted for societal level charascteristics[4]	1.0	1.43	4.14***	6.92***
Adjusted for all potential confounders combined[5]	1.0	1.30	1.52*	1.37

[1] The index scores were categorised as 0=0, 1-4=1, 5-8=2, 9-12=3 after analysing each score separately.
[2] Controlled for woman's education, husband's education, socio-economic status and woman's occupation.
[3] Controlled for age, number of living sons and household structure.
[4] Controlled for province, area and having visited the health centre in the past one year
[5] N (weighted) =3813.
* p<0.05, ** p<0.01, *** p<0.001.

4.2.2.6 Health knowledge index and antenatal care use

Table 4.21 shows the relationship between the health knowledge index score and antenatal care use, adjusted for a range of potential individual and societal level confounders. Adjusting for all potential confounders together shows that women who score eight or more have odds of antenatal care use that are nearly four times greater than the odds of use among women who scored zero. The strongly positive relationship between health knowledge index and antenatal care use suggests that women who have a good knowledge of family planning methods are also likely to be aware of the importance of antenatal care use. In other words, women who have family planning knowledge are also likely to have broader reproductive health knowledge. Moreover, the independent positive relationship between health education and antenatal care (adjusted for women' education) indicates that health knowledge in general can be beneficial even in the absence of formal education. This is an important observation in a context characterised by low rates of formal schooling amongst women.

Table 4.21 Estimated logistic regression odds ratios of the relationship between the knowledge index and antenatal care use currently married women (15-49), PFFPS 1996-97

	Knowledge index scores[1]			
	0	1	2	3
Uncontrolled	1.0	2.13*	3.90***	9.41***
Adjusted for socio-economic charascteristics[2]	1.0	1.83*	2.52**	3.82***
Adjusted for social characteristics[3]	1.0	2.31*	4.38**	10.7***
Adjusted for societal level characteristics[4].	1.0	1.60	2.84**	5.67***
Adjusted for all potential confounders together[5]	1.0	1.72	2.42*	3.69**

[1] The index scores were categorised as 0=0, 1-4=1, 5-7=2, 8-10=3 after analysing each score separately.

[2] Controlled for women's education, husband's education, socio-economic status and woman's occupation.

[3] Controlled for age, number of living sons and household structure.

[4] Controlled for province, area and having visited the health centre in the past one year.

[5] N (weighted) = 3812.

* p<0.05, ** p<0.01, *** p<0.001.

4.2.2.7 The combined effect of women's gendered position measures and socio-demographic characteristics on antenatal care use

Table 4.22 shows the results of the combined effect of women's gendered position indicators and background socio-demographic characteristics on antenatal care use.

Only two of the six indicators of women's gendered position, the communication index score and health knowledge index score retain significance in the final model. Assuming the communication index is a measure of inter-personal relationships, a major conclusion is that women with good interpersonal relationships with their husbands are more likely to use

antenatal services compared to women who do not. In other words, women who can discuss reproductive health issues, in this case family planning methods, with their husbands are also more likely to use antenatal services.

Similarly, women with high health knowledge index scores have odds of antenatal care use that are two to three times greater than odds of use in women who score zero. This is independent of education, which retains its very powerful effect. Addition of the health knowledge index (which is based on knowledge about contraceptive methods) to the final model had a minimal effect on the coefficients of education, indicating woman's schooling is an important independent determinant of antenatal care.

Table 4.22 also illustrates that all the socio-demographic determinants of antenatal care use identified in Table 4.13 retained significance after controlling for the measures of women's gendered position. Upper middle-class women, those who live in urban areas, women who had visited a heath facility in the past one year and whose husbands have secondary or greater than secondary education are more likely to use antenatal care services. In contrast, measures of women's gendered position, which include their patterns of mobility, decision-making in domestic domains and a control over their income lost significance and are not included in this final model. An obvious conclusion is that financial and geographical accessibility to health services are more important determinants of antenatal care use than women's mobility patterns alone or an involvement in decision-making or a control over their income. However, it is possible that the complex models lost power to detect smaller differences, and the findings presented earlier in less complex models should not be overlooked.

As noted previously, women with three or more sons are less likely to use antenatal care services. Since this finding is controlled for socio-economic status, and age lost significance, one possible conclusion is that multiparous women are less likely to seek antenatal services, irrespective of the sex of living children, compared to primiparous women.

Table 4.22 Estimated logistic regression odds ratios of antenatal care use by indicators of women's gendered position and background socio-demographic characteristics, currently married women aged (15-49), PFFPS 1996-97[1]

Dependent variable: antenatal care use	Odds ratio	95% CI
Predictors[2]		
Communication index		
0	1.0	
1	1.46	0.93, 2.29
2	1.31	0.87,1.95
3	1.76**	1.16,2.67
4	1.87*	1.15, 3.03
Health Knowledge[3]		
0	1.0	
1	1.64	0.89, 3.01
2	1.92*	1.04, 3.54
3	3.17**	1.50, 6.72
Women's education		
None	1.0	
Primary	1.90***	1.35, 2.67
Secondary	4.49***	2.80, 7.18
Above secondary	14.74***	4.87, 44.67
Husband's education		
None	1.0	
Primary	0.98	0.72, 1.33
Secondary	1.39*	1.01, 1.90
Above secondary	1.54**	1.04, 2.27
SE status		
Very poor	0.84	0.59, 1.18
Poor	1	
Lower middle	1.12	0.79, 1.58
Upper middle	2.00**	1.28, 3.15
Rich	1.64*	1.03, 2.62
Women's occupation		
Homemaker	1.0	
Professional	0.48	0.21, 1.12
Services	0.30*	0.17, 0.55
Agriculture	0.75	0.44, 1.30
Cottage industry	0.87	0.55, 1.37
No. of living sons		
0	1.0	
1-2	0.81	0.61, 1.07
3+	0.53**	0.38, 0.74
Province		
NWFP	0.65	0.37, 1.11
Punjab	0.57	0.36, 1.89
Sind	1.41*	1.81, 2.46
Balochistan	1.0	
Rural/urban area		
Urban	2.60***	1.65, 4.05
Other urban	1.62**	1.18, 2.23
Rural [r]	1.0	
Access to health services		
Visited a health centre in past 1 year	2.90***	2.27, 3.68
Did not visit	1.0	

[1] N (weighted) = 3813.
[2] Variables retained in the final model on basis of Likelihood Ratio Test on unweighted data (α =0.05).
[3] The index scores were categorised as 0=0, 1-4=1, 5-7=2, 8-10=3 after analysing each score separately.
* p<0.05, ** p<0.01, *** p<0.001.

4.3 Summary and discussion

This chapter analysed the relationships between the six measures of women's gendered position and (i) contraceptive use and (ii) antenatal care use. Table 4.23 summarises the relationships identified.

Table 4.23 Summary of the relationships between the six measures of women's gendered position and contraceptive use and antenatal care use

	Contraceptive use	Antenatal care use
Women's mobility		
• Travelled alone	Positive	NS[1]
• Travelled with company	NS	Positive
Decision-making[2]		
• Makes final decisions jointly	Positive	NS
• Makes final decisions alone	NS	NS
Control over income		
• Works for wages	NS	Negative
• Keeps all her income	NS	NS
Communication index	Positive	Positive
Exposure to information	Positive	Positive
Health knowledge	Positive	Positive

[1] NS = Relationship not significant at $\alpha = 0.05$
[2] In child health and food purchase domains with reference to women who do not participate in the decision-making process at all.

The most striking finding is the complexity of the relationships. Three of the indicators of women's gendered position, notably mobility, decision-making and control over income have a different relationship with antenatal care use on the one hand and contraceptive use on the other. Moreover, these indicators lost significance altogether in the final models of contraceptive and antenatal care use.

One of the most complex relationships is that between the different types of women's mobility and contraceptive use vs. antenatal care use. Women's *unaccompanied* mobility and contraceptive use have a borderline association (OR=1.29, p=0.07) while *accompanied* mobility and antenatal care use have a more significant relationship (OR=1.28, $p<0.05$). Women's postulated ability to travel alone to a health centre if the need arises is positively

associated with contraceptive use, but not with antenatal care use. Moreover, all three measures of mobility lost significance in the final models of both contraceptive and antenatal care use (Table 4.11 and 4.22). An additional complexity is the finding that health knowledge retained significance in these models. In view of the findings that health knowledge is positively associated with all three indicators of women's mobility (Table 3.10), it seems that women's mobility may have a greater indirect effect via health knowledge than a direct effect on use of contraception or antenatal care services.

Women's inability to travel alone has been identified as an important barrier to their ability to access health service outlets (Khan 1999). The postulate therefore is that if a woman can travel alone, she can access health services. The findings of this chapter do not support this postulate. Instead the data suggest that there is no relationship between a woman's pattern of mobility and contraceptive use, while women who travel with company are more likely to use antenatal care services. The former conclusion agrees with previous research from Pakistan (Sathar and Kazi 1997 in Punjab; Fikree et. al 2001 in urban Sind), raising a number of questions:

- Does the importance of restricted mobility as a barrier to uptake of healthcare services vary between types of service?
- Do the obvious physical manifestations of pregnancy have a role to play in whether women can travel alone or not? Do notions of *purdah* vary during pregnancy such that even women who may otherwise travel alone for contraceptive services would not do so when pregnant?
- Is there an underlying socio-economic or class connection between accompanied mobility and antenatal care use?
- What are the patterns of women's mobility in Pakistan and how do local constructions of space and movement compare to outsider definitions?
- Is a focus on unaccompanied mobility and use of health services valid, particularly for the indirect relationship via health knowledge?

These issues are further explored in chapters six and seven.

The relationship between the decision-making variables and the two reproductive health outcomes is also complex. On the one hand, there is a positive association between women's levels of involvement in decision-making in three domestic domains and contraceptive use. On the other hand, there is no relationship between the same set of variables and antenatal care use. An obvious conclusion is that women, who make final decisions in the routine

household matters, jointly with their husbands or alone, are in a position to make decisions about their fertility. These findings agree with previous research from Pakistan (Sathar and Kazi 1997). However, the lack of a similar relationship with antenatal care use is puzzling, raising a number of questions:

- Do patterns of women's involvement in the decision making process vary by domain under consideration?
- Does an involvement in domestic decisions translate into an ability to make fertility control or pregnancy-related decisions or are they two separate issues?
- Where greater involvement in decision-making is found to be associated with higher use of services does the relationship reflect a direct link, or is the greater involvement an indicator of other factors, not necessarily related to women's gendered position or other unobserved dimensions of a woman's gendered position?

An additional complication highlighted in this chapter is the manner in which husband and wife's desire to avoid another birth is translated into contraceptive use. The husband's desire has a stronger effect on outcome than a woman's desires, pointing to the possibility that fertility control is not a woman's individual decision, but located largely with the husband. Interestingly, neighbours' approval of contraceptive use appears to have a greater role than a woman's desires (OR 2.16 vs. 1.0, Table 4.11). The data thus suggest that fertility decisions are not under the control of an individual woman, but located with the husband, and even the larger society. Critics of demographic explanations of fertility control have long argued that a focus on individuals as the final determinants of their fertility is simplistic (Greenhalgh, 1994). A number of questions arise that are further considered in chapters six and seven:

- What is the exact role of the woman, her husband and the larger family in fertility control decisions.
- How does the context, in terms of societal norms regarding family size, fertility control and socio-economic forces influence reproductive patterns?

The relationships between women's work and control over their income are complex and difficult to decipher. There is no relationship between women's work for wages and contraceptive use, while the relationship with antenatal care use is negative. There is also no relationship between women keeping all their money, keeping some or giving all away and contraceptive or antenatal care use. These findings, which agree with previous research from Pakistan (Sathar and Kazi 1997 in Punjab; Fikree et al. 2001 in urban Sind), suggest that

earning an independent income and how it is controlled is irrelevant for women's use of a contraceptive methods and possibly antenatal care use as well.

However, this may be a rather simplistic conclusion. Chapter 3 showed that women who work do so because of poverty (Table 3.5). They tend to have no formal education and work largely in the low-paying, low prestige services and agricultural sector. The whole economic and cultural context in which they work places them in a situation which limits their options in complex ways. It could be that these 'structures of constraints' (Folbre 1994), rather then their employment or a lack of control over their income, are the real barriers to their use of reproductive health services. A more nuanced and sensitive approach would be to identify the larger gender and possibly class structures that create a climate and the 'structures of constraints' that prevent women's use of reproductive health services.

The relationships between communication index, exposure to knowledge and health knowledge index and the two reproductive health outcomes are positive. The communication and health knowledge indexes are also strongly significant in the final models (Table 4.11 and 4.22). A major conclusion is that women who have good communication with their husbands are more likely to use both contraceptive methods and antenatal care services. It is worth exploring what gendered values surround couple communication in a context characterised by metaphorical separation of women and men. To what extent do husbands communicate their fertility desires and how does that shape a woman's fertility desires?

Similarly, women who are exposed to sources of information and have good knowledge of health are more likely to be users of both services. Health knowledge, while strongly associated with women's education (Table 3.9), is also an independent determinant of contraceptive and antenatal care use. This indicates that health knowledge alone can lead to improvements in reproductive health, an important consideration in a context of very low education levels. It is therefore worth exploring to what extent interpersonal communication networks are a source of health knowledge and which individuals constitute these networks.

To summarise, the quantitative data analysis show that women's gendered position in Pakistan is variable, multidimensional, and that the different dimensions vary not just at the individual level, but at the larger societal level as well. The findings also support the hypothesis that the relationship between the different dimensions and contraceptive use are different from those with antenatal care use. However, it is worth noting that while there are some important relationships between measures of women's gender position contraceptive and antenatal care, their importance is rather limited compared to the measures of socio-

demographic characteristics, both in term of the size of the coefficients as well as significance. Overall, the complexities demonstrated in the last two chapters highlight the limitations of survey methods in capturing a rather illusive concept. In the next three chapters, qualitative data from a village in Punjab will be used to throw light on the issues identified above.

Chapter 5

Jatti and its the socio-cultural context

The objective of this chapter is to describe the wider social context from which the qualitative findings emerged. As discussed in chapter 1, I will use the social relations analysis framework to understand 'gender' as a social construct. According to this approach, to truly understand women's gendered position vis-à-vis men, it is important to first understand, in-depth, the wider societal structures of class, economic systems, and power that affect both women and men.

The chapter is organised as follows. First it describes the social set up of the village, and the differential socio-economic classes. Second, it describes the economic system, education and health care facilities. Interwoven in these descriptions are how social and economic power are concentrated in a few individuals and families and the subtle manner in which the system is perpetuated. The differential effects of these on women and is also described.

5.1 The village

Jatti *ghran* (village) is a small, remote village located in Tehsil Fateh Jang, District Attock, North-West Punjab. A poorly maintained metalled road connects it to Rawalpindi, the nearest large city, a three-hour drive away. Fateh Jang is a small provincial town in the opposite direction, about one and a half- hours drive (see Figure A3.2, Appendix 3).

The village consists of a well-defined main settlement and 20 *dhokes*[1] scattered in the surrounding fields. The main settlement consists of 54 houses densely packed together surrounded by fields (see Fig 5.1 for map of the main settlement made by men in a social mapping exercise). Some of the *dhokes* are located at distances greater than an hour's walk, which makes them further afield than the neighbouring village of Lodhial and Pind. Nonetheless they are considered a part of the village. An all weather stream flows around the main settlement.

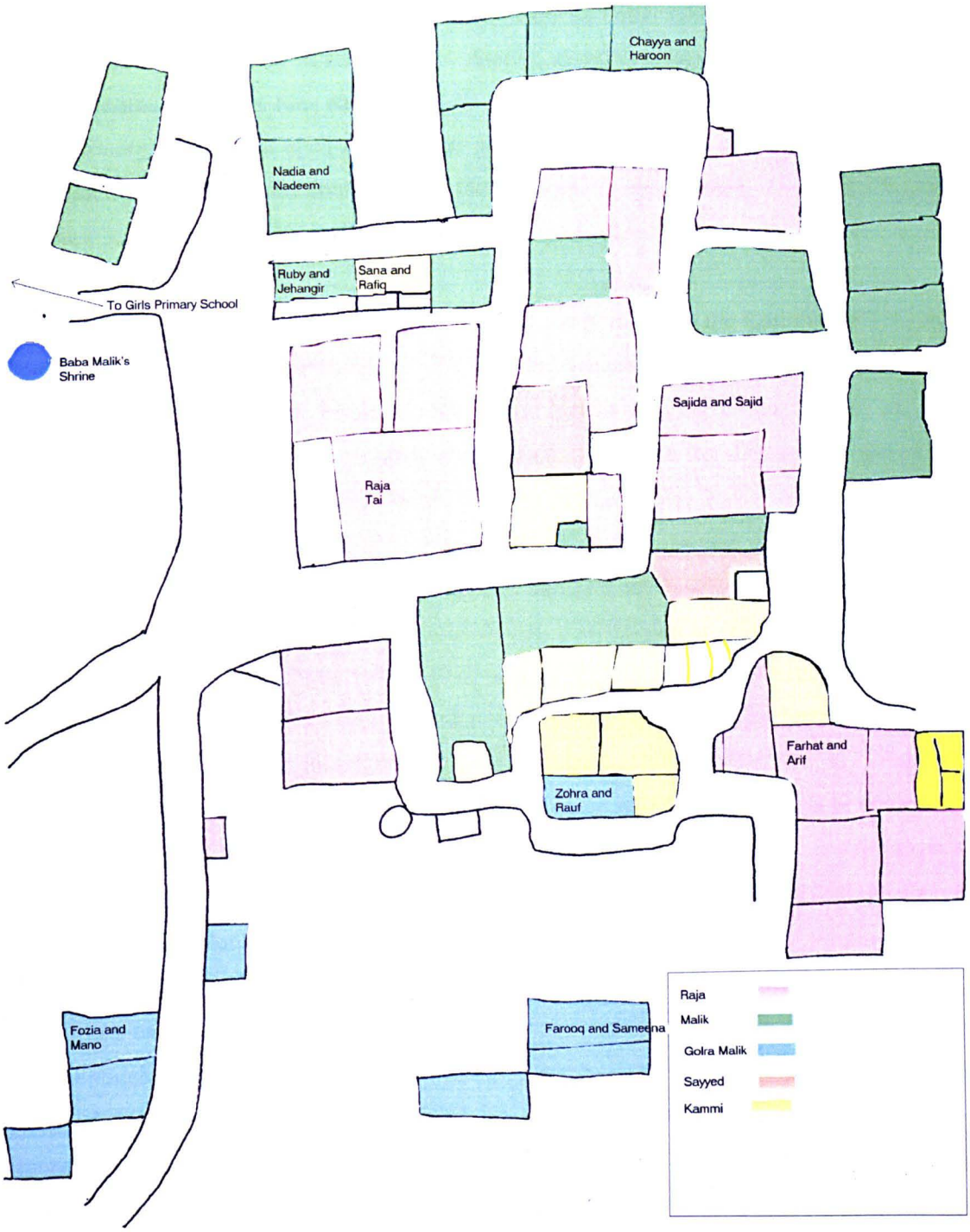
[1] A *dhoke* is an isolated farmhouse, sometimes two located in the surrounding fields away from the main settlement.

Plate 5.1 Village Jatti

With a few exceptions, the houses are made of stones layered with mud, with mud floors and flat roofs. A typical house consists of a *vera* (open space) surrounded by two or three rooms, enclosed by high mud walls. Open fields are used for toilet purposes and the stream for washing and bathing. Water is drawn from wells. The better off houses have private wells while the poorer households either use their neighbours or the three public wells. A few wealthier households have *pucca* houses made of cement with pit latrines and bathrooms. A *pucca* house is essentially a status symbol with little utility as they are uncomfortable in the extreme weather conditions. This is the only village in the region that has electricity and a telephone connection. Open drains choked with rubbish line the village lanes.

Historically Jatti area was dominated by Hindus. Up until 1947, the Hindus were the largest landlords and the narratives of the old men indicate that the Muslims were poor tenants. Following partition in 1947, all the Hindu population migrated to India. The current residents of Jatti, all of whom are Muslims, have always lived in the village. There is a small amount of emigration to largely the nearby urban areas, but no immigration into the village.

Figure 5.1 **The village of Jatti (drawn during male social mapping exercise)**



5.2 Social organisation of the village: The *biradari* system

The basic social unit of the village is a *biradari,* which at its simplest can be defined as a group of households related by blood. It also constitutes a social, a class, an economic and a political unit. The primary identifier of a *biradari* is *zaat*, which can be considered a multidimensional identifier similar to caste. *Zaat* is, at the first level, a social division based on occupation. A man's *zaat* determines his occupation which in turn largely determines socio-economic class, and upon class hinges prestige and power. Thus the *zaat* and *biradari* into which one is born determines social and economic opportunities. This is a simplistic overview and the complexities will be addressed as appropriate.

There are three major *zaats* in the village, the Rajas, the Maliks and the Kammis. Within each *zaat*, there can be a number of unrelated *biradaris* but because Jatti is a small village, there is only one Raja *biradari*, two Malik *biradaris* (the Maliks and the Golra Maliks) and one Kammi *biradari.* Within each *biradari* are a number of families. Figure 5.1 shows the distribution of the various *biradari* houses.

The Raja *biradari* are the landlords and together the 21 households own about 90% of the land. Land ownership confers prestige and power. Not all Rajas own land, a couple of households are quite poor. Nonetheless, their *zaat* gives them a status above that of landed Maliks. Raja Tai is the richest amongst them, the local feudal lord. His family practically owns the whole village and nine other surrounding villages. He is referred to as 'Chairman Tai' because he is always elected chairman of the Union Council whenever local bodies are functioning. As the largest landlord, he is the default chairman. The election process is a meaningless exercise for nobody in the village and surrounding areas would dare challenge the largest landlord for political power.

The Maliks can be considered the middle-class. They work as tenant farmers on the Raja lands although some of them own small pieces of land. As tenants, they are economically and socially dependent on the goodwill of the Rajas. Some of them own virtually nothing, and are dependent on the Rajas even for the land on which their houses are constructed. But some amongst them, particularly members of Golra Malik's *biradari*, are educated and work as schoolteachers and health care providers.

The poorest and socially weakest are the Kammis. The word 'Kammi' meant different things depending on who was present when the term was used. In public, the word was hardly ever used. But when used, it was with the explanation that we call them Kammi*s* because they are

kam karne wale (i.e. those who work). They do low prestige work such as *mochis* (shoemakers), *kasai* (butcher), *nai* (barbers), *darzi* (tailor) and *lohar tarkhan* (carpenters). This *biradari* carry out their assigned tasks all year round and are paid annually in kind when wheat is harvested. As the poorest group, they are also the most helpless and politically marginalised in the face of blatant violation of their rights. Most own virtually nothing, do not grow their own food and are dependent on the Rajas and Maliks for everything, ranging from wheat to the land on which their houses are built.

Analyses of the social stratification of Muslim communities in the sub-continent repeatedly discuss whether the Hindu concept of 'caste system' is a relevant paradigm for understanding the class differences. In his *Homo Hierarchicus*, Dumont (1972) argues that while the Brahmanic values of inequality, idiom of purity and the strict hierarchical scale were not accepted by the ruling Muslims, the caste system definitely influenced the ideal of equality stressed by Islam. When Hindus converted to Islam, they did not transform the social order.

The *zaat* system in this village supports Dumont's postulate. Although it lacks the basic criteria of the Hindu caste system which is based on notions of purity and pollution, it is nonetheless, very hierarchical. People are very status minded. The Rajas have the highest social status while the Kammis the lowest. The inherent values systems attached to the *zaats* are reflected in the terminology used. The word 'Raja' connotes kings, while the word Kammi means, as Nadeem succinctly expressed,

> 'they may have a number of '***kamian***' (weaknesses), ...for other people.....but for us...they were like *biradari*....they were very clean....we had such a trust on them...you know these people were Kammi people we consider ***katia*** (low class) ***kameenee*** (low form of life)... (Nadeem, aged 42 years, Malik)

Similarly, the Maliks refer to themselves as *zamindars,* a term used for landowners, but the Raja's refer to them as *mazaras* which is the equivalent of 'peasants' with all its value connotations.

These value systems are interwoven into daily social life and implicitly underlay all social and economic interactions. Even though men and to a limited extent, women have social interactions across *biradari* boundaries, the difference of social status is always present in people's manner of communication. The general attitude of the Rajas, towards the Kammis in particular, is one of arrogance. Social class interacts with gender divisions in numerous and complex ways to create a context which favours Raja men disproportionately. More

importantly, the differences in social status based on *zaat* are accepted as given a fact that few challenge.

Despite the rigidities of the *zaat* system, there is room for upward social class mobility. This is slowly happening in Golra Malik *biradari*. With education and an improving economic status, they are slowly making this transition. They do not call themselves Maliks and had difficulty in recalling their *zaat* during the social mapping exercises. During informal conversations, they referred to themselves as Rajpoots (similar to Rajas), but it later emerged they were indeed Maliks. Farooq has even attached the title 'Raja' to his name for correspondence outside the village. They carefully cultivate the Rajas company, while simultaneously distancing themselves from the other Maliks in the village.

Figure 5.2 lists the respondents (of the in-depth interviews and case studies) by *zaat* and occupation.

Figure 5.2 List of respondents (of in-depth interviews and case studies) by *zaat*, occupation and land-ownership status

	Woman and her husband's name	Age F/M	*Zaat*	Land-ownership status	Husband/wife's occupation
1	Nadia and Nadeem*	25/42	Malik	Landless	Security guard/ homemaker
2	Sameena and Farooq*	30/35	Malik	Small landholding	Medical technician/ homemaker
3	Salma and Nadeem*	34/29	Malik	Landless	Cook/teacher
4	Sana and Rafiq	40/45	Kammi	Landless	Carpenter /homemaker
5	Rafia and Rafiq	42/50	Malik	Landless	Farming-both
6	Naheed and Akram	32/38	Malik	Small landholding	Farming/ homemaker
7	Chayya and Haroon*	45/55	Malik	Small landholding	Retired army personnel/farming
8	Muzzamil and Mukaram	32/28	Malik	Medium-sized landholding	Farming/ homemaker
9	Sajida and Sajid	28/35	Raja	Large landholding	Video-business/ cum landlord/ homemaker
10	Ruby and Jehangir*	25/26	Malik	Landless	Farming/ homemaker
11	Shazia and Salim	40/55	Raja	Large landholding	Farmer/homemaker
12	Fozia and Mano*	35/31	Malik	Landless	Farming/teacher
13	Zohra and Rauf	42/37	Malik	Medium-sized landholding	Teacher/teacher
14	Farhat and Arif	39/46	Raja	Landless	Retired army personnel/ homemaker
15	Mazloom and Mukarram	39/45	Malik	Landless	Teacher/ homemaker

* Couples that also constituted the case studies.

5.3 The economic system

Agriculture and livestock rearing is the primary economic activity. Arid agriculture produces an annual wheat, maize and millet crop. About 90 % of the land in the area is owned by the 21 Raja families, of which 80% is owned by two families only. Labour for cultivation and harvesting is provided by tenants, mostly the Maliks. According to the tenancy system, the tenant is responsible for all the expenses incurred in planting and cultivation and the yield is divided equally between the land-owner and the tenant. The same system is applied to animal husbandry. The Rajas own the cattle, but the Maliks are responsible for the day to day care and the profits are shared equally.

This tenancy system is probably one reason for sub-optimal use of land and widespread poverty. An annual rain-dependent wheat crop is clearly sub-optimal use of land, whose potential was demonstrated by one land-owing Malik family. With the help of foreign remittances, they transformed a bare landscape into a lush fruit orchard that yields much higher returns than the traditional farming practises. The tenants are trapped in a cycle of poverty, barely surviving at subsistence level. They have no margins for investment in modern agricultural inputs and possibly a lack of desire to invest in somebody else's land. The landlords on the other hand, as detached owners, receive sufficient income from the large landholdings. They see little reason to reinvest the profits.

Farming alone is insufficient to meet the basic needs of most households. This is even true of some of the Raja households because patterns of inheritance according to the *shariah*[2] meant diminishing size of landholdings in subsequent generations. Consequently it is perceived amongst all *biradaris* that at least one male family member should work in the formal wage-earning sector.

A job in the formal sector, particularly a *pucci nokri* (permanent job) in the government or armed forces is a matter of prestige second only to land ownership. But jobs are scarce and unemployment a severe problem. Lack of formal education and specific skills, coupled with a social system in which *zaat* determines the kind of work people do results in a lot of young men hanging around the village lanes with nothing to do. For Raja men in particular, unemployment is complicated by values that dictate the type of work deemed suitable for a Raja.

[2] According to the Muslim Family law or the *Shariah* Law of Inheritance, sons and daughters share in their father's property is at a ratio of 2:1 after the widow has been allotted her one-eighth share.

This is a context where status is most explicitly expressed in leisure. Therefore, m*azdoori* (labour) is low prestige work beneath the status of a Raja. They even view farming labour on their own lands beneath their prestige, so when landholding reduce in size, they prefer to work in the formal sector. In contrast, the Maliks are more versatile and willing to do any job, however menial. This versatility was commented upon by Raja Arif when he said

> 'These Maliks will rule over us one day because they do not have any inhibitions about work'. (Raja Arif, 32, big landowner)

However, employment of Malik and Kammi men in the formal wage-earning sector, is viewed as a threat by the two dominant land owning Raja families. It has the potential to move them from the landlord's sphere of economic and social control, an aspect viewed with alarm. The traditional relationship between the land-owning Rajas and their Malik tenants is mutually inter-dependent, as in any capitalist system with its supply and demand principle. But in this context, the interdependence is not symmetrical. It is not perceived or conducted as a straightforward business relationship. It is, instead, a hierarchical relationship with the landlords dominating the tenants, using power differentials embedded in land ownership. They subtly combine coercion with moral strictures of altruism. A sense of obligation on behalf of the tenants towards the landlords is a defining feature of this relationship; that somehow the landlord, by letting his field for cultivation is doing the tenant a favour. An underlying theme is the threat that the favour can be withdrawn anytime. This level of control over a very poor tenant's livelihood and even the roof over their heads gives the landlords immense power over their tenants.

To ensure supply of this cheap and compliant labour, the landlords employ a number of mechanisms to prevent the villagers from obtaining employment in the formal sector. The foremost is actively withholding educational opportunities, an issue I will discuss in detail in the next section. There were incidences of Rajas intercepting mail known to contain offers of employment from the armed forces since the army appears to be the only non-partisan source of employment that does not require inter-personal connections and one over which the Rajas had little influence.

They also employ other subtle mechanisms to maintain their social and hence economic control. One is by providing loans to the villagers at interest rates the villagers could not articulate precisely, and were obviously unable to calculate. From what we gleaned, the interest rates are exorbitant, ensuring the loan-taker remains financially indebted to the Rajas for a very long time. Another very subtle mechanism is discouraging the villagers from

building a house on personal land if available. They'd rather the house was constructed on the Raja lands, ensuring a leverage and control that will be reduced if the villager have their own property. They grant favours to people like Farooq who, by virtue of their education and employment in the government sector, are no longer dependent on them for their livelihood. Farooq was charged with the theft of medicines from the BHU[3] and reselling them in his private practice. Raja Tai went out of his way and used his political networks to get Farooq released from jail before completion of his prison sentence. This ensured Farooq is forever obliged to them. They seek situations to dispense favours even when not requested. Farooq's brother Qadir, who lives in nearby Fateh Jang was involved in a car-accident. The whole process was handled to Qadir's satisfaction, but when Raja Tai came to know, he chided Farooq for not informing him, saying he would have helped them; in effect making Farooq feel guilty for not seeking his help.

Women's role in the village economic system is complex and varies by class and *zaat*, although the two are closely related. Normative values ordain them as economic dependants, a role women are not only proud of, but something they aspire to since it is a symbol of higher socio-economic class. As a result there is a supposedly rigid division of labour, which broadly speaking allocates 'indoor' domestic work to women and outdoor income-generating work to men. But there are large variations, particularly by class, and *biradari*. On one level, there is variation in how this gender value is presented as a norm and then there is variation in what actually happens. Men in particular, of all *biradaris* are very keen to present this division of labour as the absolute truth. While this was true of women as well, some of the poorer Malik women openly state their contribution, justifying their involvement on the basis of poverty. On the whole, men, consider themselves as the primary providers. This image is presented even when the wife is the obvious source of cash income as in the case of Fozia and Mano. Fozia, as a school teacher earns a cash income that exceeds Mano's farming income in both cash and kind. He even takes pocket money from her.

While this is a rather unusual case, women's real level of engagement in the income generating activity is determined by differing levels of economic resources at the disposal of each household. Most Malik and Kammi women, besides their domestic work, participate in agriculture labour and livestock care. In some families, such as Nadia's, women's involvement in farming activities is extensive for all the able-bodied men of the family work in the formal sector.

[3] BHU is the Basic Health Unit, a public sector first level health care facility manned by a Medical Technician, a Lady Health Visitor and a TBA.

Plate 5.2 Harvesting wheat

Women are also routinely involved in activities that normatively fall in the male domain, although they are usually carried out within the confines of the family unit. For example, Akram was building a poultry farm. All the women of his family were involved in the construction of the building, particularly applying mud on the walls and floor. Although application of mud is a female domain activity, the fact that it was for a poultry farm, a source of cash income, and so a male domain made it an 'outside male activity'. When questioned Akram first stated only men do this work. Since there were about 15 women and two men working, he quickly qualified his statement saying this is an unusual situation since he cannot afford outside labour. Some women also earn cash income by embroidering *shalwar kameez* and *dupattas* for businesses in Rawalpindi. Most breed chickens and sell eggs, although none would ever admit their involvement in these activities. Their narratives referred to other women, usually an unpopular relative, who resorts to such demeaning work. Only a few well-off women, mostly the Rajas and some Maliks, fit into the norm of economic dependency. Their work is limited to domestic activities, although they too will pitch in harvesting if the need arises.

Despite all this involvement, there is no denying that women are largely excluded from the main economic activities. More importantly, they are excluded from direct control over means of production and are normatively not supposed to make decisions in this domain, an

issue that discussed in greater depth in chapter 6. On the whole, poverty does not lead to women working in the formal sector. This is due to a combination of a lack of specific skills, lack of social networks (a critical requirement), the work they are supposed to do (domestic) and the belief that upholds prior right of men to scarce employment opportunities. An example of gender values constraining uptake of employment opportunities is the vacant position of a Lady Health Worker. The job requires interaction with all village women, and even men, providing them health and family planning services. There are two major barriers that prevent uptake of this position 1) the LHW will have to interact with women of other *biradaris*, something that is frowned upon and 2) she will have to interact with and discuss reproductive health issues with men, both of her own *biradari* and non-*biradari*. The first barrier is not stated openly, but subsumed in the language of limited mobility. The issue of women's mobility will be discussed in greater depth in chapter 6, but with in village mobility is not the real issue here. The second barrier is based on the perception that reproductive health and family planning issues are *sharam ki baat* (topics of shame) and as Farooq said of a LHW

> ' It is a '*very besharmi ki baat*' (shameless) thing, her talking about and distributing family planning materials to her relatives'.

5.4 Education facilities

The education facilities within the village are limited, more so for girls than boys. There is only one primary school for girls, compared to two primary and one middle school for boys. Furthermore, the girls' school is located in the village graveyard. The primary reason given for this unfortunate location is that the graveyard land is *Mushtarka zameen* (common land). A government policy of school construction insists the villagers contribute the land for schools, a form of community participation. As no landowner was willing to donate land, the graveyard was the only option.

This is, but one example of how education is deliberately and systematically withheld. Both class and gender divisions underlie this implicit policy. Class-based differential access is covert, but nonetheless systematic. According to a number of villagers, Raja Tai actively intervened to prevent the setting up of a boy's secondary school till the funds finally lapsed. The objective is to prevent their tenants and farm workforce, the Maliks, from getting an education and finding work in the better paying formal sector. Surprisingly, this was openly stated and repeatedly shared with us by some of the '*chote*' (directly translated as small, but refers to the other cousins who have smaller landholdings) Rajas as well as the Maliks. The

children of the *wade* (bigger landholdings, more power and wealth) Rajas attended schools in Rawalpindi.

Girls' access to education was restricted, in addition to class, by a layer of gender norms and values regarding social definition of femininity, what constitutes ideal female behaviour, *purdah*, and sexual chastity. An ideal woman should have a pleasant nature, a positive attitude with a *kirdar* (actions, total sum of behaviour) that is acceptable to everyone. She should not be controversial. A good woman should first and foremost, cook food and welcome her husband's guests. From this perspective, a school-based education with its emphasis on reading and writing appears to have little relevance to the daily lives of village girls. At the same time, the potential of education to raise women's awareness and leading them to question the existing social system is viewed with alarm. Such questioning women will not fit into the norm of non-controversial docility. This fear is couched in the language of sexual morality, that somehow educated women are sexually immoral. Kauser teased her 15-year-old daughter that she will send her to school, to which the young girl took great offence since going to school implied she was involved in illicit sexual activity. Whenever, the example of Fozia and Salma as educated women earning good money was brought up, there was an invariable story raising the question of their sexual morality.

At the same time, education is not a priority issue. This is captured well by a visitor's disdainful comment 'there is no *riwaj* (culture) of educating children in this village'. As Akram said '*assan na mahol*[4] *nahi hai*' (Its not the way we do things). However, this varies somewhat by *biradari* and of course by gender. The Golra Malik *biradari* are very aware of the importance of education. One member has a college degree, four men and four women have received secondary education. They are the village teachers and health care providers. In turn they send their children, both girls and boys to private schools in Fateh Jang. The Raja's are just beginning to appreciate the importance of education, but only for boys. They are yet to act on their realisation of the importance of education. It is still a non-issue for girls as they see no benefit in educating girls. The girls assigned work is limited to domestic activities which, according to them, has no relationship with formal schooling. For the majority of the villagers, the Maliks and Kammis, education is a low-priority non-issue. While ambiguous about its value for boys, for it does not ensure a job, a girl's education is not even a matter under consideration.

[4] *Mahol* refers to the larger social climate.

This lack of priority and widespread under and unemployment discussed earlier feed into a vicious cycle. Although lack of education and specific skills are one cause of unemployment, there are a few young men who have received an education at very high personal costs and then found themselves unemployed for years on end. Lack of investment in employment generating projects, by both the government and private sector underlies this situation. There is thus, on the one hand, a severe need for schools and a large number of children do not attend school for the lack of facilities. On the other hand, men like Mano and Rashid, who have received an education, are desperate to work as teachers. Their unemployed status, further reinforces the impression that an education does not lead to a job, confirming its worthlessness as an investment. Lack of education and skills remains one of the primary reasons for the high unemployment rates in the village.

Another consequence of the lack of education and from there unemployment (and under-employment) is the insecurity of the general environment. Unemployed young men, mostly Rajas, with time to kill, are involved in drugs (mostly marijuana), *sharab* (alcohol brewing and drinking) and pre-marital sexual activity, which if the young mens' accounts are to be believed, amounts to rape. These activities, that are counter to prevailing social norms and the law, may not be directly linked to unemployment of men, but is definitely accentuated by it. As members of the land-owning dominant *biradari*, the Raja men involved in these activities are practically above the law. This has created an environment of insecurity, particularly for young women, providing further justification for the existence and perpetuation of gender norms of seclusion and limited mobility. It is also the most frequently cited reason for not sending girls to far-away secondary schools. However, class is an important determinant of vulnerability. The poor Malik and Kammi women are the most vulnerable, both by virtue of their lower social class and poverty that forces them to work in the fields. Apparently the vulnerability of women working in the fields is appreciated by the men like Raja Wakar and his brothers Bashir and Akram, men repeatedly named in various incidences of rape.

5.5 Health care services

Modern medical facilities are practically non-existent in the village. Farooq, a medical technician is the only 'doctor' available, and then only early in the morning or late at night. There is one dispensary in the nearby village of Lodhial, about half hours walk away. Although largely non-functional, there is an old *dai* in residence, who practices privately. A Family Welfare Worker is assigned to this village, but she has never visited Jatti and nobody in the village knew of her existence. I stumbled across her by chance. There is no Lady Health Worker either, although in the early stages of the programme, Farooq's wife was employed as

a LHW. She never really worked and Farooq informed us that he used to generate false activity reports.

Despite the obvious lack of facilities, there is nonetheless a turf battle for patients and Farooq's narratives has an underlying theme of hostility to any doctor who wants to practice in what he considers his domain. The government had recently hired young doctors to serve in the rural areas. Farooq informed us how he had petitioned, on the behalf of the villagers, to get the doctor removed. The sin the young doctor had committed was that once the severely rationed stock of drugs was finished, he had supplied some out of his own pocket and charged the patients. As a result, private practitioners in Fateh Jang and Rawalpindi are the primary source of health care for the villagers. This will be discussed in greater depth in chapter 7.

5.6 The role of Islam

In view of the frequent references to Islam to legitimise gender norms, its postulated role in family planning and the rise of militant Islam in Pakistan, I specifically focused on its role in the village.

Traditionally, the Kazi family performs the tasks of a *maulvi*[5]. They give *azaan*, (call for prayer), lead the prayer and teach the *Koran* besides officiating at marriages. They are paid in kind with both cooked food and wheat. This mode of payment, similar to the Kammis, reflects an implicit low status in the social hierarchy of the village. The Kazi family of the village do not perform their duties because the father is too old, and his elder son prefers to work in Lahore, a large city about 500 miles away. The senior Kazi has a bad reputation regarding the way he treated his wife, consequently nobody in the village is willing to give their daughter in marriage to his son. So about three years ago, the Kazi family bought a bride for the elder son at a cost of Rs 25,000, but the bride ran away on the wedding night with all the jewellery (having drugged the groom senseless). This incident is repeatedly narrated with gales of laughter and the Kazi family is the laughing stock of the village.

As a result, the villagers performed the *maulvi's* job although two men have been hired specifically for the task. One is a retired army *jawaan* (sepoy) who sells *samosas*[6] on the side and other, a young man of 19 years who is trained in Islamic theology. Nonetheless, the villagers take turns giving the *azaan* and Master Mushtaq, a primary school teacher teaches

[5] A *Maulvi* is a the religious leader responsible for leading the prayers in a mosque, teaching the Koran and officiating at marriages.
[6] A *Samosa is* patty made of meat and vegetables in a wrap.

the *Koran.* The two *maulvi's* are responsible for the two mosques in the village, but by and large the villagers do not take either of them seriously. During the Friday *Khutba*[7], usually a platform used to transmit militant ideas, the villagers laugh back at preachers if they don't agree with what they are preaching.

By and large, Islam as a religion is a personal affair and there is none of the extremism portrayed in the largely western media. There are two mosques, but there is no evidence of sectarianism or any other divisions. The men say their prayers in the mosques and the women at home. The villagers are religious in terms of regular prayer, but hardly ever refer to Allah or Islam to explain their activities and as is seen in the following chapters, Islam hardly emerges as a determinant of gender roles, relations or behaviours in the field-site.

To summarise, this chapter described the wider social context of the field site. It described how *zaat* determines an individual's occupation, and from there, socio-economic class and power. Feudalism, with social and economic power vested in one dominant family, characterises the political and power structures. While class-based barriers limit educational and employment opportunities for men, an additional layer of gender based values, that interacts with class, to create a context in which the poor women are disproportionately disadvantaged. It is worth mentioning that Northern Pakistan in which the field-site is located is not as strongly feudal as the remainder of Pakistan. While it is difficult to find a typical village representative of the country, it can confidently be stated that the power structures described above are not as strong as in other parts of the country.

The findings to be presented in the next three chapters will be analysed in the context of these wider societal level characteristics.

[7] Friday *khutbah* is the sermon given by the *maulvi* before the Friday prayers.

Chapter 6

'Mazboot Aurat'

This chapter explores how socio-cultural constructions of femininity/masculinity and female/male roles underlie the different dimensions of women's gendered position and how larger societal structures of socio-economic class, *biradari,* and *zaat* modulate individual behaviour. Interwoven in the analysis is an exploration of whether women contest the normatively prescribed gender rules and restrictions and what individual characteristics or social structures enable women to do so.

A particular objective is to 'unpack' and understand in greater depth the contextual meaning of the dimensions of women's gendered position explored in the PFFPS, namely: women's mobility, participation in decision-making, access to financial resources, communication with husband, and exposure to information.

The chapter is organised as follows. The first part is an analysis of the primary themes emerging from the data: the interconnectedness of individuals and families and the interconnectedness of household resources in this society. Within this framework, women's position in the kinship system is described. I then turn to consider three particular dimensions of women's gendered position: control over economic resources; decision-making and mobility.

6.1 An interconnected society

The most striking characteristic of Jatti's social ethic is the pre-eminence of communality rather than individuality. The concept of *'akhathe'*, roughly translated as 'togetherness' or 'jointness', is the bedrock of the society. The joint family system is just one of its more obvious manifestations for *akhathe* is the principle that forms the basis of the villagers' sense of self as well as their socially recognised identity. The interconnectedness operates at two levels binding the individual to the family, and families to the *biradari*[1].

[1] A point that needs to be clarified at this stage is that a *biradari* is made up of a number of families related by blood. A number of unrelated *biradaris* can belong to one *zaat,* but in Jatti, probably by virtue of its small size, there is only one *biradari* in each *zaat*, except the Maliks, which have two *biradaris.*

6.1.1 The interconnectedness of individuals with their families

Women and men in Jatti emphasise their social connectedness with their families and *biradari*. Kinship networks of family and *biradari/zaat* constitute an individual's frame of reference and the social relationships constitute their identity. This is true of both women and men but with some variations. A man is identified by his *zaat* followed by father's name and finally his name. For a woman, the frame of reference varies by life-cycle stage. It consists of *zaat*, followed by father, husband or later sons' names and finally her name. In the introductory stages of our fieldwork, the villagers would introduce themselves by their names and their kinship relationships with each other. 'I am so and so's brother and my sister lives in that house etc.....' .

From a Jatti resident's perspective, anchoring relationships are more important than his or her individual name, for an individual is not a construct separate from others. He or she is embedded within a network of relations that actually constitutes their identities. The importance of social relations can be gauged by the plethora of different words to denote specific kin relationships (Table 6.1).

Table 6.1 Local terms to describe familial relationships

Relationship	Local word
Father's father/ mother	*Dada/ Dadi*
Mother's father/ mother	*Nana / Nani*
Fathers elder brother/ his wife	*Taya/ Tayi*
Fathers younger brother/ his wife	*Chacha/ Chachi*
Fathers sister/ her husband	*Phuphi/ Phupha*
Fathers brother's son/ daughter	*Dadpothra/ Dadpothri*
Father's sisters son / daughter	*Phupher/ Phupheri*
Mothers brother/ his wife	*Mama / Mami*
Mothers sister/ her husband	*Masi/ Masa*
Mothers brother's son/daughter	*Mamaer/ Mameri*
Mother's sisters son/daughter	*Maser/ Maseri*
Daughter-in-law	*Nuu*
Husbands elder brother/his wife	*Jeyth/ Jethani*
Husbands younger brother/his wife	*Dewar/ dewrani*
Brothers wife	*Parjai*

This is a context in which it is essential to belong to a family and a *biradari* for without these anchoring relationships, an individual does not have a recognised identity. A person whose *agla-pichla* (larger familial and *biradari* network) is not known is viewed with suspicion. Such men are assumed criminals and women sex workers. At the same time, close and trusted friends can be 'adopted' into the *biradari* and given fictive kinship names.

It is the necessity of these anchoring networks that prevents Mukarram from contracting a second marriage.

> Mukarram and his wife Mazloom are childless after 17 years of marriage and Mukarram is very keen to get married again. But the idea is opposed by Mazloom and Mukarram's family, which includes his father and brother. Their opposition is strong enough to ostracise him from the family and *biradari* if he ignores them. The fear of fracturing his familial and *biradari* networks is his only deterrent. As he says
>
> 'If I get married, my *vyas* and *maatams* (weddings and funerals) will be in this direction (pointing in one direction) and theirs will be in this direction (pointing to the opposite direction)' (Mukarram, age 45).

The jointness or *akhathe* has other functions as well. It is an economically maximising strategy. This is further discussed below.

6.1.2 Interconnectedness at the *biradari* level

The *biradari* constitutes a social unit within which each person participates in a network of relationships. Members of a *biradari* tend to live together, occupying a part of the village, which then constitutes a *mohalla* (neighbourhood). While not a hard and fast rule, most *biradari* houses are built close to each other (See Figure 5.1). The villagers, in particular women and children, tend to stay in their respective *mohallas*. I once requested a group of Malik boys (aged around 10-12) to accompany me home since it was dark. The minute Farooq saw them outside his door (we were next-door neighbours), he shooed them off, angrily wondering how they dare come into his *mohalla*. The Malik women hesitated to visit us because we lived in another *biradari's mohalla*.

However, it is the *social* boundaries of a *biradari* that are particularly well defined. Farooq described his *biradari* as *'aik mahol jis say hum bahir nahin nikelte'* (a 'social environment/

climate out of which we do not move). A number of institutionalised mechanisms ensure sustained within-*biradari* interaction and limited cross-*biradari* interaction. The most important is regular and intense social activity within the *biradari* that leaves little room for interaction beyond the *biradari*. A lot of time and energy are expended in maintaining these relationships and women keep a strict tally of who visited whom and who has not visited whom.

Cross-*biradari* interaction is limited to funerals and weddings. There is a gender difference in the extent women and men are allowed social relationships beyond the *biradari*. Men are permitted to have extensive extra-*biradari* relationships, which are justified in terms of economic activities. Nonetheless, there is a clear distinction between their *biradari* and non-*biradari* friendships. Latif describes a non-*biradari* friendship as 'a friendship that stops at the gate and is not allowed into the house'. In contrast, women have minimal extra-*biradari* social interaction and any such relationships are frowned upon and discouraged. Even children are not allowed to mix with other *biradari* children. In particular, girls are discouraged from making *sahelian* (friends) from other *biradaris*. The absence of schooling with its potential for establishing friendships, further limits girls' opportunities for social interaction beyond their *biradaris*.

Endogamy is another mechanism of maintaining cohesion of a *biradari*. It is the norm and one that is largely followed in practice in Jatti. The primary reason given for the practice is that relationships between brothers and sisters, which start weakening as their children grow up, are strengthened if their children inter-marry. So strong is the need to reaffirm cohesion of the *biradari* that Rafiq equated it to a *juram* (crime) if he refuses to marry his daughter to his brother's son. Thus, marriages are arranged, not on basis of affective ties, but *biradari* requirements. If there are reasonably age-matched cousins, their marriage is a forgone conclusion.

An additional, often unspoken, understanding underlying endogamy is that a marriage to a niece reduces the probability of the new wife causing a break-up of the patriarchal joint family. In one sense, this is an acknowledgement of the power of women in the maintenance or break-up of a patriarchal joint family. Daughters-in-law are carefully chosen and every effort is made to marry two brothers to two sisters with the understanding that sisters are more likely to get along well in a household than two strange women. Farooq's mother had insisted her two sons, Farooq and Qadir, marry two sisters because she wanted them to remain *akhathe* (together). So strong was this demand that it overrode Farooq's desires regarding the woman he wanted to marry.

Membership in a *biradari* confers both claims and obligations. One of these is *vartan bhanji*, a reciprocal exchange of gifts at life-cycle marking stages and ceremonies such as a birth of a child or a wedding. It can be considered an institutionalised form of insurance for it helps with the financial expenses involved in marking these life-cycle stages. The most common form of gift is money, which then goes a long way in covering wedding expenses, including the *jahez* (dowry).

> At Surraiya's daughters wedding, her two brothers and three sisters each gave at least Rs 5,000[2] because Surraiya is relatively poor. This was used to make her daughter's *jahez*. Although they each named an item they were gifting her, the actual transaction was made in cash. Similarly, during Fozia and Salma's operative deliveries, all members of the *biradari* gave cash gifts, ostensibly to the new-borns, but which were very helpful towards covering the hospital expenses.

Vartan bhanji also extends across *biradaris*, but the amounts involved are small. Non-engagement in the *vartan bhanji* indicates social ostracism. The amounts of money or the value of gifts exchanged in *vartan bhanji* are loaded with values, which sometimes get misinterpreted and are a source of much anguish. A common cause of the anguish is as follows. Reciprocity is a primary rule underlying *vartan bhanji*. Furthermore, an effort is made to match, if not exceed the value of the gift given. However, since the life-marking stages of different families occurs at different times, along with the fact that fortunes of the receiving family may have changed during the intervening period sometimes results in violation of the rules of reciprocity or more commonly, in the value of the gifts returned.

There is also a reciprocal exchange of a whole range of services and favours between the men of the *biradari*. They give and get help from each other in a concept called *wangar*. *Wangar* is best described as a social exchange of labour. The activities can include cultivation/harvesting, construction of a house or poultry farm, arranging a wedding or a funeral. Money is not involved in this exchange of labour although *biradari* membership is an essential component of the exchange. In some cases, men help *non-biradari* friends or even other people simply because they live in the same village. However, *wangar* between *biradari* men is an obligation.

In the absence of formal welfare institutions, these strong social ties constitute the only form of social insurance, a fact implicitly understood by the villagers. A commonly stated reason

[2] Rs 5000 = £ 56.00

for endogamy is that it strengthens intra-*biradari* relationships, which are essential during *gammi peshi* (tough times). Loans between *biradari* members are common and do not involve interest. When Qadir's car had an accident, his brother Farooq and a brother-in-law Rauf pooled money for repairs.

The society is thus based on institutionalised relationships of mutual dependency. Membership of a *biradari* is crucial for securing benefits, material and emotional. The central elements of this membership are blood relationship, affective ties, trust and reciprocity. These in turn generate a system of claims and obligations, rights and responsibilities. Members draw upon, favours, privileged information and better access to opportunities.

However, *biradari*-based networks and their institutionalised role in accessing resources have their disadvantages, which were never openly voiced by the villagers as a feature of the system, although they bristled at the perceived injustices. The system constrains opportunities to non-network members. Some social groups are more powerful than others. As discussed in chapter 5, income-generating and employment opportunities in this context are based on networks rather than ability. Raja Tai gives only his *biradari* members the licences to run the transport system in the region. Employment in government jobs is limited to one *biradari* only. While this *biradari* members are the most educated, other members of their *biradari* are employed in jobs that do not require academic qualifications. For example, Yasi's mother-in-law is employed as a sweeper in the school in which Yasi and her sisters work as teachers. The mother-in-law has never *actually* worked, but draws a regular salary. Yasi, as her daughter-in-law, substitutes for her, sweeping the school and then later teaching.

Biradari membership can also place excessive demands on other members. A classical example is the position Raja Tai has to take with respect to his cousins Ghaffar and Zulfiqar. Ghaffar has been identified as the culprit in two rape cases in the village. The authority of the judicial system of Pakistan does not extend to rural areas. In this vacuum, Raja Tai, as the largest landlord, is the default arbitrator. In cases where his *biradari* members are accused, as in the rape cases, he is obliged by *biradari* relational rules to support his cousins, whether he condones their behaviour or not.

6.1.3 Women, the family and kinship systems

For women, the family and *biradari* system as described have a number of contradictions. On the one hand, it gives them their identity, besides being the locus of ties of love and affection. At the same time, it places them in specific positions in a hierarchy of age and gender that

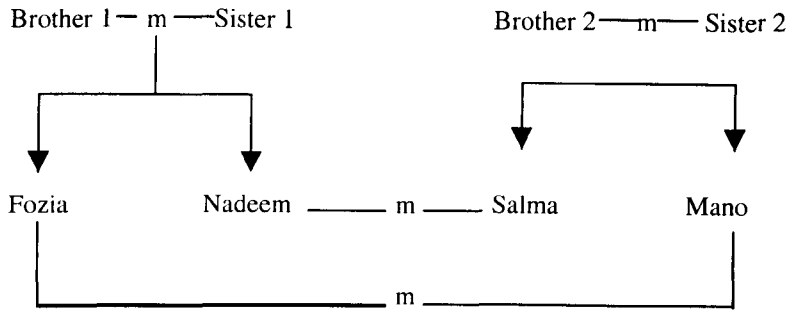
severely constrain their access to resources of numerous types and can therefore be considered disadvantageous.

Jatti is a patriarchal, virilocal society. At marriage, women move from their natal home to their *susral ghar* (marital home). Endogamous marriages, the most common form of marriage in Jatti and even Pakistan (67% in the PFFPS 1996-97), are characterised by move to a home that is well-known. Endogamous marriages thus attenuate the radical change and sense of dislocation that accompanies arranged exogamous marriages between strangers. Endogamy also blurs the lines between natal and marital families. In joint families, where cousins are brought up together, a marriage between two cousins may not even entail a change in physical location as Zahira's case demonstrates.

> Zahira is married to her *dadpotra* (father's elder brother's son) Aqeel. But Aqeel's father and Zahira's father are brothers who lived together as a joint family. So Zahira and Aqeel grew up in the same house and after marriage Zahira continues to live in the same house. Since Aqeel's parents are dead and her parent's are alive, she is essentially living with her parents, although in principle she is living in her husband's home. Such complexities are not captured in surveys, for she normatively describes her residence as virilocal.

Even if separate households have been set up, the intense inter-*biradari* social interactions mean the *susral kaar* (marital home) is a familiar place. She is not a stranger-bride as in village exogamy. More importantly, endogamy diffuses the tensions inherent in the mother-in-law / daughter-in-law relationship frequently commented upon in the literature. Genealogy and network analysis demonstrate that the practice of endogamy with sisters marrying brothers means that a woman's mother-in-law, who happens to be her *chachi* (father's younger brother's wife) also happens to be her *maasi* (mother's sister). Such dense networks mean a marriage does not rupture young women's social networks. In a context, where social relations constitute a woman's major resource, the implications of these relationships extend beyond an academic interest. As will be discussed in chapter 7, the quality of the relationship with the mother-in-law is of crucial importance in a woman's access to antenatal services.

Figure 6.1 The genealogy network of case study 1



Endogamy thus ensures that a woman's links with her natal family are retained. Together these links and her rights as a member of the same *biradari* as her husband constitutes her chief social resource. The advantages of these resources are most obvious in situations where things go wrong as for example, a childless marriage. In five childless marriages in the village, not one of the men had remarried despite lengthy marriage durations as the larger *biradari* would not allow them to. It was difficult to explore further why the men had not remarried or why their families were opposing their remarriages because it would have very insensitive to do so. However, I postulate that when a man marries his first cousin, she is not just his wife, but the daughter of his mother or father's sister, who can apply considerable social pressure on the women's behalf. In a situation where family connections are practically sacrosanct, he is bound to the woman by more than a marriage contract.

A focus on normative values of patriarchy and virilocal residence tends to hide the fact that women-to-women bonds play important structural roles in kinship and social networks. A woman's position in the kinship system is not just passive by virtue of her being a daughter, wife or mother, but has important practical ramifications as the following story demonstrates.

> Chayya is the eldest daughter and is married to her *maser* (mother's sister's son) in the same village. A couple of years after Chayya's marriage, (about 20 years ago), her mother developed post-partum schizophrenia and was unable to look after her children. Chayya's five younger brothers and sisters, including the newborn, were left without an adult woman to look after them. Kinship rules and affective ties deemed Chayya or her mother-in-law (Chayya's mother's sister) as the people who should look after the young children. That is what happened. To make it possible, the two households, Chayya's natal and marital households, merged. Since Chayya's father's house was the bigger one and he owned the property, Chayya with her husband, children, mother-in-law and her children moved into it. This enabled Chayya to bring

up younger brothers and sisters as well as look after her own family. In essence it enabled her to fulfil her role as a wife and daughter-in-law and also mother her younger brothers and sisters. The entire episode is narrated with little mention of Chayya's father and father-in-law. This is not an oversight, but a deliberate obfuscation of facts because the whole process went against the norms of virilocal residence. Real needs overrode norms. Later, Chayya's younger brother Sohail was married to Rabia, her husband's younger sister, all of whom had lived in the same household. Sohail died young, leaving behind a young widow with three daughters. All continue to live in the same house. In-line with patriarchal norms, Rabia is presented as a widow who is supported by her brother (Chayya's husband) although she is physically living in her dead husband's home.

In a context of dependency and sexual segregation, women's relationships with each other constitute their chief resource. Women, particularly *biradari* women, are easy to access without arousing suspicions. This accessibility is particularly important for women's covert activities. One common use is company for travel.

Ruby wanted to use a contraceptive method, but her mother-in-law opposed it. One day, taking advantage of her mother-in-law's absence, she asked a female cousin to accompany her to a reproductive health facility and got an IUCD inserted.

Mutual help relations between women also operate on a day-to-day basis in enabling women to fulfil their domestic obligations. They get together to apply mud in one's *vera,* look after each other's children, and even help out during harvest time.

Women are also fully involved social actors beyond the immediate confines of the family and *biradari*, though this varies by life-cycle stage. Cross-*biradari* interaction is largely conducted by the elder women of the family. They, along with older men, act as their families' representatives. Women's role in the maintenance of cross-*biradari* relationships is highlighted by the importance of their presence at key social events such as weddings, funerals, seeing somebody off to Haj (pilgrimage to Mecca) or an illness episode. Women's presence or absence at these events is loaded with meaning. Thus, if women of the family (which is usually the mother-in-law, but in her absence, younger women carry out the activity) do not attend an event, it is a sign of severe discord in the relationship.

Farooq's family has a long-standing feud with Akram's family. When Akram's son got married, Farooq and family were invited. Rather than completely ignore the

invitation, only Farooq attended the wedding. The absence of the family women sent a clear message that all is not well.

On the other hand, if the women alone attend an occasion, usually a funeral, it is excused on the grounds that men are busy working and could not take time off. Men's absence at such occasions does not have the same meaning as women's absence does. Similarly, women play a critical role in marriage negotiations. It is not so much their presence as their absence that sends the strongest signals of their disapproval.

6.2 *'Mazboot aurat'*

The social relationships that construct personhood discussed above have an important gendered dimension. For men, the key social ties, in accordance with patriarchal norms, are based on blood relationships only. These include the father and mother, brothers and sisters, *chachas* and *tayas*[3]. The relationships based on marriage ties, besides with the wife herself, are not so critical. On the other hand, a woman's key social resources are her marriage ties; that is the relationships with her husband, mother-in-law and marital family in general. Despite the protection provided by endogamy, patriarchal values and virilocal residence mean that the ties of marriage have an effect on the day-to-day lives of women in a manner not applicable to men.

The second aspect of these relationships is the strength of the relationships. Blood ties, by their very nature, are secure and certain. For men, whose primary relationships are based on blood ties, the issue of strength is therefore not a major concern. In contrast, the strength of the relationships holds greater importance for women since their important ties are marriage-based and hence subject to greater variability and vagaries of *kismet* (luck). Marriage is a critical rite of passage and all life's events are divided into before and after marriage. Women intuitively understand the significance of their marital relationships, which is best captured in the terms *mazboot aurat* and *kamzor aurat.* These are the two local terms used to describe a woman's marriage and position in her marital home. The word *mazboot* literally translates as 'strength', and *kamzor* as 'weakness', with the emic understanding of these terms referring to the strength of a woman's *relationships* and *linkages* with her marital family. It describes the degree to which a woman is embedded in her marital family; *'you don't just marry a man, you marry his family as well'.* A *mazboot aurat* is a woman who is deeply and securely embedded in her marital family with strong ties to her husband and his family. A *kamzor*

[3] *Taya* is father's elder brother and *chacha* is the father's younger brother.

aurat, on the other hand, is one whose ties with her husband and his family are weak and uncertain. The most important linkage determining a woman's *mazbooti* is the husband-wife bond, an issue I will turn to now.

6.2.1 Husbands and wives

Marriage is an institution associated with numerous contradictions. The patriarchal kinship system aims to keep the son's primary allegiance to the patriarchal joint family. From this perspective, the husband–wife bond is viewed as a threat to the solidarity of the patriarchal group. Romantic love between husband and wife is discouraged to the extent that husband and wife, at least in the early stages of marriage, rarely address each other directly in front of other family members. An oft-mentioned dimension of masculinity is that a *marud* should not appear to care too much for his wife or spend too much time in her company. Such a man is derogatively called a *zanankhuna.* At the same time, a good stable marriage is considered essential for peace and harmony. It is considered a *'saathion ka jor'* a relationship of partners. Women who perceive they have a good relationship proudly state so, while women who do not lament their *kismat* (fate).

Another contradiction is sex. One the one hand, sexual relations are considered *sharam ki baat* (a matter of shame), and on the other hand, celebrated as an essence of procreation. Husbands and wives rarely share a bedroom, yet a pregnancy in the first few months of a marriage is much expected.

Nonetheless, despite the tensions, the husband-wife interpersonal relationship emerges as the most important determinant of a woman's *mazbooti* in her marital home. The larger marital family also treats her on cues received from the husband. If the husband-wife relationship is good, a mother-in-law's hostility may not affect her *mazbooti* significantly, while a poor husband-wife relationship cannot be offset by a good relationship with the larger marital family.

> Zohra can be described as a *mazboot aurat.* She is educated upto 'matric' (secondary level) and works as a teacher, a role supported initially by her parents and later by her husband and marital family. She is married to her cousin, who is about six years younger than her. The marriage was arranged as per rules of endogamy and they now have three children, two boys and a girl. She lives with her husband's joint family. Zohra's real strength are her good interpersonal relationships with her husband and his family. Her personal attributes (a pleasant nature, a positive attitude, her

acceptable '*kirdar*' (actions, total sum of behaviour) enable her to fit in with the ideal of a 'good woman'. One sign of her *mazboot* position that she points to proudly is that her opinion is sought for all household matters. This may partly be because of her personal characteristics, for she played a major role in decision-making in her natal home as well. As Farooq, her younger brothers says:

'After our father, Baji Zohra was a *bara* (elder, decision-maker) in our family. She was consulted for every decision that was made'

However, this decision-making authority has been carried into her marital home. As a matter of fact, even before she married her husband Rauf, his father, who is also her *mamu* (mother's brother), consulted her regarding Rauf's choice of a career. In other words she was consulted what career her future husband should take up. Zohra travels within and outside the village without asking permission to do so. She just informs her mother-in-law where she is going, although she avoids travelling alone.

In contrast Mazloom can be considered an example of a *kamzor* woman. The only reason for her *kamzori* is her childlessness. Her marriage to Mukarram was a 'love marriage' and an elopement for their respective families opposed the union. Despite the obvious strength of her inter-personal relationship with her husband initially, her subsequent childlessness weakened it. Now her husband frequently stays away from home and is rumoured to be involved with another woman.

These two examples highlight two closely interlinked characteristics of the strength of a woman's marital ties or how *mazboot* a woman is. The first is variation in the strength of the ties. The strength can be considered a spectrum that extends from a very *mazboot* woman to a very *kamzor* woman and the range in between. The other is the role of various factors that determine the strength of the linkages. These include circumstances of marriage, birth of children, a woman's individual level skills and attributes, the extent to which the marital family adheres to norms of gendered roles and behaviour, and age/marital duration. Largely inter-linked, they are discussed separately below for clarity.

6.2.2 Circumstances of marriage. Normatively parents arrange marriages. Endogamy is the rule and to a large extent the practice. *Rishtas* (arranging a marriage) between cousins (within reasonable age groups) are not always the result of deliberate decision-making, but somehow assumed and even unspoken. Within these parameters, an element of choice exists. Intense intra-*biradari* social interaction coupled with lack of *purdah* (from *biradari* members)

means potential sexual partners are repeatedly thrown in contact. Affective ties thus formed can ensure the woman has greater probability of becoming *mazboot* than a marriage arranged against the couple's will (which is surprisingly common).

The tenacity of the ideology of jointness means marriages within the *biradari* can be arranged despite poor relationships between the two families concerned. In such a situation, the young woman faces an uphill task in establishing herself in her marital home.

> Abida and her sister Hafiza were 'expected' to marry their *phuphi's* sons (father's sister's sons) Abid and Hafeez in accordance with the rules of endogamy. The marriage got delayed by a number of years because of the following event. About seven years ago, a cow belonging to Abida's family strayed into and grazed in Abid's father's fields. This so enraged Abid's father's brothers that they beat up Abida's father, who then went to the police. The case was fought in a court of law. Despite the enmity, mutual distrust and unhappiness, the marriage arrangements were not abandoned in deference to the ideology of jointness of *biradari* members. The wedding itself was fraught with tension and two fights broke out during the wedding ceremony itself (personal observation).

6.2.3 Birth of children. The birth of children strengthens the marital bond and is best captured in the saying *'bache zanjeer honde ne'* (children are chains). Children as *zanjeers* (chains) between a couple alludes to the fact that children, particularly sons, cement the husband-wife tie. The desire for a pregnancy within the first year of marriage is not just the husband's or his family's desire but equally that of the young woman and her family, for the birth of a child will strengthen the young woman's ties in a manner nothing else can. Male bias in the culture means the birth of a son strengthens the marital bond even more greatly. In this context, infertility is extremely unfortunate for it means the woman is never going to become a fully embedded and *mazboot* woman, however strong her relationship with her husband may be. While she may not be divorced, a second marriage remains a possibility and she remains a *kamzor* woman.

6.2.4 Women's individual attributes and skills. The most crucial feature of a woman's personal attributes that can increase a woman's *mazbooti* is the extent to which she fits into the ideal of femininity. The ideal woman has a pleasant nature, a non-controversial *kirdar* (actions, total sum of behaviour), is hardworking, lives in the virilocal joint family and does not attempt to separate her sub-unit. If she fits into this framework, the possibility of good inter-personal relationships with husband and his family increase. Once the relationships are

cemented as strong, she can manoeuvre around the gendered restrictions, all the while appearing to be working within the rules. Zohra, the example of a *mazboot* woman given above has the personal attributes that can promote *mazbooti.*

6.2.5 Family's leniency regarding adherence to gendered roles and behaviour. A striking feature of gender values, norms and behaviour in this society is their fluidity and variation. While there are certain 'norms' that everybody purports to adhere to, actual behaviour varies. Although all families operate within the same ideology, operationalisation at the family and individual level varies significantly. Two closely related and complementary aspects of leniency are the male family members' sense of masculinity and their valuation of femaleness. Men's self-perceived sense of their 'masculinity' is often derived from their perceived degree of adherence to the social ideals of a *'marud'*(a masculine man). This includes, amongst others, fulfilment of the role of a provider and the degree to which they insist upon their women's seclusion, citing their *izzat* as being at stake. Some men, in order to demonstrate their masculinity (acting like a *marud*) tend to be very strict regarding their wife's (even unmarried sisters and mothers) seclusion, while others are relatively relaxed about it. Similarly, there are variations in the degree to which families 'value' women. Together the two 'values and behaviours' constitute a family's *'mahol'*. The characteristics of different *mahols* in families are difficult to describe, but are apparent in the manner in which boys and girls in a family are treated, as for instance, in terms of food allocation and more obviously, education. Family's leniency is closely related to the above discussion (6.2.3) for a woman's personal attributes that can pave her way towards becoming *mazboot* need a receptive environment. Thus a family's leniency and a woman's personal attributes are inter-related in a dynamic relationship.

> The families' of Golra Malik *biradari* are a relatively lenient. They do not differentiate between boys and girls in terms of food allocation, health care or even education. Both men and women of the *biradari* are equally educated. The sense of fairness is in a sense a family tradition for they started educating their daughters over forty years ago, all of whom now work as teachers.
>
> In contrast, there are three Raja households who practise very strict seclusion. The wives are housebound, with restrictions on socialisation with even their *biradari* women. More interestingly, these households belong to the three men, an uncle and two nephews who have repeatedly been identified as rapists. It appears the women's very strict seclusion is part of an overall devaluation of women in these households.

6.2.6 Age and duration of marriage. With the passage of time and increasing age, women tend to become more *mazboot* as there is a shift in the domestic power balance. The parents-in-law become old, the son replaces his father as the head of household and the husband-wife relationship starts to pre-empt the mother/son relationship. Ironically, a very strong mother-in-law may set a pattern of female centrality in family affairs. The women take on a policy-making roles and represents the family at extra-*biradari* functions.

An issue that is closely related to a woman's *mazbooti* is domestic violence. Domestic violence, as reported by the men (no woman ever admitted she suffered from domestic violence), appears to be more common in the early years of marriage. With the passage of time, birth of children and development of affective ties between the couple, incidences of domestic violence reduce or as in most cases, complete cease. In other words, as the women become *mazboot*, domestic violence reduces.

6.3 Household production and reproduction: the interconnectedness of resources

The power of the ideology of interconnectedness described above is further revealed in the extent to which household resources are joint. A joint household consisting of parents living with their adult sons, or brothers living together, is not a simple matter of co-residence, but of a unit that pursues a collective subsistence by maintaining joint resources. The power of the cultural ideal is best reflected by the fact that even if households physically separate, the resources frequently remain joint.

> A classical example of *mushtarika* (joint resources) is Raheem and Ghafoor's common-pot. The two brothers are the most prosperous Maliks in the village. They farm their own land and run two businesses, a diesel and cattle depot. Raheem is the dominant brother and the brains behind the family businesses. Ghafoor and his sons provide the labour. The family unit, by pooling all its resources, have managed to greatly improve their economic situation. Although the brothers live in separate households, all household needs, including groceries, are bought jointly and then redistributed. The extent of the jointness can be gauged by the fact that Rauf, Raheem's son, who has a government job, pays Ghafoor's granddaughter's school fees. This little girl is Rauf's niece as well, as his sister Muzammil is married to Ghafoor's son. The networks are extremely dense.

In fact, it would be more accurate to describe a joint family as an integrated whole, in which members contribute to a collective fund. They often live under one roof, but may also live in

separate households. However, the presence of joint resources does not mean that all members contribute equally. More commonly, one member is a major contributor and the rest contribute either in kind or not at all. The pooling of resources and redistribution in a manner that masks who contributed what amount and who spent what is another symbol of jointness. It makes the individual collective. It also manages to support members whose contribution is in kind, usually the farming men, and in some cases, unproductive members.

> Khatoon's four sons share from a common source of income even though the sub-units cook separately and would be classified as nuclear if defined on basis of number of generations living together. One brother runs the family shop and is responsible for the groceries of all the four sub-units. Another brother farms the joint lands, while the younger two are unemployed.

> In Ruby's family, her *jeyth*,[4] Masood, works as a cook. He supports a joint family consisting of a mother, two brothers and their families and of course his own family.

The primary advantage of this jointness is that it allows for maximisation of household income by increasing options, a common one being to send one member to the city, while another farms or looks after the cattle. Another advantage is pooling resources to buy land, which would be an impossible undertaking for an individual alone.

> Farooq, his brother Qadir, and nephews Mano and Nadeem are joint owners of 15 kanals of land. As landless Maliks, individually they would never have been able to collect the necessary amount of money. By pooling their resources, the possibility could be actualised.

However, this jointness is not without its tensions and conflicts. While there is an explicit acknowledgement of collective responsibilities and considerable sharing of resources, there is also a potential for infringement of rights. The system is highly dependent upon personal integrity. It is also vulnerable to abuse in the name of jointness and interconnectedness of families. At its simplest, it acts as a glass ceiling for those who could do better, but end up supporting a large number of non or not-so-productive members. At worst, it enables usurpation of land rights.

[4] Jeyth is the elder brother of the husband.

Akram is a well-off Malik, who owns 18 kanals of land, a poultry farm and real estate property in the nearby urban areas. As fieldwork progressed, it emerged the land, which he alone farmed, was actually inherited property and legally two other brothers had a right to it. One is dead, but Akram has usurped the widow and her three daughters' shares, saying they have willingly given it to him (the widow denied it). The other brother is working as a *chowkidaar* (night security guard), a poorly paid job. His share has been taken over by Akram with the explanation that since he is earning enough, he has given me the land to farm. It transpired that this brother cannot access his share of the land or its yields because he is physically absent. Akram is taking advantage of his brother's absence and familial ties that would act to restrict his brother from fighting for his right in a court of law.

In the preceding discussion, I analysed the main themes or organising principles of this society. I now turn to consider three key aspects of women's lives where gender rules, regulations and relationships operate to affect women's gendered position, both at the household and societal level. These are women's access to and control over economic resources, decision-making; and mobility. Interestingly, these three aspects were relevant in the eyes of the respondents as well as the researchers who framed the PFFP survey questions, though with important differences of emphasis.

6.4 Women's access to and control over economic resources

The essentially corporate character of Pakistani households and sense of interconnectedness described above applies to women as well as men. Women view their well being as closely connected with their families. But this kinship ideology interacts with the gender ideology to produce a complex situation characterised by a tension between their interconnectedness with their families on the one hand and a patriarchally engendered economic vulnerability on the other.

Normatively, gender rules assign men the responsibility to provide and, in principle, all they earn belongs to their families. As a dependant, a woman should not work for wages. She should have all her needs met and ideally have full access to all her husband's resources. This should mean that a husband shares all his income with his wife and both women and men go to great lengths to give this impression.

6.4.1 Alternative arrangements: when women are the primary providers

Largely, men of Jatti do fulfil their roles as economic providers as has been discussed in chapter 5. However, larger economic forces can lead to alternate arrangements in which women end up as the primary economic providers of the household. Some of these women not only earn the money, they also play central roles in the managing household resources. Nonetheless, as the following example shows, even when women are the primary providers, they make a concerted effort to reconstitute an illusion of men as the primary providers. This is done in deference to the ideology of male provision, preservation of their marital ties and in acknowledgement of the fact that they have limited extra-marital options. Women's well being remains tied to their family's well being. Moreover, when women do behave in ways that contradict normative behaviour, the underlying aim is to strengthen their social resources rather spend the money on their personal luxuries.

> Khan and Sughra's household consists of son Mano, daughter-in-law Fozia, married daughter Salma and their four children. Khan and Mano farm as tenants and their income is mostly in kind. Fozia and Salma work as teachers and their regular income is the primary cash household income. Mano is educated, but has not found a job for the past 12 years. He is currently doing a computer course to improve his chances of employment. Similarly Nadeem, Salma's husband has not found a job in the village. He works in Islamabad and hardly ever comes home. When questioned, he says he sends home money, but Salma denies it. Both Fozia and Salma hand over their salaries to Sughra (mother-in-law and mother respectively), who as the acknowledged head of the household, is responsible for its redistribution. Sughra manages not only the household finances, but those related to the farming business as well because Khan, a gentle hardworking man, is not a good negotiator and gets cheated.

This example is clearly a woman-headed, women-provided household in the presence of healthy active male members. Larger economic forces, beyond the control of individuals, have placed women in the role of primary providers. In one sense it is a complete reversal of the ideal male-headed, male-provided household. It exemplifies how gender norms can be manipulated and individual behaviour adjusted to fit in with the larger societal level economic forces. It also exemplifies how a woman's personal characteristics and abilities enable her to take a dominant position when it is perceived to be in the best interests of the household.

Before proceeding further, there is a need to distinguish between control, access, and management of economic resources. Pahl distinguishes the three as separate dimensions,

where control over income indicates who makes the policy decisions as to how intrahousehold resources are to be allocated and who is to benefit, access merely indicates the availability of additional resources, while management entails the translation of policy decisions into practice, an essentially implementation function (Pahl 1989).

In the above example, Fozia and Salma's handing over of their wages to the family is done in deference to the kinship ideology of *akhathe* (togetherness). It is a part of their responsibility and obligation to the family unit. Equally important, they do not see their well-being as separate from their families. By contributing to a common household pot, they are improving the overall status of the household, which in turn benefits them as well. The money is used for collective welfare and togetherness of their lives and their longer-term interests are likely to be better served through forms of behaviour that preserve household solidarity and co-operation.

The fact that Fozia and Salma hand over their incomes does not necessarily imply an appropriation of their wages, an indifference to their priorities or that the women will not access any of it. Although it would seem that giving their wages away results in losing all control over it, it apparently is not quite so. The policy-making processes of expenses and management do not necessarily go hand-in-hand. To a large extent, the money is earmarked for expenses imperative for basic survival or decisions already made (sending the children to a private-fee-paying school in Fateh Jang). The money is thus spent in collectively discussed ways for collectively beneficial issues. Sughra is in one sense just a manager of the resources, performing an implementational function. Even if she does have some control over the money she is managing, the inadequacy of the amounts involved (in view of the expenses) means the control is illusionary.

Nonetheless, the balance achieved is the result of implicit, unspoken negotiations in which each party negotiates from a position of both strengths and weaknesses. The relative bargaining power is based on gender, age, affective ties and type of relationship (kinship association). The balance achieved also demonstrates that manifestation of power relationships in the household is determined not only by observable conflicts, but also as the result of operation of rules and practices which systematically favour men. Fozia's strength is her financial power embedded in herself. However, that alone is clearly insufficient for her to live alone, independent of her family and social moorings. The gender norms situate women's social identity in the men of the family. Her major financial contribution has not resulted in a reduction of household work, including tasks like application of mud on walls and looking after animals. Mano's weakness is his 'unemployed status', but his gendered position as a

mard (man) provides him an unquestioned location as the provider of a social identity and support that is essential for enabling Fozia to work as she does. Despite his inability to provide, his access to resources is not reduced in any way for in addition to basic requirements, he is a member of a group that drinks alcohol and has wild parties, both expensive options. Salma is living with her natal family with her two children, a much-feared situation of the married daughter becoming an economic burden on her natal family. But her financial contribution has totally negated this concept and instead she is viewed as an asset. In essence Salma is paying for her stay in the family. Sughra, as a financial controller is located in her status as a *wade* (an elder) and a mother, with its life-cycle related authority. By handing over their wages to her, Fozia and Salma are demonstrating their 'respect for elders', an important aspect of age hierarchy. Underlying the entire set up are affective ties that differentiate this co-operation from conventional economic analysis. It constitutes the sense of 'togetherness' that characterise the relationships between women and men.

Nonetheless, the young women's behaviour is in conflict with gendered ideology of male provision. Men are not just expected to provide, but they should not live off a woman's earnings either. Living off a woman's earnings, and that too a daughter or daughter-in-law, is considered *beghairat* behaviour (a man with no izzat). However, since the larger economic forces create situations over which the individuals have little control, two strategies have been adopted to diffuse some of the conflict. One is pooling of the household income. By masking who contributed what amount and who spent what, the household is able to maintain an illusion of male provision. Secondly, the money is handed over to Sughra, a non-earning senior member who does not represent the same threat to the ideology of male provider that the younger women do. As a matter of fact, an active effort was made to devalue the women's contribution, an aspect discussed in detail in the next section. The gender ideologies are very resilient.

A question now arises: what happens when there is breakdown in this co-operation? Crises bring forth the gendered asymmetries embedded in the linkages that constitute the connectedness of women and men and the togetherness of their lives. As the following example indicates, women's well-being is not only tied to their marital households, they also have limited options beyond it. Although conventionally, a woman looks to her father or brothers for help in such a situation, this varies by class (White 1992). If her family is poor, she may not be able to ask and they may not be able to help. The following example also brings out the importance of inter-personal relationships that interweave seamlessly in determining access to material resources.

Akhter's husband, a Raja, sold all his land to finance his drinking and womanising. Despite the beatings and the fact that he threatened her life, for which he spent a year in jail, the marriage did not 'end' in the official sense and she continued to live in her husband's home, punctuated with long periods with her natal family. Despite the fact that her brother was supportive, she did not seek divorce, and the reason for not doing so is brought out in the statement

'I was in my own house and so nobody had the *jurat* (dared) to point (gossip) at me'

Although Akhter's husband was apparently the culprit, gossip would also lay some blame on her. Her sexual morality could be questioned and this would jeopardise the marriage prospects of her three daughters. Also, by staying in her husbands home, Akhter managed to harness the support of his four brothers as well (in addition to her own brother), who would intervene on her behalf. They were a source of social pressure on the husband to change his ways. Once, her husband in a drunken fit sold the house for Rs 300 only. A brother-in-law bought it and turned it over to her, in essence giving her physical and legal right to her home.

6.4.2 Devaluation of women's contribution

It is important not to assume automatic shifts in gender relations because of women's income. The rules and practices that systematically favour men reflect deeply entrenched cultural values, rather than individual behavioural choices and they tend to be taken for granted by all members of the household, including the women who are discriminated against. There is no doubt that women who earn a salary do gain recognition, at least in their own households. But a real effort is made to downplay their contribution and exaggerate male contribution. This is best brought out in the Golra Malik *biradari* because women here earn cash income that is equal to if not more than the men.

Before they were married, Zohra, Yasi and Fozia used to hand over their salaries to Amijee (Zohra and Yasi's mother and Fozia's *nani*[5]). As a matter of fact, Zohra worked for nearly 15 years before she got married. This common pot of course included the father's income and later on the son, Qadir's, income. As a result of the large number of contributors, the family managed to build a house in Fateh Jang, buy some land in the village, build a house on it, and arrange three weddings. Since the

[5] *Nani* is the maternal grandmother.

property was in the father's name, it was distributed amongst his male heirs only. The house in Fateh Jang was given to Qadir, the one in the village to Farooq and a part of the land bought in the village was transferred to grandsons Mano and Nadeem as a 'gift'.

The two most interesting aspects of this is the manner in which the whole situation is presented and the fact that the land and property are all in men's names. Everybody, the men and women, credit the father/*Nana*, and the *mamas* (Farooq and Qadir) as the people who financed the purchases. Over and over it is reiterated that the *nana /nani* married Fozia and Nadeem and that the *mamas* have gifted Mano and Nadeem the land. The women's very large contribution is downplayed, and they have no property in their names. The men's contribution is exaggerated, particularly Farooq's (the mamu), Mano and Nadeem's, whose actual contributions were minimal.

6.4.3 Women's secret savings system

Information about sources of income and amounts involved emerges as a key measure of trust in a husband-wife relationship. As customary earners of the family, men have always enjoyed a prerogative control over information regarding their sources of income. They do not always share this information, particularly about savings and assets, although most go to great pains to clarify that all they own is an open secret and the wife has full access to it. Having chatted at length with both husband and wife, it was evident that Sameena has no idea of Farooq's total monthly income although she thinks she does. Farhat cannot articulate her husband's army pension or insurance.

Women too withhold information about their earnings and resources. They save the small amounts of money earned from selling eggs and chickens, embroidery or even saved from household money most men ensured their wives had for small on-going expenses. The money is collected by participating in a *kammitee*, a group-based savings system, in which a number of women get together and decide on a specific amount of money each woman will contribute for a specified period of time. Every month the money is collected from all the members and given to one contributor selected by random draw. The *kammitee* lasts till each member of the group has received the said amount, before it starts all over again. The primary objective of this group activity is that small amounts of money are frittered away and group collection, with associated peer pressure, forces savings. It involves a high level of trust because no written records are maintained. The amount of money set aside each month varies by the

socio-economic status of the women. Although men knew of the *kammitee* system, they were not always aware of their wife's involvement and even less about the amounts involved.

At first glance, there is an inherent contradiction between the idea that women's lives are tied to their family's well-being as discussed above and that women have secret savings over which they maintain absolute control. This contradiction is particularly puzzling because the *kammitee* savings are primarily meant for making non-essential household purchases, such as *bartan* (utensils) or *bister* (duvets and pillows) or their and their children's clothing. Richer women may buy gold jewellery, but this too is usually meant for their daughter's dowries. These items, although non-essential, reflect upon a woman's housekeeping skills. A *ghar banane wali aurat* (woman who makes a home) is a clearly articulated aspect of femininity and an abundance of *bartan* (utensils) and *bister* (duvets and pillows) reflects prudent and skilful management of household resources. The savings are also meant to act as back-up savings for a rainy day and women happily hand over the money to their husbands if a need arises. From this perspective, it would be expected that women would share this information with their husbands at least.

However, the value of secrecy and concealment emerges when the other manner of spending the *kammitee* money is seen. This is spending money on their natal families, a transfer of resources that contravenes socially acceptable direction of transfer of resources.

> When Zohra's *phatijee* (sister's daughter) was getting married, her 'family' (marital) gave a gift of Rs 5,000[6]. However, Zohra, gave an additional Rs 5,000 that nobody in her marital family knew of. At the same wedding, Fozia, the sister of the bride, gave Rs 11,000 that her marital family had no idea of. The transfer of these large amounts of money remained secret despite the fact that both Zohra and Fozia's marital families are also Surraiya's family.

The element of secrecy hints at the gendered economic vulnerability of women embedded in a system primarily designed on the basis of togetherness and jointness. Women's resort to secrecy and clandestine activities is an attempt to carve out some measure of control in a system that assumes such individuated control as unnecessary. The secrecy element thus highlights the tension between the kinship ideology of interconnectedness and gender ideology that disadvantages women. Women perceive themselves as the vulnerable partners in what is otherwise a mutually dependent relationship.

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[6] Rs 5000=£56

Women's spending money on their natal families, which mostly is as *vartan bhanji* (exchange of gifts) is essentially a mechanism to ensure their linkages with their natal family and *biradari* remain strong. In fact, the strength of these linkages constitutes a dimension of a woman's *mazbooti.* Her natal family and larger biradari constitute her social resource, which can be a source of influence or pressure on her husband and marital family when needed. An example of how this social resource can benefit women are the childless women discussed earlier. One of the reasons Sahil could not remarry (Sana, his wife of 20 years is childless) was because Sana's brothers opposed the idea, and apparently their opposition was strong enough to deter Sahil despite his desire to marry again.

6.4.4 The effect of women's resource contribution

An obvious question now is what is the relationship, if any, between women's economic contribution, her control over economic resources and the strength of her linkages with her marital family or how *mazboot* she is.

To answer this question, we must distinguish between types of economic contribution. The *jahez* (dowry) is a more culturally acceptable manner of economic contribution than women's wages and therefore its influence on women's *mazbooti* acts in a different manner. The *jahez* is essentially a culturally ordained transfer of resources from a woman's natal family to her marital family. It starts at the time of marriage and continues throughout her lifetime. Although parents justify the giving of *jahez* as ensuring their daughter does not lack for anything in her marital home, it is, on one level a tool with which the woman's family 'buy' out the gap created by gendered values that situate men in a dominant social position. Rich families use money to reduce this gender 'gap' while poor families have to suffer the consequences of unequal gender rules and values. Amijee encapsulated it all in the statement

> ' If we don't give a *jahez* family her *susral* will not give her *izzat'* (Amijee, 65 years old, mother and mother-in-law)

In effect this traditional transfer of resources from the natal to the marital family rather than to the woman herself is meant to increase the marital family's receptivity to the new bride. Their increased receptivity will pave her way towards becoming a *mazboot* member of the family. The size of the *jahez* is thus very important and is increasing with changes in consumption patterns. Every single item is displayed at the wedding and later in the bedrooms for years. Women proudly point to the size of their *jahez*, while most men sound defensive, insisting they did not ask for anything and it is just a meaningless ritual. The transfer of resources

continues after marriage. Sajida's natal family sends her a certain fraction of the wheat harvest annually. Sameena's relatively richer parents help out by paying her daughter's school fees, besides other gifts.

The effect of a woman's wages on strengthening her linkages with the marital family is more difficult to decipher. There is no denying that a woman's wages improves the financial position of the household. However, Jatti is a context where a woman's work for wages is a sign of economic poverty and the man's inability to provide. Both reflect badly on the men. As long as the women's earnings are insignificant in amount and not visible, men do not feel threatened. However, where the wife's earnings are visibly more than the husband, the situation can test the inter-personal relationships between the couple in a manner which can only weaken the marital bond.

> Salma works as a teacher in the village. Her husband Nadeem has not been able to find a similar 'respectable' job. He has worked in various '*kutchi nokris*' (temporary jobs) which have included casual labour and cooking in a restaurant. According to Nadeem, Salma is ashamed of the jobs he does, so he prefers to work outside the village where nobody will know him. His visits home are very infrequent, about once every 3-4 months considering it is possible to make a day-trip. Although Salma's wages are relatively large, he has requested her to give up her job, which she has refused. The situation has taken its toll on the marriage. Today Salma is economically independent of her husband, but they live apart. There is no marital home and Salma and her children live with her natal family.

A point worth noting is that the norm of men as economic providers and women as dependants is not explained of terms of Islam and religion although Islam authorises men to economically provide for their dependent women and children. Similarly, Islam is not used as the basis of other gendered behaviours, including mobility discussed below.

6.5 *Slaa mashwara*

Common wisdom in Jatti states do *slaa mashwara* before making any *faisla* (decision). *Slaa mashwara*, is roughly translated as 'discussion and opinion', and the term captures the co-operative and consensus-based nature of the decision-making process in this society. While negotiations and consensus are an inherent characteristic of any decision-making process, it is emphasised more because it indirectly confirms that the respondents are acting within the ideology of *akhathe* (togetherness). Our attempts to identify a single decision-maker were met

with an element of 'shaking of heads' and an objection that we are asking a wrong question. To make a decision alone without consulting anyone goes against the notion of togetherness. Not only should *slaa-mashwara* be done with family members, but for some decisions, particularly marriage negotiations, it is essential to consult with the larger *biradari* members. As matter of fact, not discussing the issues can be taken as an offence.

Nonetheless, the decision-making process is highly gendered. Despite the emphasis on joint-decision-making, there is an implicit understanding that men make the decisions. The respondents' insistence that all decisions are made jointly after *slaa-mashwara* does not say anything about who are the people with whom the *slaa-mashwara* is done. It transpired that they usually are other men and older women of the family. The younger women are present during the discussions, but it is difficult to assess to what extent they influence the final decision, for influence can be very subtle. Opinions need not necessarily be voiced in a meeting, and it is possible to influence the outcomes by speaking to people individually later.

However, women's role in the decision-making process is acknowledged and as Mano says my *faisle* (decisions) are taken, but after everybody's (including his wife) *razamandi* (consent). In the same vein, Latif described a man who forces his opinion on women as

> '.....*jahil* (uncouth) and *unpar* (uneducated). A smart man is one who manages to get his idea accepted as the final decision without the others realising it '.

A further gendered complexity is that the issues emically perceived (by both women and men) to 'need' a decision are the 'big' issues such as sale and purchase of animals, land, arranging a marriage or *vartan-bhanji* (exchange of gifts). These are also the issues that affect men directly and are considered important by men. The day-to-day domestic issues that impact on women's daily lives are not identified as issues over which a decision has to be made by either women or men. In fact, the decision-making questions asked in the PFFPS did not emerge spontaneously in conversations as 'important' issues over which *a faisla* (decision) has to be made. However, as the following discussion demonstrates, this is also probably because the three issues: treatment of a sick child, food purchases and clothes purchases are associated with a whole range of practical constraints, individual priorities, economic costs and gender values, all of which interact to determine who makes the decision and who does not. These day-to-day issues tend to be pre-decided and there is no need to make a 'decision' every time one has to go to the market. Either way, it is not a simple matter of decision-making authority leading to the making of a decision.

6.5.1 'Unpacking' the three decision-making questions: treatment of a sick child, food purchase and clothes purchase

The question of who makes the decision regarding treatment of a sick child used to slightly surprise the respondents for they felt that there really is no decision to be made for a sick child is patently obvious to everyone and the logical thing to do is to seek treatment. Nonetheless, the perceived seriousness of the illness, gender norms of women's seclusion and economic costs considerations all determine who makes the decision. The first line of treatment are usually home remedies and this is decided by the mother and other elder women. If that fails, the next step is to seek a health care provider. Most turn to Farooq, the medical technician because he is the only provider in the village. This decision can be made by the mother, father or elder women. If the child does not get well in a couple of days, the next step is to consult a private practitioner in Fateh Jang or Rawalpindi. For most respondents this means that a man will either accompany the mother or take the child alone. Since the man has to accompany the women, the decision lies with the men. All these complexities make identification of one person as the final decision-maker difficult. Probing usually led to normative answers although respondents resisted identifying any one individual as the final decision-maker.

Food purchase decisions are also not a simple reflection of decision-making authority of any one individual. When the question was asked upfront, the answer was men purchase *sodha* (groceries). However, the decision regarding what should be purchased is largely made in the following manner. As women cook, they know what is required. Men make the actual purchases based on lists given. However, their physical presence at the point of transaction does give men a certain veto. He may buy an item not on the list and drop an item deemed unnecessarily expensive. But again, the choices are limited. Availability of vegetables is seasonal and limited finances ensure only essentials are bought. Once home, the purchases are handed over to the women. What is to be cooked on a day-to-day basis is solely and wholly the woman's domain. Men may request a favourite dish, but that is probably the limit of their influence. In joint households, the mother-in-law has the authority to decide what will be cooked, but that too is not always exercised and the younger daughters-in-law who actually do the cooking cook whatever is available.

Men purchasing groceries is a gender-based activity largely followed in practice because food items are not available locally and have to be bought from Fateh Jang. Surprisingly, no vegetables are grown in the village because it is not profitable in a rain-dependent area. Occasionally the butcher slaughters an animal, which is sold house to house. It is the women

who are present at home when the butcher makes his rounds and it is their prerogative whether to buy or not. However, since men travel to the towns more frequently, they make the necessary purchases on a more regular basis. When women travel to Fateh Jang, they too shop.

Therefore, purchase of food is more than the simple decision regarding feeding the family; it is compounded by the practical reality of unavailability of local produce and *purdah* with its mobility restrictions. A more interesting dimension of gender values is the distribution of the cooked food amongst the two sexes. Foods perceived as nutritious such fish, chicken or *desi ghee* (butter) are directed towards men and boys, while vegetables and *dal* (lentils), foods locally associated with lower nutritional value, are meant for women and girls. There is, of course, wide variation by household. It was difficult to discuss the patterns in this behaviour because our presence had a reactive effect. The men would not eat with the women in our presence and few women were willing to discuss the issue.

Purchase of women's clothes is a fluid zone where gender norms state one thing, but the practice is another thing and no-one appears too concerned about it. Men are normatively supposed to purchase women's and children's clothes. However, the majority do not make such purchases even if they occasionally accompany their wives. The women either make the purchases or at least make the decision regarding the fabric or colour even of they do not make the actual transaction. However, they are ambivalent about this laxity for under the provider ideology, the husband and marital family is obliged to provide them with clothes. Ruby, while proudly stating she buys her own clothes wondered what kind of a man her husband was as he never buys her clothes or even accompanies her for shopping.

In sum, the three decision-making domains addressed in the PFFPS do not measure an individual's decision-making authority alone. While they appear domestic domains, in reality they are affected by a range of societal level factors, some of which are as far-reaching as climate-based agricultural practices. These complexities prevented the respondents from giving a single-word answer as to who makes the final decision. Nonetheless, there is a tension between the kinship ideology of *akhathe* with joint-decision-making and a gender ideology that gives men the decision-making authority. This is discussed next.

6.5.2 Deference to the ideology of the male decision-maker

The normative notion of men as decision-makers is subject to considerable variation. For one, men's involvement in decision making is determined to a large extent by the domain in

which the decision has to be made. Just as there is a gendered division of labour, there is a gendered division of decision-making domains. Some domains are considered exclusively male or female, while others overlap. For example, men's employment or work-related decisions are a male domain, while women's pregnancy and related activities are a women's domain. Arranging marriages, buying and selling cattle, building or adding rooms to a house, and exchange of *vartan bhanji* (exchange of gifts) are the domains where both women and men participate. It is in these domains that men are normatively supposed to be the final decision-makers though after having done *slaa-mashwara.*

Secondly, there is a need to make a distinction between socially recognised institutions and the influence exerted through informal channels. Women's involvement is acknowledged, but it should not be too obvious. Women should not be 'seen' as making the *akhri faisla* (final decisions), for doing so is seen as eroding her husband's 'masculinity'. While there is space for women to participate in and greatly influence the decisions in the privacy of their personal space, in public women go to great lengths to credit men for making the decision, all in deference to gender norms.

> At Eid, Chayya's family decided to sell a couple of animals since prices are good at this time. A customer came. Chayya's asking price was Rs 7,000, but the customer was unwilling to pay more than Rs 6,000. Unsure, she refused to carry out the transaction, saying her husband is not at home. The frustrated customer nearly left, but was called back because a *marud* (man) had become available at the last moment. Chayya's brother-in-law, Rafiq had just sauntered in and he knew nothing about the sale. But as the only man around, he was placed as a front man to implement the transaction. The customer renegotiated the price and Rafiq agreed to Rs 6,000, while Chayya stood behind the gate. Rafiq took the money and a few minutes later handed it over to a rather disappointed Chayya. Had Chayya wanted to stop the transaction at any stage, she could have done so, but chose not to. More importantly, she did not want to be seen as the decision-maker although in essence she made the decision by allowing the transaction to proceed.

6.5.3 *Mazboot aurat* and decision-making

Within the structure of gendered constraints, there are some culturally institutionalised decision-making roles that women can use to make themselves *mazboot*. One example is the women's, particularly younger women's, critical role in arranging marriages. As discussed earlier, marriages are arranged along endogamous lines. Although normatively parents arrange marriages, there exists an institutional norm in which the eldest *nuu* (daughter-in-law) has a culturally sanctified role in choosing her *dewar's* (younger brother-in-law) wife. This role has strong positive connotations as the saying *'dewar na wya parjai ne zimme'* (the younger brother-in-laws marriage is the sister-in-laws responsibility) demonstrates. The woman's involvement is a sign of her integration in her marital family, that she wishes well for her marital family as well as a means to further enhance her linkages and increase her *mazbooti*. Ensuring a friendly, non-threatening woman to share her marital home is a mechanism women employ to assure their position and linkages are not threatened in any way.

Another mechanism women use to strengthen their linkages is through economic resource contribution. As discussed earlier, a *jahez* (and the on-going transfer of resources from the natal to marital family) is essentially a tool women use to strengthen their marital linkages. This economic contribution is an important determinant of their participation in the decision-making process, particularly of major decisions like sale and purchase of land. Men state they make the final decisions in areas that require financial input since they alone are in a position to collect the necessary financial resources. This means that if the woman can contribute financially, she can use it to make inroads in the decision-making process.

> Shabir once came across an opportunity to buy some land. He negotiated the price, and nearly finalised the deal, except he needed some more money. He 'informed' his wife and mother of the potential deal, and asked them if they had any money to makeup for the shortfall. They did not, so the sale fell through. He argues what is the point of discussing these issues with women since they are no help.

The relationship between a woman's *mazbooti* and her involvement in decision-making is a circular relationship. On the one hand, decisions such as the above example enable women to become more *mazboot*. On the other hand, it is her *mazbooti* that enable her to participate in decision-making processes and influence the final outcome domains such as buying and selling cattle, building or adding rooms to a house, and exchange of *vartan bhanji* (exchange of gifts), domains that are normatively men's decision-making domains.

6.5.4 Informed decision-making

Information is power, a fact that is instinctively recognised by both men (as the gender male) and by the economically powerful groups (the Rajas) in Jatti. Mechanisms designed to withhold information have been subtly combined into class (*zaat*) and gender values making them issues beyond question or negotiation. The most obvious are the practical and ideological barriers to education for girls and to some extent, boys (see chapter 5). Restriction of women's social networks to within the *biradari* is another. The restrictions have obvious implications for the extent of information that can be transmitted in a fixed group. Men face fewer restrictions on their social networks, and they are mostly class-based. Another gendered value means that people look down upon women sitting in groups chatting as *chaskhe laga dian ne* (pleasurable activity with no benefit), whereas such an activity is acceptable for men. Some men found our discussions about reproductive health as unnecessarily alarmist, saying we were giving women ideas of problems where none existed.

However, like the other dimensions discussed, there is tension between normative prescriptions and practical reality. The advent of electricity, TV and radios is forcing a change that has its own momentum, a momentum paradoxically driven by men. TVs and radios are purchased by men for their own entertainment. In *dhokes* that have no electricity, generators driven by petrol are kept for the sole purpose of a TV. Raja Sajid bought a VCR and movies for his personal entertainment, but it later expanded into a thriving business, indicating the latent demand. Whilst this phenomenon is driven by men for men only, women are there all along, watching and listening. The younger girls know of the latest Indian movies and sang the latest songs at weddings, incorporating them into the traditional *tappes* (songs).

6.6 'I never go anywhere': women's mobility in Jatti

Women's mobility is a complex and contested issue. The cultural norms glorify restricted mobility and seclusion (*purdah*) for it epitomises women's sexual chastity and upholds family honour. Furthermore, the institution of *purdah* can be seen to be grounded in the need to maintain *biradari* identity and delineation of its boundaries[7].

However, for the large majority of women, the practical needs of survival necessitate mobility outside the home. The resultant tension between two opposing forces and the manner in

[7] A reason commonly given for women's seclusion and *purdah* is the danger of loss of men's *izzat* if she is sexually molested. However, the reasons for *purdah* extent beyond issues of one man's *izzat* and are further addressed in Appendix 5.

which it is handled classically exemplifies the fluid nature of gender 'norms'. Reported and observed activities diverge sharply.

To start off, a statement every woman makes as a matter of routine is *'mai kidde nai jandi'* (I never go anywhere). Further probing usually elicits an admission that she does travel out, but only to attend *wya ya maatam* (weddings or funerals), and this mobility is represented as an unavoidable *majboori* (necessity). However, there is some variation by *biradari* with the Raja women strictly emphasising their restricted mobility, while a few very poor Malik women admitting it is a luxury they can ill-afford. Without exception, all subscribe to the notion that women *should* not travel out.

6.6.1 Emic construction of space and movement

Despite what they say, women are quite mobile and a woman walking alone in a lonely field is not an unusual sight in Jatti (Plate 6.1). They visit each other's houses, making *roties* in one *tandoori* and collecting water from one well. They wash clothes and bathe in the nearby stream. The Malik and Kammi women look after livestock, which includes herding cattle in the fields and collecting fodder for the *bhans*[8] (Plate 6.2). Since the fodder can only be collected from the fields cultivated by their family, this can involve walks of greater than one or two hours in lonely fields. A drought during the field-work period meant they had to travel even greater distances. Similarly, women travel to and from the *dhokes*[9], alone or in groups. Some of these *dhokes* are located at distances of 30-45 minutes walk from the main village, with no clearly defined paths.

[8] A *Bhans* is a huge black buffalo only kept for milk and has to be fed large amounts of fodder for it does not graze.

[9] A *dhoke* consists of a house or two build in a field away from any main settlement, usually by Maliks on their own land. It is considered a part of the village. See chapter 5.

Plate 6.1 **A woman travelling alone in the fields**

Plate 6.2 **Collecting fodder for animals**

One explanation for the variance between their stated and observed mobility is the emic construction of space and movement. Women's construction of space is not determined by physical geography but by social geography. The presence and identity of people who share a space at a particular moment in time determines whether the space is classified as '*baar*' (outside) or '*ander*' (inside) space. Presence of *biradari* members, both women and men makes it socially acceptable 'inside' space, while the presence of a *non-biradari* man, or even a woman, makes it an 'outside' space.

More interestingly, there is little correlation between the social boundaries and physical village geography. Women can visit a relative's house that involves a lonely 45-minute walk in the fields, but will not visit a non-*biradari* house, a five minutes walk away. Since most of the *biradari* houses are located in close proximity constituting a *mohalla* (neighbourhood) (see Fig 5.1), women of the *biradari* move from home-to-home as if it is an extension of their own home. Even the *ghalian* (village lanes) are a socially acceptable space to linger around, chatting.

This construction of social space based on *biradari* boundaries is the primary reason there are no takers for the Lady Health Worker's (LHW) job. The LHW's are supposed to provide family planning and basic health care services at the doorstep. This is a part of the government's drive to provide universal health care services designed in a context of women's seclusion and limited mobility. The job requires making home visits and does not differentiate between different *biradari* houses. Such a regular breach of social boundaries and the woman's interaction with *non-biradari* women is unacceptable. The fear of such regular cross-*biradari* interaction is couched in terms of *purdah* and seclusion. Similarly, attending school or going to a health service outlet falls outside the limits of social boundaries, even if they are geographically nearer than *biradari* houses.

6.6.2 Larger societal determinants of women's mobility: the role of the *mahol*

The '*mahol*', translated as the larger social climate, is the most frequently cited reason for limiting women's mobility. At one level, it refers to the gender norms of seclusion, but at another level, it refers to the issue of insecurity, of the absence of law and lack of accountability should a woman get molested. In the case of Jatti, the insecure *mahol,* is created and perpetuated by a group of largely land-owning Raja men. Subordination by class and gender converge to place the Kammi women in a particularly vulnerable position. Their

higher within-village mobility is taken advantage of by men whose accounts[10] suggest that sexual activity in the fields with Kammi women is commonplace. Although presented as the result of highly-sexed Kammi women chasing rich Raja men, such sexual activity is evidently embedded in power differentials based on class and gender. One reason why women of Golra Malik's *biradari*, the teachers, can afford to be mobile is because, despite their Malik *zaat*, they are rich and have close links with the Raja *biradari*. This provides them protection not available to poorer Malik or Kammi women or teachers and health care providers from outside the village.

This abuse of women by the Raja men continues unchecked because they are powerful, socially, economically and politically. The poor Malik and Kammi men are unable to speak out for they are dependent on these men for their livelihood and even the roofs over their heads (see chapter 5). Their only recourse is to protect their women, which is done by secluding them as far as they can afford to. The biggest casualty of this gender-based violence is girls' education as parents hesitate to send their daughters to far-away schools.

A further restriction on mobility outside the village is the transport system itself. The two daily buses to Rawalpindi and Fateh Jang belong to the same group of Raja men responsible for sexual violence and the insecure *mahol* of the village. By virtue of their financial strength, the Rajas alone can afford to invest in the transport business. Furthermore, Raja Tai, as the chairman of the Local Council is responsible for issuance of road licences that permit a vehicle to ply a route. He issues the licences to his *biradari* members only as kinship rules' authorise kinsmen priority over others. During our fieldwork, one entrepreneur from Rawalpindi tried to run a smaller bus at a different time, but was hounded out by the Rajas. There was a fight and the police impounded all the vehicles, leaving the villagers without any means of transport for nearly a month. The new entrant in the business quickly withdrew. As a result, there are only two broken down unreliable buses providing transport from the village and surrounding areas to Rawalpindi and Fateh Jang. Apparently this monopolisation of the routes and transport system is common in other areas as well. A common sticker on the buses read *'yeh route hamara hai'* (This route belongs to us). The lack of fair competition also means that the poor transport infrastructure has no chance of improvement and remains a real limiting factor for women's ability to travel beyond the village.

[10] The Raja men, particularly the younger ones, openly discussed their sexual activities with Kammi women. The women, despite all our attempts, never talked about it. Apparently, it is this 'culture of silence' the men depend on. One Raja man stated that if a woman resists the first time, the sexual act is carried out forcefully with the confidence that she will not tell anybody. It then becomes a routine activity.

6.6.3 Accompanied mobility

Despite some variation between individuals and households, the inhospitable *mahol*, the overarching danger to loss of *izzat* by a simple accusation of sexual misdemeanour (of *women* only), and poor infrastructure act as a powerful deterrent to women's desire to travel. When there is a need, women travel *with company*. The type of company varies, depending on availability, and the social construction of space and movement discussed above. For mobility within *biradari* boundaries, company is not necessary unless the distances involved are large. For travelling 'outside', *biradari* boundaries, be it within the village or outside the village, company is essential. The nature of company itself is a measure of the woman's social resources and *mazbooti* in the family. Ideally, it should be a man, but women and even children are acceptable.

For example, Sameena never visits her parents without Farooq's company. By doing so, she is sending a message of her status as a *sohagan* (a married woman). Women insist upon it as it reflects she is a much-loved and wanted member of her marital family, that they care enough for her to accompany her. As Ruby said

> ..... A good relationship ..is ....a husband should accompany his wife. ...*ae gal sorhni ye*...(this looks nice, this is the way it should be)...am I right? *ae gal sorhni ye*? Especially, if she falls sick, or any other *okhe wele* (a hard time)... anytime....he should accompany her....anything....to buy clothes... (Ruby, 24, Malik)

Notwithstanding the structures of constraints, there is room for women to manoeuvre. Personal characteristics such as resourcefulness, initiative, ability to deal with non-familiar situations and to an extent, risk-taking behaviour play an important role. One common reason given for women not travelling alone outside the village is that since they are unable to read and write they would not know how negotiate their way around in the cities. As Akram described it

> *Aae granh dian hastian*[11] *ne* (these are simple village women) ....where would she know where to go....somebody would have to accompany her.
>
> (Afzal, 32, Malik Landlord)

[11] *Hastian*, while referring to simple village women, is a rather derogatory term since implicit in the word is the understanding that they are not capable of learning either.

While a valid enough reason, some resourceful women manage to overcome this handicap. Khalida, a Kammi woman decided to use a family planning method and without asking her husband, travelled alone to Rawalpindi and reached a reproductive health facility. While this is admittedly an unusual case, most women use their inter-personal networks to by-pass barriers such as an uncooperative husband or mother-in-law and thereby make trips that are needed.

6.7 Interaction of class and gender

A common assertion in the literature is that gender relations are more unequal in richer households in South Asia (Sather and Kazi 1997; Balk 1994). However, others researchers question this assertion (White 1992). The findings of this thesis support the latter. While all women are disadvantaged by their gender, their experiences at the societal level vary significantly by class. A higher socio-economic class somewhat attenuates the impact of gender divisions on women's well-being, while subordination by class and gender converge to doubly disadvantage poor women.

Within the household, the overall wealth of the richer households means that women can afford to adhere to the notion of economic dependency, with all its respectability connotations. Rather than viewing dependency as an exclusion from main economic activities, women view it is a privileged relief from hard labour that farming and animal husbandry entails. Only extreme poverty and a breakdown of the male support system forces them to work for wages. Moreover, the conditions of employment for the large majority of women (informal, unskilled low-paid, low prestige jobs with their real potential for sexual and other harassment) are not 'liberating'. Women in richer households are also more likely to have gold jewellery, and even in some cases land (if only nominally registered in their names). Because of the overall wealth of the household, they are more likely to keep control of their personal wealth.

Women in richer households are more likely to have greater exposure to the outside world, with its positive implications for knowledge, development of interpersonal skills and increased self-confidence. For one, richer families are more likely to educate their daughters for they can afford the costs, both economic, social and opportunity costs. Secondly, richer households are more likely to own TV's and radios, with obvious implications for ideas and information

Although unaccompanied mobility within the village is higher among the poorer women than the better off, largely because of the necessity of their work-related movement., it comes with the price of physical insecurity and loss of social prestige. In contrast, the daily unaccompanied mobility of educated, professional women who work as teachers in the village is accepted by their families and the wider community. Their high socio-economic status, strong social linkages and employment as professionals means that their movement is not a legitimate target for exploitation by Raja men.

Overall, a higher socio-economic class greatly attenuates the effects of gender divisions, a protection not available to poor women who suffer the consequences of both class and gender inequalities.

6.8 Life-cycle variations

A striking feature of women's gendered position is its variation by life-cycle stages, namely age, marriage and birth of children. As seen in chapter 3, quantitative analysis revealed that age is an important predictor of all the direct measures of women's gendered position. However, age is primarily a proxy measure of different structural positions at different stages of a woman's life.

Marriage is the major rite of passage on which all of a woman's fortunes depend. As young wives, women occupy a structurally weak position, possibly the weakest in their lives. Although endogamous marriages ensure they are not complete strangers in their marital homes, they nonetheless have to strengthen their linkages with the husband and marital family. This is best done through submission and compliance with the ideals of femininity, at least in the early stages of married life.

Thus, newly married young women are not expected to participate in household decision-making, major or minor. This marginalisation is culturally sanctioned as an integral component of femininity. A good woman does not start household turf battles early in her marital life. Instead she waits and the passage of time grants her a traditional authority as she becomes a *wade* (an elder). Some women grasp this traditional authority and even become the major decision-makers, who can overrule young men.

Women also become more mobile with increasing age, both within the village and outside the village. The mobility restrictions are strictest for young unmarried women, followed by young married women, and finally the post-menopausal women, although there is some variation by

socio-economic class. The older women were free to travel, accompanied or unaccompanied, within the village or beyond the village. The acceptability of older women's mobility means they frequently substitute for men in activities that are normatively male activities such as shopping for *sodha* (groceries). More importantly, younger women use the company of older women to provide a cover of respectability when seeking, for example, family planning services. In this way the mobility of older female relatives can be seen as a significant 'resource' for younger women

6.9 Summary

The ethnographic analysis highlights the interconnectedness that is the defining characteristic of the kinship system. Embedded within this system of interdependency and jointness is an unequal gender ideology, that disadvantages women. The two ideologies are in tension, for while the interconnectedness means that social linkages and ties are the women's primary resources, the gender ideology makes them the vulnerable partners in what is supposedly a mutually dependent relationship. The resulting situation is characterised by complexity and variability with room for negotiation and manoeuvre.

The role of Islam in the gender order merits a comment. A striking aspect of the ethnographic analysis in this chapter is the absence of Islam as an explanation of women and men's normatively prescribed behaviours. Although the villagers are deeply religious people, they did not verbally justify their behaviours in terms of Islam. However, this does not mean that their gendered behaviours contradict Islamic proscriptions of women and men's roles and behaviours. In fact, a more likely explanation for the lack of Islamic perspective is that because there was such a high level of correlation between the two that the issue did not merit attention in the villagers narratives.

I now turn to seek women's understanding of their reproductive health and how socially constructed expectations of female behaviour are associated with different aspects of contraceptive and antenatal care use.

Chapter 7

'A son or a daughter, one should have only two or three children if you want peace and happiness in your home'
An emic perspective of contraceptive and antenatal care use

Drawing on the ethnographic fieldwork in Jatti, the objectives of this chapter are to

1. Seek women's and men's emic concepts of fertility control, contraceptive use, pregnancy and antenatal care use.

2. Explore what gendered roles, processes and structures create individual and contextual norms that promote or restrain women's desires to use contraceptive methods and antenatal services.

3. Examine the relationships, if any, of these with other processes that may independently influence contraceptive and antenatal care use.

The chapter is arranged as follows. First, women's and men's perceptions of fertility control and contraceptive use are explored. The second section addresses their perceptions of risk in pregnancy and the utility of antenatal services use. Interwoven in the analysis is an exploration of whether gendered roles and relationships affect fertility control, contraceptive use and antenatal care use.

7.1 Contraceptive use

Unexpectedly, contraceptive use in Jatti is widely accepted and common. An informal survey of the village revealed that 25 out of 49 (51%) eligible couples reported current use of a method. The IUCD is the most common method (63%), followed by female sterilisation (16%), condom (8%), withdrawal (8%) and the pill (4%). Only five women out of the 49 women (10%) are not using a method and do not want any more children. The remainder are either pregnant, trying to conceive or are infertile (Table 7.1). The acceptability and common use of contraception cuts across all socio-economic classes, *zaats*, *biradaris* women's educational and occupational levels. The variations seen in the last column are largely an artifact of small numbers for it is by chance that most of the women pregnant or trying to conceive were either the Kammi or Malik women

although Kammi women are less likely to use a contraceptive method. Of the six infertile women in the village, four are Maliks and two are Kammis.

Table 7.1 Contraceptive use by *biradari*, currently married women aged 15-49, Jatti 2001

Biradari	Total no. of women	Using contraceptive method	Intentionally not using contraception *	Not using contraception and at risk of unwanted pregnancy	Percentage users
Raja	11	7	2	1	64%
Golra Malik	6	3	2	1	50%
Maliks	22	12	10	0	50%
Kammi	10	3	4	3	30%
Total	49	25	18	5	50%

* The women are either pregnant, planning to conceive or infertile

Other unexpected behaviours include use of reversible methods as early as after the first birth, irrespective of the sex of the child and contraceptive use to space rather than limit childbearing. Of the three women who have been sterilized, one did so after completing a family size of four children, while the other two had eight and six children respectively.

> Shameem is using an IUCD, which she had inserted after the birth of her first child, a daughter. The child is now three years old and Shameem has, as yet, no plans for another child saying she wants to ensure her daughter gets her full attention.

> Fozia has two boys, aged seven and two. She used an IUCD to space the two births and is currently also using the same. There are no immediate plans for another child. More importantly, her mother-in-law actively and openly discourages her from having another child, stating that two children are enough.

These findings are unusual in the Pakistani context for Pakistan has been characterized by a stubborn resistance to any changes in fertility. Only recently has there been some evidence that

marital fertility might just be starting to decline (Sathar and Casterline 1998). A number of theories have been suggested to explain fertility transitions and there is a large literature attempting to explain why fertility starts to decline in a particular geographical locale at a particular point in time (Notestein 1953; Lesthaeghe 1983; Caldwell 1982; Easterlin 1975; Cleland and Wilson 1987; Cleland 1998; Cleland et al. 1994; McNicoll 1980; Coale 1973). I shall not attempt to do the same in this thesis for explaining a fertility transition was not the objective of this research. I shall instead focus on the relationships, if any, between gender roles and relations and contraceptive use (see chapter 1). Nonetheless, the most important theme emerging from the empirical data is the acceptance of the concept of pre-natal volitional fertility control, primarily through contraceptive use. Whether this is the result of any changes in gender ideologies and behavioral norms or whether it is an independent process, possibly linked to other social and economic structures, is addressed.

7.1.1 An ideational change

A striking finding in Jatti is the villagers' positive attitude towards fertility control and the norm of a small family. The respondents, both women and men, vocalized their ideal family size numerically[1], as three children, two boys and one girl[2]. Small families are, in the absence of a better term, 'fashionable'. However, despite the overall positive attitude, these values are not shared equally by everyone and are particularly divided along age and gender lines.

An unexpected finding is that the contemporary *mahol* (social climate) regarding reproductive behaviour is created by elder women, the mothers and the mothers-in-law. This group of women is the most vocal advocate of smaller families and spacing between births. The younger women and even younger men tend to simply nod their heads in agreement, smiling shyly. It is only the older men and a few religiously inclined younger men who are found to oppose the idea, saying the number of children and the timing of their birth should be left up to Allah.

The older women's positive attitude towards small families is located in their own reproductive histories. The concept of fertility control is not new for them and as most respondents clearly articulated, they had wanted to control their fertility when they were young, only they did not

[1] About 60% of both husbands and wives surveyed in the 1990-91 Pakistan Demographic Health Survey said it was 'up to Allah' in response to the question on the ideal family size (NIPS 1992).
[2] The ideal family size most commonly enumerated in the Pakistan Demographic and Health Survey, 1990-91, is four children, two boys and two girls (NIPS 1992).

have the technology to do so. It is this cohort of women that probably constituted the latent demand for fertility control repeatedly identified in surveys (PCPS 1984-85; NIPS 1992). Most resorted to abortions and a history of three to five abortions is common in this generation, as are tragic stories of abortion related maternal mortalities. A chicken feather was used as an abortifacient: one of our respondents had even terminated a seven-month pregnancy. Men's role in this activity is shadowy; some consented to it, others were informed after the event.

The older women are therefore comfortable with the idea of fertility control. By virtue of their central role in the family and a life-cycle related authority discussed in chapter 6, they are now playing a leading role in the attitudinal change underway. They are creating a *mahol* (social climate) in which a small family is the norm rather than a deviation. An interesting incident demonstrated the older women in action.

> Sajo, a woman in the neighbouring village of Kak gave birth to her ninth child. The news was met with absolute horror by her aunt Zebunissa, who also is Zohra's mother-in-law. She promptly went over (I accompanied her) and in a gathering of 10-12 women openly expressed her displeasure over such behaviour. She was not only critical of Sajo for being so careless, but also her mother-in-law for not looking after her *nuu* (daughter-in-law). As she succinctly put it, ' I fail to understand what is the need for so many children and how one can become pregnant by mistake in this day and age when so many family planning methods are available?' It was interesting to see Sajo's mother-in-law defending the situation with excuses like she was not aware of the pregnancy until the last trimester or she would have had it aborted.

The younger men, largely under 40 years of age, are the other important group playing a crucial role in the new *mahol* regarding a small family norm and acceptability of pre-natal fertility control. This group of men, most of who started their families in the nineties, has imbibed the notion of fertility control and the small family norm from the health education messages of the Pakistan Family Planning programme. They even use the same language and words utilized by the media (the words in bold).

Beta....ya beti...bache do *ya tin horne cheday ne....****agar kaar*** *which* ***khushaali*** *chande yo...* (son or a daughter.....you should only have two or three children..if you want happiness and peace in your home)

(Hanif, 32, father of one daughter, contraceptive user)

The young men have internalized the concept of fertility control and it is difficult to identify any one particular factor that alone may be responsible for their positive attitude. They grew up in an environment that was different from their parents generation in a number of ways, the most important of which, according to them, is the cost of living. Rising costs of living (*mehngai*) is the only one factor that was clearly articulated as a reason underlying the need to control fertility. This issue is discussed in detail in the next section.

The older men, largely over 40 years of age are the only group of people who express opposition to the notion of volitional control of fertility. Their opposition is largely based in the Islamic belief that 'Allah provides for any soul He gives a life to'. The older men's opposition confirms previous findings from Pakistan in which husbands' attitudes have been identified as a major barrier to women's ability to implement their fertility desires (Shah and Shah 1984; Hashmi 1993). It would be this older group of men who constituted the opposing cohort of men. However, in Jatti the older men's opposition is generally disregarded by all. A curious observation is that, in contrast to older women, older men's influence in family affairs declines with age. Furthermore, the rules of separate spheres disconnect men from their older sons and daughter-in-law in a manner not applicable to older women. It appears this cohort of opposing men is gradually being phased out of the decisions regarding family size and is being replaced by men supportive of fertility control.

The younger women, who give birth, appear to have the least say in the creation of the new *mahol.* Largely less than 35 years of age, this group of women also states two or three children as the ideal family size. However, it is difficult to extricate to what extent women's desires for a small family result from the social influence of their group (and *biradari)* members and to what extent they are the result of independent thinking. This is a context in which young women, particularly in the early years of marriage, are not expected to have independent opinions, much less desires or goals regarding family size. The young women's narratives did not contain any evidence that they had been influenced by the health education messages of the family planning

programme nor did they demonstrate the positive attitude characteristic of the older women and younger men.

It appears that the women's stated desires for fewer children are really the products of information that is held by the larger society, which in turn has exerted a powerful influence on women's thinking. The collective power of structures of authority (mother-in-law, other *biradari* women, and husband) has established a context in which family size is small. While diffusion of information and values held by the larger society affects all members of society, it is particularly relevant for the younger women because the cultural construct of young women is such that they are not encouraged to think independently or have independent opinions and desires. Despite probing, there is little evidence that women's desires for small families are based in their individual ability to decide the number of children they want, whether it complies or contravenes the socially prescribed family size. The young women are just conforming to a new culture, which in this case promotes fertility control.

The role of *maulvis*[3] in this *mahol* is interesting (see chapter 5). Neither of the two *maulvis* in the village deemed it their responsibility to discuss family planning with the villagers and the villagers did not turn towards them for advice on such matters. This contrasts sharply with the behaviour of *maulvis* in other parts of the country, urban areas in particular, where they tend to actively oppose fertility control. One reason for village *maulvis* behaviour could be that the older *maulvi* is not a professional *maulvi* but a retired *fauji* (army personnel) who sells *samosas*[4] to top up his income. He is a firm believer of family planning. The younger *maulvi* is trained in Islamic theology, but is only 19 years of age and found the topic of family planning too embarrassing to discuss in his sermons. More importantly, both *maulvis* are not members any organised Islamic group. Members of organised groups and Islamic parties tend to veer towards militancy and extreme ideas, which includes opposition to family planning.

7.1.2 Belief-systems versus practical realities

Further evidence of the depth to which the notion of fertility control has taken root is demonstrated by the manner in which the villagers have subverted an Islamic tenet of reproduction in the face of real practical needs.

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[3] *Maulvi* is local religious leader responsible for leading the prayers (*namaz*), conducting marriages and teaching the children to read the Koran.

The most common reason given by young men for limiting the number of children they are having is *mehngai* (everything has become expensive). The younger men, less than 40 years of age, who started their families in the 1990s have a clear understanding of the linkages between the rising costs of living and the number of children. As they put it succinctly,

> 'It is much more difficult to bring up children now than it was 10 years ago'.
>
> (Hanif, 32, 1 daughter, contraceptive user)

Pakistan's economic conditions have steadily deteriorated in the past decade and a half. Today, over 33% of the population (40% in rural areas) is living below the poverty line, an increase from 26% ten years ago (World Bank 2002). The impact of this economic decline is being felt even in remote villages like Jatti. As discussed in chapter 5, wheat and maize are the primary produce, which are then sold to meet other demands of day-to-day life including groceries. The village economy is thus monetised and linked to the larger regional and national economy.

However, an Islamic tenet that '*Allah* provides for any soul He gives a life' to complicates the economic issue. This is the cornerstone of older men's opposition to contraceptive use and a source of much contention. The villagers hold deep convictions about *Allah* as the ultimate authority and provider. '*Rab* does what is for the best' or '*Allah* provides' are common comments accompanying any situation over which the villagers feel they have little control. There is thus a deep tension between this Islamic tenet and the practical reality of diminishing purchasing power. On the one hand, it is unacceptable to openly admit an inability to feed a child as it goes against deeply held religious convictions. On the other hand, the reality is that it is no longer economically feasible to continue bearing an unlimited number of children.

The manner in which individuals cope with the tension between the two opposing forces indicates the depth to which the ideational change regarding small family sizes has taken root. The majority of the villagers are actively controlling their fertility. Some use health as the rationale for contravening the Islamic proscriptions since health concerns are a morally more acceptable explanation than acknowledging that they cannot afford another child. The Pakistan Family Planning Programme has developed a series of health education messages that focuses on the deleterious effect of too many, too closely spaced pregnancies on the health of the mother and child. However, as the discussion on pregnancy and antenatal care shows, few really believe

[4] A snack item commonly sold by hawkers on the roadside.

pregnancy is detrimental for health. Essentially the notion of mother and child's health enables them to subsume the economic calculations in more morally acceptable arguments.
Others simply acknowledge it as a *majboori* (necessity). As Mano says:

> 'Let the *Maulvis* say what they want to...we are responsible for our actions. We have to bring up the children.' (Mano, 32, father of 2 boys, contraceptive user)

7.1.3 Contraceptive use

Contraceptive use is the primary mechanism through which fertility is controlled in Jatti. The high levels of contraceptive use are, according to the respondents' narratives, a recent phenomenon, about three to five years old. The most interesting aspect of this behaviour in Jatti is that it has taken place in the absence of a grassroots, door-to-door service delivery system, something that is postulated to be very important in a context where women's mobility is restricted (Simmons et al. 1988). There is a Family Welfare Worker assigned to this village, but she has never visited the village and nobody knows of her existence. I stumbled across her when I went to visit the Local Council dispensary in the neighbouring village. She had come to the static health facility that particular day because she was expecting a supervisory visit. There is no Lady Health Worker either, although Sameena was employed as one for a short while in the early stages of the programme (1995-96). She never actually worked and her husband used to generate false activity reports until they were caught.

Nonetheless, the building of a road and electrification of the village emerge as major milestones in the evolution of the small family norm and uptake of contraception. I postulate the following sequence of events. In a context where the concept of fertility control was an alive, but dormant idea, only women perceived the need for contraceptive technology. Their husbands were possibly insensitive to this need. Electrification of the village five years ago exposed the villagers to health education messages, which had a two-fold impact: they highlighted and gave legitimacy to what was essentially a women's, possibly unspoken, need and they recruited and converted the younger men, a powerful decision-making group of the future. The economic deterioration acted as a catalyst in an environment primed for change. The newly built road then provided the infrastructural support enabling women to access contraceptive services located at a significant geographical distance.

The possibility that the advent of new means of regulating fertility may bring about radical reappraisals of desired family size has been an issue under intense debate. The findings of this study show that easy availability of family planning is not as important a determinant of contraceptive use as ideational changes in attitudes and norms towards family size, fertility control, and contraceptive use. Once people decide on a course of action, they will do whatever it takes, within certain limits. The importance of ideational changes is further supported by the fact that there has been no observed or reported change in the quality of services provided by the existing private and public sector services used by the villagers.

> During the fieldwork, Rehana developed a pelvic infection after an unhygienic insertion of an IUCD in a public-sector health facility. The pelvic infection spread to cause a generalized sepsis, which resulted in a hospital admission and treatment with intravenous antibiotic therapy. Despite the complications suffered and expenses borne, the couple did not give up on the idea of using contraception. Instead they switched methods and now use a condom.

It appears that if societal attitudes towards contraceptive use are positive, and motivation strong enough, the barriers created by a poor health care delivery system are somehow overcome.

7.1.4 Shifting costs and benefits of childbearing for the woman versus the wider family

A general idea in the literature is that fertility is, at least in part, determined by the extent to which women of reproductive age are able to act on their own behalf. The demand for children is postulated to depend on the value of children, costs of children and gender preferences for children (chapter 1). The value of children for a woman are assumed to act at four different levels: as insurance against divorce; as securers of the woman's position in the family (Cain 1993; 1982); as a source of loyalty, labour or route to household resources (Caldwell and Caldwell 1987) and old age risk insurance (Cain 1984; 1993).

The findings of this study indicate that at least three of the four aspects of patriarchy that increase the value of children for women exist in Jatti today. The birth of a child/children is a crucial determinant of whether a woman can become *mazboot* in her marital home (chapter 6). A childless woman will remain *kamzor* irrespective of the presence of other contributing factors. The kinship ideology of *akhathe* (jointness and togetherness) ensures strong intergenerational

linkages in which sons look after their old parents. Thus, in the current social setup in the field-site, children do act as insurance against divorce, as securers of the woman's position in the family and as old age risk insurance. If these arguments are followed to their logical conclusion, it should be in the women's interest to have many children. Yet, women in the field site are having fewer children.

One explanation for the lack of fit between the empirical data and postulated hypothesis of the pathways linking women's gendered position and fertility is that Cain's arguments, while plausible, are based on a premise of questionable validity. The argument that women have high fertility because children are valuable to their mothers assumes women are independently and autonomously controlling their fertility or at least have a major say over their fertility decisions. This assumption is not supported by the ethnographic data nor is there any evidence of women's independent control over their fertility in the South Asian literature.

The data instead support the notion that women's stated preferences for the small number of children they want and their reproductive behaviour are the result of social influence and social learning. The society now deems a small family as the new norm and the women are just conforming to the new norm. There is no evidence that the current small family norm is propelled by any transformations in the value of children in terms of their utility as securers of a woman's position in her marital home or old-age insurance. While the former has been adjusted at a lower level (a woman can become *mazboot* with the birth of two or three children instead of six or seven children), it does raise questions about what impact, possibly a negative impact, that lower fertility might have on women in their old-ages.

7.1.5 Decision-making and contraceptive use

Further evidence that women's lower fertility is the result of their compliance with the new societal norms and not the result of any shifts in their gendered position or of the gender order is the manner in which decisions are made regarding contraceptive use. The process also supports the findings in chapter six that decision-making in this context is characterized by *slaa-mashwara* (consult and advice) and collective decision-making rather than independent decision-making.

The first child is, almost without an exception, expected within the first year of marriage so there is no proactive decision-making involved at this stage. It is after the birth of the first child that the

issue of birth control emerges. The exact decision-making process is, however, complex and far from being the outcome of isolated decision-making of one individual, couple or even families. The final decision is instead the result of a complex *slaa-mashwara* between the woman, her husband, other family members and the larger *biradari* women. The process consists of discreet, back and forth exchanges regarding types of birth control, characteristics of particular methods, the side effects, other women's personal experiences, stories about other women's experiences and so on. Information exchange goes hand in hand with assessment and evaluation. Other women's experiences play a critical role in shaping a particular woman's reproductive desires as well as her ability to act on the desire. Thus, the decision to use or not to use and type of method to use is subject to both social support and social pressures. Nasra's experience illustrates this best.

> Nadia initiated the possibility of using contraception after the birth of her second son and she names her husband, her mother, *nand*[5] and *jethani*[6] and *biradari* women as the people she discussed the issue with. It would be inaccurate to identify any one individual with veto power, but the fact that she mentions all these people indicates their importance in the process. Her need was a *waqfa* (break) from childbearing. Her husband went along with her desire, but the rising costs of raising the children were his primary consideration. The *nand* is not married and plays the role of the mother-in-law, which includes looking after the interests of the family cooperative. The *jethani* was consulted because she is the only other married woman in the family with whom such matters can be discussed and who is in a position to provide her with the company that is necessary when seeking contraceptive services. The *jethani* and Nadia then went and discussed the issue with *biradari* women who they knew were current users of a contraceptive method to seek further information regarding different types of methods and sources of family planning services. Since most of the women in the village use an IUCD and their experiences have largely been positive, Nadia too decided to use an IUCD. The *jethani* also accompanied her to the family planning centre in Fateh Jang.

Interestingly, as the above example also shows, the younger men have created a *mahol* that is conducive to fertility control and contraceptive uptake, but they are not directly involved in the use of the method or even seeking it. This is best indicated by the fact that 83% of the methods

[5] *Nand* is the husband's sister, who in this case is not married and lives with her brothers.
[6] *Jethani* is the husband's older brother's wife.

used in Jatti are women-based methods (63% IUCD, 16% female sterilization and 4% the pill). Women travel with other women when accessing family planning services. In the above example, Nasra's husband is a shadowy figure in the whole process. The behaviour is best captured in Rafiq's narratives in which he states that he and his wife have decided to limit further births and he thinks his wife has done something about it, but he is not sure what. Men's level of involvement in their wives' reproductive health issues is discussed in further detail in the next section below.

7.1.6 Son-preference

An important aspect of the demand of children is preferences regarding the gender composition of offspring. Patriarchy engenders a preference for sons over daughters and Jatti is no different from this general trend. As Hussain said

> We know a *beti* (daughter) is *Allah Tallah's rehmat* (blessing from God), but sometimes a person thinks a *rehmat* (blessing) has been born, but she may become a *zehmat* (a source of distress and pain).
>
> (Hussain, 34, one daughter, contraceptive user)

Son preference has been identified as a possible drag on fertility decline (Cain 1984). The argument is that in the South Asian context (Bangladesh specifically), where women are unable to economically fend for themselves along with the absence of state provided social insurance, sons are the only form of old-age insurance available (Cain 1984). Sons are also valued for social reasons and mothers of sons have a higher social status compared to women with no sons (Winkvist and Akhter 2000).

These arguments are also true of Jatti. As discussed in chapter 5, women are rarely involved in main economic activities. They are dependent upon their fathers, husbands or sons for economic as well as social security. Sons are the only culturally acceptable source of old-age support. Nonetheless, fertility control and contraceptive uptake have become a new social norm. The notion of fertility control has been accommodated within an existing gender ideology of son preference. Once a woman has given birth to a child and proven her fertility, the new social norms are consistent with a gap of two to four years before the next child. If the woman has given

birth to two sons she can stop childbearing altogether, and if she has no son, she is expected to continue childbearing until she does.

> During her third pregnancy, Zohra felt, in line with societal norms, that three children, two sons and a daughter are enough. She started throwing hints in general to her husband, and both their families that she wanted to have the *operation*[7]. At no stage was there an open discussion or a *slaa-mashwara* session, not even with her husband. At the time of delivery (an elective C-section), she authorized the doctors to perform a tubal ligation. It was only when her husband's co-signature was sought for that he realised what was happening. He managed to talk to her while she was being wheeled to the operating theatre to ask her if this was what she really wanted and signed the consent form.

Although apparently Zohra's narrative could be taken to mean that she independently decided to limit childbearing, it actually was not so. She was only complying with the societal norms since she has had three children and two of them are boys. In contrast, Nighat who has four daughters only needs to continue child-bearing until she gives birth to a son or two. However, Nighat is the only one woman (out of forty nine women of reproductive age in the village) who does not have a son. A fertility decline has also occurred in other high son-preference contexts, Bangladesh being the most dramatic example (Cleland, Philips, Amin and Kamal 1994).

7.1.7 Covert contraceptive use

While there is little evidence of female independent autonomous decision-making regarding contraceptive use, a small proportion of women use a method without their husband's knowledge or their mothers-in-law's blessings.

> Ruby is using an IUCD. According to her, her husband knows about it but Jehangir's narratives indicate that he is not aware of it. Ruby's mother-in-law does not openly support the decision, but expresses helplessness saying 'who can stop Ruby if she wants something'?
>
> Shameem admits using an IUCD that her husband does not know about. When asked why, she dismissed our query, saying she had not yet had a chance to inform him.

In another, admittedly extreme example, Parveen, the village *maulvi's*[8] daughter-in-law had an IUCD inserted after the birth of her first child, a daughter. She does not have a good marriage and her husband was not aware of her use, which she managed to arrange with her mother help. After seven years of use, she decided to have another child, removed the IUCD, became pregnant and gave birth to a son.

Covert contraceptive use is an interesting phenomenon for it might indicate woman's independent control of her fertility. The examples above indicate that women do struggle to try to influence their fertility and carve out some space for themselves. This group of women has the knowledge that they can control their fertility and desire to do so, but their husbands and marital families do not share their views. Instead of passively giving in to their fate, they resorted to their social resources to actualise their desires. Social resources are a woman's primary resource in this context and consist of their natal families and larger *biradari* networks and relationships. In fact, the existence and size of these social resources constitutes a dimension of women's *mazbooti.* In the above examples, the women apparently are not *mazboot* in their marital homes, but they still have access to social resources that enables them to actualise their desires. In Ruby's case above, Ruby was able to draw upon a cousin sister in the neighbourhood, who accompanied her to the health centre for contraceptive services. Parveen used a visit home to her natal family as an opportunity to access contraceptive services. Her mother accompanied her to a health centre.

However, it would be inaccurate to assume the women's actions are totally due to their agency and in complete contravention of societal norms. Women remain tied to their social structures even if their lives are not completely dominated by them. The women's behavior in the examples given above has been influenced by the larger societal level changes in aspirations and attitudes towards contraceptive use taking place in Jatti. The fact that women can access contraceptive services without the husband's knowledge demonstrates the tacit support and enabling conditions of the larger society. When these women contravene their husband's or family's rules or expectations, they do so knowing the consequences will be acceptable. In Ruby's case, although her mother-in-law is apparently unhappy about her contraceptive use, she is not unhappy enough to share the information with her son, assuming he really does not know.

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[7] *Operation* is the term used by the villagers to describe tubal ligation.
[8] *Maulvi* is local religious leader responsible for leading the prayers (*namaz*), conducting marriages and teaching the children to read the Koran.

Although Shameem told us that her husband does not know about her use of an IUCD, her husband was a vocal proponent of small families during a focus group discussion.

To summarise, the ethnographic analysis indicates that an ideational change is the primary reason for the current fertility behaviour of the residents of Jatti. There has been a change of world-view and in norms about appropriate reproductive behaviour. A detailed exploration of why these changes are taking place is beyond the scope of this thesis. However, from the perspective of the link between gender roles and relations and fertility, the ethnographic analysis does not provide any concrete evidence of a positive relationship between the two. While there is no denying that profound changes are taking place regarding the notion of fertility control, attitudes towards contraceptive use and reproductive behavior, there is little evidence of any corresponding changes in gender roles and relations that may explain these changes. In other words, there is no evidence of a change in the gender system or specifically of increases/changes in women's access to or control over economic resources, decision-making authority, unaccompanied mobility, social identity or valuation of the boy-child. It appears that at this moment in time, in this particular locale, other social and economic forces are playing a more important role than changes in the gender system in bringing about the changes in fertility behaviour.

Nonetheless, fertility behaviour in Jatti, as else where, remains highly gendered. Although women are having fewer children, it is not the result of their independent autonomous decisions, but is rather a behaviour embedded within the norms of the larger society which now deems a small family size more desirable. The process is being driven by older women and younger men with the former playing an active and direct role. Younger women are still essentially the conduits through which the society's fertility desires are being operationalised. Fertility, it appears, remains the collective property of the society and is highly gendered.

7.2 Antenatal care use

In contrast to widespread acceptance of the notion of fertility control and contraceptive use, antenatal care use in Jatti is an emerging behaviour, not as widely accepted. Table 7.2 shows the distribution of antenatal care use among women of reproductive age (15-49) by *biradari.*

The numbers are based on an informal survey of the village and include women's self-reported use of antenatal care for any pregnancy in their lifetimes. Although the numbers look quite large, there is an element of misclassification here that leads to an overestimation. Women in Jatti use the term *'check-up'* to describe pregnancy related health care. Most women understand that 'check-up' refers to preventive care of a normal pregnancy, but in a survey situation, some do not differentiate between preventive care and health care sought for symptoms of ill health. The ethnographic analysis showed that it was only women of the Golra Malik *biradari* and some of the Raja *biradari* who used antenatal services as a purely preventive activity, a fact not captured in Table 7.2. In the remainder of the discussion, antenatal care is understood as a preventive activity by the respondents and researchers.

Table 7.2 *'Check-up'* by *biradari*, currently married women aged 15-49, Jatti 2001

Biradari	**No. women**	**No. of users**	**Percent report having 'check-up' during pregnancy**
Raja	11	6	54 %
Golra Malik	6	6	100 %
Malik	22	8	36 %
Kammi	10	3	30 %
Total	49	23	47 %

Antenatal care use by a particular woman is primarily determined by the acceptance of its utility by her marital family, whether it is an acceptable behaviour in the eyes of the larger *biradari* and a financial ability of the marital family to pay. Thus, while the gendered context of pregnancy is common to all *biradaris*, the larger social and economic structures are equally important determinants of health-seeking behaviour during pregnancy.

7.2.1 The gendered context of pregnancy

A pregnancy may be a physiological phenomenon, but in Jatti, the whole process is intertwined with gender and patriarchal ideologies. Gender and age hierarchies ensure that the authority to make pregnancy-related decisions are located in remote authorities (usually the mother-in-law and other older women, occasionally other men in the family who are above the husband in the age hierarchy). The individuals most intimately involved in the process, that is the woman whose body is under consideration and her husband who possibly has an emotional interest in his wife's health, are distanced from the decisions.

7.2.1.1 Older women, authority and responsibility

Pregnancy and its associated issues (such as whether or not antenatal care should be sought, place of delivery or type of attendant at delivery) is normatively the older women's domain. This includes not only the mother-in-law, but the mother, older sisters and even other *biradari* women. Older women are considered *siyarni* (wise and experienced) and they are vested with the authority to make decisions that are binding. Normatively, the pregnant woman is not supposed to voice her opinion or have any desires. All her health care needs are her mother-in-law's responsibility.

> Sughra, when narrating the events surrounding her daughter-in-law Fozia's pregnancy, focused only on her observations of Fozia's symptoms of ill health. At no stage of the narrative was there a mention of Fozia complaining or requesting medical help. When I pointed this out, her response was that Fozia is 'not that sort of a girl' indicating an unspoken gender norm that young women are not expected to 'ask' for anything related to their pregnancy and health.

The older women's authority over the younger woman's pregnancy and her well-being is characterized by a tension between a culturally ordained authority of the mother-in-law and the fact that this authority is subject to the quality of inter-personal relationships which traditionally tends to be more hostile than friendly. The latter can be a more important determinant of whether the younger woman receives health care than any real need. The older women's involvement is highly valued and largely their decisions are the final word in the matter. A mother-in-law's absence during a delivery sends a very strong message of her unhappiness with her daughter-in-law.

> Zaida informed me, in all honesty that she gave birth to her daughter *akeli* (all alone). I took this to mean she gave birth unassisted, but what she really meant was that her mother-in-law was not present during the birth. The birth had actually been assisted by a *dai.*

A young woman with good inter-personal relationships with her mother-in-law and marital family is more likely to receive antenatal care than a woman who does not, within the practical parameters discussed below. It is this dimension of inter-personal relationships that Sughra was referring to when she said it is her duty to look after her daughter-in-law's health during pregnancy since she is a *wade* (elder) and inter-personal relationships between the two are good. Narrating the events surrounding a maternal mortality that took place a few years earlier, the villagers quite explicitly identified the dead woman's mother-in-law and marital family as the cause; that mother-in-law did not seek the healthcare her daughter-in-law needed.

In an interesting twist, the older women's authority in this domain becomes a conduit for transfer of resources from the richer to the poorer households. The following case gives an example of this.

> Kauser's last delivery was prolonged beyond what was considered acceptable. But as a poor Malik family, they are financially constrained. So Kauser's mother-in-law sought the advice of Raja Tai's mother, who is considered a *siyarni (*wise woman*).* Her authority in women's pregnancy related issues is embedded in her advanced age and social status as a rich Raja woman rather than being a reflection of any real expertise. An unspoken, but very important reason underlying the consultation is that if she deems it necessary to take the labouring woman to a hospital, she will authorize her sons to provide the

necessary transport, saving a very large expense. This is exactly what happened. Here is an example of transfer of resources between households that is based wholly on women's inter-personal relationships and social networks. It is conducted by the older women alone, is meant to address women's needs only but is part of larger obligation of the rich landlords towards their poorer tenants and neighbours. The event also demonstrates women's centrality in social relations beyond the domestic domain. Men on both sides of the transaction are peripheral spectators and act on female instructions.

7.2.1.2 Men's limited involvement in women's pregnancy-related issues

Another aspect of the gendered context of pregnancy is men's limited role in their wives pregnancies or any other issues related to it. Consequently, most men in Jatti have minimal knowledge of risks during pregnancy or of any signs and symptoms of danger in pregnancy. Most men could not recall whether their wives had sought antenatal care or not. Their narratives of events that related to their wives' pregnancies and deliveries are sketchy with a poor recall. Probing usually drew blank stares. This contrasts sharply with the women's narratives, which are rich with minute detail. The men were clearly uncomfortable discussing pregnancy-related issues, particularly in focus group discussions. They were also quite unconcerned and uninterested in women's reproductive heath issues, dismissing them as an exclusively female domain.

The basis of this behaviour is a gendered norm that states pregnancy and related issues are a woman's domain from which men are excluded. So strong is this exclusion that is incorporated into societal prescriptions of men's gendered behaviour and how an ideal *marud* (man in the sense of masculinity) should behave. One such dimension of masculinity that acts to separate men from their wives' pregnancy experiences is the notion that a *marud* should not spend too much time in his wife's company. Masculine men should socialise other men; only a *zanankhuna*[9] prefers the company of women.

Secondly, pregnancy and contraception are by their very nature, associated with sex. Therefore, the whole issue is shrouded with the concept of *sharam* (shame). In joint families, where there is an older generation present, a man should not be seen to be too interested or involved in his wife's pregnancy. He is considered a *besharam* (shameless) man if he exhibits an 'excessive'

[9] A *zanankhuna* is a derogatory term to describe a man who spends too much time in the company of women, particularly a wife or sisters.

interest in his wife or her condition. So powerful is the concept that the only answer men gave to a specific question in focus group discussions was that 'this is a woman's domain...we don't know anything about it'. Conducting focus group discussions and interviewing men on this topic was a difficult task.

Another gendered aspect that excludes men from women's pregnancy related domain is a belief system that the whole physiological process of reproduction is *napaak* (impure) and 'polluting'. Lochia, and the placenta are *napaak* and polluting, and therefore to be avoided. Women are *gandi* (impure) for 40 days in the postpartum period. They are forbidden from saying *namaz* (prayers) and handling the Koran, although not physically isolated. The delivery bed is covered with old sackcloth and the newborn wrapped in an old piece of cloth, all of which are disposed of by burning. Furthermore, pregnancy is a uniquely feminine attribute and the very essence of its femininity renders it impure and off-limits to men. The metaphorical separation of men and women characteristic of this society is most obviously manifested in this domain. Men, who are never *napaak* (impure) are separated, more metaphorically than physically, from women during periods when she is *napaak*. Tellingly, men's body fluids, including semen, are not associated with impurity, but strength. It is believed that one drop of semen is extracted from a hundred *ser*[10] of blood, and one *ser* of blood is made from a hundred *ser* of milk.

Taken together, these gendered norms, values and beliefs mean men are largely excluded from women's pregnancy related issues. However, a paradox is that while the pregnant woman's husband is not supposed to demonstrate an interest in his wife's condition, other men in the family, particularly the husband's older brothers (*jeyth)* are involved at the time of delivery. This is because while the husbands are excluded from women's pregnancy-related issues, men are still required for getting the *dai* or arranging transport in the event of an emergency. Thus, women's narratives of their pregnancies, and in particular deliveries, rarely include the husband but are liberally interspersed with contributions of their *jeyth* or other male family members.

> Nadeem did not accompany Nadia to the hospital when she was in labour with their first child because he felt *sharam.* She was primarily surrounded by her mother and sisters-in-law, who made all the decisions regarding use of hospital services. However, her *jeyth* arranged the transport to take Nadia to the hospital and her narrative is full of his happiness at the birth of her son.

When Fozia and Salma developed complications and were advised operative deliveries, the final decision was deferred until their *mamu* (mother's brother) arrived. The decisions to go ahead with the operative deliveries were then made jointly by the older women and the *mamu*. The husbands are shadowy figures with no authority. They were deemed too young to make such weighty decisions. Interestingly, the *mamu* is not much older than the husbands' are, but it is his status as *wade* (elder) in the kinship hierarchy that is more important than chronological age.

The net result of the gendered context of pregnancy is that the power to make pregnancy-related decisions is located in a remote authority, the mother-in-law and occasionally other men in the family who are above the husband in the age hierarchy. However, all this does not mean the younger women are passive actors mindlessly complying with the norms. Women do negotiate between their sense of entitlement to care during pregnancy and desires and what is in their power to achieve. Despite the fact that the kinship and age-related norms of compliance with the older women's decisions limit their space to manoeuvre, some women do manage to exert their agency.

Naheed has never sought antenatal care and her untrained grandmother attended her last three deliveries. When I suggested she should take iron supplements as she was pregnant during the fieldwork, she declined saying her husband will accuse her of *chaske lagandi* (useless pleasure), in effect giving the impression she is helpless. While true to some extent (her husband was ambivalent about my prescription), Naheed alone decided to call the *dai* during her fourth delivery. She made the decision because a bloody vaginal discharge worried her. The other women in the family simply complied with her decision and the husband went to collect the *dai* without any questions.

Similarly, Zohra had little say during her first pregnancy as her sisters made all the decisions. However, when the baby was stillborn, she took over and sought care from a doctor of her choice during subsequent pregnancies.

In the preceding discussion, I analysed the gendered context of pregnancy. I now turn to consider emic concepts of risk during pregnancy and how they relate to bio-medical conceptualization of

[10] One *ser* is about one litre.

risk during the same. However, since the concept of risk during *pregnancy* was remote, most respondents answered our questions in terms of events that happened during *labour* and *delivery*. I will therefore first discuss pregnancy in general and then narrow down to the antenatal period specifically. Interwoven in the analyses is the interplay between gender roles and relations, social and economic forces and how they affect a woman's ability to use antenatal care.

7.2.2 Perception of risk in pregnancy

Most women and men, young and old, view a *hamal* (pregnancy) as a normal physiological process and a condition that, with a few exceptions, is not *khatarnak* (dangerous). *Koi khatre aali ghal nai* (there is no risk in it) is the most common response to specific questions, although there is some variation by *biradari*. Probing identified two major risk factors, *parchawan* and excessive movement, both of which can lead to an abortion. As the following discussion indicates, these risk factors do not correlate with the bio-medical conceptualization of risk in pregnancy.

Parchawan is the most commonly stated risk factor for adverse outcomes in pregnancy. *Parchawan* is a state in the realm of the supernatural and spirits that, if it affects a pregnant woman, can cause an abortion. In a complex and difficult to explain manner, a woman who has aborted, both induced or spontaneous, is said to be suffering from *parchawan*. She is a source of danger to other pregnant women and even young unmarried girls. Therefore, pregnant women should avoid public spaces and situations where such women may be present, such as weddings or funerals. The treatment for *parchawan* includes visiting Baba Malik, a spiritual healer for *salaam*, a process in which he then reads out some specific *suras* (sections) from the Koran and gives a *taweez*[11] (amulet) that protects the wearer from bad spirits.

Another risk factor for adverse pregnancy outcome is excessive and sudden movements. Included in these movements are travelling and climbing stairs. Since the roads are in very poor condition and a bus-ride on such roads can be very bumpy indeed, travelling is generally prohibited, unless it is unavoidable. Hard labour, such as carrying water or cleaning *goya* (animal dung) is also a risk factor, but there is an interesting gender variation in opinions regarding the extent to which the rules are followed in practice. Most women, while stating it as a risk factor, laughed it off as impractical: 'How could a woman not do work? Who would do the work if she did not do it?' So

[11] A *taweez* is a necklace made of pieces of paper bound in a cloth and strung as a necklace using thread. It is worn around the neck at all times.

they all work during pregnancy, both *zore na kaam* (heavy work) and *halke na kaam* (light work). Men, on the other hand, while acknowledging that women continue to work till the last moment, lay the blame on women themselves, somehow accusing them of irresponsibility towards their own health. According to them, if only women realized the importance of rest, they would take the time off for it. Interestingly, belief in these risk factors cut across *zaat*, *biradaris*, class, and education (of both women and men).

The symptoms of *khatra* (danger) in pregnancy did not emerge spontaneously either. Probing in women produced single word answers which include *patte ya kammar na dard* (abdominal or back ache), *safed panni* (clear vaginal discharge), and *daag lagna* (bloody spotting). All are perceived as symptoms of an impending abortion. The men could not name a single symptom of danger in pregnancy. There is no recognition of symptoms of serious pregnancy related disorders such as convulsions or excessive weight gain (pre-eclampsia or eclampsia) or excessive vaginal bleeding (antepartum haemorrhage), two of the top five causes of maternal mortality in Pakistan (Fikree et. al 1994; WHO 1991). On the whole, the villagers perception of risk in pregnancy does not correlate with bio-medical concept of risk in pregnancy, and as the following discussion shows, only a small proportion believe in bio-medical concept of risk management by preventive care.

7.2.3 Utility of antenatal services

Overall, belief in the utility of antenatal services varies by *biradari*. Members of the Golra Malik *biradari* and a few of the Raja *biradari* are firm believers of the value of antenatal services as a purely preventative care, while a larger majority of the Malik and Kammi *biradari* is not convinced of its utility. Amongst the latter, and the non-users in general, the common belief is that since a pregnancy is a linear process that can only end with the birth of a child, it should not be tampered with. Antenatal care is viewed as tampering with a natural process. As Akram commented

> '*kam kharab kar dene ne* (antenatal check-up spoils things). The child will be born when it is time...these doctors spoil things...we are *zamindar* (farmers) people...we don't do such things'.
>
> (Akram, 42, Malik landowner)

This tampering was explained in metaphorical terms using the language of nature – the 'seed' and the 'earth'. Once a seed is planted, it should not be tampered with. Tampering during the embryonic stage damages it and can even kill.

> 'Look, it's like this...when you plant a seed...the leaves come out after eight days...if you tamper with it, the leaves don't come out properly...you leave it alone and all is fine...it's the same here' (Sajid, 32, Malik landowner)

> 'No..it's like this...we have our own ways....you doctors have your own ways...we are *zamindar* people...when we plant a seed we know when it will bear fruit...and women know these things...they know when it's time' (Rafiq, 35, Malik)

This is not to say that the villagers do not seek healthcare at all during pregnancy. The women do seek health care when they feel *zayada takhleef* (more unwell). The most common reasons for seeing the doctor are *maide di takhleef* (literally meaning stomach problems, referring to nausea of pregnancy), *bou kamzoor* (weakness) and *akhian age nera* (feeling faint). In other words, it is the concept of antenatal care as a preventive activity that is not appreciated by people in Jatti. The fact that male doctors are also consulted indicates they do not view the illness as pregnancy related, but as an isolated illness episode. This is a context in which norms of *purdah* deem women's reproductive health concerns should only be treated by women healthcare providers, although as a *majboori* (of necessity) male health care providers can be consulted for non-reproductive health issues.

Amongst the users of antenatal services, there has been a change in their *rhujanaat* (aspirations), which is being driven by a combination of increased awareness of the utility of antenatal care and a financial and social ability to access services. Women's education emerges as one of the most important factors leading to an appreciation of the utility of antenatal care use. Interestingly, it is not quite an individual level relationship in that an educated woman will use antenatal care, although it was true of the innovators. More commonly, women's education acts by creating a *mahol* (social climate) in which antenatal care is considered advantageous. The number of educated women present in the family and *biradari* is an important determinant of the creation of a *mahol.* Thus, in the Golra Malik biradari, a relatively large number of educated women has resulted in a *mahol* in which antenatal care is viewed as essential. A death of a baby during delivery was the turning point after which antenatal care became a norm for the biradari.

Women's education, and to an extent, men's education allowed an analysis of causes of this tragedy and it was concluded that proper medical care might have prevented it.

> Zohra had an uneventful pregnancy, and a trusted dai attended the delivery, but the baby died during birth. While a still-birth or early neonatal death is not an unusual event, Zohra, an educated woman learned from it and sought antenatal care from a University teaching hospital for subsequent pregnancies. Her experience has changed the meaning of antenatal care for the whole *biradari*.
>
> In contrast, Iffat , a Malik woman nearly died during childbirth when her placenta was not delivered for nearly eight hours after the birth. She was pregnant again during the fieldwork, but was not seeking any kind of antenatal care. Her mother-in-law and mother informed us that 'they don't do such things'

In Iffat's *biradari*, the Malik *biradari*, where educational levels are low, a near-miss maternal mortality has not lead to any changes in behavior regarding antenatal services.

Equally important is the fact that families and *biradaris* where young women use antenatal care services are characterized by the presence of older women who appreciate the utility of routine preventive care during pregnancy. As discussed above, this is a context in which older women make all pregnancy-related decisions, which includes the decision regarding antenatal care use. Even if the younger women appreciate the importance of antenatal care, the kinship and age-related norms of compliance with older women's decisions mean they have to first convince the older women. In the Golra Malik *biradari*, the older women are convinced of the utility of antenatal care, while in Iffat's family women appear not to have made a link between Iffat's last pregnancy experience the possibility of prevention next time round. However, it is not valid to draw this conclusion without considering the wider economic and social context in which the behaviour is located, for as will be discussed next, the costs of seeking antenatal services are beyond the reach of poor people like Iffat.

7.2.4 Costs of seeking antenatal care services

Costs, both social and financial, are a crucial variable in the calculus of using antenatal care. Table 7.2 shows that the majority of non-users are women of the Maliks and Kammi *biradaris*, both of which are largely the poor *biradaris* (see chapter 5). Further analysis shows that the belief about tampering with an embryo damages it are articulated by members of the same *biradaris* and families. Apparently, use of antenatal care services does not only depend on an appreciation of the utility of antenatal care, but this awareness itself is conditioned by the financial and social costs of accessing the services. Amongst the poor, the decision to use or not to use antenatal services is assessed in view of the financial outlays involved, other competing needs and perceived risks. Where financial resources are limited and competing needs include items of basic survival like food and clothing, antenatal care gets low priority. An antenatal visit as a preventive activity in the absence of overt symptoms of ill-health is considered a *fuzuul* (unnecessary) expense, particularly when the costs are as large Rs 200 per visit (includes transport, doctor's fees and medicines prescribed).

The social costs of using services, which are of a doubtful utility from their perspective, are also particularly high for this group of women. Large class-based barriers prevent villagers from seeking health care. Both women and men are very clear about the fact that they are treated badly by the health care personnel, particularly of the public sector services, because they are 'poor villagers' while the richer gentry gets better treatment. The attitude is best captured by Akram when explaining why his wife does not seek antenatal care

> 'Hospitals....we only go to a hospital if there is a *majboori* (necessity) ...we are poor village people...to go to hospitals you need to know somebody....have some contacts....nobody looks after you in a hospital....you tell us people to go for a check-up (antenatal care)....do you know how much trouble it is...? First a woman has to sit in a bus with young children...in the heat it is a miserable experience....when you reach a hospital ...you wait there in a long line....those who have *sifarish* (know an insider) get seen by the doctors...others just wait in lines and come back home without being seen by anybody...'

It is the richer women, largely of the Raja and Golra Malik *biradari*, who use antenatal care services. While an awareness of the importance of antenatal care is an important dimension of

their behaviour, they appreciate their family's ability to pay as a more critical factor. As discussed in chapter 5, there are no public sector reproductive health services available in Jatti or the surrounding areas, leaving only the fee-paying private sector in nearby urban areas. Thus, only the relatively wealthier families can afford to seek antenatal care, which is, by its preventive nature, essentially a luxury item. These rich women do not assume antenatal care as a self-evident need, but continually justify its use, repeatedly giving Zamli's obstetric history as a classic example of its utility.

> Zamli suffers from maternal-fetal Rh blood group incompatibility, which was diagnosed during routine antenatal care. She was given anti-D globulin and has had uneventful pregnancies.

The pattern of utilization of antenatal services by *biradari* and socio-economic class provides an interesting example of how class and economic forces shape and modify gender norms. Pregnancy, an obvious manifestation of sexual activity, is associated with *sharam* (shame) and pregnant women avoid public space including travel. However, economic might and dominant social position enable families to maneouvre around these specific mobility restrictions when they realise that such care is advantageous. They are willing to by-pass the traditionally strong proscriptions against pregnant women's visibility and mobility. However, this travelling is always done with company, usually the mother-in-law, mother or an elderly *biradari* woman. Moreover, most women who had sought antenatal care had one or at the most, two visits.

7.3 Summary and discussion

This chapter has provided descriptive emic concepts of fertility control, contraceptive use, pregnancy and antenatal care use. In particular, I explored if any changes in gender relations or improvements in women's gendered position in any way determined or conditioned the widespread contraceptive use or emerging use of antenatal care services.

Overall, the conclusion is that changes in the gender order have not been the most important factor in the change in ideas of fertility control or contraceptive use. It appears that at this moment in time, in this particular locale, other social and economic forces are playing a more important role than changes in the gender system in bringing about the changes in fertility behaviour.

The older women and younger men are the primary forces underlying the change. The important role of the mother-in-law as an influence on contraceptive use has been highlighted previously in Pakistan. However, it is usually identified as a drag on fertility (Qurub 1995). More recent work supports our picture that mothers-in-law can encourage use. Fikree et al. (2001), using survey methods, interviewed 717 triads, consisting of a woman, her husband and her mother-in-law. There was some inconsistency in reported discussions about family size between the women and their mothers-in-law - 57% of the women reported having discussed family planning with their mothers-in-law, while 38% of mothers-in-law reported having discussed the issue with their daughters-in-law. Nonetheless, women whose mothers-in-law report having discussed the issue of contraceptive use with them were significantly more likely to use a method compared to women whose mothers-in-law do not report any such discussions (OR=3.6, $p<0.01$).

The younger men's support and role in the creation of new fertility norms is also supported by recent research from Pakistan. Levack and Rahim (1998) and Sathar and Casterline (1998) note a discernable transformation of men's views towards fertility regulation; that a growing number of men in Pakistan are getting convinced that family size must be limited, above all for economic reasons but also for health reasons. In fact, Casterline et al. (2001) suggest, on the basis of empirical evidence from Punjab, that husbands opposition to contraceptive use will become even more weaker in the coming years in Pakistan.

The conclusion that change in the gender order does not represent the key causal factor applies to antenatal care use as well, but women's education does play an important role. Women's education emerges as a crucial factor determining antenatal care use. Education increases women's awareness of the importance of antenatal care use as well as enabling them to actualise their desires. In a context where antenatal care use is an uncommon behaviour, education enables women to innovate, and realise that they can exert their agency to alter outcomes, particularly those related to their and their family's well being. Interestingly, the educated women do not question or challenge the gendered context of pregnancy. Rather they use the existing gendered structures to access the health care they desire. The older women remain the final authority regarding pregnancy-related decision-making.

This chapter has added greatly to the understanding of the role gender ideology plays in reproductive health. Both pregnancy and fertility control are deeply gendered processes. The chapter also reinforces some of the themes that emerge in chapter 6. For example, the notions of

slaa mashwara and joint decision-making as a feature of this society emerge in the manner decisions around contraceptive use and delivery management are made. The importance of personal networks as a social resource and the underlying interconnectedness of individuals emerge in the manner women draw upon each other for company to seek contraceptive or antenatal care services. Furthermore, the notion of *mazbooti* is also reconfirmed when it is seen that women with good interpersonal relationships with mothers-in-law are more likely to use antenatal services. *Mazboot* women can also draw upon the social resources of their natal family and *biradari* networks to prevail upon the marital family to provide them with the health care they desire. If that fails, the women use their social resources directly, and covertly, if necessary.

I now go on to chapter eight in which I bring together the quantitative and qualitative data to further examine the extent to which differentials in uptake of reproductive health technology are explained by variations in dimensions of women's gendered position. The chapter will attempt to explore the extent to which changes in fertility and contraceptive use and antenatal care use are likely to reflect changes in women's gendered position.

Chapter 8

The relationships between women's gendered position, contraceptive use and antenatal care use: Integrating the quantitative and qualitative data

The objective of this chapter is to integrate the quantitative and qualitative findings presented in chapters three, four, six and seven to further understand the possible ways in which gender rules, relations and behaviour affect contraceptive use and uptake of antenatal services.

The chapter is arranged as follows. First, the differences in the universe from which the quantitative and qualitative samples are drawn is highlighted. Then the two sets of data are integrated to further understand internal rules, practices and pathways that underlie the relationships identified in the survey. Finally I discuss how gender ideologies operate at the broader societal level to affect women's reproductive health, both directly and indirectly.

8.1 The differences in universe

Before proceeding to integrate the quantitative and qualitative findings, it is important to point out the differences in the universe from which the quantitative and qualitative samples are drawn. The quantitative data is a national sample believed to represent a large and heterogeneous country. The four large provinces of Pakistan, Punjab, NWFP, Sind and Balochistan can be considered proxy measures of four distinct ethnic groups, the Punjabis, the Pathans, Sindis and Balochis respectively. There are, in addition, the immigrants from Northern India, the Kashmiris and the Afghan refugees. Each ethnic group has its own distinct language and culture. More importantly, there may be significant variations in gender rules, regulations and behaviour by the social milieu created by each ethnic group. For example, the PFFPS survey demonstrates that women's mobility or their level of involvement in decision-making varies in different provinces. Overall, women in Punjab tend to face fewer gender restrictions than women in Balochistan with NWFP and Sind lying somewhere in between.

Another layer of variation is provided by the rural-urban areas. For one, nuclear households are more common in urban areas (42% vs. 35%). Urban areas also tend to constitute a context in which larger proportions of women are educated, more likely to travel outside their

neighbourhoods, make the final decisions alone, and have greater exposure to sources of information (Table 3.1, 3.3, 3.4, 3.8).

The qualitative data, on the other hand, are drawn from one small village in Northern Punjab. The field-site is a rural setting only. The social milieu of a village, particularly the density of social networks may not be comparable, in its entirety, with urban areas. Moreover, the local agro-climatic characteristics of Jatti have had their own unique impact on the local political economy and consequently upon gender roles and relations in a manner that may not be applicable even to other rural areas of the country represented in the quantitative data. Farming in Jatti is rain dependent, so it alone is not enough to meet the imperatives of survival. Men tend to look for off-farm work in nearby urban areas leaving the women to look after farming activities. The men's greater exposure to urban ideas and lifestyles, and women's greater involvement in farming activities means that gender rules and relations are probably more relaxed here than in other rural areas of the country.

An example indicative of the differences between the field-site and the national data set is the contraceptive prevalence rates. Contraceptive use rate (all methods) in the field site is 51%, which is twice the national rate measured in the PFFPS (24%). It is worth noting that the PFFPS survey was conducted in 1996-97, while the ethnographic fieldwork was conducted in 2001. Considering that the high contraceptive uptake in Jatti is a recent phenomenon, three to five years old, it is possible that had the fieldwork been done in 1996, the findings might have been quite different. Another example of differences between the field-site and national data set are the patterns of use by type of contraceptive method. Eighty three percent of the contraceptive methods used in the field-site are woman-based methods compared to 59% nationally. All these differences caution us against extrapolating the qualitative findings in their entirety to other parts of Pakistan.

Nonetheless, I believe the qualitative findings can be used to contextualise the quantitative findings because gender ideologies, values and norms tend to be common over large regions (Jejeebhoy and Sathar 2001). Furthermore, the two sets of results, based as they are in different methodologies, enable us to address the issue of level of analysis. The survey data are based at the level of individual woman and are cross-sectional. The qualitative work on the other hand allows a study of the context in which the women are located. The context is particularly important for the research question because gender systems are a characteristic of

social systems rather than of individuals alone (Mason 1993)[1]. The ethnographic work also enabled a study of change in gender systems over time via life stories, and a wider analysis to include age-gender hierarchies, class, economic and *zaat*-based structures.

A point to note is that in Northern Punjab the agricultural industry is not very profitable and land distribution not as skewed as in Southern Punjab, Sind or even Balochistan. In Southern Punjab and Sind, land-holdings are larger, land-distribution more skewed and the feudal landlords correspondingly powerful (Sathar and Kazi 1997). Consequently, class and gender hierarchies are more acute in these regions. The gender structures and relations identified in Jatti are likely to be less unequal than in other parts of Pakistan.

8.2 Integration of the quantitative and qualitative findings

Within the framework of the above-mentioned constraints, this section integrates the quantitative and qualitative findings. Before proceeding further, I would like to point out that two different sets of models were used to explore the relationships between women's gendered position and contraceptive and antenatal care use. One set of models explored the relationships between each of the six measures of women's gendered position and contraceptive use / antenatal care use controlled for socio-demographic characteristics only. A second set of models combined all the six measures of women's gendered position and socio-demographic characteristics together in one model (Tables 4.11 and 4.22). In the latter two models, only two dimensions of women's gendered position, the communication and health knowledge index, retained significance. Women's level of involvement in food purchase decision-making has borderline significance in the contraceptive use model. Women's mobility (all three measures of mobility), their level of involvement in decision-making (in all three domains) or control over their income lost significance and were dropped from these final models. But because one of the objectives of this thesis is to identify and understand the relationships between each of the different dimensions and contraceptive use / antenatal care, the results of the former set of models are also addressed.

[1] A comparison of two locales with differing gender systems (or at least differentials in the extent of gender inequities) might have been even better to understand the role of the societal-level factors. See Morgan and Niraula (1995).

8.2.1 Communication index, contraceptive and antenatal care use

I start with the communication index because of the six measures of women's gendered position analysed, it emerges as one of the most important dimensions of women's gendered position affecting both contraceptive and antenatal care use (Tables 4.11 and Table 4.22).

Communication between a husband and wife has long been a focus of interest for demographers for it is considered an important indicator of husband-wife negotiation regarding their fertility and contraceptive use (Mason and Smith 2000; Mahmood and Ringheim 1996; 1997). From a gender perspective, spousal communication is a key indicator of direct inter-personal relationships in Pakistan for this is a context in which conjugal intimacy is discouraged (Sathar and Kazi 1997). Other postulates are that a more egalitarian husband-wife relationship will increase the probability that the couple will communicate about fertility control and contraceptive use and that a more egalitarian relationship will increase the weight given to wife's health and well-being in fertility decisions (Mason 1987).

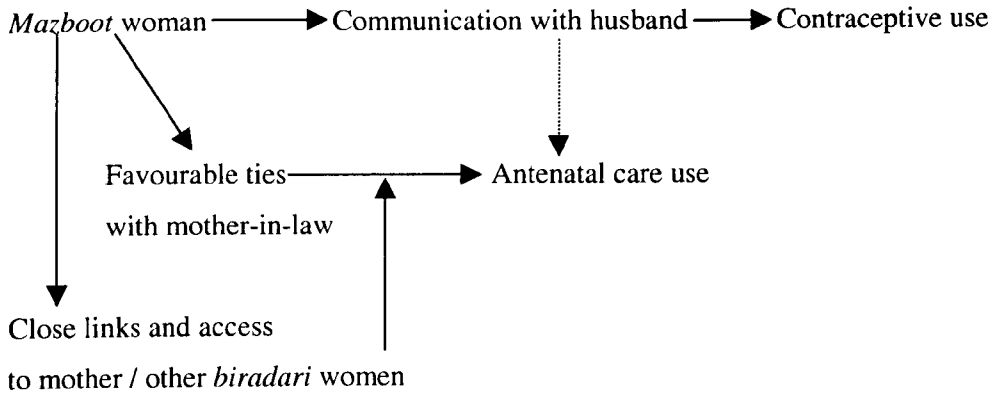
The quantitative data does show a strong positive relationship between the communication index score and contraceptive use (Table 4.8 and Table 4.11). Controlled for a range of socio-economic characteristics and other dimensions of a woman's gendered position, a woman with a communication index score of three (range 0-4) has odds of using contraception that is eight times greater than the odds of use in a woman with a score of zero or one.

The communication index is also positively associated with antenatal care use (Table 4.19 and 4.22) although the size of coefficients is much smaller. Since the index is based on husband-wife discussion of family planning matters only (chapter 2), its positive relationship with antenatal care use suggests that it also reflects wider husband-wife communication. It seems reasonable to conclude that women who discuss reproductive health issues (specifically family planning issues) with their husbands are also more likely to use antenatal care services.

The qualitative findings, while supporting the quantitative relationship between communication index and contraceptive use as a direct and causal relationship, also suggest that the degree of a woman's *mazbooti* affects uptake of these services in part via its influence on husband-wife communication, and to an extent, with other key individuals in the family and *biradari*. As discussed in chapter 6, a *mazboot* woman is one who has good interpersonal relationship with her husband. A characteristic of a good interpersonal relationship with the husband is an ability to discuss a broad range of issues, including family planning issues and, to an extent, the wife's pregnancy experiences. Although the desire to limit fertility at the new

low levels is embedded in the larger societal norms of family size, and actual use of a contraceptive method is the outcome of discussions with a whole range of family and *biradari* members, the husband's tacit support of the behaviour is important. A *mazboot* woman is also more likely to have the confidence and space to initiate discussion of family planning issues with her husband. In marriages where the husband-wife interpersonal relationship is good, the wife's health is also a consideration in spacing pregnancies. The communication index thus captures something about a woman's *mazbooti* besides actual husband-wife discussion of family planning issues.

Figure 8.1 Linkages between the communication index and contraceptive and antenatal care use



In contrast, the qualitative findings suggest that the statistical relationship between the communication index and antenatal care use is indirect and the result of a third factor that predicts both a high communication index score and antenatal care use. This third factor is woman's *mazbooti* (Fig. 8.1). As discussed in chapter 7, the gendered context of pregnancy situates the authority to make the young woman's pregnancy related decisions with the mother-in-law. The young husbands are actively excluded from their wives' pregnancy experiences. The quality of the young woman's relationships with her mother-in-law is therefore a crucial determinant of her ability to use antenatal services (assuming other requirements such as acceptance of the behaviour by the larger *biradari* and financial ability to pay are met). A *mazboot* woman is more likely to have a good interpersonal relationship with her mother-in-law. Equally important, a *mazboot* woman has access to a range of social resources of the *biradari*, including her own mother and sisters. These *biradari* women play a very important role in creating a context in which certain reproductive behaviours such as antenatal care are deemed advantageous. A *mazboot* women can also resort to the social

influence of her mother and other *biradari* women to compel her mother-in-law to provide her with the care she desires (Fig 8.1).

In sum, integration of the quantitative and qualitative data suggests that the communication index lies on the pathway between a woman's *mazbooti* and her use of reproductive health services. In other words, the communication index measuring husband-wife communication of family planning issues is also reflective of broader husband-wife interpersonal and conjugal relations. The issue is further discussed in chapter nine.

8.2.2 Health knowledge index, contraceptive and antenatal care use

I discuss the health knowledge index next because it is the other measure of women's gendered position that remained significant in the final models of both contraceptive use and antenatal care use (models that controlled for socio-demographic characteristics simultaneously with all the measures of women' gendered position). Table 4.11 show that women who scored eight or more on the health knowledge index (range 0-10) have odds of contraceptive use four times greater than the odds of use in women who score zero or one (OR=3.50, $p<0.001$). The odds of antenatal care uptake are also three times greater in these women compared to the odds of antenatal care use in women with a health knowledge index score of zero (Table 4.22).

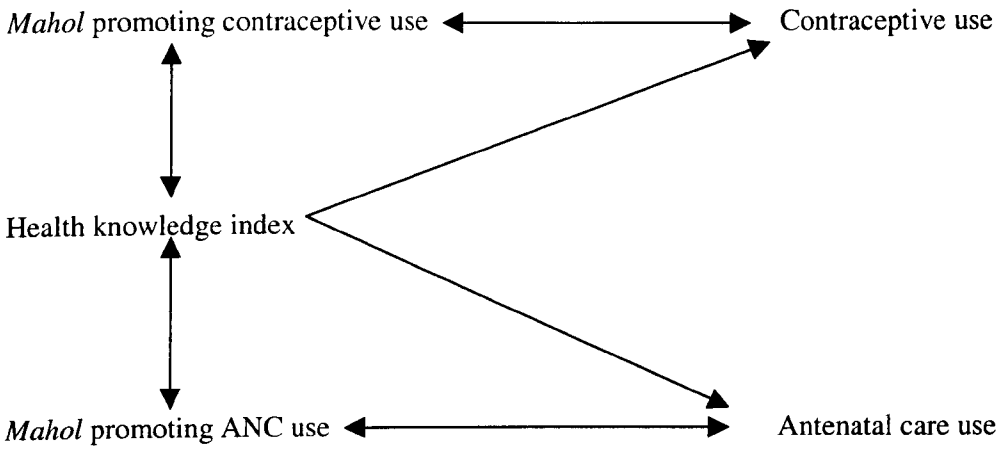
The health knowledge index is based on knowledge of family planning methods only (chapter 2). Its positive relationship with contraceptive use is logical for it is not possible to use a contraceptive method without knowledge of the methods. On the other hand, its positive relationship with antenatal care use (OR= 3.0, $p<0.001$) is interesting because it suggests that women who have a good knowledge of family planning methods are also likely to be aware of the importance of antenatal care use. In other words, women who have family planning knowledge are also likely to have broader reproductive health knowledge.

The ethnographic analyses demonstrate that knowledge of contraceptive methods and services is very common in all age-groups and both genders in Jatti. However, the role of young women's reproductive health knowledge on their use of antenatal care services is interesting because this is a context where older women have a culturally authorized responsibility for younger women's pregnancy related issues. Normatively, the younger women are not supposed to 'ask' for health care, nor are they supposed to have any independent desires regarding the type of care they want. Nonetheless, younger women's knowledge does influence their ability to access services. This is done not through their independent action,

but by influencing the older women. The younger women translate their knowledge into a *mahol* (social climate) (in a manner further discussed below) that considers antenatal care as advantageous.

Integrating qualitative and quantitative data, I postulate the relationships between health knowledge index and contraceptive use on one hand and antenatal care use on the other hand are direct and causal. However, both variables are also directly related to the *mahol* as shown below in Fig 8.2.

Figure 8.2 Linkages between health knowledge and contraceptive and antenatal care use



In the case of contraceptive use, the mass media and the family planning health education messages played an important role in the creation of a small family size norm (amongst the young men at least). The health education messages through the mass media also provided the necessary knowledge about methods and where to obtain them. The new norms (or in other words *mahol*) thus created were and are being communicated to social network members, both women and men, in day-to-day interaction, through jokes and mutual rebukes. The same networks also provide knowledge of contraceptive methods and where to obtain them. Thus an individual person's health knowledge, which promotes contraceptive use, also contributes to societal knowledge. The societal knowledge in turn educates other individuals. Social interaction with social learning and social influence of the network are a particularly important source of exposure to ideas and information for women in a context of relative confinement of women with minimal educational opportunities and exposure to mass media. The *mahol* is also important for translating knowledge into actual use.

Health knowledge regarding the utility of antenatal care use spreads in a similar manner. A particular woman's positive experience with antenatal care use, particularly how antenatal care detected and prevented a potential mishap, becomes a focal point for discussion. The notion spreads throughout the *biradari* as women discuss the pros and cons of use and thus create a *mahol* in which antenatal care use is viewed as advantageous.

The concept of a *mazboot* woman is also linked to a woman's health knowledge. A *mazboot* woman is one who has a network of social relationships beyond her immediate marital family (see chapter 6). These relationships include her natal family and the larger *biradari*. A woman with larger social networks will, in all probability, have greater health knowledge. A *mazboot* woman can also translate her knowledge into use by drawing upon her natal family and other *biradari* women to press upon her mother-in-law to allow her to use the health services she desires.

8.2.3 The role of education

Women's education has generally been considered an important determinant of their fertility and family planning behaviour (Sathar and Mason 1993; Sathar et al. 1988). Education is postulated to lead to better health practices, including use of contraceptives services, by exposing women to health knowledge, new ideas and making them more open to changing their behaviour (Jejeebhoy 1995; Sathar et al. 1988; Lockwood and Collier 1988). However, empirical evidence indicates that the relationship between women's education and their fertility is neither direct nor consistently inverse (Kumar 1992; Vlassoff 1991) and some even question the relationship altogether (Jeffery and Jeffery 1999; 1996a; 1994).

In the quantitative data, women's education emerges as a significant independent determinant of both contraceptive use and antenatal care use (Table 4.11 and Table 4.22). Its effect is particularly pronounced for antenatal care use. Controlled for health knowledge, women with a secondary education and those with greater than secondary education have odds of antenatal care use that are five to 15 times greater than the odds of use in women with no education (Table 4.22). During the model-building process, addition of the health education variable reduced the coefficients of education minimally (the largest change in coefficients was in the group with greater than secondary education) indicating that formal education affects women's health seeking behaviour in ways besides just increasing health knowledge.

However, qualitative data from Jatti show that the high contraceptive use rates cut across all educational strata. An explanation for the divergence between the survey-based positive

relation between education and contraceptive use and a lack of it in the field-site is as follows. In a context where a particular behaviour, in this case contraceptive use, is common and no longer innovative, as has happened in Jatti, women's education loses significance as a differentiating factor between users and non-users. This happened in other similar settings such as Bangladesh and India where, because the fertility transition is well underway, there is now no appreciable difference in the fertility rates of women with or without schooling (Cleland and Jejeebhoy 1996). However, since the Pakistan national contraceptive prevalence rates are still low at 24%, the national data set demonstrates women's education as a significant variable in the final model (Table 4.11). This finding suggests that educated women tend to be forerunners of innovative behaviour. However, because of widespread use of contraception, the exact manner in which an education leads to contraceptive use could not be analyzed in the ethnographic work.

In contrast to widespread acceptance of contraceptive use, antenatal care use in Jatti is an emerging behaviour. It is also largely the educated women who are more likely to use such services. The ethnographic analyses also show that even amongst the marital families of educated women, the decision-making patterns regarding pregnancy and antenatal care remain unchanged. The decisions are still made by the older women. The younger women's education acts indirectly through the creation of a *mahol* (social climate) in which antenatal care is viewed as advantageous. Equally important is the fact that in a context where girls education is uncommon, families who educate their daughters are different from those who do not. These families appear to have certain *rhujanaat* (aspirations) and *riwaj* (culture, norms) that lead them to educate their daughters in the first place. It is these same set of values of openness to new ideas and learning from previous experiences that may make them, and in particular the older women, amenable to new ideas the younger women have regarding ANC use.

Overall, there is no evidence that women's education alters the gender ideologies, values and behaviours that form the bedrock of this society. The educated women in Jatti are obviously different from their less educated sisters. The difference lies in their overall demeanour, confidence, and approach to problems. Yet, these women are not challenging the gender structures and norms in any significant manner. They do not disturb or even question the gender structures and values. Rather, the educated women take pride in the fact that their education enables them to be 'good' wives and mothers.

8.2.4 Decision-making and reproductive health

Decision-making is of central concern in the gender and reproductive health discourse. Women's exclusion from the decision-making processes is believed to the primary underlying cause of their limited access to material and social resources, resources that are necessary for their well being (Kabeer 1994). It was within this framework that the three decision-making questions were included in the PFFP survey. The underlying hypothesis is that women who are in a position to make the final decisions in domestic domains (child health, food and clothes purchases), will also be more likely to make the final decisions regarding contraceptive or antenatal care use.

The quantitative data show a positive relationship between increasing levels of women's involvement in the decision-making process and contraceptive uptake controlled for socio-demographic characteristics only (Tables 4.4, 4.5, 4.6). Interestingly, the highest use rates are amongst women who make the final decisions *jointly* with their husbands, followed by women who make the decisions alone (in all three domains explored). It is, however, worth noting that the size of the coefficients is not large. In contrast, there is no relationship between women's level of participation in decision-making in these three domains and antenatal care use controlled for socio-demographic characteristics only (and Tables 4.14, 4.15, 4.16).

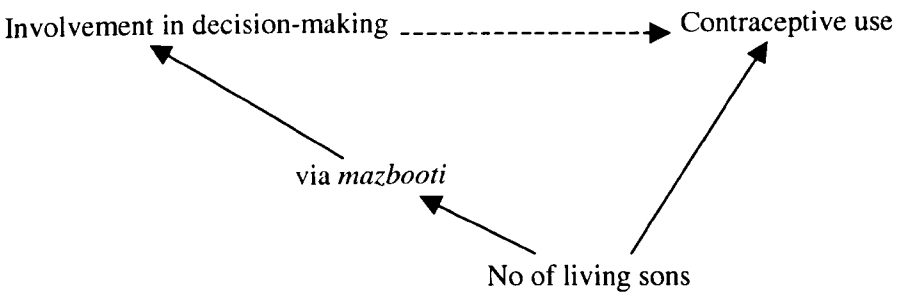
In the models that included all measures of women's gendered position and socio-demographic characteristics, the child-health and clothes purchase variables lost significance and only the food purchase variable remained significant for contraceptive use (OR=1.45, $p<0.05$) (Table 4.11). All three variables lost significance in the antenatal care model (Table 4.22).

Looking at the first set of models only (Tables 4.4, 4.5 and 4.6) and (Tables 4.14, 4.15, 4.16), the question is: how does a woman's involvement in the three domestic decision-making domains affect her ability to use a contraceptive method, but have no effect on antenatal care use? One likely explanation for the positive relationship between contraceptive use and level of involvement in decision-making is as follows. Rather then being directly causal, the relationship is the result of a third factor that is independently related to both decision-making and contraceptive use. This third factor is the number of living sons (Fig 8.3). Both the quantitative and qualitative data show that once a woman has given birth to a required number of children, particularly the required number of sons, they start using contraceptives. Qualitative data also show that giving birth to children, in particular sons, increases a woman *mazbooti,* which in turn, increases her participation in routine household decisions. Therefore,

it is the number of living sons that underlies the apparent statistical relationship between level of involvement in decision-making and contraceptive use. It can be argued that the number of sons is controlled for in this relationship, but I found no evidence of a relationship between women's level of involvement in routine household decisions and their ability to make the final decision regarding contraceptive use in the ethnographic work. The fact that two out of the three decision-making variables lost significance in the final contraceptive use model (Table 4.11) support the qualitative findings.

Nevertheless, there appears to be a residual relationship between involvement in food purchase decision-making and contraceptive use. This can be explained as follows. A *mazboot* woman with a good relationship with her husband and marital family would not just tend to have a positive view of the power balance in her marriage and martial home, but be more likely to be involved in decision-making. Further evidence supporting this assertion is seen in Table 3.11, which shows a positive relationship between good communication scores and joint decisionmaking.

Figure 8.3 Decision-making and contraceptive use



The lack of any association between level of involvement in decision-making and antenatal care use is explained as follows. Women in the early stages of marriage are quite *kamzor* for they do not as yet have children and in particular sons. They have also not had enough time to develop of ties of love and affection with their husbands. Secondly, the decision-making process regarding pregnancy are the older women's specific domain. Even if younger women express a desire for care, based on their awareness of the importance of ANC, it is usually done subtly and through the older women. The decision-making processes related to women's pregnancy are unrelated to the decision-making process regarding the three domestic decisions, hence a complete lack of association between the two in the quantitative data.

Further evidence of a lack of association between the domestic decision-making domains and those related to pregnancy issues is their respective relationships with women's education. The quantitative data show no relationship between women's education and their involvement in decision-making in the three domestic domains while there is strongly positive relationship with their education and use of antenatal care services. Ethnographic analysis show that decision-making in the three domestic domains is not just the result of gendered authority in these domains, but the product of a whole host of practical and economic constraints. Women's education does not alter these constraints. On the other hand, women's education does lead to an increased awareness and then use of antenatal care services, through creation of a *mahol* that considers antenatal care advantageous.

8.2.5 Mobility and use of reproductive health services

Women's restricted mobility is central to the gender and health discourse for it is viewed as a crucial barrier to their ability to geographically access reproductive health services (Khan 1999). In addition, restricted mobility is postulated to indirectly affect health by restricting access to information, development of inter-personal skills and self-confidence.

The models that adjust for only socio-economic characteristics show a positive, if somewhat weak relationship between unaccompanied mobility and contraceptive use on the one hand (OR=1.29, p=0.07) and a more significant relationship between accompanied mobility and antenatal care use on the other hand (OR= 1.28, $p<0.05$) (Tables 4.3 and 4.14). Interestingly, women who state they can travel alone to a health centre if needed are significantly more likely to be users of contraceptives but not of antenatal care (OR=1.40, $p<0.01$ and OR=1.19, p=0.12 respectively).

However, all three types of mobility lost significance in the final contraceptive and antenatal care use models that adjust for socio-demographic characteristics and measures of women's gendered positions simultaneously (and are therefore not included in these models) (Table 4.11 and Table 4.22).

The qualitative data from Jatti shows that women's mobility is a complex and contested behaviour. Accompanied and unaccompanied mobility are quite distinct behaviours implying different sets of constraints and resources. Unaccompanied mobility is not a sign of a woman's independence of her household, nor is it necessarily an index of her position within it. While it may reflect a woman's personal characteristics of resourcefulness and initiative and her husband's and family's trust, it is more reflective of a necessity, economic or

otherwise. Poor women are more mobile, but it comes with a price of physical insecurity and loss of social prestige. Accompanied mobility, on the other hand is a norm, largely followed in practice. It is also a prudent behaviour in a context of an insecure environment. Women themselves view it positively, for it demonstrates their social resources, and the husband's and family's concern for their welfare.

An explanation for the differences in associations between mobility, contraceptive and antenatal care use identified in the models that adjust for socio-demographic characteristics only is as follows. The association between unaccompanied mobility and contraceptive use is not directly causal but the result of a third unmeasured factor (or set of factors) that predicts both contraceptive use and unaccompanied mobility. Where contraceptive use is uncommon, its uptake indicates innovative behaviour. In such a context women-based characteristics such initiative, resourcefulness and good interpersonal relationships with the husband and his family are important. The same set of characteristics also enables women to travel unaccompanied. These confidence-enhancing characteristics may also explain the positive relationship between a postulated ability to travel to a health centre and contraceptive use. However, it should not be assumed that willingness or an ability to travel alone translates into travelling alone to obtain contraceptive methods. In Jatti, where contraceptive use is acceptable and common, the women based characteristics are no longer an important determinant of use. But the complexities associated with women's mobility have not changed. While some women may travel unaccompanied if there is a need, they *always* travelled with company when seeking contraceptive services. An ability to travel unaccompanied does not translate directly into traveling alone for contraceptive services.

In contrast, the association between accompanied mobility and ANC use is postulated to be directly causal. Antenatal care use in Jatti is concentrated in just a few families and is associated with strong financial resources and positive familial attitude towards its use. Within these parameters, women with good interpersonal relationships with their marital families are more likely to receive antenatal care. The families then also provide the necessary company to geographically access antenatal care services. Moreover, in these predominantly richer families women usually travel with company which may explain the positive relationship in the quantitative data.

The lower uptake of ANC services among women who report no mobility in the past four weeks probably reflects the fact that these women have relatively weaker social resources and less possibility of drawing on others to accompany them for ANC. It should be noted, however, that the effect is small. Other factors, most notably socio-economic status and

female education, are far more important predictors of antenatal care use as shown in the quantitative models (Table 4.22).

Women's mobility is also postulated to affect their health indirectly via exposure to information, development of interpersonal skills, and increased self-confidence. Support for this argument comes from the observation that the variable for health knowledge retained significance while all three indicators of women's mobility lost significance in the final models of both contraceptive and antenatal care use (Tables 4.11 and 4.22). Moreover, all the three indicators of women's mobility are positively associated with health knowledge (Table 3.10). Together these two sets of findings suggest that the relationship between women's mobility and use of reproductive health services is mediated by health knowledge. In other words, women's mobility, whether accompanied or unaccompanied, leads to greater health knowledge (through greater exposure to sources of information), which is the actual factor determining use of health services. Nonetheless, it is possible that women's mobility is acting both directly (as explained above) as well as indirectly through health knowledge to determine their use of reproductive health services.

In sum, the integration of the quantitative and qualitative data suggest that while an inability to travel *alone* is not the most important factor in women's uptake of reproductive health services, the larger climate of restricted mobility does limit women's exposure to information and health knowledge. The latter has a greater, though indirect, impact on women's use of contraceptive and antenatal care services.

8.2.6 Women's work, wages and reproductive health

Women's economic dependency is considered the major factor in structuring inequalities between woman and men in general and a crucial cause of their reduced access to household and familial resources, including health care resources. Therefore, it is argued that if women work for wages and control their income, it will have a positive effect on their decision-making power in the household (Sen 1990). A personal income will give women increased leverage in intra-household bargaining and reinforce their claim on the consumption of resources within the household (Sen 1990; Joekes 1985). It is also hypothesized that in patriarchal contexts, economic dependency limits women's choices to fulfilling the maternal role (bearing sons in particular) as the only route to accessing familial resources (Cain 1993). A logical postulate is that if women have access to independent financial resources the value of children, as a conduit to resources, would decline, leading to fertility reduction and

contraceptive use. However, while these arguments are reasonable, the empirical data analyses of this thesis do not support them.

The quantitative data show *no relationship* between women's work for wages and contraceptive use (Table 4.7). The relationship between women's work for wages and antenatal care use is *negative* (4.17). In other words, women who do not work for wages are equally likely to use contraceptives but more likely to use antenatal care compared to women who work for wages. Furthermore, amongst the wage earners, there are no significant associations between keeping all their money, giving away some or giving away all and the two reproductive health measures.

The qualitative data support the quantitative findings. Women in Jatti are embedded within their families and do not consider their needs at a different level from their families, in particular their children and husbands. Women do have a savings system, which is largely secret, but the savings are again spent on the family's needs, usually marital families, but also natal families. Overall, women's work for wages, except in the professions, is a sign of poverty and only the very poor women, largely the Kammi women, work as domestics. The Malik women, however poor, do not work outside the family's farming unit. When women do work for wages, it is not a sign of independence, but a part of broader household survival strategy. In households where a woman is the primary source of cash income, she is not socially recognized as the 'breadwinner'. Overall, women's waged income does not alter the gender values, rules and practices that constitute the gender order of the society.

One explanation for the lack of any linkages may lie in the larger social context in which women in Pakistan are located. The kinship system of *akhathe,* and a gender system of female dependency, acts to connect women to their families by affective as well as structural ties. The structural ties include deeply ingrained value systems that place a high priority on marriage, husband and family, while simultaneously limiting women's choices outside this framework. The latter are the 'extra-environmental parameters' (McElroy 1990) and include a cultural unacceptability of work outside the home, a cultural unacceptability of female ownership of land and property and male-biased laws concerning divorce and child-custody. At the same time, the circumstances of entry into work (poverty pushed), class difference in access to labour markets, lack of skills, a real risk of harassment and violence, low pay and lack of benefits, means employment fails to alter the gender order that women's work for wages was postulated to change.

In this context, women view their links with their families to be in their best interests and combined with affective ties, do not consider their needs as separate from their families. When poverty does push them to work for wages, their income is meant for their families. Whether women keep all their money, give some away or give all away, the ultimate beneficiaries are their families. I postulate that the lack of relationships in the quantitative data between women's work for wages and whether they keep the their wages and their reproductive health is because the measures trying to capture women's control over resources are not well conceptualised in this context. A focus on work for wages and keeping all their money is misplaced in this context. What should be addressed is discussed in chapter 9.

8.3 Summary and discussion

This chapter addressed the question of whether variations in dimensions of women's gendered position explain the differentials in women's use of contraceptive methods and antenatal care. Tables 8.1 and 8.2 summarise the quantitative and qualitative findings of the relationships between the six measures of women's gendered position and contraceptive and antenatal care use receptively.

Table 8.1 Summary of the integration of quantitative and qualitative relationships between the six measures of women's gendered position and contraceptive use

Dimensions of woman's gendered position	Quantitative findings	Qualitative findings	Integrated conclusion
Communication index	Strong association	*Mazboot* woman has good inter-personal relationships with her husband, and the confidence and space to initiate discussion of family planning issues.	Good interpersonal and conjugal relationships promote contraceptive use, although the key underlying factor is women's *mazbooti.*
Health knowledge/ Exposure to information	Strong association	Social networks and to a smaller extent the mass media are sources of health knowledge. *Mazboot* women have access to larger *biradari* networks, so a larger probability of exposure to information networks and greater health knowledge.	Health knowledge is a pre-requisite for use but operationalisation of knowledge into use is modulated by the acceptability of fertility control and contraceptive use by the larger social group.
Decision-making	Association only with joint decision-making in all three domains	Decision to use a contraceptive method is located in larger societal norms of smaller families. The final decision to use a method is the outcome of discreet consultations with husband, family members and other *biradari* women.	Domestic decisionmaking is not related to reproductive health decision-making, although both are related to a women's *mazbooti.* The decision to use a contraceptive method is made through *slaa-mashwara* with husband, family women and even larger *biradari* women.
Mobility	Borderline relationship with unaccompanied mobility only	Women willing to travel long distances to seek contraceptive services, but they always travel with company.	Patterns of mobility are not directly related to contraceptive use. However, both accompanied and unaccompanied mobility increase access to information and health knowledge, which in turn is an important predictor of contraceptive use.
Access to and control over resources	No relationship	Women do not see their interests as separate from their families, particularly children and husbands.	A control over financial resources is not an important pre-requisite for women to use contraceptive services.

Table 8.2 Summary of the integration of quantitative and qualitative relationships between the six measures of women's gendered position and antenatal care use

Dimensions of woman's gendered position	Quantitative findings	Qualitative findings	Integrated conclusion
Communication index	Strong association	*Mazboot* woman has good inter-personal relationships with her mother-in-law and can communicate her health needs to her mother-in-law. Can draw upon a range of natal family and larger *biradari* social resources to influence her mother-in-law.	Relationships between communication index and antenatal care use reflects a woman's underlying *mazbooti.*
Health knowledge	Strong association	Social networks are the primary source of health knowledge. *Mazboot* women have large social networks, so a larger probability of exposure to information networks. Education important for appreciation of the utility of antenatal care.	The relationship is direct, but operationalized through creation of a *mahol* supportive of the health seeking behaviour. A *mazboot* woman more likely to have the knowledge and means to operationalise the knowledge into use.
Decision-making	No relationship	Decisions regarding pregnancy and antenatal care are the older-woman's domain and responsibility. Husbands are excluded from their wives' pregnancy experiences or decisions. Women may be able to influence the decisions, but indirectly.	Pregnancy and its related decision-making processes are highly gendered and domain-specific, with no relationship to domestic decisions. *Mazboot* women can influence the decisions, either directly because of good-relationships with the mother-in-law or indirectly through the birdari and natal family linkages.
Mobility	Small, but significant association with accompanied mobility	Women travel long distances to seek antenatal care if the behaviour is acceptable and affordable. Older women accompany the pregnant women when seeking antenatal care services.	Increased independent mobility or an ability to travel alone is not necessary for antenatal care use. An appreciation of the utility of antenatal care and affordability are more important determinants of use.
Access to and control over resources	No relationship	Women do not see their interests as separate from their families, particularly children and husbands. Women's work is poverty-pushed, therefore their wages are meant for imperatives of household survival.	Household financial ability to pay is a more important determinant of antenatal care than a woman's income per se. Women's work is poverty pushed and poverty more than a woman's lack of control over her income is the cause of non-use.

Clearly the integration of the quantitative and qualitative data (in the context of the experience of Jatti) illustrate that a major rise in contraceptive use is possible in the Pakistani context without significant changes in gender structures or gender order. This finding is not unusual and has been reported from similar settings in South Asia (Vlassoff 1996; Cleland 1994; Basu and Amin 2000; Ravindran 2002). Basu and Amin (2000) go as far as to say that it is possible that declining fertility (specifically in Bangladesh) may be a profound cultural change in itself rather than an outcome of other kinds of cultural change. For example, it is possible for a change in family size norms (one kind of cultural attribute) to occur without changes in women's gendered position, which is another kind of cultural attribute of that society.

Similarly, there is little evidence that major changes in gender ideology are required to promote uptake of antenatal care services. Other factors, most notably socio-economic status, an acceptance of the utility of services by the larger family and women's education are far more important predictors of ANC use. Moreover, women's education, despite being one of the most important predictors, does not translate directly into use, but operates via the pre-existing and highly gendered decisionmaking routes. Clearly, changes in gender ideology are not *necessary* for improvements in women's reproductive health.

However, it would not be valid to conclude that gender structures are irrelevant for women's reproductive health. The dimensions of women's gendered position as measured by their mobility, decision-making, or control over financial resources at the individual level may not be major predictors of either contraception or antenatal care use, but broader structures of institutionalised gender inequality operate at multiple levels to affect women's reproductive health in general.

For one, women's fertility, high or low, remains a property of the wider society in Pakistan. Women's experiences of fertility and pregnancy are socially organised within structures of gender and age hierarchy. The larger society determines fertility norms and the role of the younger women in the creation of these norms is limited. In Jatti, for example, the older women and younger men are spearheading the change in fertility norms, but the young women are not making any apparent contribution despite the fact that the health education messages are directed at both men and women.

These findings are supported by other research in South Asia. According to Jeffery and Jeffery (1997), fertility decline in many parts of South Asia is the outcome of the logic of the male-dominated gender system in which low fertility has come to be seen as economically rational. It is not the younger women's needs, which are being considered when the fertility

order is changed (Jeffery and Jeffery 1999). Boserup says 'when rural development raises men's interests in family limitation, the subordinate status of women may actually service to reduce fertility because the husbands desires dominate' (Boserup 1990, pg. 59).

Another aspect of the larger gender order is son-preference. The whole notion of son-preference creates a social climate in which maleness is valued and femaleness devalued. The devaluation is manifest in sexual violence against women and the creation of an insecure *mahol* (although class hierarchies interact with gender here). In such a context, the only option parents have of protecting their daughters is by secluding them. Girls education is the most significant casualty of these restrictions. Seclusion also has indirect effects on women's reproductive health by restricting women's exposure to new ideas, development of interpersonal skills, initiative and a greater confidence in interacting with the larger world.

The larger gender ideology that devalues women also plays an important role in determining the quality of reproductive health services for women. Demeaning images of female physiology and reproduction are transmitted onto the health care providers such that the role of the traditional birth attendant (*dai*) itself is devalued. The status of the *dai* in the South Asian context is that of a low menial (Jeffery and Jeffery 1993). The poorly paid *dai* is not respected as a health care provider, but a person who carries out tasks considered impure and demeaning (Jeffery and Jeffery 1999). The larger gender ideology also produces a context in which health policy-makers are usually all men. In Pakistan, they have failed to appreciate women's reproductive health needs, which results in allocation of insufficient resources for women's reproductive health services (Midhet, Becker and Berendes 1998).

However, it is important to highlight the interplay between class and gender. Pakistani society is characterised by two separate institutionalised systems of inequality, class and gender. Severe inequalities in the distribution of the primary resource, land, interwoven with notions of *zaat* have created a hierarchical and feudal society in which households, families and even *biradaris* occupy distinct positions in the social division of labour and in consequence enjoy differential access to and control over resources (Hafeez 1998). In the gender stratification women and men are assigned distinct roles in the social division of labour, behavioural expectations and access to and control over social and material resources. The coexistence of two systems of stratification means that an individual has two distinct, but interrelated, aspects of their identity. A woman may thus be vulnerable, say to sexual harassment, because she is a women, but the vulnerability is compounded if she is a poor woman belonging to a lower status *zaat.*

It is therefore important to contextualise individual and household level behaviour in the prior social and economic context for at the macro-level class, rather than gender structures, may be a more important determinant of access to resources, including health services. Both poor women and men suffer the consequences of an inequitable social and economic system. In a poor nation characterised by very low levels of expenditure on health, both poor women and men suffer disproportionately, while the rich have access to health facilities that can be compared to any in the developed world (Zaidi 1996).

The confounding of class and gender has very important implications for women's well being. For example, awareness of the utility of antenatal care is an important determinant of use. Awareness is influenced by women's education, which in this context is a class-based characteristic. It is only the well-off families who can afford the costs, both financial and opportunity costs, of educating their daughters, who in turn will be married into affluent households and thus be able to actualise their awareness of the importance of antenatal care.

While clearly gender systems do affect women's reproductive health, gender inequalities also need to be addressed simply because any inequality is unjust and is a violation of human rights. Girls education is the most obvious example. While there is little evidence that women's education (in the current educational system in the current context) alters women's gendered position in any significant way (Jeffery and Jeffery 1996a; 1999), education is a human right that needs no justification.

The qualitative data have also highlighted the limitations of the measures of women's gendered position as used in the quantitative data. How women's gendered position should be conceptualised in Pakistan, the primary objective of this thesis is discussed in the next and final chapter of this thesis.

Chapter 9

Reassessing the concept and measures of women's gendered position: Autonomy vs. centrality

This chapter draws together the findings presented in preceding chapters and the literature review to address the first objective of this thesis, which is to explore a conceptual framework for understanding women's gendered position from a 'centrality' perspective.

The chapter is organised as follows. First, I discuss how the kinship ideology of togetherness is an essential component of the sense of self and personhood in Pakistan and how these in turn are interwoven into emic conceptualisations of women's gendered position. I then describe what the centrality approach is and how it differs from the autonomy approach, before proceeding to develop a conceptual framework of women's gendered position from a centrality approach. Some indicators that may measure the concept more sensitively are postulated and finally I discuss how the centrality approach compares with other discourses, its strengths and limitations.

9.1 Personhood and subjectivity

The most important theme emerging from the ethnographic work in Jatti is the ideology of interconnectedness (*akhathe*) as the defining characteristic of the kinship system as well as the economic and social structures of the society (see chapter 6). This is a society in which both women and men are highly interconnected with their families, and families with *biradaris*. These kinship linkages and social relationships constitute an individual's frame of reference as well as social identity.

More importantly, the ideology of togetherness (*akhathe)* is incorporated into the sense of self and personhood of women and men in Jatti and possibly Pakistani society more generally. To understand how kinship systems affect personhood, the concept of personhood as a cultural construct is useful. Mauss (1939) was amongst the first social theorists to address this idea when he suggested that personhood consists of two dimensions, what he called 'la personne morale', the moral person and 'moi', the awareness of self. The moral person, which has also been described as the cultural aspect of personhood (Jacobson-Widding 1990) is the social concept of the person, a complex of rights, moral responsibilities and social relationships.

This is the person located in a network of social relationships, of one's place in a society. In contrast, 'moi' is the awareness of self as lived through personal experience. It is the individual's interpretations of lived experiences, and is also culturally informed. Thus, both dimensions of personhood, the moral person and the sense of self are formulated by the social climate in which the individual is located. One very important aspect of the social climate is the kinship values, which, not surprisingly, are incorporated into both an individual's sense of 'moi' and the social person. Moreover, the links between concepts of self and personhood and gender constructs are intricate (Strathern 1981a; 1981b; 1988).

As cultures and kinship systems vary, so does the construction of 'personhood'. Notions like the 'self', 'person' and the 'body' vary enormously from culture to culture (Sax 2002a, pg. 3-15). According to Moore (1988) a person in the Euro-American societies is constructed as an individual that is a unique entity, separable from society. In contrast, the ethnosociologists at the University of Chicago argue that persons in India are constructed through their social relationships, not in contradistinction to them (Inden and Nicholas 1977; Marriott 1976; 1990). Thus, a Hindu person is 'constituted by his or her relations to, and transactions with, larger corporate groups such as family, lineage, village and caste' (Sax 2002b, pg. 14). As Sax (2002b) puts it 'the Hindu person is 'dividual' (pg. 14). The notion of a connected person is also true of other non-European contexts, such as Africa and the Pacific Islands (Jacobson-Widding 1990; Strathern 1988). In these contexts, persons are not one constructed by their 'indivisibility', but rather by the extent to which they are the 'composite site of the relationships that produced them' (Strathern 1988, pg. 13).

Some researchers take issue with the stark dichotomy of a 'westerners hard individualism' and the 'connected person of India' (Jeffery and Jeffery 1996b, pg. 13). They argue that the notion of a western person's individuality is an image of debatable applicability, while people in India do have a notion of their own individuality (Jeffery and Jeffery 1996b). Despite the debates and lack of consensus, the issue upon which there is some agreement is that the social construction of a 'person' in the western culture is not universal, nor is the primacy that is accorded to the 'individual' and to 'autonomy' (Strathern 1981b; Ogden 1996).

My analysis suggests that Pakistan is a context in which a person is constructed not by their 'indivisibility', but rather by their social relationships with others. Even if the notions of hard individualism of the western person and fluid interconnectedness of the Indian person are extreme, there is no denying that there are differences in the degree to which the individualism and autonomy is accorded importance in the two contexts. Assuming there is a continuum from the 'individual person' on one end to the 'dividual person' on the other end,

the Euro-American person is more likely to be situated on the individual end, while the South Asian person is more likely to be situated on the 'dividual' end. Nonetheless, these differences are ignored and the thrust of the current gender discourse and policies is an exclusive focus on women's 'autonomy' as desirable change in South Asia. This focus is even more striking considering that its applicability in its place of origin, the Euro-American context, is questionable. There is no denying that the gender order in Pakistan is unfavourable for women. The kinship ideology of togetherness and jointness in which all members of a social group are mutually inter-dependent is in tension with a gender ideology that disadvantages women. Nonetheless, I do not believe the desirable changes include detaching women from their social moorings. The need therefore is to construct new ways of talking and thinking about women's gendered position that are context sensitive and have realistic policy implications. With these considerations in mind, I propose that women's gendered position in Pakistan is more appropriately conceptualised in terms of 'centrality' rather than 'autonomy'.

9.2 Centrality vs. autonomy: a difference in approach

Reconceptualising women's gendered position in terms of centrality is essentially a change in approach, or a change of 'lens' through which the issue of women's gendered position is viewed. It can be considered a paradigm shift in the approach to the study of the subject, rather than the subject itself, for it alters the entire frame of reference within which women's gendered position is conceptualised. As discussed earlier, the concept of 'autonomy' is located in Western feminism. Western feminism in turn is rooted in liberal and liberal egalitarian philosophies with their focus on individuality and autonomy (Evans 1977). This ideology of 'individuality' has permeated through the entire gender and reproductive health discourse (and the health discourse more generally (Sax 2002b; Engelhard 2001)), forming the primary approach or 'lens' through which women's gendered position is viewed. It is most obvious in the common use of the term 'autonomy' although some researchers do vary in their emphasis on independence (for example see Dyson and Moore 1983). More importantly, it has developed the frame of reference within which the notion of an 'autonomous' woman is located. Underlying the whole notion is an unspoken, but implicit assumption that increased independence and autonomy is desirable and will lead to improvements in women's well-being and that these changes will come about through modernisation and westernisation.

I argue that this approach, with its emphasis on individuality and independence, is incongruous in the context of Pakistan where individuals largely conceive of themselves as the composite site of relationships that produced them. Although the 'individual' is

recognised, the patterns of behaviour, interactions and obligations give primacy to the social being. A concept based on notions of an individual, as an entity unique from and separable from society is at odds with ethnographic evidence which indicates that concept itself is not explicitly recognised.

The centrality approach I propose is a more appropriate way to assess women's gendered position because it is sensitive to the kinship ideology of togetherness and jointness. It addresses the linkages and relationships that constitute the anchoring framework of a woman's identity. It incorporates women's sense of self as individuals connected to their families and *biradaris* by ties of love and affection as well as claims and obligations. As White (1992) says of Bangladesh, women want to be central members of their families, not autonomous of their families.

9.3 Conceptualising and operationalising women's gendered position from a centrality perspective

The objective of conceptualising and operationalising women's gendered position from the centrality perspective is to permit an empirical evaluation of its various dimensions as well as to examine its influence on women's well being and reproductive health and thereby identify viable routes of intervention to improve the same. The emic concept of a *mazboot / kamzor aurat* discussed in chapter 6 provides the key to how women's gendered position should be conceptualised. In contrast to an autonomous woman, the concept of a *mazboot* woman is firmly located within the kinship ideology of togetherness. In this section, I will discuss what *mazbooti* is, what are its dimensions, and how we can measure it. I will then proceed to discuss what the outcomes of *mazbooti* are.

9.3.1 *Mazboot aurat*

A *mazboot aurat* is a woman who is deeply and securely embedded in her marital family with strong ties with her husband and his family. *Mazbooti* is what Pakistani women aspire to, not autonomy. Men are, by the nature of their linkages with significant others, inherently *mazboot,* while women have to achieve it. By its nature, *mazbooti* is a dynamic concept in which women are practical actors rather than passive and helpless victims. Furthermore, it does not situate men as the reference point, from whom women need to break away. Rather it incorporates the togetherness of a husband and wife who live under the same roof and share a life, a primary facet of the social relations analysis framework (chapter 1).

Our analysis suggests that *mazbooti* itself is a multi-dimensional concept consisting of three major inter-dependent dimensions:

1. The strength of a woman's linkages with her husband. The husband-wife relationship is the most important dimension of *mazbooti* and possibly the most difficult to measure.
2. The strength of a woman's linkages with her marital family. Together with linkages with her husband, the strength of a woman's linkages with the martial family determines the degree of her embeddedness in her marital family.
3. The extent of a woman's social linkages beyond the marital family. This refers to women's networks beyond the marital family to include the larger *biradari* and possibly beyond that.

9.3.2 Suggested measures of a woman's degree of *mazbooti*

1. Measures of a woman's linkages with her husband. The objective of these measures is to capture the strength (or quality) of a husband-wife bond. These could include:

    a. Couple communication over a broad range of issues. This can include issues related to sex and sexuality, pregnancy, contraception, issues related to children's upbringing, their education, future plans, possibilities of separating their sub-unit from the larger joint family, as well as discussion about the larger village or neighbourhood affairs. Another measure could be whether they share a bedroom because in a joint family a bedroom may be the only place husbands and wives can talk in privacy.
    b. Degree of trust between the couple. One measure of this could be whether the husband gives his wife money and savings for safekeeping.
    c. Husband's respect for wife's social linkages with her natal family. Measures of this can include whether he willingly accompanies her to visit her natal family and whether he attends her natal families *vyas* and *mataams* (weddings and funerals or other life-cycle marking ceremonies).
    d. The wife's ability to initiate discussion of issues that are important to her but may not have been perceived important by the husband. This could include a need for large household purchases like a refrigerator, other household issues like sale and purchase of animals/ land or health related issues like contraceptive use. It could also include her desires regarding arranging her children's marriages with her natal family.

2. Measures of a woman's linkages with her marital family, particularly the mother-in-law (if present). The measures can include:
   a. The ease with which she can discuss day-to-day household issues with marital family members.
   b. Whether she can cook whatever she wants to (subject to availability) and whether she can freely eat foods emically perceived as nutritious and expensive (such as animal food products).
   c. Whether she can discuss her reproductive health needs with her mother-in-law. This is particularly pertinent because mothers-in-law have a culturally sanctioned responsibility regarding their daughter-in-law's reproductive health needs, particularly pregnancy-related needs.
   d. The extent her opinion is sought for and her level of participation in major household decisions such as arranging a *dewar's* (younger brother-in-law) marriage (assuming a *dewar* is present), buying and selling of animals or land.

3. Measures of a woman's social networks beyond the family. This can include

   a. Frequency of contact with natal family, including brothers and sisters. The frequency of contact can be considered a measure of her access to the social resources of her natal family.
   b. Frequency of contact with other *biradari* members and if an exogamous marriage, the frequency of contact with her own *biradari* members.
   c. Whether she can call upon her *biradari* members in time of need including company for visiting a health services outlet for treatment of a sick child or visit to the market for shopping; whether she has 'friends' amongst her *biradari.*
   d. Whether she can discuss issues related to health, finances etc. with her *biradari* members. Whether there is sharing of information and ideas.

9.3.3 Determinants of *mazbooti*

The five important factors that lead to *mazbooti* have been discussed in chapter 6 and are only listed here.

1. Circumstances of marriage (including whether the groom and bride desire marrying each other).
2. Birth of children, particularly sons.

3. A woman's individual level skills and attributes. These include the extent to which she fits into the ideal of femininity, the most important dimensions of which are that she lives amicably with the virilocal joint family without attempting to separate her sub-unit and is hardworking.
4. The extent to which the marital family adheres to norms of gendered roles and behaviour. In other words how lenient the family is regarding issues such as *purdah*, and mobility for example.
5. Duration of marriage.

9.3.4 Outcomes of increased *mazbooti*

A *mazboot woman* has

1. Access to all household assets and financial information. She has information of all sources of household income and details of and household (and husband's) assets, such as land, animals and other properties.
2. A policy-making role in household finances and budgeting.
3. Freedom to travel outside the house without having to request permission to do so. Mobility can be accompanied and she has ready access to company if she so desires.
4. An ability to make household and personal purchases without permission from the husband or mother-in-law. This does not necessarily mean that the woman herself has to personally make the purchase, but that she has the authority to do so, possibly through other people. It also indicates her access to household economic resources including money.
5. The authority to transfer resources to her natal family if she so desires. Traditionally, the patterns of resource transfer are normatively from a woman's natal to marital family. While largely carried out in practice, the reverse also takes place particularly if the woman's natal family is relatively poor. There are two aspects to the reverse transfer: one is *vartan bhanji* (exchange of gifts at specific occasions) and the other is a more need-based resource transfer, which tends to be covert. The latter need not be covert if the woman is a *mazboot* member of her marital family.
6. Complete freedom from threat or actual violence.
7. Ability to request and seek health care if she so desires, including preventive health care such as antenatal care.

9.4 Compatibility with other discourses

The centrality perspective, as discussed above, diverges significantly from the autonomy perspective. Nevertheless, a rereading of the recent literature in this discourse indicates that the divergence is largely at the conceptual level for certain elements and measures are common. Not every aspect of the centrality perspective opposes the autonomy perspective. More importantly, the authors, while using the term 'autonomy', at times refer to issues that more closely reflect a centrality perspective. As discussed in chapter 1, a number of definitions have been used to describe a woman's gendered position. They range from such terms as the 'status of women' (Dixon 1978; Sathar et al. 1988), 'female empowerment' (Kishore 2000; Schuler and Hashmi 1994), 'women's autonomy' (Sathar and Kazi 1997; Jejeebhoy 1995; 2001; Dyson and Moore 1983; Mason 1984; 86), to 'gender systems' (Mason 1995). Some authors refer to 'prestige' (Epstein 1982), and 'power and control of material resources' (Dixon 1978; Cain 1979; Safilios-Rothschild 1980).

Despite the large number of terms used and confusion surrounding the concept, a critical rereading of the recent literature demonstrates that most authors share the assumption that women should be 'free of men's control' (Sathar and Kazi 1997; Kishore 2000; Jejeebhoy 1995; Mason 1986; Dyson and Moore 1983). This theme also permeates the indicators developed to measure the concept in the demographic and health literature. Thus, a focus on 'control' over material and other resources, the authority to make independent and final decisions and freedom from constraints on physical mobility. In other words, despite the large number of definitions proposed, they are all, more or less, based in a common framework, best described as the 'autonomy framework or approach'. Therefore, in the remainder of this section, I will discuss how the centrality approach compares with the autonomy approach. In addition, I will comment on the less common emphasis on prestige and power, which some authors have adopted.

Table 9.1 summarises the similarities and differences in the two paradigms, taking the dimensions of autonomy as identified by Jejeebhoy (1995) as the starting point.

Table 9.1 Centrality versus autonomy: similarities and differences

Autonomy perspective	Centrality perspective
Desirable changes	
Increased autonomy of women	Increased *mazbooti* of women
Dimensions of autonomy	
Economic autonomy	**Jointness of resources**
• Independent access to economic resources – waged employment/ landownership • Control over her income/ independent resources	• Access to information regarding household assets, sources and amounts of income • Policy-making role in household financial budgeting • Sharing of economic resources
Physical autonomy	**Mobility**
• Freedom to travel *alone* • High degree of mobility alone	• Freedom to leave home without permission when need arises • Availability of companions for necessary travel
Decision-making autonomy	***Slaa-Mashwara***
• Women have the authority to make independent and final decisions	• Active participation and joint decision-making • Women's opinion valued and sought
Social autonomy	**Social relations and networks**
• Social self-reliance	• Strong and secure social relations and linkages within and beyond household (marital, mother-in-law and natal)
Emotional autonomy	**Marital bond**
• Women are free to enjoy close bonds with spouses • Freedom from violence	• Strong inter-personal ties with spouse-secure 'marital entitlements' • Freedom from threat of or real violence
Knowledge and exposure to the outside world	**Knowledge and exposure to the outside world**
• Exposure to outside world through mass-media and formal education, travelling alone beyond the home	• Social networks are important sources of information and health knowledge in addition to formal education, mass media and travel (which can be with company)

One area where a large divergence is in approach is evident between the two perspectives is in the economic domain. 'Economic autonomy' (Jejeebhoy and Sathar 2001; Jejeebhoy 1995) envisages women with access to independent sources of income, either as waged labour or through landownership (Mason 1986; Agarwal 1994). More importantly, they should have independent control over their income since the prevailing gender hierarchies are believed to result from women's economic dependency on men. However, the evidence to support this argument is inconclusive and the most recent consensus states women's work for wages is not necessarily sufficient to change gender ideologies (Hossain, Jahan and Sobhan 1990).

The findings of this study concur with the conclusion that women's works for wages does not alter their bargaining stance within the household, increase their mobility or alter the prevailing gender identities. However, rather than concluding that women in Pakistan are highly disadvantaged, I argue that the issue may be one of conceptualisation and measurement of the dimension. Instead of assuming that work for wages and control over the income is the only way to ensure women have access to material (including financial) resources, it might be more fruitful to understand the existing gendered system of rights and obligations and find solutions from within. Women in this context have a traditional right over their husband and marital household resources. The outsider's etic perspective of this is *'economic dependency'* while the emic perspective is *'a right to economic support'*. Men internalise economic provision as a dimension of their masculinity and women are proud of their status as economic dependants. As Basu says 'The internalisation of norms over generations means that subjective perceptions about inequality and subordination need have no connection with an outsider's view on these matters. And nor is it clear that one view is more real than the other' (Basu 1996, pg. 57).

From the centrality perspective, it is the women's security of marital entitlements (right to economic support) that should be addressed. Instead of focusing on 'control over their income' (as in most surveys including the PFFPS), it might be more fruitful to focus on issues like access to *information* regarding total household assets, including sources and amounts of income; whether a woman has a policy-making role in household financial budgeting (jointly with her family members); whether she has the confidence, space and opportunity to initiate discussion of issues and related expenses that she deems as important.

It is, however, important not to idealise women's economic dependency, particularly in poorer households. Women may be proud of it, but it is also potentially the source of their gendered vulnerability. The point of vulnerability is that these rights are informal and there is thus the possibility that they may not be upheld. This is where women's social linkages and

resources may be essential in ensuring her rights are met. Nonetheless, women who do not become *mazboot* are very vulnerable, a vulnerability further compounded by very limited options and choices because of the persistent gender inequalities within the broader social, economical and legal structures of Pakistan. It is worth noting here that the notion of *mazbooti* is not incongruous with women's employment. Women can adopt new roles as working women and still maintain their *mazbooti* within their families. At the same time, their employment is neither necessary nor a sufficient condition for their *mazbooti*.

Another divergence between the autonomy and centrality approach is women's physical mobility. The autonomy perspective views seclusion as highly restrictive and insists upon *unaccompanied* mobility as a critical component of 'autonomy'. The centrality approach in contrast is more context sensitive, and takes into account the larger societal structures such as the insecure *mahol*, which is a complex class, *zaat* and power-related issue. It is sensitive to the findings of the empirical data, which show that while seclusion is the highest normative ideal, mobility varies by emic construction of space and movement and economic needs. Rather than focusing on unaccompanied mobility, the centrality approach views *trust*, whether the husband and marital family trust the woman to maintain their *izzat* (honour) as a more important measure. Therefore, from a centrality perspective, a more sensitive measure of women's mobility would be whether or not the woman requires permission to travel. Actual mobility can be accompanied or unaccompanied and it is up to the woman to decide whether company is required or not. It is worth pointing out that some researchers (notably Sathar and Kazi 1997) have addressed the issue of women's need to seek permission to travel, but their primary focus remained on women's ability to travel alone.

Independent and final decision-making is also central to much of the autonomy discourse. Assuming decision-making is a proxy of power relations within the household, the 'autonomy' focus has been on independent and final decision-making (Dyson and Moore 1983; Sathar and Kazi 1997; Jejeebhoy 1995). There are numerous problems with this as a focus of analysis. First, decisions are difficult to access. They are made through complex processes, perhaps over an extended period, and may involve diverse negotiations of interest. Women's and men's involvement varies by the domain under consideration. It is very hazardous to weight the importance of different actors for even the people involved themselves have very different views on what took place. In view of these complexities, and the ideology of *akhathe* that deems *slaa mashwara* important, the centrality perspective focuses on participation, the value given to a woman's opinions and joint decision-making rather than independent and final decision-making. Interests do not always converge but the process of *slaa-mashwara* gives women space and opportunity to influence the outcome.

There is also a large divergence between the notion of 'social autonomy' and the focus on social links and networks viewed from the centrality perspective. The call for 'social autonomy' is the response to the observation that women's social identity is manifest only through men: father; husband; or sons. The idea is that a woman should have their own identity, not one that is dependent upon a male family member. However, the kinship network analysis discussed in chapter 6 shows that social relationships constitute the frame of reference and social identity of *both* women and men. As a matter of fact, the anchoring relationships are more important than individual names, for an individual is not a construct separate from others. A person whose *agla–pichla* (larger familial and *biradari* network) is not known is viewed with suspicion, whether a man or woman. The Pakistani legal structures incorporate these relationships in the legal identity of a person. A man's legal identity is constructed though his name and his father's name. A woman's legal identity is her name and her father's name before marriage, and husband's name after marriage. There is no system of surnames, although some people use the *zaat* and *biradari* as an identifier. In such a context, it is invalid to talk of an individual alone, as an entity separable from society. The incorporation of kinship systems and social relationships into gender analysis (the social relations analysis) is *the* primary strength of the centrality perspective.

There are, however, a number of similarities between the two approaches. For example, Jejeebhoy (1995) identifies 'emotional autonomy' as a component of autonomy, but one she gives a relatively low priority to in the discourse. The description that follows indicates the author's real understanding of the term is that women should be free to develop close bonds with spouses. The centrality perspective too recognises the importance of the inter-personal linkages between the husband and wife, only it gives it a much greater priority. In fact, this aspect of a woman's gendered position, that is the strength of her linkages with her spouse, is *the* most important dimension of *'mazbooti'*.

Another similarity between the two approaches is women's exposure to information and their knowledge. The autonomy perspective emphasises formal education, exposure to the mass media and travelling (usually alone) as important for exposure to information and knowledge. The centrality perspective also acknowledges the importance of formal schooling, and exposure to mass media. But this approach appreciates the role of social networks as a source of ideas and information. Travel beyond the home is also important for development of inter-personal skills and confidence, but it need not be unaccompanied.

The discourse on women's gendered position tends to draw a sharp line between traditional 'status' and modern 'status'. In this discourse, autonomy can only be achieved by a negation

and removal of factors that traditionally confer prestige and status. In other words there has to be a trade-off between traditional values that confer 'prestige' and 'modern' values that take the form of individual autonomy and authority. Studies from South Asia show that women who follow the traditional norms of behaviour are believed to have more prestige while women who become 'autonomous' lose the prestige and respect (Kabeer 1995). A classical example of this tension is a requirement that women, in order to be autonomous, should work for wages and keep control over their wages. In a context in which women's work for wages is considered demeaning, it is a complete negation of traditional values. The centrality approach, in contrast, is cognisant of these complexities. Rather than imposing notions of what 'should happen', it focuses on strengthening the traditional but informal rights women have. In the above example of women's work for wages, it focuses on women's right to economic support. There is, nonetheless, a need for further research in order to develop policies that strike a right balance between values that confer traditional prestige on the one hand and factors that ensure women's well being on the other hand.

9.5 Limitations of the centrality approach

The concept of centrality as discussed above raises a number of questions. The first is whether the concept, in the process of being culturally sensitive, is actually framed by an existing unequal gender contract and thereby limits the possibilities for enhancement of women's well-being. In other words are the strategies and efforts aimed at increasing a woman's *mazbooti* misinformed? Would not autonomy really be more in women's best interests? The concept of *mazbooti,* as the extent to which a woman is embedded in her marital family, can be accused of locating some of the control over a woman's life beyond her reach. It focuses on informal claims and rights, which may not be met in practise. Is it not better that she retains a control of her life and be economically and socially independent?

One answer to this question is as follows. A central tenet of the sociological perspective is that individuals are formed and moulded through their interactions with other people. People experience their lives bound up with the concerns of other people, with obligations and demands, joys and benefits of a social life. These features of social life assume a crucial importance in the Pakistani society characterised as it is by a high degree of interconnectedness, and one in which inter-personal relationships are a primary source of access to resources of all kinds. There is no denying that women are the disadvantaged partners in the current system. However, social relationships of co-operation and exchange do not have to imply exploitation and subordination. The need is to understand how, within the existing kinship, social and economic structures, can women's well-being be improved.

The second answer to the above question is that the concept of centrality is based on women's stated preferences. They want to be *mazboot*, not autonomous. This, however, does lead to a deeper question. Are women stating their preferences fully informed of their possible choices and options or are their preferences an adaptive response to a set of concrete constraints over which they had no control? To what extent can women's stated preferences be accepted as objective measures of self-interest (Sen 1990)?

A contrasting position is taken by theorists like Nussbaum (1998). She argues the fact that people desire or prefer something should not be taken as it is stated, given our knowledge of how unreliable desires and preferences are as a guide to what is really just and good (Nussbaum 1998). 'Habits, fear, low expectations and unjust background conditions deform people's choices and even their wishes for their own lives' (pg. 114). Using the term 'preference deformation', she argues that there is something wrong with preferences that do not respect universal values of basic liberties and choices (pg. 114-115).

Nussbaum's argument is based on the approach that stems from a concern with justice and human values, from a recognition that in the real world, 'some preferences are deformed by ignorance, malice, injustice and blind habit' (Nussbaum 1998, pg. 114). The issue of choice, options, and access to information are a valid point of discussion. Are women in my field site stating their preferences fully cognisant of their choices? Choice by definition implies alternatives and is inextricably linked with poverty because an insufficiency of the means for meeting one's basic needs often rules out the ability to exercise meaningful choice. Even if poverty is not the dominant issue, the question that arises is that do women have a choice beyond their stated preferences and equally important, are they aware of their choices? It is this issue, of inadequate information and withholding of opportunities for development of abilities (such as a formal education) that would enable women to be aware of their range of choices, that underlies Nussbaum's argument that women do not know what is good for them.

Nussbaum suggests women's stated preferences and satisfaction with their way of life is because they have internalised their second-class status and consequently make choices, or rather accept decisions made for them, decisions that perpetuate their subordinate position in society (referring to Becker (1995) as the source of the idea). In other words, social conditioning shapes women's preferences and women's acquiescence with the system is an 'adaptive response' (pg. 137). Women adjust their desires to the only way of life they know.

She argues that while adaptive responses are not necessarily bad, the fact that these are adjustments in response to a perception of one's circumstances, rather than the result of

deliberation, makes them questionable. They lack the condition of 'freedom to do otherwise' (pg. 137-138). What increases their unacceptability is that it is an adjustment to unjust gendered structures that have failed to provide basic security and opportunities. Therefore, if stated preferences are to be accepted, it is essential that there is an absence of authority, intimidation and hierarchy. 'Only when people are respected as equals, and free from intimidation, and able to learn about the world, and secure against desperate want, then their judgements are likely to be more reliable than judgements formed under pressure of ignorance, fear and desperate need' (Nussbaum 1998, pg. 152).

Nussbaum's arguments are very persuasive. Clearly, women's options and choices in Pakistan are severely limited by the larger social, economical, legal and political structures. For example, when women insist upon company for travel, it is, at one level, a response to a danger of sexual harassment. Thus, women's stated preference for accompanied mobility is clearly not a real choice for there is no real alternative. Moreover, women are not always aware of their choices. For example, during the fieldwork, a new political framework was launched in which 30% of seats at the district level governing bodies were fixed for women. But the women in the field-site could not even comprehend the notion that they could stand as candidates. They thought women could now vote independently and would discuss the unfeasibility of the idea in a context where the feudal landlords are the default candidates and winners simply by virtue of being the largest landowners. The feudalistic and militaristic governing structures of Pakistan don the cover of democracy under external, usually donor pressure, but they remain very hierarchical and authoritarian. To legitimise their control, they link up with Islamic political parties and the resultant nexus locates its authority and control in divine ordination. Thus women, and even men of the lower socio-economic classes, are subordinated in a manner that means they are not aware of their choices, even if actual choices exist. This situation clearly does not fit into Nussbaum's requirement of an absence of authority, intimidation and hierarchy before women's stated preferences can be accepted.

However, the concept of *mazbooti* as the women's stated desire under conditions that are not ideal does not imply that the concept itself is suspect. *Mazbooti* and centrality are women's stated desires and the biggest strength of this concept is a sensitivity to cultural construction of personhood and kinship systems in this society. However, sensitivity should not be taken to imply an acceptance of unjust gender or class structures. The centrality approach aims to highlight ways to strength women's informal rights within the household and make them more secure and valued members of their families. Women as secure and valued members within their families is not a notion that is inconsistent with stronger formal legal, political and economic rights within the broader society.

Nonetheless, the concept of *mazbooti* and the centrality approach does accept a certain rigidity of roles and relations within the household for it takes the husband-wife bond as the focal point. It does not address issues of women who choose not to get married at all, or women who choose to live alone (as divorced, widowed or homosexual women). It does not address whether women and men can exchange roles.

The analysis and focus of the thesis has been largely at the intra-household level because the aim was to address autonomy vs. centrality of individual women. However, individuals cannot be divorced from their wider societal structures and forces. Gender roles and relations are multi-sited. While there is no denying that individual and household/family gender roles and relations shape the wider social climate, the same larger social climate in turn acts to limit women's choices and in particular opportunities. The persistence of the larger class, economic, political and legal inequalities in contemporary Pakistan severely limit what women can achieve in terms of their well being. The clearest example of this is the role of the larger social *mahol* on women's mobility. The insecurity of the *mahol* is a major factor underlying women's restricted mobility. Since this is not a recent change, the more important question is why does the *mahol* remain insecure. The answer lies in a complex interplay of feudalistic political structures, hierarchical social and power structures and unequal resource distribution. One consequence of these structures is a poorly functioning police and judicial system that is unable to provide security to the citizens of the state. While a poorly functioning security system affects both men and women, it can be considered a gendered failure because of its differential effects on women compared to men (of the same class). Men do not have to spend their lives in seclusion for the fear of sexual molestation.

However the links between individual and household/family level gender ideology and societal level gender structures provide a route through which women's *mazbooti* can be translated into wider societal level effects. *Mazboot* women may lead to an increased valuation of women and girls, which can have a knock on effects at the larger societal levels. One example is education. If parents aspire to educate their daughters, they will make the effort needed to access schools, increasing the demand for girls education.

This brings us to the final issue of whether the dimensions of *mazbooti* as defined from the centrality approach are amenable to policy formulation. There is little doubt that women are disadvantaged in the existing gender system. However, a social system characterised by relationships of co-operation and exchange and a central role in the family does not have to imply exploitation and subordination. Efforts to increase women's centrality and *mazbooti* can be consistent with achievement of human rights. To do this, first there is a need to

differentiate between elements of the present system that necessarily devalue and discriminate against women and those that do not necessarily do so. There is also a need to address the inequalities at the wider societal level for these create structural disadvantages that limit women's options beyond the home and family. While these appear broad and possibly impractical, a start could be made by first identify 'weak points' where gains can be made and then address the more radical changes later.

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Appendix 1

Table A1.1 Bivariate relationships between the three measures of women's mobility and socio-demographic characteristics, currently married women (15-49), PFFPS 1996-97

	Travelled in company of an adult		Travelled alone		Can travel alone to a health centre		No. of women
	%	F-test	%	F-test	%	F-test	n
Woman's age							
15-19	49.9		4.8		6.5		529
20-29	50.7		11.7		15.7		3025
30-39	47.4		21.7		31.3		2630
40-49	45.0	1.9, p=0.13	28.5	43.4, p<0.01	34.5	27.0, p<0.01	1401
Women's education							
None	47.0		16.0		20.7		5672
Primary	43.8		17.9		24.6		810
Secondary	56.1		22.3		33.7		677
Above secondary	63.3	5.4, p<0.05	34.7	8.67, p<0.01	50.5	7.2, p<0.01	425
No. of living sons							
0	51.0		9.9		13.4		1813
1-2	48.0		19.5		24.8		3434
3+	47.1	1.4, p=0.25	21.5	18.6, p<0.01	30.9	17, p<0.01	2337
Women's occupation							
Homemaker	51.8		17.4		28.4		6127
Professional	56.0		53.4		73.7		160
Agricultural	22.0		11.1		18.0		387
Services	36.0		10.5		14.4		406
Cottage industry	35.4	20, p<0.01	23.1	9.6, p<0.01	32.6	32, p<0.01	502
Type of marriage							
Husband–wife related	47.5		15.9		21.4		5045
Husband-wife not related	50.3	2.0,p= 0.15	21.7	8.0, p<0.01	28.9	6.0, p<0.01	2539
Household structure							
Nuclear	45.1		22.9		37.4		3121
Vertically joint	49.3		14.6		22.2		3918
Horizontally joint	61.3	9.5, p<0.01	11.8	17.7, p<0.01	20.4	33, p<0.01	545
SE status[1]							
Very poor	49.6		12.8		18.4		1717
Poor	42.9		14.7		26.8		2534
Lower middle	48.5		21.0		32.0		2085
Upper middle	55.8		25.8		37.9		880
Rich	62.6	4.9, p<0.01	25.3	4.6, p<0.01	42.5	3.9, p=0.03	362
Province							
NWFP	76.6		15.6		16.9		1102
Punjab	39.0		19.1		34.7		4429
Sind	48.0		18.8		23.3		1680
Balochistan	79.2	41, p<0.01	4.7	3.0, p<0.01	8.5	8.4, p<0.01	373
Rural/urban residence							
Major urban	56.4		29.8		45.3		1235
Other urban	45.0		17.8		33.0		1009
Rural	47.2	4.3, p<0.05	15.0	15.4, p<0.01	23.5	15.8, p<0.01	5339
N (weighted)							7584

[1]Information missing for 6 women.

Note: Design-based F-test adjusts for the fact that the sample was both weighted and based on cluster sampling design.

Appendix 1

Table A1.2 Bivariate relationships between socio-demographic characteristics and decision-making regarding treatment of a sick child, currently married women (15-49), PFFPS 1996-97

Background characteristics	Women did not participate (%)	Women participated but did not make the final decision (%)	Women made the final decision, jointly with husband (%)	Women made the final decision alone (%)
Women's age*				
15-19	17.8	71.6	9.7	0.9
20-29	11.6	56.8	24.3	7.3
30-39	7.4	47.5	35.1	10.0
40-49	6.3	50.3	32.8	10.6
Women's education*				
None	10.5	55.6	17.0	7.9
Primary	6.3	52.6	18.0	9.8
Secondary	4.3	38.2	27.3	14.0
Above secondary	3.5	32.6	39.3	11.1
Type of marriage*				
Husband–wife related	9.3	54.1	27.7	8.9
Husband-wife not related	8.8	49.1	33.5	8.7
No of living sons*				
0	10.6	58.8	23.6	7.1
1-2	9.7	51.8	29.6	8.9
3+	7.8	51.1	31.8	9.3
Women's occupation*				
Homemaker	9.2	52.2	30.0	8.6
Professional	3.5	23.6	50.3	22.7
Services	7.0	61.8	21.8	9.4
Agriculture	12.5	62.5	22.2	2.8
Cottage industry	9.0	50.0	30.8	10.3
Household structure*				
Nuclear	7.0	46.9	36.2	9.9
Joint	10.8	56.9	24.4	8.0
SE status[1]*				
Very poor	12.6	62.1	20.5	4.8
Poor	9.5	54.0	27.6	8.7
Lower middle	7.1	49.4	31.9	11.6
Upper middle	8.3	43.3	40.7	7.7
Rich	4.0	36.5	44.3	15.2
Province*				
NWFP	9.3	69.0	16.0	5.8
Punjab	5.9	49.6	34.5	10.1
Sind	11.0	50.4	30.0	8.6
Balochistan	40.3	47.1	9.9	2.7
Rural/urban residence*				
Major urban	6.9	35.5	43.8	13.8
Other urban	8.6	46.9	33.9	10.6
Rural	9.8	57.6	25.4	7.3

*The variable is significant at $p < 0.05$ based on the Design-based F-test

[1] Information missing for 6 women.

Note: Design-based F-test adjusts for the fact that the sample was both weighted and based on cluster sampling design.

N (weighted) = 6618.

Appendix 1

Table A1.3 Bivariate relationships between socio-demographic characteristics and decision-making regarding food purchases, currently married women (15-49), PFFPS 1996-97

Background characteristics	Women did not participate (%)	Women participated but did not make the final decision (%)	Women made the final decision, jointly with husband (%)	Women made the final decision alone (%)
Women's age*				
15-19	27.8	62.3	7.2	2.7
20-29	17.5	60.9	14.2	7.3
30-39	11.6	50.0	25.8	12.7
40-49	10.9	47.7	25.8	15.7
Women's education*				
None	16.0	56.9	17.9	9.2
Primary	14.0	53.0	20.5	12.5
Secondary	11.1	49.1	25.4	14.5
Above secondary	9.0	38.1	37.2	15.6
Type of marriage				
Husband–wife related	15.4	55.1	19.5	9.7
Husband-wife not related	14.2	54.0	20.6	11.3
No of living sons*				
0	21.2	59.4	12.8	6.5
1-2	13.7	53.4	21.0	11.9
3+	11.9	53.2	23.8	11.1
Women's occupation*				
Homemaker	15.1	54.5	20.6	10.3
Professional	9.9	36.8	32.2	21.1
Services	8.6	70.0	13.9	7.6
Agriculture	25.9	62.3	8.2	3.5
Cottage industry	12.8	49.1	24.7	13.4
Household structure*				
Nuclear	8.3	49.8	28.4	13.6
Joint	19.6	58.2	13.9	8.2
SE status[1]*				
Very poor	18.8	61.4	14.5	5.3
Poor	14.4	56.3	18.2	11.1
Lower middle	14.1	52.5	21.8	11.6
Upper middle	13.4	49.8	24.7	12.2
Rich	8.8	37.3	35.0	19.0
Province*				
NWFP	16.2	70.2	8.3	5.4
Punjab	9.9	53.4	24.4	12.3
Sind	19.8	51.5	18.3	10.4
Balochistan	50.0	39.7	8.1	2.9
Rural/urban residence*				
Major urban	12.9	36.7	32.3	18.1
Other urban	13.1	55.7	18.9	12.2
Rural	15.8	58.8	17.2	8.3

* The variable is significant at $p < 0.05$ based on the Design–based F-test.

[1] Information missing for 6 women.

N (weighted) = 7584.

Appendix 1

Table A1.4 Bivariate relationships between socio-demographic characteristics and decision-making regarding clothes purchases, currently married women (15-49), PFFPS 1996-97

Background characteristics	Women did not participate (%)	Women participated but did not make the final decision (%)	Women made the final decision, jointly with husband (%)	Women made the final decision alone (%)
Women's age*				
15-19	20.5	56.5	16.2	6.8
20-29	12.9	42.2	30.4	14.4
30-39	10.0	34.5	34.8	20.7
40-49	9.3	33.8	33.0	23.9
Women's education*				
None	13.4	43.5	27.9	15.2
Primary	9.3	32.2	35.4	23.0
Secondary	6.0	24.0	45.4	24.6
Above secondary	4.3	16.3	47.8	31.6
Type of marriage				
Husband–wife related	11.8	39.6	31.4	17.2
Husband-wife not related	11.6	38.1	31.4	19.0
No of living sons*				
0	13.0	47.1	26.5	13.5
1-2	11.4	36.2	33.3	19.2
3+	11.4	37.0	32.4	19.2
Women's occupation*				
Homemaker	11.0	39.9	31.6	17.5
Professional	9.9	20.0	33.0	37.2
Services	13.5	41.4	32.1	13.0
Agriculture	20.9	47.9	22.2	9.0
Cottage industry	11.7	31.8	33.7	22.8
Household structure*				
Nuclear	8.5	35.9	35.0	20.6
Joint	14.1	41.2	28.9	15.9
SE status[1]*				
Very poor	16.3	51.3	23.4	9.0
Poor	12.0	42.3	28.5	17.1
Lower middle	10.2	33.4	34.1	22.4
Upper middle	7.4	25.5	44.1	23.0
Rich	7.6	24.1	43.3	25.0
Province*				
NWFP	12.2	60.2	17.1	10.2
Punjab	8.9	33.7	38.0	19.5
Sind	13.1	40.0	28.2	18.7
Balochistan	38.9	35.2	9.3	16.6
Rural/urban residence				
Major urban	7.8	20.8	40.2	31.2
Other urban	8.9	32.4	36.1	22.6
Rural	13.2	44.5	28.5	13.8

* The variable is significant at $p < 0.05$ based on the Design–based F-test.

Note: Design-based F-test adjusts for the fact that the sample was both weighted and based on cluster sampling design.

[1] Information missing for 6 women.

N (weighted) = 7584.

Appendix 1

Table A1.5 Bivariate relationships between women's access to and control over their wages and background characteristics, currently married women (15-49), PFFPS 1996-97

Background characteristics	Women do not work for wages	Women work for wages, and keep all	Women work for wages and keep some	Women work for wages but give all away
Women's age				
15-19	79.5	8.2	5.8	6.5
20-29	82.0	6.6	5.3	6.2
30-39	81.5	8.1	3.9	6.5
40-49	77.3	9.0	4.3	9.4
Women's education*				
None	78.9	8.1	5.0	8.1
Primary	87.5	5.9	3.9	2.7
Secondary	88.8	4.8	3.3	3.1
Above secondary	80.8	9.9	4.3	4.9
Type of marriage*				
Husband–wife related	79.0	8.2	5.4	7.4
Husband-wife not related	84.0	6.6	3.2	5.9
No. of living sons				
0	80.3	8.2	5.8	5.6
1-2	81.0	7.2	4.6	7.2
3+	81.0	7.9	3.8	7.5
Husband's occupation*				
Professional	84.7	5.9	4.1	5.3
Services	82.5	7.1	5.7	4.7
Agriculture	71.5	7.9	6.1	14.5
Labourer	85.4	8.6	2.8	3.3
Others	87.1	6.4	5.5	1.0
Household structure				
Nuclear	80.0	8.4	4.7	7.0
Vertically joint	81.4	7.0	4.8	6.8
Horizontally joint	81.2	7.9	3.7	7.2
SE status[1]*				
Very poor	74.4	7.0	5.6	13.1
Poor	77.3	10.6	5.6	6.5
Lower middle	85.0	6.8	3.8	4.4
Upper middle	90.7	3.4	2.0	3.4
Rich	87.1	3.4	5.2	3.7
Province*				
NWFP	95.3	1.5	1.4	1.9
Punjab	80.0	8.6	4.7	6.8
Sind	70.7	10.6	6.9	11.9
Balochistan	93.9	1.7	3.3	1.1
Rural/urban residence*				
Major urban	87.8	5.8	2.0	4.5
Other urban	82.9	8.2	4.2	4.7
Rural	78.8	8.0	5.3	7.9

* The association is significant at $p < 0.05$ based on the Design–based F-test

[1] Information missing for 6 women.

N (weighted) = 7584.

Table A1.6 Distribution of communication score by socio-demographic characteristics, currently married women (15-49), PFFPS 1996-97

Background characteristics	Communication score (mean)	95% confidence limits	Design-based F-Test [1]
Women's age			
15-19	1.77	1.53, 2.00	
20-29	2.23	2.13, 2.34	
30-39	2.41	2.29, 2.53	
40-49	2.15	2.06, 2.25	9.3, p<0.01
Women's education			
None	2.11	2.01, 2.25	
Primary	2.52	2.37, 2.67	
Secondary	2.65	2.51, 2.80	
Above secondary	2.79	2.52, 3.05	7.2, p<0.01
Type of marriage			
Husband–wife related	2.16	2.06, 2.26	
Husband-wife not related	2.43	2.30, 2.54	11.8, p<0.01
No of living sons			
0	1.80	1.68, 1.91	
1-2	2.32	2.22, 2.43	
3+	2.47	2.36, 2.58	25.1, p<0.01
Women's occupation			
Homemaker	2.29	2.18, 2.39	
Professional	2.55	2.08, 3.01	
Agricultural	1.17	1.52, 1.92	
Services	1.82	1.64, 2.02	
Labourer	2.38	2.11, 2.65	4.6, p<0.01
Household structure			
Nuclear	2.37	2.26, 2.48	
Joint	2.16	2.05, 2.27	3.4, p<0.01
SE status*			
Very poor	1.90	1.73, 2.09	
Poor	2.15	2.03, 2.27	
Lower middle	2.42	2.30. 2.54	
Upper middle	2.68	2.54, 2.81	
Rich	2.45	2.24, 2.67	6.8, p<0.01
Province			
NWFP	2.65	2.40, 2.91	
Punjab	2.25	2.11, 2.39	
Sind	2.11	1.99, 2.23	
Balochistan	1.64	1.46, 1.82	9.2, p<0.01
Rural/urban residence			
Major urban	2.59	2.37, 2.81	
Other urban	2.42	2.28, 2.57	
Rural	2.13	2.00, 2.25	5.5, p<0.01

[1]This measures the overall significance of the association between the background characteristic and communication score.

* Information missing for 6 women.

N (weighted) = 7584.

Table A1.7 Distribution of exposure to information index score by socio-demographic characteristics, currently married women (15-49), PFFPS 1996-97

Background characteristics	'Exposure to information index' score	95% confidence limits	Design based F-Test
Women's age			
15-19	3.19	2.76, 3.62	
20-29	3.69	3.29, 4.08	
30-39	3.41	2.86, 3.48	
40-49	3.09	2.57, 3.18	2.9, p=0.02
Women's education			
None	1.99	1.80, 21.8	
Primary	6.82	6.50, 7.14	
Secondary	8.59	8.35, 8.82	
Above secondary	8.18	7.70, 8.66	89.0, p<0.01
Type of marriage			
Husband–wife related	3.19	2.91, 3.48	
Husband-wife not related	3.94	3.46, 4.43	8.3, p<0.01
No of living sons			
0	3.66	3.25, 4.06	
1-2	3.65	3.28, 4.02	
3+	2.98	2.68, 3.28	5.1, p<0.01
Women's occupation			
Homemaker	3.48	3.14, 3.82	
Professional	7.35	6.56, 8.14	
Agricultural	2.37	2.02, 2.7	
Services	1.78	1.15, 2.40	
Labourer	3.88	3.12, 4.64	9.9, p<0.01
Household structure			
Nuclear	3.20	2.84, 3.58	
Joint	3.61	3.27, 3.94	2.7, p<0.01
SE status*			
Very poor	0.93	0.75, 1.10	
Poor	2.32	2.13, 2.52	
Lower middle	4.93	4.67, 5.19	
Upper middle	7.14	6.76, 7.53	
Rich	5.14	4.59, 6.83	55.4, p<0.01
Province			
NWFP	2.91	2.41, 3.41	
Punjab	3.44	3.05, 3.82	
Sind	4.26	3.44, 5.09	
Balochistan	1.40	0.83, 1.97	8.5, p<0.01
Rural/urban residence			
Major urban	6.17	5.93, 6.42	
Other urban	4.71	4.55, 4.87	
Rural	2.57	2.33, 2.82	53.9, p<0.01

[1]This measures overall significance of the association between the background characteristics and exposure to information score categories (0=0, 1-4=1, 5-8=2, 9-12=3)

* Information missing for 6 women.

N (weighted) = 7584.

Appendix 1

Table A1.8 Distribution of health knowledge index score by socio-demographic characteristics, currently married women (15-49), PFFPS 1996-97

Background characteristics	'Health knowledge index' score	95% confidence limits	Design-based F-Test [1]
Women's age			
15-19	3.83	3.47, 4.19	
20-29	5.10	4.87,, 5.35	
30-39	5.58	5.30, 5.86	
40-49	5.40	5.10, 5.69	10.8, p<0.01
Women's education			
None	4.90	4.64, 5.15	
Primary	6.05	5.75, 6.35	
Secondary	6.23	5.88, 6.58	
Above secondary	6.68	6.08, 7.28	12.6, p<0.01
Type of marriage			
Husband–wife related	5.09	4.82, 5.36	
Husband-wife not related	5.36	5.29, 5.78	6.3, p<0.01
No of living sons			
0	4.53	4.23, 4.84	
1-2	5.46	5.23, 5.70	
3+	5.45	5.18, 5.73	16.8, p<0.01
Women's occupation			
Homemaker	5.26	5.02, 5.50	
Professional	6.61	5.88, 7.34	
Agricultural	4.67	4.11, 5.23	
Services	4.25	3.51, 4.99	
Labourer	5.59	4.94, 6.24	4.0, p<0.01
Household structure			
Nuclear	5.54	5.29, 5.80	
Vertically joint	5.01	4.76, 5.26	
Horizontally joint	5.14	4.67, 5.61	5.6, p<0.01
SE status*			
Very poor	3.98	3.49, 4.48	
Poor	5.06	4.82, 5.30	
Lower middle	5.87	5.62, 6.11	
Upper middle	6.31	6.04, 6.57	
Rich	6.23	5.82, 6.65	13.6, p<0.01
Province			
NWFP	5.65	5.36, 5.95	
Punjab	5.36	4.99, 5.72	
Sind	5.23	4.88, 5.59	
Balochistan	2.63	2.07, 3.18	13.2, p<0.01
Rural/urban residence			
Major urban	6.01	5.55, 6.47	
Other urban	5.85	5.58, 6.12	
Rural	4.94	4.64, 5.26	6.8, p<0.01

[1]This measures overall significance of the association between the background characteristics and health knowledge score categories (0=0, 1-4=1, 5-7=2, 8-10=3).

* Information missing for 5 women.

N (weighted)= 7580.

Appendix 2

Table A2.1 Bivariate analysis of contraceptive use and women's background characteristics, currently married women (15-49), PFFPS survey 1996-97

Background characteristics	Number of women (weighted)	Percent women currently using a contraceptive method	Design- based F test
Women's age			
15-19	529	6.2	
20-29	2991	15.2	
30-39	2396	25.4	
40-49	1204	21.1	17.8, p<0.01
Women's education			
None	5354	14.1	
Primary	750	30.0	
Secondary	622	36.7	
Above secondary	395	35.7	43.4, p<0.01
Type of marriage			
Husband–wife related	4756	16.6	
Husband-wife not related	2364	23.7	18.8, p<0.01
No of living sons			
0	1808	5.2	
1-2	3283	21.5	
3+	2029	27.0	49.4, p<0.01
Occupation			
Homemaker	5765	20.0	
Professional	135	32.9	
Services	363	8.45	
Agriculture	397	7.17	
Cottage industry	461	20.2	7.57, p<0.01
Household structure			
Nuclear	2824	23.8	
Vertically joint	3782	15.8	
Horizontally joint	514	15.4	12.1, p<0.01
SE status*			
Very poor	1673	8.95	
Poor	2423	14.1	
Lower middle	1876	24.6	
Upper middle	814	35.6	
Rich	329	32.3	29.2, p<0.01
Province			
NWFP	1066	15.9	
Punjab	4144	21.8	
Sind	1542	16.6	
Balochistan	368	5.9	5.92, p<0.01
Rural/urban residence			
Major urban	1068	30.5	
Other urban	937	27.2	
Rural	5114	15.0	17.9, p<0.01
N (weighted)	7120	19.0	

* Information missing for 5 women

Appendix 2

Table A2.2 Bivariate analysis of direct measures of women's gendered position and contraceptive use currently married women (15-49), PFFPS survey 1996-97

Direct measures of women's gendered position	Number of women (weighted)	Percent women currently using a contraceptive method	Design- based F test
Woman travelled with company			
• Yes	3447	19.2	
• No	3673	18.8	0.07, p=0.8
Woman travelled alone			
• Yes	1201	28.2	
• No	5919	17.1	36.9, p<0.01
Woman can travel to a health centre			
• Alone	1910	28.4	
• Accompanied	5210	15.5	57.5, p<0.01
Decision making regarding treatment of a sick child*			
• Women not involved	581	11.8	
• Women participate, but don't make the final decision	3291	19.8	
• Women make the final decision jointly with their husbands	1764	28.9	
• Women make the final decision independently	518	22.3	14.3, p<0.01
Decision making for food purchases			
• Women not involved	1111	11.6	
• Women participate, but don't make the final decision	3947	16.3	
• Women make the final decision jointly with their husbands	1350	30.9	
• Women make the final decision independently	713	22.5	19.6, p<0.01
Decision making for clothes purchases			
• Women not involved	863	11.4	
• Women participate, but don't make the final decision	2852	13.8	
• Women make the final decision jointly with their husbands	2186	26.7	
• Women make the final decision independently	1219	22.3	25.7, p<0.01
Access to financial resources			
• Women do not work for wages	5765	20.0	
• Women work for wages, keep all of it.	494	16.6	
• Women work for wages, and give some of it away	331	16.1	
• Women work for wages and give it all away	531	11.3	2.94, p<0.05
Communication index scores			
▪ 0	679	1.0	
▪ 1	1192	3.4	
▪ 2	2272	11.2	
▪ 3	1773	27.5	
▪ 4	1204	46.6	107.8, p<0.01

Continued next page

Direct measures of women's gendered position	Number of women (weighted)	Percent women currently using a contraceptive method	Design- based F test
Health knowledge index			
▪ 0	559	1.2	
▪ 1-4	2000	7.1	
▪ 5-7	3847	23.0	
▪ 8-10	710	44.5	71.5, p<0.01
Exposure to information index			
▪ 0	2048	9.7	
▪ 1-4	2908	17.0	
▪ 5-8	1349	25.7	
▪ 9-12	815	38.0	38.3, p<0.01
N (weighted)	7120	19.0	

* N (weighted) = 6155.

Appendix 2

Table A2.3 Bivariate analysis of antenatal care use and women's background characteristics, currently married women (15-49), PFFPS survey 1996-97

Background characteristics	Number of women (weighted)	Percent women who used antenatal care	Design- based F test
Women's age			
15-19	231	35.4	
20-29	2141	40.4	
30-39	1230	31.2	
40-49	211	26.7	5.7, p<0.01
Women's education			
None	2900	25.9	
Primary	427	52.5	
Secondary	296	77.4	
Above secondary	191	96.3	99.4, p<0.01
Type of marriage			
Husband–wife related	2542	34.7	
Husband-wife not related	1272	39.7	2.33, p<0.01
No of living sons			
0	654	40.0	
1-2	2070	39.6	
3+	1091	28.0	11.8, p=0.13
Occupation			
Homemaker	2917	37.9	
Professional	52	64.2	
Services	200	15.5	
Agriculture	209	21.3	
Cottage industry	437	40.1	5.75, p<0.01
Household structure			
Nuclear	1362	32.5	
Vertically joint	2158	38.0	
Horizontally joint	294	42.6	1.87, p= 0.16
SE status*			
Very poor	958	20.1	
Poor	1350	26.8	
Lower middle	1017	46.0	
Upper middle	336	77.8	
Rich	153	68.3	47.5, p<0.01
Province			
NWFP	618	32.8	
Punjab	2192	33.0	
Sind	781	52.1	
Balochistan	223	25.3	7.8, p<0.01
Rural/urban residence			
Major urban	494	76.8	
Other urban	477	50.4	
Rural	2843	27.0	59.6, p<0.01
N (weighted)	3814	36.4	

* Information missing for 1 woman.

Appendix 2

Table A2.4 Bivariate analysis of direct measures of women's gendered position and utilization of antenatal care services currently married women (15-49), PFFPS survey 1996-97

Direct measures of women's gendered position	Number of women (weighted)	Percent women who used antenatal care	Design- based F test
Women travelled with company			
• Yes	1870	41.7	
• No	1944	31.3	13.0, p<0.01
Women travelled alone			
▪ Yes	488	44.7	
▪ No	3326	35.2	4.6, p<0.05
Women can travel to a health centre			
▪ Alone	860	42.0	
▪ Accompanied	2954	34.7	4.8, p<0.05
Decision making regarding treatment of a sick child			
▪ Women not involved	406	29.0	
▪ Women participate, but don't make the final decision	2104	32.9	
▪ Women make the final decision conjointly with their husbands	983	44.7	
▪ Women make the final decision independently	252	45.4	6.7, p<0.01
Decision making for food purchases			
▪ Women not involved	619	32.1	
▪ Women participate, but don't make the final decision	2251	34.6	
▪ Women make the final decision conjointly with their husbands	634	42.3	
▪ Women make the final decision independently	310	46.2	3.38, p<0.01
Decision making for clothes purchases			
▪ Women not involved	575	27.9	
▪ Women participate, but don't make the final decision	1592	28.2	
▪ Women make the final decision conjointly with their husbands	1131	47.0	
▪ Women make the final decision independently	576	45.9	12.6, p<0.01
Access to financial resources			
▪ Women do not work for wages	3107	38.9	
• Women work for wages, keep all of it.	274	30.9	
• Women work for wages, and give some of it away	169	17.9	
• Women work for wages and give it all away	265	24.5	6.65, p=0.14

Direct measures of women's gendered position	Number of women (weighted)	Percent women who used antenatal care	Design- based F test
Communication index scores			
• 0	323	16.5	
• 1	552	28.3	
• 2	1097	31.8	
• 3	1107	42.8	
• 4	735	48.3	16.5, p<0.01
Health knowledge index scores*			
• 0	251	14.5	
• 1-4	1090	26.6	
• 5-7	2106	39.8	
• 8-10	364	61.5	18.9, p<0.01
Exposure to information index scores			
• 0	1161	19.6	
• 1-4	1554	28.9	
• 5-8	710	60.0	
• 9-12	390	73.5	66.5, p<0.01
N (weighted)	3814	36.4	

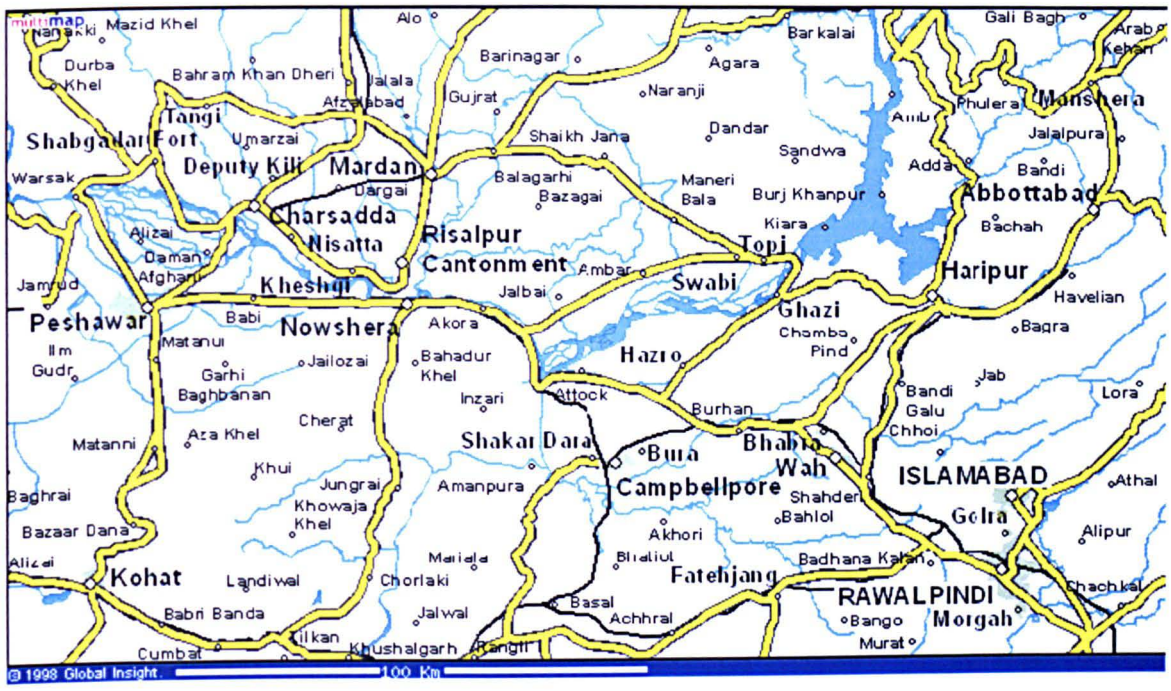
Note: The score categories of the 'health knowledge' and 'exposure to information' indices were developed after analysing each score separately.
* Information missing for 2 women.

Appendix 3

Fig A3.1 The Map of Pakistan

Appendix 3

Fig A3.2 **Map of District Attock**



Appendix 4

Statistical methods

A4.1 Regression analysis

Most of the multivariate statistical analysis presented in this thesis is multiple logistic regression carried out in Stata 6.0. Stata (1999) is a useful statistical package for analysing survey data for it contains commands that incorporate the effect of survey design including probability sampling weights, stratification and cluster sampling.

Logistic regression was used when the outcome variable of interest was categorical (Hosmer and Lemshow 1989). Linear regression was used when the outcome variable of interest was continuous as, for example, the communication index (Rosner 1995). Multiple regression was used since it allows a number of independent variables to be included in the analysis.

A forward selection method was used in model building. Variables with a univariate Wald statistic of greater than 0.25 (Mickey and Greenland (1989) were added to the model one by one and the effects analysed. At times, a variable was added to the model if a relationship seemed plausible or I wanted to study its effect even if the univariate Wald statistic was greater than 75%. The variables included in the final model had a Wald-statistic of $p<0.05$. To further assess the importance of these variables, Likelihood Ratio Tests were also conducted, but on unweighted data for Stata cannot conduct the LRT on weighted data.

A4.1.1 Binomial logistic regression

Binomial logistic regression models the relationship between independent variables and a dichotomous outcome variable, which can take on a value of 0 or 1. The regression equation is shown below.

$$\ln\left(\frac{P}{1-P}\right) = \alpha + \beta_1 x_1 + \beta_2 x_2 + \ldots\ldots \beta_i x_i$$

A4.1.2 Multinomial logistic regression

Multinomial logistic regression takes a similar form to binomial regression but is used when the outcome variable has three or more categories, which are nominal.

$$\ln\left(\frac{P_r}{P_s}\right) = \alpha + \beta_{r1}x_1 + \beta_{r2}x_2 + \beta_{ri}x_i$$

Where r=1,.....s-1 and s is the reference category.

A4.1.3 Linear regression

Linear regression models the relationship between independent variables and a continuous outcome variable. The least squares methods regression equation is shown below.

$$y = \alpha + \beta_1 x_1 + \beta_2 x_2 + ...\beta_i x_1 + e$$

where α is the intercept and β is the slope of the line. e, the error term is assumed to follow a normal distribution with a mean 0 and variance σ^2.

Appendix 5

Purdah, *izzat* and *biradari* boundaries

When specifically asked what *purdah* meant, the majority of the respondents, both women and men, explain it as the avoidance of a *'ghaer mard'. A ghaer mard* refers to a man who does not belong to their *biradari.* It is not simply any *namaharem*[1], (a man that a woman can have sexual relations with), but specifically a non-*biradari* man. In contrast, women do not maintain *purdah* from *biradari* men and any such attempts are construed as an insult. These two opposing sets of behaviour are particularly paradoxical when placed in a context in which strictly enforced rules of endogamy limit sanctioned sexual activity to within the *biradari* only. If the objective was a simple control women's sexual activity, seclusion and *purdah* rules should also apply to all men, irrespective of *biradari* identities. Instead, dense intra-*biradari* networks and rules limit social interaction to within the *biradari* only. This, coupled with lack of *purdah,* ensure potential sexual partners are thrown together repeatedly. Although marriages are arranged, hidden choice operates covertly. Cousins grow up in joint households knowing they will marry each other. Chayya's 18-year-old son and 14-year-old niece are betrothed to be married, all the while living in the same house. Salma and Mano, Fozia and Nadeem, respectively siblings, now cross married (Salma/ Nadeem and Mano/ Fozia), all grew up in a single household knowing they would marry each other.

It is documented in the literature that practices associated with the maintenance of *purdah* vary by class (Sathar and Kazi 1997, White 1992, Papanek 1973). Apparently *izzat* (honour) also varies by class. When asked what honour meant for men, the majority answered in terms of women and land. A *ghairatmand* (a man of *izzat*) man fights to maintain his honour: be it women or land. For a poor landless man, the land related aspect of honour is automatically a non-issue. Similarly, the rules of endogamy are followed very strictly by the landed Rajas. While the language is couched in terms of 'we don't give or daughters out: it's a matter of our *izzat*', it is obviously meant to keep the landed property within the *biradari.* In contrast, the poorer Maliks and Kamis, although trying to emulate this ideology, do admit in hushed tones that 'we do give our daughters away'.

Schneider's (1971) analysis of the ideology of honour and shame in the Mediterranean has relevance in this context. She argues that honour became a major concern in areas where agriculturists and pastoralists were brought into conflict over resources and boundaries. In the absence of the state to settle such disputes, these communities developed their own means of

social control. Schneider (1971, pg.2) refers to honour as 'the ideology of the property holding groups which struggles to define, enlarge and protect its patrimony in a competitive area'. Furthermore, she says concern for honour is greater when the definition of a group is problematic, its boundaries are difficult to maintain and internal loyalties are questionable.

Purdah is thus a metaphorical notion, internalised by both women and men to create a separate spheres imagery that is not real in any sense, but designed for a specific purpose. Women's role as boundary markers and carriers of group identity is supported by Rozario's analysis of notions of purity and *purdah* in Bangladesh. In her book titled 'Purity and Communal boundaries: Women and social change in rural Bangladeshi Village' she argues that values of *purdah* and *sharam* are tools used to maintain communal boundaries, specifically between the Muslims, Hindus and Christians (1992). The sexual control of women with its emphasis on virginity, and sexual chastity are essentially intervening variables on the pathway. The ideology has much more to do with institutional arrangements of power and resource distribution than a simple code of culture.

Appendix 6

Glossary of non-English words

Agla–pichla	Larger familial and *biradari* network
Akhathe	Jointness, togetherness
Akhian age nera	Feeling faint
Akhri	Final
Ander	Inside
Azaan	Call for prayer
Baar	Outside
Bache	Children
Bara	Big, elder
Bartan	Utensils
Beghairat	A person with no *izzat*
Besharam	Without shame
Beta	Son
Beti	Daughter
Bhans	A large black buffalo kept for milk
Biradari	Group of families linked by blood
Bister	Duvets and pillows
Bou kamzor	Feeling very weak
Buzurgh	Old person
Chaske	Pleasurable, but useless activity
Chador	2 x 1 m long piece of cloth
Chote	Small
Daag lagna	Spotty per vaginal bleeding
Dal	Lentils
Dai	Traditional Birth Attendent
Darzi	Tailor
Desi ghee	Butter oil
Dewar	Husband's younger brother
Dhoke	Hamlets, houses built in the fields away from the main village
Duppata	2 x ½ m long scarf made of flimsy chiffon-like material

Eid	Annual religious festival observed after a month of fasting
Faisla	Decision
Fauji	Army personnel
Fuzuul	Unnecessary
Gandi	Impure, dirty
Ghalian	Village lanes
Gammi peshi	Hard time
Ghran	Village
Goya	Animal dung
Hakim	Practitioner of traditional herbal medicine
Halke na kaam	Light work
Hamal	Pregnancy
Hastian	Simple village women
Izzat	Honour
Jahez	Dowry
Jahil	Uncouth
Jawan	Young, also refers to Army Sepoys
Juram	Crime
Jurat	Dare
Kaar	House/home
Kamzor	Weak
Kammitee	A group-based savings system
Kanal	Measure of land. Four kanals is equal to one acre of land
Kasai	Butcher
Khatarnak	Dangerous
Khutba	Friday sermon held before the Friday prayers
Khushaali	Peace and happiness
Kirdar	Actions, total sum of behaviour
Kismat	Luck
Kutchi nokri	Non-permanent employment
Lohar-tarkhan	Carpenter
Mataam	Funeral
Mahol	Social climate
Maide di takhleef	Pain in the stomach

Majboori	Necessity
Marud	Man
Maulvi	Muslim religious leader who leads the prayer in mosque, teaches the Koran and officiates at marriages
Mazboot	Strong
Mehngai	Increase in the cost of items and living expenses in general
Mochi	Shoemaker
Mohalla	Neighbourhood
Mushtarka	Joint
Nai	Barber
Namaz	Prayer
Napaak	Impure, polluting
Nuu	Daughter-in-law
Parchawan	Sprits that affect pregnant women causing an abortion
Patte ya kamar na dard	Abdominal or back ache
Pucci nokri	Permanent job
Purdah	Veiling by women (see text for more definitions)
Razamandi	Consent
Rhujanaat	Aspirations
Rehmat	Blessing from God
Roti	Round, flat bread
Rishta	Arrangement of a marriage
Riwaj	Culture
Safed pani	Clear vaginal discharge
Sahelian	Friends
Susral	Marital family
Shalwar/kameez	Standard mode of dress in Pakistan amongst both women and men. It consists of loose pants and a long shirt.
Sharab	Alcohol
Sharam	Shame
Slaa-mashwara	Consulting and taking advice
Sodha	Groceries
Siyarni	A wise woman
Tandoori	Oven to make roti's

Tappe	Traditional songs sung at weddings
Unpar	Uneducated person
Vartan bhanji	Exchange of gifts at life-stage marking events
Vera	Courtyard
Vya	Wedding
Wade	Big or elder
Wangar	Social exchange of labour
Waqfa	Break
Zaat	Caste (see text for in-depth explanation)
Zameen	Land
Zanjeer	Chain
Zanankhuna	A man who spends too much time with women: a woman-like man
Zamindar	Landowners / sometimes farmers
Zayada takhleef	More pain and discomfort
Zehmat	A source of distress and pain
Zore na kaam	Hard work