SOCIO- CULTURAL CONSTRAINTS TO WOMEN'S ACCESS TO HEALTH IN PAKHTUN SOCIETY

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DEDICATION

This flourishing and humble effort is dedicated to

"My Loving Parents,

Respected Teachers,

Splendid Friends

&

Ms. Azra Hussain (Women Rights Activist)"

With out whom prayers and encouragement it would not have been possible for me to complete this thesis

LIST OF ABBREVIATION

CEDAW	Convention on Elimination of Discrimination Against Women
COPD	Chronic Obstructive Pulmonary Disorder
CWS	Common Wealth Secretariat
DHQH	District Headquarter Hospital
ESP	Economic Survey of Pakistan
GOP	Government of Pakistan
HOD	Head of Department
HSYB	Health Statistic Year Book
IMF	International Monitory Fund
KPK	Khyber-Pakhtunkhwa
LDC's	Less Developed Countries
LHWs	Lady Health Workers
MOH	Ministry of Health
NGO	Non Governmental Organizations
NHS	National Health Survey
TBA	Traditional Birth Attendant
UN	United Nation
UNDP	United Nation Fund for Development
US	United States
WB	World Bank
WHO	World Health Organization

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HUSSAIN ALI

ABSTRACT

The present study examined socio-cultural constraints to women's access to health in Pakhtun society. The study was quantitative in nature. Stratified random sampling technique was used for selecting the respondents. A total of 315 respondents were selected from three districts Mardan, Dir Upper and Swat from Khyber-Pakhtunkhwa. The in-depth interview method was used to collect the information from the respondents. The research instrument was self-constructed and reliability of the interview schedule was checked through the validation test. Based on the objectives and hypotheses stated for the study, correlation, chi-square tests were applied. The findings revealed significant relationship between culture codes and religious codes, custom of Parda and practice of health seeking, educational status and checkup in pregnancy and sharing about illness in the family and company to doctor by family member. The result of chi-square found highly significant. It is thus considered that the women face socio-cultural constraints in access to health facilities in Pakhtun society. In addition to that public and private patriarchy has articulated in Pakhtun structure.

On the basis of the present study it was suggested that media, civil society, community groups, academia and religious leaders should join hands with government to bring a change in the Pakhtun culture. Government should also concentrate on the missing facilities in the health providing institutions.

CHAPTER ONE

INTRODUCTION

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1.1. Background

Women's health is closely linked to their social status. At global level, particularly in Pakistan, inequality between women and men started from birth and continued till death. Due to women's gender roles they become ill. Evidence shows that women are biologically healthier than men, and a result have a natural border in terms of expected life span. This biological advantage is completely cancelled out in many South Asian societies with women's social disadvantage.

Mostly in Pakistan and especially in Pakhtun society, women are deprived of their basic rights as compare to men, both within and beyond the family sphere. Women through out their life endure inequity based on gender, the expression of which range from preferential treatment of boys in provision of food and health care, to rape, dowry death and female infanticide. Women are expected to leave best food for male while eat last by her, while managing the entire family affaires. This often results in undernourishment, and which is one reason behind the high rate of morbidity and mortality of women in South Asia.

Women constitute about fifty percent of the population of Pakistan. The majority of them have been subjected to various social and legal disabilities and the result of these neglects are in term of low productivity, illiteracy and poor health have been enormous. Her physical weakness and economic dependency on their family and the community brought further deterioration in her position. Society have in robbed her individuality, treated her

as a private property, which gives rise to the evils of propitiation, female infanticide and trafficking in women, Pakistani women suffering from health crisis, and especially in Pakhtun society, there are various social, cultural and economic constraints which decrease the status of women. According to the Pathan, women are for home or for grave , they have no right in the decision making process in the family, they did not decide their health matter, even in Pakhtun society women can not go alone to the doctor, if there is no female doctor then the strict custom and tradition cause women poor health. Because of the social and cultural bond which restricted women to home.

Even after more than sixty years of independence, medical facilities especially for women and children are almost non existent in Pakistan and especially in Pakhtun society, with the prevalence of male dominancy, patriarchic cultural, conservative thinking, strict customs and tradition and religious misperception are causes of women poor health in Pakhtun society. As a result their health standards are extremely low, especially in rural areas, In view of this fact, along with general health facilities which are needed both for men and women, special medical services are needed for women and children.

The patriarchic system and male dominancy not ever decrease women health status but it also creates other social, psychological and economic problem in Pakistan and especially in Pakhtun society. Male member are responsible for the productive activities outside the home while women are expected to be responsible for indoor activities. In almost globally, women are restricted and have less access to economic resources and control over economic resources, this lead to inequality in balance of power that favor men, the

girl and boy are discriminated in school enrollment. The imbalance in power measure with literacy, labor force participation, land ownership and access to health (WIN, 2007). Men are empowered and socialized as independent while women are expected to be dependent on men for economic resources. Men are not showing their emotions and pressure to women (WHO, 1999).

A Feminist Post-Structuralist perspective on health has suggestion for increasing awareness on issues that cause difference, imbalance & inequalities in women's health care. It seeks to expose and change & convert social, political and economic power structures that lead to prevention and resistance for evaluation and comprehensive treatment receiving forcefully by women. Furthermore a feminist post structuralist perspective trying to clarify and amend the slight and determined biases present in our health care system that marginalize the women's access to health. From back history, it is observed that knowledge has a source for using the male as the example for disease management, diagnostic practice, and decision taking at clinical level (Engoren, 2002). Women's health is important especially in developing countries since their traditional and cultural identified role as family caregiver makes them chiefly responsible for the health seeking of their children, husband, and other elder family members in the home (Ishida, 2000). Women's domination is bad for their health and access to health facilities in most developing countries, the mortality rates of females is higher as compare than those of males of all ages because women have less access to health care, decision making power and because female children get lower level of nutrition in this context advancing women's health can not be develop from political efforts to transform oppressive social relationship and institution that deny women of their fundamental rights and right to

access to health facilities. If women are to fully enjoy their right to the higher possible standard of health we have to fight not only viruses and epidemics, but also cultural traditions, customs, values and attitude (Sarkin, 2002).

A classic definition of access to health care has been given by Penchansky and William Thomas in 1981[A]cess is an evaluate of the "fit" between characteristics of providers and expectations of client and that this concept includes five reasonable distinct scope Accessibility, Availability, Affordability, Accommodation, and Acceptability (Buttain, 2008). In a patriarchal society where women are subordinate to men gender these factors generally have determined consequences for their access to health care facilities. Further more power relations between women and men draw the limits of what women may or may not do in access to health care (Hang leng, 2007).

In developing countries, especially Pakistan lack of access to health facilities is still an important problem and issue for rural/poor social classes. Gender bias in health care institutions has also been documented in the developing world which leads to poor health access for women (Ojanuga, 1992). The social determinants of a women health are also very important especially in societies that favor male and patriarchal system exist their social determents relate predominantly to gender norms and values which assign and allocate different roles and values to females and male, generally the disadvantage of females in many societies is women's inferior status and subordinate role lead to social, cultural, health and economic problems for women that men do not feel. Women also tend to be among the least well-educated people in a community and almost women in rural areas are illiterate and low income and education mitigate severely against the health of and access to health facilities of such women (Skolink, 2008). The structure of

Pakistani society in general and Pakhtun society in particular is widely acknowledge to be highly patriarchal clearly demarcated gender roles, responsibilities and large gender differential in access to resources of all types exist like political empowerment, decision at domestic level, basic right to education, heath facilities and so on (Zubia, 2003).

In South Asia women from much perspective considered their selves as subordinate to men while male of the family considered all and all for those women and they are dependent socially, culturally and economically their male family members. Women have no permission for taking decision regarding their health checkup and treatment; they have limited access to health facilities. Women are restricted from mobility because of cultural constraints (Fikree, 2004). There are a number of areas where women particularly the poorest women experience gender related constraints and resistance on their access to health services. These include lack of transportation to take them to services. Lack of alternate care for their families while they go to the treatment; refusal of the spouse or head of the family to give permission for the treatment, lack of humanitarian, sympathetic and culturally appropriate care; and their inhabit to afford payment for health care for themselves. Once they permitted and gained access to health care the quality of care that is provided for women is often inferior to that provided to male member of the society. It can also be unnecessarily time consuming because it is frequently difficult and some time impossible for women to take treatment for themselves at the same time as they take their children for checkup and immunizations etc (UNDP, 2008). The services which they receive frequently fail to provide them with an acceptable degree of privacy and security. They are often not consulted about the treatment they receive and are given little or no information about their health condition to health service

provider. The equal power relationship between women and men puts women on socio-economic disadvantages and this has bad effect on their health, access to health facilities and well being (CWS, 2002). Women's health status will also vary with their economic, political and social status. All over the world many million of women continue to be denied access to basic health care facilities as a result of social, cultural, economic and political inequalities. When they do receive services, there is evidence that women may experience particular problems and issues in their relation with those who are paid to care for them. To improve access to health services, many women will need better transport facilities and child care arrangement as well as more effective financial support whatever earn by own or family members. Access the rang of health care setting it is also important that women and men be treated with respect and equality. Women should not be humiliated by sexist behaviour for example or be damaged by discriminatory and unequal practices. Men on the other hand should not be expected to live upto stereotypical concepts of heterosexuality and masculinity. The economic, social and cultural and demographic characteristics of different groups of women (and men) also need to be understood and their implication for proper care and checkup respected. Looking at the more technical aspect of the care, health care also need to be more aware of importance of both sex and gender issues in formation appropriate treatment strategies (Vivienne O'Connor, 2003). Women health considered inferior because of their subordinate role in the family. Women are discriminated socially, culturally and politically in community and family. All the policies for the welfare of citizens only focusing on male interest and women are ignoring at all spare of life in policy implementation at gross root level. The religious and traditional leaders misinterpreted the religious values and traditional leaders

strengthen the cultural norms for practicing in the society. Women in the assemblies have representation but no interest in women issues to mainstream them in policy formation and implementation (SOG, 2009). Women who suffer from domestic and workplace violence and harassment are also confronted with a health care system which is not equipped to deal with this problem appropriately often the consequences for health caused by violence are not known and treatment is insufficient (Vera Lasch, 2010). The women health report 1998 concludes that women health is inextricably linked to their status in society and family. It benefits from equality and suffers from discrimination and violation (Laurie, 2007). Within community, there are groups that could be termed vulnerable with regard to their state of health by virtue of their physical mental, social, spiritual or economic status. It has been recognized that women all over the world are vulnerable group with regard to their health status and permission for health treatment (Narendra, 2007). Women in most places need more health services than men but often have less access to health facilities (Gita, 2010). There has been a growing acceptance that women's health does not mean solely a women's reproductive health but rather the numerous health issues and needs that are distinctly different from men's health issue (Wendee, 2001). Women's decision making process of reproductive behaviour is not only shaped by socio-cultural norms but also by political, economical structure (Constanze, 2010). Health status and access to health care statistics also show inequalities and discrimination between women through out the world and with in particular politics and economics (Isabel, 2001). The studies on different sort of physical activity on women's health are important and significant because women's physical patterns are different from men (Laura & Gloria, 2008). It is becoming increasingly

recognized that an individuals health status is determined not only by chance genetic inheritance and the geographical availability of nutritional resources, but also by socio-economic and socio-cultural forces (Grodin, 1999). Due to barriers at service at individual, familial and community level, the barriers are often manifestations of women's low status, powerlessness and lack of autonomy and rights at domestic and societal level (Gita, 2010). Socio-cultural and socio-economic constraints on women does not allow them to utilize the available health services and resources among them is gender discrimination in form of gender stereotype roles and duties assigned and expecting from girls and women which reduce their access to health facilities. Women's health is determined by a multitude interrelated forces and factors such as the availability of health services, by her educational level and by her socio-economic and socio-political conditions, women in the region often lack access to health facilities and services (Ramesh, 2004). There is a need to do away with the social constraints and barriers restricting women from approaching health services (Narendra, 2007). Institutional, legal, socio-economic and socio-cultural constraints which women have been unable to escape in any country have denied them access to opportunities that are available to men in health department and broadly in health sector (Eva, 2000). Health care and health can not be isolated from the larger socio-economic and socio-political context in which they occur: poverty both contribute to and also caused by poor health (Arachu, 2004). Women's vulnerabilities are enhanced by the discrimination to which they are subjected in patriarchal societies. This includes their lack of access to information, education and health services, recreational facilities and their inability to negotiate safe sexual practices even with in marriage with her husband. Women are denied access to income and

property and have very less control over the family income. The responsibility for the care of the family however lies with women. Decision to seek treatment for illness also lies with the purported head of family and mainly by male family member (Shaila, 2006). Traditional and cultural beliefs play an important role in socio-cultural factors which disadvantaged women in the society for access to health facilities (V.V devasia, 2009). Women have very low and subordinate status, and the traditional and customary beliefs confine and defined them in their roles as mother and views. Women's low status is confined reflected in physical abuse, limited access to education facilities and limited access to health care services including family planning and delivery at hospital level (Merey, 2008). Life expectancy is the most common statistics used to gawage the health of a population whatever the population is male or female. It is appears globally at world level that women are healthier than men since women have higher life expectancy in most developing countries (WBG, 2010). A constraint in determining women's health status in developing countries is the lack of health studies focusing in women health issues (Sitthi-amron, 2000).In developing countries the average maternal mortality rate is 480 deaths/100,000 live births in deep contrast maternal mortality in U.S is only 8 deaths/100,000 live births (UNDP 2004).

1.2. Statement of the Study:

Male and female are two important vehicles of social life. Both are very important for each other for the smooth functioning of society. In advance societies both male and female share equal rights and facilities. Both play their role for the progress and development of society and both having equal opportunity in all sphere of life. But the situation is different in Pakhtun society. In Pakhtun society female are living in a very

miserable condition. They do not have equal rights and facilities as like man. Although women are facing so many problems but the burning issue is that of poor health standard in these areas. Women have no or less access to the modern health facilities. Some where the rigid culture does not allow women to these facilities and in some areas they have no health facilities because of the unavailability of health facilities in their areas. Women in Pakhtun society's faces various hurdles in their life and the health condition of women is very weak due to various socio cultural and economic factors and causes of their poor health some other causes may be patriarchal system, male dominancy etc.

1.3. Objectives of the Study

1. To identify the socio-economic characteristics of respondents in Pakhtun Society
2. To identify the socio-cultural constraints to women's health a ccess in Pakhtun society.
3. To identify the availability of health resources/facilities in the area
4. To suggest policy measures to address the issue of women health in Pakhtun society.

1.4. Purpose of the Study

The purpose of this research activity is to know about the socio- cultural and economic barricades' to women stipulated health in Pakhtun society. And also to know about the level of patriarchal system, male dominancy, strict culture and traditions, and religions misperceptions which decrease the status of women in health sectors.

1.5. Significance

This study is of great significance in term of scholarship as well as practical step to be taken for saving health institution as women. The study findings are great addition to sociological knowledge and sociology of health. This has opened new area of debate in teaching and research. The recommendations are important for government as well as male member of the pakhtun society to adopt and ensure the women participation, permission, protection and access to health facilities.

1.6. Limitation

The area of study for this research is containing highly populated three Districts of Khyber-Pakhtunkhwa which represent the Pakhtun society.

This research study focus on both urban and rural areas

Research was focus only on married women age group (16 year to 50 years of age)

The respondent of the study was only married women

Gender discrimination is the focus of study in pakhtun society.

The theoretical model of the study shows the present status of the pakhtun women in access to health facility in Khyber-Pakhtunkhwa. It has been concluded that the socio-cultural constraints has a strong connection with women resistance from access to health such as,

Pakhtunwali: one cultural constraint to women's access to health is Pakhtunwali. Pakhtunwali is a term which is using in Pakhtun society by men for the status of all member of society. Men are considered superior and decision maker in the family especially regarding the women matters. Women are totally dependent on their decision

regarding their lives. Under Pakhtunwali a men considered Begairate when women of their family came out from their houses at the time of need. Due to Pakhtunwali women are constrained and resisted to indoor.

Besharma: Women in pakhtun society considered Besharma when they came out from their family with out informing their family male members. Women who are talking with male members in society at the time of need considered Besharma and Behaia due to which men strictly prohibited women from outside visits of the house.

Begairate: in pakhtun society those men who are not controlling their family women and permitting women for visit to doctor considered Begairate. Due to this social stigma men resisting women from health facility and when women visit with out husband and male permission to doctor they are punished by family.

Nang: women are considered the property of men in pakhtun society. When some one talks to their women and facilitate them in health facility thus the men considered it that their women have unfair relation with that person due to which they committee an offence against that person.

Gharibie: Gharibie is a term which is considered economic constraint to women's access to health in pakhtun society. In pakhtun society men are responsible for earning and fulfilling the needs of the family while women are subordinate than men and restricted to indoor. Due to overburden on men they prioritize their family needs where women health considered inferior than men and children of the family. So Gharibie considered constraint to women's access to health in pakhtun society.

Sater: Sater is a term which is used for parda in pakhtun society under religious interpretation for women. Religious mollas preaching that "*Haza ya da kor day ya da*

gor" women are for home or for grave. They preaching to men that women are your subordinate and Allah ask from you regarding your women. They resist the use of modern technology in treatment due to which men using traditional "Korany Totkay" for women treatment.

Berozgare: one economic constraint to women's access to health in pakhtun society is Berozgare of men. Those men who are not doing any labor work and have no major income source they not permitting women to go to health facility for treatment due to no money.

Unpar: Unpar term using in Pakhtun society for those people who are uneducated. Majority of the pakhtun men are uneducated due to their ignorance women have no access to health facility.

Ghairate: Ghairate is term in pakhtun society using for women exploitation and violence. Those women who visit to health facility and show their body for physically examination to doctor considered unfair with husband and family. Those women are killed on the name of Ghairate. So Ghairate is a constraint on women access to health facility.

Kamakla: Kamakla a term in pakhtun society using by men regarding women ability to cost vote and choose representative for their own rights and protection. Men considered that women have no thinking so how they select a leader to represent them. In pakhtun society it is famous for women that *"Ko Da Hazo Pozay Na Vay No Ghol Ba Ye Khwaral"*.

CHAPTER TWO

LITERATURE REVIEW

CHAPTER TWO

LITERATURE REVIEW

This literature review examines the general literature on women's health and their access to health facilities in developing countries, and explains the leading factors and causes of poor health and the factors that prevent women's access to health care services. A focus on socio-cultural and limited access to health care services as the leading causes of women's poor health status is center stage.

Women in Pakistan face bigger and severe challenges as they are offered fewer opportunities than men in access to health facilities. More than half of the women suffer from poverty of opportunities in term of access to income, health facilities, education facilities compared to a little over a tired in the case of men in the society (Singh, 2009). According to Kapil Kapoor Despite considerable improvement in equality of life over time, the general level of human deprivation for women as compare to men in Pakistan remains high. The fertility rate in developing country Pakistan is around 4.7 children per women; maternal mortality rate stand at 500 /100,000 live births (Kapoor, 2009). According to Arachu Castro Women need permission from male family members to attend health centers for treatment and checkup (social) having a low income and the convenience of home care (economic) and the distance to health centers (physical) are all factors constraints women's ability to access to health services (Arachu Castro, 2004). Women ability to obtain health care services is constrained is in reaching a place of health service delivering having decided to seek health care, a women has now to over come a service of other obstacles, such as health facilities far away, distance from the health center and lack of time and economic resources. In many cultures and societies a

women may only travel if accompanied by male family member, elder women from the husband family and therefore his convenience and interest become a determining factor for male family member. If there is no female health service provider in health center, women may not express all their concerns to male health service provider. Individuals and community level constraints are composed of two main elements to women poor health access. Problem women face as a result of being poor, illiterate and power less at family level, due to factor including class, race, religion or ethnicity and problems arising from the fact that women in a patriarchal society which has, inherent gender based discrimination and gendered based violence (Ravindran, 1995). Sharyn Janes stated that Poverty dramatically affects women's health and women access to health facilities. Poor women have limited access to health care services and preventive health care services, which result in delay of, diagnose of diseases and injury and result lead to shorter life spans (Karen, 2009).

Georg Pfeffer discussed that health status of the women which includes their physical, mental and social condition in addition to their biological and physiological problems is also affected by the prevailing norms, values and attitude of society in general and family in particular (Georg Pfeffer. 1999)

Gendered cultural and social constraints make access to medicines and health services more difficult for women when they need permission from her husband or any other male members of the household to seek treatment. The social, political and economic consequences of some infections diseases may also be greater for women examples some conditions are attributed to sexual behaviour which is seen as un-acceptable for women

and which means women receiving treatment are stigmatized and leads to broken of family relation (Payne, 2006).

According to Kelly Lee & Jeft Collin Un-equal gender relations affect men and women's choices in relation to health or employment and tend to deepen economic and social inequalities and discrimination based on race, class, sexual orientation and age etc. Using a gender perspective to understand health is therefore importantly about analyzing the different power relations, customs, traditions and norms that are reflected in almost all levels of life including economic and political changes at the world level (Kelly, 2005). Women unequal access and distribution to resources including health care services is well known in which stark gender disparity and discrimination are a reality (Jejeebhoy, 1995). The un-skilled, ignorant and poor debtors and hence un-qualified in practice, for credit facilities or for the up grading of skills inequalities severally barriers the ability of women and adolescent girls to acquire good health facilities and women centered health services. At the household level there disparities translate into a lack of autonomy, less decision making power and central over household resources both material and knowledge women have little decision making authority and freedom of movement few women including working women have any control over the household economic resources. Seclusion practices and other behavioural norms and values further reinforce women's lack of freedom of movement, self confidence and their acceptance of self-denial including in matters relating to health seeking, access to health facilities and food intake. Poor quality of care can inhibit women from seeking health care, women lack of autonomy in decision making or movement is also an important barrier on women's health seeking. Distance from the health centers and lack of time and economic resources. In many cultures a

women may only travel if accompanied by a male family member and therefore his convenience and interest become a determining factor. Even if a woman begins treatment, the opportunity cost of follow-up may be high for her to continue with and complete her treatment (Kistiana, 2009).

> *"The influence of women's independence on the use of health care and access to health facilities appears to be as important as other known determinants such as education. Women dependency on men for economic survival has been a principal barrier to women's control over their reproductive behavior in developing countries especial reference to Pakistan. Employment can increase women's economic autonomy, economic stability and reproductive health status because it raises awareness and provides new ideas, behavior and opportunities through interaction with other people outside the family and community (Sharma, 2007)."*

Socially and economically dependent women on men restricted from checkup. Women are waiting for permission from her male family members when they go for checkup or treatment. Women need a guideline from male family members that what type of health treatment they take form health service provider at the time of visit to doctor (WHO, 2003). Women's in some countries at global level constrained to mobility and access to health care due to discriminatory norms and values in the society and family (Rekho, 1992).

Women feel shame and due to privacy issue they not permitted male health provider th physically examine them (Auerbach, 1982).

> *"Place of residence can also be an important factor of the use of modern health care resources for childbirth. A higher proportion of births in urban areas occur in modern health care facilities compared to rural areas where all most women deliver at home (Paul, 2002)".*

The health of women in developing countries is also challenged by socio-cultural and socio-economic factors such as low education level, age and marital status, women unemployment (William, 2000). Culture and tradition of a family or society influence women's poor health access through inherent inequalities and discrimination in the social system. Gender also affects access, pushing women into gender specific role assigned by society in large that negatively influence their health or force them to seek permission to obtain health care from the male member of the family (Puentes-markides, 1992). Perry and Gesler (2000) found limited physical access to health care to be a major constraint in improved health limited access is especially important in rural areas where there are fewer health care facilities and villages may be physically isolated from one another and far away from health facilities. Another barrier in rural areas is that travel time often takes longer per kilometer than in urban areas due to poor quality of roads, unavailability of transport facility and the burden of having to use several modes of transportation (Perry, 2000). Organizational barriers such as long waiting time in health service facility, lack of equipments and shortage of doctors and nurses also constraint access to health care services (Allman, 1992).

In 1997, Taylor and Dower reported that sometimes overwhelming constraints may also encourage women in developing countries to turn to traditional medical practices and consult with traditional birth attendant (Taylor, 1997). As women on many developing countries are expected to conform to social and gender roles, responsibilities and remains at home due to cultural constraints to perform household work, they can not develop economic independence. As a result they may be un able to afford services, especially since essential goods such as food and education must be purchased before health

checkup and treatment thus their access to health care services limited due to food and education (Yoder, 1989). A review was conducted in which point out in which indicate a number of constraints that affect women's health condition and their access to health facilities. These factors consist of social and economic constraints (MoH, 2006).

Poverty and women health have strong relation. In relation to one another it is stated that illness id because of poverty while ill health condition cause of poverty (Oanh, 2006). Educated people have good health condition as compare to illiterate people. Education brings economic stability and independency among the people regarding the choice of place for delivery which constraint by financial issues (MoH, 2006).

Mostly women deliver at home which reflect the health care standard and available resources regarding health care in the area. In developing countries mostly more than half of the married women deliver at home. The reasons behind women's delivery at home are transportation unavailability, faraway the health facility centers, mountainous areas, economic instability and strongly follow-up the rules made by male of the society and family (NHS, 2001-2002).

Following are the important factors which contribute to resistance of women's access to health centers for treatment in Pakhtun society. Socio-cultural and economic, demographic, environmental, life style and hygienic are all the important factors. Health services provided to women are different in urban, rural and mountains areas in pakhtun society. Among the constraints transport facility un-presence, long waiting, financial problems, behavioural and attitude change of health facilitator, custom and traditions (Asia-pacific Population Journal, March 2004).

Even when health care facility is geographical near and transportation available they may be psychological constraint such as women's knowledge and sense her subordination position and role in family decision making. In fact, in some cases health facilities are located in close proximity to women but because of the lack of confidentiality and privacy in reproductive health choices and services, some women may travel out side their communities for health seeking. Lack of transport to reach health care facilities is a major factor contributing to maternal deaths and women poor health access in time of emergency (Boateny, 2006). Women's lack of access to social, economic, education and other political resources have made them unable to protect their own health and take checkup on time and the health of their children especially women living with in developing countries. In early, 1990's Geoffrey Rose (1994) wrote in the book title the strategy of preventive medicine that the primary constraint of ill health and diseases, including women's reproductive health are mainly social and economic & that remedies must also be social and economic (Ashgate, 2010). Poverty is the major cause of the poor heath care of women. Poor health victimizes women and children. Women does not use health care facilities as often as they need and like part of the reason women do not use health care facilities enough is that rural women are denied access to health services through decision made at the household level by her husband or any other male member of the family because their husband do not wish their wives to show their bodies to a male doctor for a medical physical examination. Another reason women do not use health care facilities enough is that the health care system does not adequately address women's health needs. Existing health facilities particular in rural areas are short health care

personnel and limited equipments (particularly women), basic drugs, pharmaceutical equipments and medical supplies are limited in health centers (Gebremedin, 2002). Maternal and reproductive health care services are well developed patriarchal constructs of what constraints 'women health' form constraints to access and effective keep out certain groups of women from easily accessing health care. Heath care access can be seen to be affected by three sets of major factors 1. The characteristics of the population seeking health care 2. The structure of the health center 3. The behaviour of health professional and health service providers (B.W, 2001). Especially women severally restricted access to health care due to lack of qualified health service provider/staff and health workers. A significant part of health facilities currently do not have female health service provider/staff which substantially restricts and constraint female access to health care (IMF, 2006). For women access to health care facility means much more than just distance and location it includes the extent to which services care appropriate, culturally and affordable safe (Isabel Dyck, 2001). Strategies to affect health behaviour need to control of all there involved in making health seeking decisions (B.W, 2005).

Lack of or low levels of education and low social status of women in many families and societies seriously constrain the access of women to health care services. With out the permission of a husband or a male family member or with out have a male relative take women to the health services which also constraints attendance, even when women need emergency care such as during complication of pregnancy, cultural and social constraints some time prevent them from seeking such care and inhabit their husbands from taking them for treatment and checkup (Skolink, 2008).

Mobility constraints in our society play a large role in per petuating gender gap in health out comes. Barriers women face in seeking health care include on decision making at domestic level regarding her health condition and access to information. Women thus face a series of daunting resistance to seeking timely health care, even if in well-functioning facility is available near by and the household can offer the treatment and checkup (B.W, 2005). the most persistent consequences of women's economically disadvantaged position are those resulting form poverty unequal access to health care; lack of information on sexual and reproductive issue and available services inadequate nutrition, resistance from education and gainful employment and the inability to talk safe sex or spacing of pregnancy. Violence against women including sexual violence is also because of poverty. Some health challenges affect both men and women's but because they have a greater or different impact on women they require responses that are personalized specially got women's need. Traditional differences may also affect the perception of health illness, prevention and access to health care, and the lack of mutual understanding of health, illness and treatment its risk and benefit his insinuation for both health service providers and women as patient. (Vera Lasch, 2010). The women health report 1998 concludes that women health is inextricably linked to their subordinate status in society. It benefits from equality and suffers from gender discrimination (Laurie, 2007). Many times women have to wait for their husband's or any elder male member of the family permission in order to seek care or the women her may not recognized that she has a complication that required treatment. Other women require economic resources in order to access to the available transportation but she has not money to access health facility (Laurie, 2007).

There is a need to do away with the socio-cultural constraints resisting women from approaching health facilities and services (Narendra, 2007). Women lack of control over economic resources is widespread. While the majority of rural Indian women are economically playing active role, their work goes largely unorganized and poorly paid (Narendra, 2007). The lack of female medical personnel in the health facilities itself a reflection of gender bias in education opportunity is an important barricade to utilization of health services for many women (Gita, 2010). Women's decision making process of reproductive behaviour at domestic level is not only shaped by socio-cultural norms but also by economic and political structure (Constanze, 2010). Health status and access to health care statistics also show inequalities and difference between women at global level and with in particular politics and economics (Isabel, 2001).

The studies on different kinds of physical activity on women's health are important because there is difference between women's physical patterns and men (Laura & Gloria, 2008). Feminist scholars and social scientist have criticism on biomedical model that discounts the socially constructed barriers on women's health such as social norms, culture, traditions, codes, and practices (Guang, 2010). Health worse condition is not because of genetic diseases and mountains areas but rather socio-cultural barriers responsible for poor health condition (Grodin, 1999). Traditional forces empirically that women's natural place is in the home and that their natural functions in the rearing of children and nursing of elders must always be protected can not imagine that women can aspire to achieve the same advance in areas of male-gendered activities as a men (J.Annas, 1999). Difficulties in access to health facilities either due to Geographical Distance, Socio-economic Distance, socio-cultural distance and Gender Distance it is said

that health of society is reflect from the health of its female population. Women are largely excluded from decision making at domestic level especially when they face health issues, women have limited access and control over resources restricted their mobility (Milind, 2001). Women's talked about other serious problems and issues in public health facilities that are not exclusive of the crises period but women are not helped when patient demand is higher employees are underpaid, supplies are scared and hospitals are riddled by social conflict (Barbara, 2010). The removal of financial, physical and cultural barriers for utilization of health care services is a key measure for addressing gender-based inequalities and gender based violence (Vera Lasch, 2010). In some cultures, social-cultural norms, socio-economic status and practice restrict social and physical contact between women patient and male health service providers. This lack of female's doctors and health service provider may in some context be serious constraint for women to access to health care, checkup and treatment. Gender inequalities may also be manifest in the ways men and women are treated by the health care system. Evidence suggests that both female and male health care providers may be gendered biased in their perception of patient preferences and their problems (Vera Lasch, 2010). Confidential and Privacy are not always ensured and information about treatment options is not always provided. Lack of time, economic resources is an increasingly important barrier for poor people to utilize health care services for women patient (Vera Lasch, 2010).

Service factor include high transportation, distance to services, parda, mobility, limited women's information regarding health, unknowing about health facility available in area, men control over decision making, using local method of treatment, and self medication (Dean, 2006). Women with own income tend to rate their health as better than women

with out then economic resources (Suzanne, 2009). Institutional, legal, socio-economic and socio-cultural constraints which women have been unable to escape in any country have denied them access to opportunities that are available to men in health sector (Eva, 2000). Of course in many other cultural societies there are few formal or structural barriers to women receiving equitable attention and consideration with in any Programme. But constraints may lie in attitude of helplessness, acceptance and depression of women (Padmini, 2010). Compared with men, women are disempowered all over the world. However their levels of disempowerment are differing in developed and less developed countries. Broadly speaking low status among women is associated with large family size and this of course is linked to poverty. Many cultural and traditional practices that are widely prevalent in the LDC's force and fall women into a situation in which their health is compromised (Theodore, 2007). The interplay between gender and class can be important in relation to access to health care facilities, even in high income countries with universal health insurance. A part from gender, class and race, ethnicity and caste are other constraints that impose upon causes to access to health care (Gitasen, 2010). Women living in poverty tend to have limited access to formal institution that might offer assistance in resisting violence and provision of health facilities. These include health, education, social, psychological, legal and police services, law enforcement agencies (Francine, 2001).

Unequal health outcome may reflect the fact that health services are imbalanced between men and women. Certain health needs are gender specific and are often linked to reproductive in the case of women. The poor and disadvantaged persons enjoy less access to health care services generally, women may be at great disadvantaged because their

well being is culturally and socially discounted with in the family because men make the key decision about women health consultation and expenditure or because women's mobility in the public domain in restricted due to local culture and traditions (Nalia, 2003). Socio-cultural and socio-economic constraints on women does not allow them to utilize the available health care services among them is gender discrimination in form of gender stereotype roles, assigned to girls and women by their families which reduce their access to health facilities . Women's health is determined by a multitude of interrelated forces such as the availability of health services, by her educational level and by her socio-economic and Socio-cultural conditions women in the region often lacks access to health facilities and services at the time of poor health condition (Ramesh, 2004). Women domestic responsibilities including care of children, nursing of ill person in the family restrict women's mobility and the time available to seek health care (Tessa, 1999). Gender relations, structure household's responsibilities, priorities, access to finance and other assets which may determine treatment or predispose women's willingness, to expend resources on their own health. Power relations with in household also influence the distribution of resources and women decision regarding health checkup and treatment (Tessa, 1999). Women's poor health determined by social, cultural constraints and it is greatly interlink with economic condition of the family, restriction on political mainstreaming is responsible for bad health condition of women (PHM, 2005-2006). Access to appropriate quality health care was limited in several ways but by far the most significant limited way was the substantial and in some cases increasing distance that women had to drive, the cost in term of time and financial reason, lack of providers and delay in accessing health care. In addition to the structural barriers there are also social

barriers that limit access to quality and timely health care access by women. A particular challenge relates to perceived constraints on privacy, confidentiality and anonymity in rural, mountains and remote communities which can out as a barrier to women seeking health care (Jennie, 2007). Discrimination in provision of health facility make an important constraint which realize women's that their health is not much important than men, women's have more indoor responsibilities and they are restricted due to mobility and financial constraints. In traditional societies women's realize that their home work and family caring is much important than their health. Women are allowed to take their kids for treatment while when they going for own checkup need permission from male member and some one company her to doctor (WHO, 2010). Shame and discomfiture can lead to unwillingness on the part of women to share disease condition with family members and heath providers (Jennifer, 1996). Women's not knowing that where go for treatment and how take the health services from the center also language change with some distance so not understanding clearly the language of health service provider. Beside these barriers stigma, privacy, hold of male member on women also resists women's from better treatment regarding their ill health (Dinsesh, 2011). Social and cultural barriers such as social disadvantages, cultural health beliefs and values, discrimination, inequality and culturally insensitive health care provider may also serve a risk factor or many interferes with health care access (Ano, 2007).

The lack of social, cultural and legal support for the empowerment of women can be seen as key factors contributing in poor maternal health and high rates of maternal mortality (Norman, 2008).

Traditional and customary beliefs play a vital role in cultural and social factors which disadvantaged women in the society. Every social grouping in the world has specific traditional and cultural practices and beliefs, some of which are beneficial to all while other are harmful to a specific group, such as women. The indicators which decide the status of women range from respected, harassed, neglected to gender discrimination and traditional role change occurs due to socio-cultural and socio-economic barriers (V.V devasia, 2009). Women's right to health requires the removal all constraints interfering with access to health services, education and information including in the area of sexual and reproductive health (Andra, 2009). Belief and attitudes that may hamper health education and foster continued health disparities include prejudices, poor traditional and cultural communication resulting in misunderstanding, lack of understanding or acceptance of the concept of preventive health behaviour, fatalistic attitude of the women toward illness, family unwilling to seek care until the problem are severe, inadequate health knowledge, literacy, strong belief on traditional remedies, the lack of a cultural concept of mental health, and the cultural rules made by the male members of the family about women and what may or may not be discussed with in family and with health service provider (Sade, 2009).

Women from social, traditional, cultural and religious sects may be uncomfortable being examined by a male doctor or health service provider because of there constraints to accessing to health care, the health status of women tend to be worse than of the men. Access to health care is co-related with wealth, prestige, respect and education but it is also related to power. Some time power is strengthen by cultural systems while some time culture resist all practices against the society whatever for betterment or destruction

(Kathryn, 2008). An obstacle in determining women's health status in developing countries is the lack of health studies focusing in women's health issues (Sitthi-amron & Somrong thong 2000). In the 1948 constitution of the WHO health is defined as *"a state of complete physical, mental, & social well-being and not merely the absence of disease or infirmity"* (W.H.O, 2003). The susceptibility of women in developing countries to these poor health conditions is a direct resulting of poverty, inferior socio-cultural status; limited access to health care services poverty contributes to poor health through economic dependence poor nutrition, substandard housing, and limited access to sanitation and safe drinking water (Buor, 2004). With out financial resources, women are unable to obtain nutrition & adequate housing that protect & improve their over all health condition in the society (Buor, 2004). Sexual transmitted diseases, particularly HIV & AIDs are increasingly contributing to poor women's ill health in developing countries...women infected with HIV may be unable to provide care when ill to their family, nursing of ill persons and they can pass on diseases to their children which giving birth & breast feeding (Cohen, 1998). Health issue for women in developing countries is caused by poverty, socio-economic & socio cultural factors. Poverty is defined as *"the denial of opportunities and choices must basic to human development"* (UNDP-2004). The low socio-cultural status of women can also negatively influence women's health access and treatment in developing countries since a major barrier to improved health is the inequality between men & women. Health polices, created by male policy makers, often fail to consider gender, (Zaidi, 1996). Advanced transportation facility is often non-existent in developing countries and health care may be un attainable if the means of transportation are inadequate or time consuming such as walking, bicycling, using the bus (Purry & Geseler, 2000). Women inadequate knowledge regarding health complication and issues,

of various types of services provided at a health care facility lowers the availability of services through simple lack of awareness on health issues (Penchansky & Thoma, 1998). Other women require money in order to access to the available transportation but she has not financial resources (Laurie, 2007). In some cultures, social-cultural and socio-economic norms and practice restrict social and physical contact between women patient and male providers. This lack of females doctors may in some context be serious barriers for women to access to health care and treatment and to talk openly regarding health issue. Women who live in poverty and less educated like have limited access to health facilities and strongly obey the rules made by the men in the family and society.

Women's with earning have good health condition due to availing the health facilities (Suzanne, 2009). Gender relations structure, household's responsibilities, priorities and access to finance and other assets which may determine treatment or predispose women's willingness, to expend resources on their own health. Power relations between male and female with in household also influence the distribution of resources (Tessa, 1999). In reality women's health is largely determined by social and economic barriers it is difficult to separate out reproductive rights and health from economic, social and political rights and needs (such as land rights, food security and communal harmony that impact on economically poor women's lives (People Health Movement, 2005-2006).

Women's cultural barriers include fear of stigma, sham and lack of validation of depressive symptoms by family and society (Dinsesh, 2011).

Health professionals were often dismissive, treating women as though they were stupid. The women spoke of a lack of trust and felt no confidentiality and privacy in their treatment interest with health service providers. They felt that their experiences were

cheapening by the health care system (Nancy, 2007). Age, ethnicity and income influenced the women's health status and her health condition. Due to these issues women are not able to treat economically and afforded medicine due to limited economic resources of the family, women facing transportation hurdle at the time of access to health facilities (Philip, 2003). In rural areas the barriers of time, financial matters, and travel often prevent many women from obtaining necessary health care yet many of the health service providers that these women are requesting are relatively easy to teach (Sandra, 2010). Constraints that limit their access to health care such as distance from their home to available appropriate health facilities, lack of transportation at the time of emergency and more critically economic and social barriers (Narasaiah, 2004).

Lack of access to health care facilities and lack of health insurance are among the most important stressors cited by rural women although rural women generally describe the geographic and temporal constraint that they face in term of accessing the health care system. From a rural residence the cost of health care is by for the most dominant barrier cited access to care and availability of services are problems in rural areas (Raymond, 2006). Another study conducted in Pakistan found that the quality of a women interpersonal ties, particularly with her mother in law and husband were important in terms of her ability to access to resources including health care facilities (Gita, 2010). The security situation that prevailed in the year after the U.S led attack severely hampered women's full and equal access to health care facilities at global level (Sanja, 2010). The World Bank reports that in cultural and traditional societies where parents prefer sons over daughters, boys recive a larger share of the limited family resources whatever financial, educational etc they got more food and better health care. Lower

educational attainment by women, whatever due to poverty or gender bias; also affect their health in latest life. According to WHO *"Socio-economic status, literacy and access to health services have a strong impact on the development of non communicable disease and the delivery of health care"* (Padmini, 2010). Several studies have indicate that although men and women may share a number of problems and issues resulting from geographic location, living conditions and ethnicity gender inequality and discrimination places women in a vulnerable situation regarding their health (Alice, 2002). The major barrier to women accessing health services was a lack of trust between health service provider and the community persons. Health services for indigenous women have largely been influenced by the political will and community demands rather than based on an analysis of community need (Lenore, 1998). Gender discrimination damages the physical and mental health million of girls and women access the globe and also of boys and men despite the many tangible it gives men through resources, power, authority, decision making and control (Otlin, 2007). Gender inequalities make women more vulnerable to various diseases and associated morbidity and mortality from socio-cultural and socio-economic perspective women in Indian find themselves in subordinate position while men the master of the women. This gender inequality in health care access becomes more obvious when the women are unemployed, widowed, illiterate, separated or dependent on other. The combination of apparent ill health and lack of support mechanisms contribute to a poor quality of life among poor women (Milind, 2004).

Low socio-economic status is associated with higher incidence and occurrence of health problems. The high cost of health care not only deepens the poverty that is already barely getting by but also can economically destroy middle-class families (Linda, 2011).

Feminist Post structuralism:

The perspective, applied to health, examines the construction of meaning, power relationship and the importance of language as it affect, contemporary health care decision. It seeks to identify and expose biases that marginalize the health care needs of women and to contribute to health care inequalities for their population. Additionally, a feminist post Structuralist perspective seeks to develop new knowledge for understanding gender differences and discrimination (Arslanian-Engoren, 2002). Late 20th century feminist adopted the Post-Structuralist philosophy of Foucault the French social philosopher to analyze and challenge constructs of meaning and relationship of power in modern society (Foucault, 1972). Many contemporary Feminist hold Foucault writing because they challenged the notion of a fixed meaning, a unified subjectivity and control theories of power (Weedon, 1999). There beliefs provided the theoretical foundation for feminist to challenge, examine and deconstruct patriarchal conversation, social institutions and power relationships that disadvantage and oppress women in modern society. Moreover, his ideas provided a different and creative way of thinking about the politics of contextual instruction of social meaning (Scott, 1994). Foucault wanted to identify, investigate and expose those modern cultural and traditional practices and rituals that threatened the theoretical equality persisted by law and by some political philosopher (Dregfus, 1992). To achieve this objective, Foucault study the set of rules on which statement are predicated, considered additional rules that could produce similar statement, and questioned why any one particular statement appeared rather than another.

Feminist Post Structuralist Analysis

A feminist post structuralist analysis results when gender issues are included into a post structural framework. It is a mean of understanding, exposing and changing hierarchal

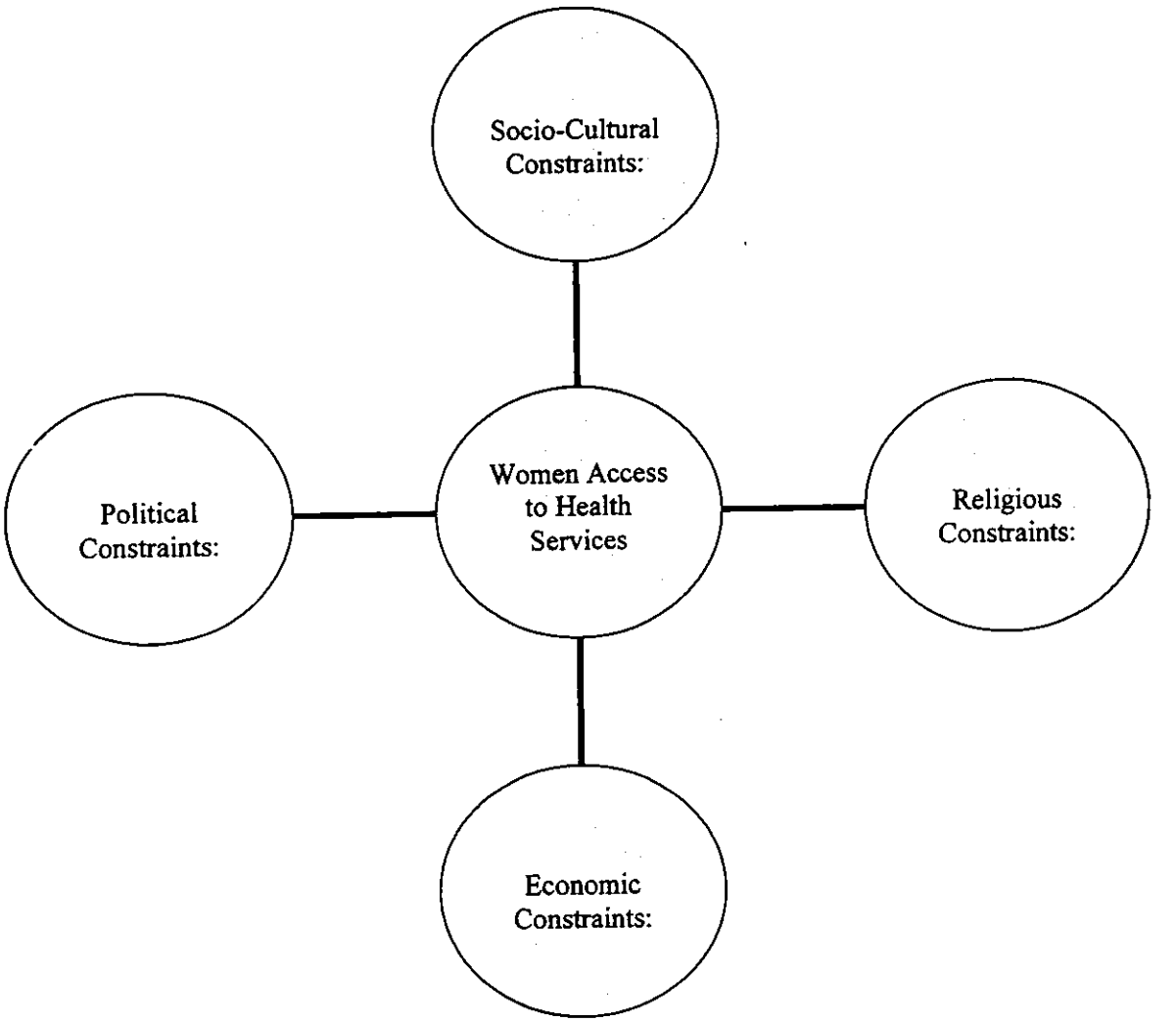
social networks that use power to silence and marginalized discursive discourses related to gender. Post Structuralist feminist seek to transform gender dismsions, to develop new ways of accepting sexual differences (Weedon, 1997), and to uncover anthropocentric biases with in socially, traditionally, culturally and politically established institutions (Gravey, 19997). That result in the domination of women. With in a post Structuralist theoretical perspective, three principles are significant: 1. Language, 2. Subjectivity & 3. Power (Dickson, 1990). Language: Language remains the central focus of a feminist post structuralist analysis. It is the mechanism by which the build of femininity and masculinity are defined, characterized and internalized in socially and culturally specific way (Scott, 1994). Language the common factor in the analysis of social organization, social meaning, power, and individual consciousness (Weedon, 1997), is how one makes sense and meaning of one's world (Doering, 1992). Socially specific meaning is constituted with in language, not by the individual who utters the word, but by society at large level (Weedon, 1997). Language not only give's voice to women's experiences that do not necessarily represent the dominant discourse, but it can also be used to convey differences in similarities. Depending upon the socio-cultural and political position and focus of the keen observer. Different type of observation and experiences may be encountered and verbally conveyed.

Subjectivity: According to Weedon (1997) Subjectivity is conscious and unconscious thoughts and emotions that allow any one to make sense of one's self and to understand and realize one's relationship to the world globally. An individual's perception of own self, but rather also shape the gaining of gendered subjectivity, by assuming current meaning and values for behaviour. Individuals are construct, whose subjectivity is

arbitrated by social discourse and cultural practices not by individual motivations and intentions (Alcoff, 1995).

Power: In Post Structuralist theory, power is not identical to knowledge; power and knowledge are mutually dependent upon one another with power generating knowledge and knowledge initiating power. Power and knowledge are used to conceptualize the relationship between languages, social institution, and individual's consciousness and are analysis exercised in relation to resistance (Dichson, 1990). A Post Structuralist perspective on access to health has suggestion for increasing awareness of issue that cause barriers to women's health access. It seeks to expose and change the power structure present in economic, social, cultural religious and political institutions of Pakhtun society that prevent and resist women form access to better health in the area. Feminist Post Structuralist perspective wants to decrease and demolish discrimination in health sector, which leads to women's poor health access (Arslanian-Engoren, 2002).

THEORETICAL FRAMEWORK ON CONSTRAINTS TO WOMEN ACCESS TO HEALTH IN PAKHTUN SOCIETY



CHAPTER THREE
METHODOLOGY

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METHODOLOGY

3.1. Methodology

Social research is the method which verifying the fact and their results, their sequences, interrelationship, informal explanation and the natural laws systemically that rules them (Fatmia, 2007).

The major objective of this chapter, therefore, is to explain various tools and techniques of research along with statistical tests and operational definitions of the concepts being used in this research.

3.2. Universe

The universe of the present study consists of six union councils (Par Hotti, Katti Garhi, Telegram, Sheen, Dir Bazaar & Palam) of five selected Tehsils (Mardan, Katlang, Khwazakhaila, Charbagh & Dir) of three selected Districts (Mardan, Swat & Dir Upper) of Khyber-Pakhtunkhwa.

3.3. Sample

For this research activity probability sampling type was used in this type sampling stratified random sampling was used. The researcher was selected 315 respondents in stratify random sampling through proportionate method. The stratified random sampling was passing through the following process. Respondents from each district were selected through proportionate method. The target population was married women population between 16-50 years of age.

3.4. Sample Frame

District wise population	Total population	Women population	Married women aged 16-50 year	Sample size as responded
District Mardan	1,460,100	620,100	3,12,115	91
District Swat	1,424,241	697878	3,45,518	101
District Dir (U)	797,852	523,020	4,20,005	123
Total : 03 Districts	**3,682,193**	**1,840,998**	**10,77,638**	**315**

Source: the data is collected form (www.khyberpakhtunkhwa.gov.pk) -2010

3.5. Tools of Data Collection

Interview schedule & Questionnaire were used by researcher for collecting the data.

3.6. Method of Interviewing

This research study was totally based on women's access to health in those three districts of Khyber-Pakhtunkhwa, which were cultural sensitive and in the range Taliban militant. Thus for collecting the relevant data of the research the researcher forms a group of qualified women interviewer for each district. Each group was comprised of five women which was lead by a team leader. Before starting the data collection from the respondents the researcher arranged a training workshop for the selected women groups in district Mardan. In training workshop the researcher discussed in details the scope and objectives of the research. Questionnaire and interview schedule was shared with survey team. He discussed one by one each and every question of the questionnaire/interview

schedule after discussing the practical session of filling the questionnaire/interview schedule from interviewers one become respondent and one collect the data as interviewer. After successful one day workshop the groups send to their located districts for data collection with a Workplan for collection of data.

3.7. Field Exercise

The field experience during data collection was very hard because of collecting from hilly area also due to winter season and cool weather the interviewer faced difficulty in collecting the data. The main difficulty was experienced that the respondents were involve in farming and making enterprise material due to which they had no more free time for the interviewer . They did not know the purpose and objective of the social research, some of them did not consider the researcher a student and took it as an NGO persons collecting data for America and west. The interviewers were feel threat from Taliban because the district swat and dir upper both were targeted by talibanization.

Therefore the interviewers collected data before 2pm every day also most of the time was consumed in explaining the objectives of the study to the respondents. Few of the respondents request for relief both they are affected by flood and crises.Some of the respondents were found hesitant to discussed about their health issues and access to maternity home during their pregnancy. The interviewers had to assure them that the information would be kept confidential. Moreover, they were realized the importance of information revealed by them.

3.8. STATISTICAL ANALYSIS

3.8.1. Percentage

Percentage was used by the researcher for various categories to bring it in comparable form from the present study. The percentages were calculated by following formula.

Formula:

$$\text{Percentage} = \frac{F}{N} * 100$$

Where:

F = Frequency

N = Total Number

3.8.2. Chi-Square

Researcher applied Chi-square test to examine the level of association between independent and dependent variables. χ^2 was computed by following formula.

$$\chi^2 = \Sigma \frac{(O - e)^2}{e}$$

Where

O = Observed values

e = Expected values

Σ = Total sum

To know the significance of the association between the attributes, the calculated values of the chi-square were compared with corresponding table at 0.05 level of significance at a given degree of freedom. Degree of freedom was calculated as:

$$d.f. = (r-1)(c-1)$$

Where "r" and "c" are the number of rows and columns respectively. The result was considered significant if the calculated value of Chi-square was greater than the table value. Otherwise it was considered as a non-significant.

3.8.3. Gamma Statistics

In present study the Gamma Statistical test was applied by researcher to ascertain the relationship between two and more than two independent and dependent variable. Formula for gamma test as under.

$$\text{Gamma} = \frac{NS-ND}{NS+ND}$$

Where NS = Same order pairs

ND = Different order pairs

3.9. CONCEPTUAL FRAMEWORK

3.9.1. Social

There are norms in society and the learning of these norms in-groups is called social. Whatever one finds in his environment are culture and the activities in which he participates become social for him"

Living in a group life and integrate to the other structures of the society along with haring of different moments is called social.

3.9.2. Culture: Culture is the Customs, Beliefs, Art, Way of life and Social organization of a particular country or group

3.9.3. Constraints: Constraints mean that hurdle/obstacle in the way of women which affect it in daily activity.

3.9.4. Health

According to the world health organization Health is "A state of complete physical, mental and social well-being and not merely. The absence of disease or infirmity"

CHAPTER FOUR
RESULTS AND DISCUSSION

CHAPTER FOUR

RESULTS AND DISCUSSION

Chapter number four focusing on Analysis and interpretation of data. This chapter is much important and contains both quantitative and qualitative date and discussion. In this chapter researcher proof the hypothesis of research as true or false.

This chapter presents the analysis and interpretation of data. This deals with the background information about the respondents in both quantity and quality shape.

Table No. 4.1. Age in complete years

Age of the respondents	Frequency	Percent
Upto 25 years	20	6.3
26-30 years	160	50.7
31-35 years	54	17.0
36-40 years	50	16.00
41 & above years	31	10.0
Total	315	100.0

Table No. 4.1 shows the age of the respondents. 50.7 percent respondents were in the age group 26-30 years, while 17.0 percent of the respondents belonging to age group of 31-35 years and a minimum 6.3 percent of the respondents were in the age of the upto 25 years.

Table No. 4.2. Occupation of the respondents

Occupation of the respondents	Frequency	Percent
Government Job	39	12.4
Farming	33	10.5
Lawyer	3	1.0
Self Employ	89	28.3
Housewife	151	47.9
Total	315	100.0

Table No. 4.2 indicate the respondent occupation. Maximum 47.09 percent women respondents were housewife, while 28.3 percent respondents self employ and 1.0 percent the minimum respondent was lawyer. The above table shows that a large number of respondents were housewife.

It is evident from the above table that 47.9 percent women house wife because of Parda in Pakhtun society

Table No. 4.3. Husband occupation

Husband occupation	Frequency	Percent
Business	93	29.5
Government Job	48	15.2
Farming	108	34.3
Doctor	5	1.6
Engineer	5	1.6
Lawyer	17	5.4
Any Other	31	9.8
Total	307*	97.5
Died	8	2.5
Total	315	100.0

* 08 respondents were widow

Table No. 4.3 shows the husband occupation of the respondents. Among the total respondents 34.3 percent respondents husband doing farming, then the second large 29.5

percent doing business, minimum 1.6 percent of the respondent husbands were lawyer & engineers. Beside the maximum and minimum percentage of the respondents 2.5 percent respondent husbands were died.

The above table indicates that most of the husbands were doing farming as occupation because of low education

Table No. 4.4. Monthly income from all sources

Monthly income	Frequency	Percent
0001-5000	45	14.3
5001-10000	96	30.5
10001-15000	92	29.2
Above 15000	82	26.0
Total	315	100.0

Table No. 4.4 indicates the monthly income of whole family of the respondents. Among the total respondents maximum 30.5 percent respondents share that their family income fall in the category of 5001-10000 Rupees, while the second large 29.2 percent of the respondents fall in the category of 10001-15000 rupees per month and 14.3 percent the minimum respondents fall in category of 0001-5000 Rupees per month.

The above table No. 02 & 03 evident that maximum respondents were house wife and husband doing farming that's why monthly income were less than ten thousand per month from all sources

Table No. 4.5. Current marital status

Pattern of living	Frequency	Percent
Separated	11	3.5
Divorced	2	.7
Widow	8	2.5
Living with husbands	294	93.3
Total	315	100.0

Table No. 4.5 shows the current status of the respondent. Among the total respondents a maximum 93.3 percent respondents were currently living with their husbands while 3.5 percent respondents were separated, 2.5 percent respondents were widow while a minimum 0.6 percent respondents were divorced.

The above table evident that most of the respondent living with their husband as subordinate and obey the rules made by husband

Table No. 4.6. Age at the time of marriage

Age at time of marriage	Frequency	Percent
10-14 years	23	7.3
15-18 years	154	48.9
19-22 years	116	36.8
above than 22 years	22	7.0
Total	315	100.0

Table No. 4.6 shows the age of the respondents at the time of marriage. Among the total respondents a maximum 48.9 percent respondents fall in a category of 15-18 years of age, while the minimum 7.0 percent respondent's age at the time of marriage was above than 22 years. So the table shows that a maximum percentage of the respondents married at 15-18 years of age.

The above table evident that a maximum number of respondents married below the age of eighteen years because in Pakhtun culture women were not considered income source.

Table No. 4.7. Type of marriage

Type of marriage	Frequency	Percent
Arranged	290	92.1
Choice	14	4.4
Arrange & By choice	11	3.5
Total	315	100.0

Table No. 4.7 indicate the type of marriage of the respondent. Among all the respondents a maximum 92.1 percent respondent marriage decision was taken by their family and 4.4 percent respondents married on their own choice while the minimum 3.5 percent respondents answered that their marriage was the combination of both choice and arranged by the family elders.

The above table indicates the Pakhtun rigid culture that women were not allowed to choice her life partner and the family male members were the decision maker about her marriage.

Table No. 4.8. Consultation regarding marriage

Consultation regarding marriage	Frequency	Percent
Yes	48	15.2
No	267	84.8
Total	315	100.0

Table No. 4.8 shows the consultation with respondents by their family members regarding their marriage. Among the total respondents a maximum 84.8 percent respondents were not consulted during the decision of their marriage while the remaining 15.2 percent respondents were consulted by their family regarding marriage.

The above table evident that the decision maker at all level for women was the male members and the decision made under rules made by the male members of the family.

Table No. 4.9. Consulting person at the time of marriage

Consultation person	Frequency	Percent
Father	9	18.75
Mother	26	54.16
Brother	2	4.1
Sister	4	8.3
Relatives	7	14.58
Total	48*	100.0

* The table is extension of table number 4.8

Table No. 4.9 shows the consultation person with respondents for their marriage. Among 15.2 percent respondents a maximum 8.3 percent were consulted by mother while the minimum 0.6 percent respondents were consults by brother for their marriage.

The above table evident that if at the time of marriage a consultation was necessary so most of the time mother consult the daughter because in Pakhtun traditions male

members of the family considered it weakness that a male talk to daughter regarding her willingness

Table No. 4.10. Type of family

Type of family	Frequency	Percent
Nuclear	93	29.5
Joint	175	55.6
Extended	47	14.9
Total	315	100.0

Table No. 4.10 shows the type of family in which the respondent living. Among the total 315 respondents a maximum 55.6 percent respondents living in the joint family system, 29.5 percent respondents living in nuclear family type while the minimum 14.9 percent respondents living in extended family type.

The above table showing the important aspect of the Pakhtun society that most of the people living in joint family system as under Pakhtun rules made by male members of the family. In Pakhtun society no one have the permission to separate from joint family system until the permission of the elder male members.

Table No. 4.11. Educational status

Educational Status	Frequency	Percent
Illiterate	163	51.8
Primary	64	20.3
Middle	23	7.3
Metric	17	5.4
Intermediate	7	2.2
Graduate	13	4.1
Any other	28	8.9
Total	315	100.0

Table No. 4.11 indicate the respondent status of education. Among the total respondents a maximum 42.9 percent respondents just knowing that how to write her name and calculation of the money and they were considered literate, while second maximum 20.3 percent respondents were at the level of primary education, 8.9 percent respondents were illiterate while the minimum 2.2 percent respondents were intermediate.

The above table evident that in Pakhtun society women were not allowed to came out side the four walls of the home that's why most of the women respondents were illiterate. The women were strictly obeyed the rules and regulation made by male members.

Table No. 4.12. Number of male children

Male children	Frequency	Percent
1	93	29.5
2	127	40.3
3	63	20.0
4	13	4.1
5	1	.3
Total	297	94.3
No male children	18	5.7
Total	315	100.0

Table No. 4.12 shows the total number of male children of the respondents. Among the total respondents 94.3 percent respondent have their male children while the remaining 5.7 percent respondents not given birth to male children.

The above table highlight the important aspect of the Pakhtun society that all most all the respondents were have the male children because in Pakhtun culture it's the sign of strongest family

Table No. 4.13. Number of Female children

Female children	Frequency	Percent
1	97	30.8
2	139	44.1
3	69	21.9
4	5	1.6
Total	310	98.4
No female children	5	1.6
Total	315	100.0

Table No. 4.13 shows the total number of female children of the respondents. Among the total respondents 98.4 percent respondent have their female children while the remaining 1.6 percent respondents not given birth to female children.

The above table highlighting the issue that most of the respondents have female children this is not because they want female children rather this is because of wish for more male children leads to increase in the number of female children's

Table No. 4.14. Perception regarding overall health

Perception regarding health	Frequency	Percent
Average	270	85.7
Poor	45	14.3
Total	315	100.0

Table No. 4.14 shows the perception of the respondents regarding their overall health. Among the total respondents a maximum 85.7 percent respondent feels their health average while 14.3 percent respondents have poor health every time.

The above table showing that most of the women perception regarding illness is average because in Pakhtun society most of the time the women collecting wood in hilly areas,

bringing water, cattle rearing, nursing of elders in the family and preparing food for all family that's why the not feel good health most of the time.

Table No. 4.15. Perception regarding illness

Perception regarding illness	Frequency	Percent
Laziness	12	3.8
Tiredness	25	7.9
Sleeping long time	23	7.3
Disability	48	15.2
Pregnancy	198	62.9
Any other	9	2.9
Total	315	100.0

Table No. 4.15 indicate the perception regarding illness among the respondents. Among the total respondents a maximum 62.9 percent respond about pregnancy as illness, while 15.2 percent respondent fall disability in the category of illness and the minimum 2.9 percent respond any other for type of illness.

The above table indicates that pregnancy was the major illness. most of the women were not properly doing checkup at the time of pregnancy because in Pakhtun society women were strictly observe parda and its considered sham by the male member that at the time of pregnancy women go out side the family for checkup. Due to such sham of the male members and strict Parda women face a lot of trouble in pregnancy time.

Table No. 4.16. Frequency of illness

Frequency of illness	Frequency	Percent
Very frequently	108	34.3
Some time	207	65.7
Total	315	100.0

Table No. 4.16 shows the level of illness among the respondents. 65.7 percent respond that they fall in illness some time while the minimum 34.3 percent respondents were very frequently ill.

As above table No. 4.16 indicate the pregnancy of women as main illness that's why beside the pregnancy the women not considered other illness as serious. So in this table women respond that beside pregnancy they fall some time in illness.

Table No. 4.17. Occurrence of chronic diseases

Occurrence of chronic diseases	Frequency	Percent
Yes	50	15.9
No	265	84.1
Total	315	100.0

Table No. 4.17 shows the chronic diseases in respondents. Among the total respondents a maximum 84.1 percent respondents have no chronic diseases while the remaining 15.9 percent respondents faced the chronic diseases.

The above table highlighting that most time women doing hard and continues work in side the home so not feel chronic diseases

Table No. 4.18. Chronic diseases in parent's family

chronic diseases in parent's family	Frequency	Percent
Yes	65	20.6
No	250	79.4
Total	315	100.0

Table No. 4.18 shows the chronic diseases in the respondent parent's family. Among the total respondents a maximum 79.4 percent respondents respond that their parents family have no chronic disease while the minimum 20.6 percent respond that their parents family have the chronic disease.

The above table evident that in Pakhtun society almost marriage was takes place with in their joint family that's why they know one another bitterly regarding any chronic disease

Table No. 4.19. Chronic diseases in husband's family

Chronic diseases in husband's family	Frequency	Percent
Yes	39	12.4
No	276	87.6
Total	315	100.0

Table No. 4.19 shows the chronic diseases in the respondent husband's family. Among the total respondents a maximum 87.6 percent respondents respond that their husband's family have no chronic disease while the minimum 12.4 percent respond that their husband's family have the chronic disease.

The above table evident that in Pakhtun society almost marriage was takes place with in their joint family that's why they know one another bitterly regarding any chronic disease

Table No. 4.20. Sharing regarding illness in family

Sharing regarding illness	Frequency	Percent
Mother in Law	168	53.3
Father in law	27	8.6
Husband	70	22.2
Sister in Law	9	2.9
Brother in Law	2	.6
Father	4	1.3
Mother	35	11.1
Total	315	100.0

Table No. 4.20 indicate the respondents sharing about their illness with other family members. Among the total respondents a maximum 53.3 percent respondents sharing their illness mother in law and the second maximum 22.2 percent respondent's sharing about their illness with husband, while the minimum 0.6 percent respondent's sharing with brother in law regarding their illness.

As the above table showing the another aspect of the Pakhtun society that women were not so empowered to share about their any issue even about their health with male members that's why most of the women sharing about their illness mother in law.

Table No. 4.21. Health seeking behaviour

Health seeking behaviour	Frequency	Percent
Doctor	70	22.2
Hakeem	28	8.9
Faith healer	35	11.1
Self medication	69	21.9
Traditional Birth Attendant	106	33.7
Any other	7	2.2
Total	315	100.0

Table No. 4.21 shows the health seeking of respondents at the time of illness. Among the total respondents a maximum 33.7 percent respondents took the treatment from TBA and 21.9 percent of the respondents doing self medication at the time of ill health, while the minimum 2.2 percent respondents using any other ways for their treatment.

The above table evident that most of the women in Pakhtun society at the time of pregnancy only allowed to checkup and given delivery under the expertly of Traditional Birth Attendant which leads not only to many complication rather even the death of the women or new born baby. In Pakhtun society women were not permitted to deliver in hospital or private clinics with male doctor.

Table No. 4.22. Company at the time of treatment

Company of family	Frequency	Percent
Mother in Law	133	42.2
Father in law	24	7.6
Husband	62	19.7
Sister in Law	36	11.4
Brother in Law	22	7.0
Father	13	4.1
Mother	12	3.8
Sister	10	3.2
Any other	3	1.0
Total	315	100.0

Table No. 4.22 shows the company of any family member with the respondent at the time of treatment. Among the total respondents a maximum 42.2 percent respondents were accompany by mother in law when respondent going for treatment and 19.7 percent respondent were accompany by husband, while the 3.2 percent respondent accompany by sister at the time of treatment.

The above table evident about the Pakhtun society that women were all most company by mother in law at the time of illness because in Pakhtun society its considered sham that male members of the family go with women at the time of illness/ delivery to TBA clinic.

Table No. 4.23. Affordability of medicines

Affordability of medicines	Frequency	Percent
Yes	84	26.7
No	231	73.3
Total	315	100.0

Table No. 4.23 shows the respondents financial affordability of medicines. Among all the total respondents a maximum 73.3 percent respondents not afforded the price of medicines while the minimum 26.7 percent respondents afforded the price of medicines.

The above table evident that most of the women in Pakhtun society housewife and not contributing in the family economy due to which the medicines were not affordable for them.

Table No. 4.24. Sharing regarding pregnancy

Sharing regarding pregnancy	Frequency	Percent
Mother in Law	196	62.2
Husband	92	29.2
Sister in Law	27	8.6
Total	315	100.0

Table No. 4.24 showing the sharing of pregnancy with the family members. Among the total respondents a maximum 62.2 percent respondents sharing about their pregnancy with mother in law and 29.2 percent respondents sharing with husband about their pregnancy, while the remaining minimum 8.6 percent respondents sharing with sister in law regarding their pregnancy.

As the above table evident that in Pakhtun society most of the women sharing about their pregnancy with mother in law/women.

Table No. 4.25. Regular check ups during last pregnancy

Regular checking during last pregnancy	Frequency	Percent
Yes	65	20.6
No	250	79.4
Total	315	100.0

Table No. 4.25 showing the checkup during last pregnancy. Among the total respondents a maximum 79.4 percent respondents not checking regularly during last pregnancy while the minimum 20.6 percent respondents checking during their pregnancy to health service provider.

As the above table evident that in Pakhtun society women observe strict parda and women are not permitted to travel alone that's why the women were not checkup their pregnancy regularly.

Table No. 4.26. Enough food during pregnancy

Enough food during pregnancy	Frequency	Percent
Yes	90	28.6
No	225	71.4
Total	315	100.0

Table No. 4.26 showing the food required during pregnancy time. Among the total respondents a maximum 71.4 percent respondents not taking enough food during

pregnancy time while the minimum and remaining 28.6 percent respondents taking enough food during pregnancy.

The above table indicates that in Pakhtun society women eating food after the male members of the family that's why they have no enough food for eating in pregnancy & daily routine.

Table No. 4.27. Place of last delivery

Place of last delivery	Frequency	Percent
Government Hospital	32	10.2
Private maternity home	90	28.6
Home	114	36.2
Midwives clinic	79	25.1
Total	315	100.0

Table No. 4.27 indicate the last place of delivery by the respondent. Among the total respondents a maximum 36.2 percent respondents given last delivery in home and 25.1 percent respondents given birth to last delivery in midwives clinic, while minimum 10.2 percent respondents given their last delivery in government hospital.

The above table evident that in Pakhtun society male have restriction on women's mobility even for their health checkup that's why the delivery take place in home.

Table No. 4.28. Reason of delivery at home

Reason of delivery at home	Frequency	Percent
Lack of transportation	27	24.0
Due to Privacy	13	11.0
Due to Expenditure	23	20.0
Traditions/Customs	17	15.0
Parda	34	30.0
Total	114	100.0

Table No. 4.28 shows the reason of delivery at home. Among the total respondents maximum 30.0 percent respondents given birth in home due to Parda and 24.0 percent respondents given birth in home due to lack of transportation, while the third maximum 20.0 percent respondents due to expenditure given birth to last baby in home. The above table evident that in Pakhtun society the male member restricted women as their property from mobility due to Parda and the health facilities far away that's why due to transportation the women were deliver at home.

Table No. 4.29. Availability of health facilities in the area

Availability of health facilities	Frequency	Percent
MCHC	35	11.1
BHU	75	23.8
Civil Dispensary	57	18.1
DHQH	58	18.4
THQH	47	14.9
Private Clinic	41	13.0
Any other	2	.6
Total	315	100.0

Table No. 4.29 shows the availability of health facilities in the area. Among the total respondents a maximum 23.8 percent respondents know about the availability of BHU as health facility while the minimum 0.6 percent respondents identified any other health facilities.

The above table shows the knowing of health facilities by women in their area. Most of The women know BHU as health facility but the delivery of women takes place in home because of Pakhtun tradition and privacy.

Table No. 4.30. Time taken to access the health facility

Time taken to access the health facility	Frequency	Percent
01-15	46	14.6
16-30	85	26.9
More than 30 minutes	184	58.5
Total	315	100.0

Table No. 4.30 shows the respondents access to health facility. Among the total respondents a maximum 58.5 percent respondents taking more than 30 minutes to reaching the health facility while a minimum 14.6 percent respondents taking 01-15 minutes for reaching health facility.

The above table evident that in Pakhtun society due to distance the women were treating by TBA at door step and male in Pakhtun society not giving preference to their health as compare to male member of the family.

Table No. 4.31. Type of illness/diseases

Type of illness/ diseases	Frequency	Percent
Depression	28	8.9
Pregnancy	124	39.4
Blood pressure	43	13.7
Hepatitis	50	15.8
Sugar	70	22.2
Total	315	100.0

Table No. 4.31 shows the different type of disease existing in the respondents. Among the total respondents a maximum 39.4 percent respondents called pregnancy as

an illness while second maximum 22.2 percent respondents shared regarding sugar as illness/diseases prevail among the respondents.

The above table indicates that pregnancy was the major illness. most of the women were not properly doing checkup at the time of pregnancy because in Pakhtun society women were strictly observe parda and its considered sham by the male member that at the time of pregnancy women go out side the family for checkup. Due to such sham of the male members and strict Parda women face a lot of trouble in pregnancy time and they consult Traditional Birth Attendant (TBA) for pregnancy. The other illness ignoring by male member as saying that was due to tiredness nothing else.

Table No. 4.32. Place of treatment

Place of treatment	Frequency	Percent
MCHC	47	14.9
BHU	83	26.3
Civil Dispensary	62	19.7
DHQH	39	12.4
THQH	37	11.7
Private Clinic	25	7.9
Any other	22	7.0
Total	315	100.0

Table No. 4.32 shows the respondents place for checkup or treatment at the time of illness. Among the total respondents a maximum 26.3 percent respondents checking/treating their illness in Basic Health Unit while 7.9 percent respondents checking/treating their illness in private clinics.

The above table shows that if women face some serious issues in their health so in Pakhtun society they only permitted upto local available health facility for treatment.

Table No. 4.33. Gender of health service provider/doctor

Gender of health service provider/doctor	Frequency	Percent
Male	190	60.3
Female	125	39.7
Total	315	100.0

Table No. 4.33 Shows the gender of the health service provider/doctor. Among the total respondents a maximum 60.3 percent respond about the male health service provider/doctor while the minimum 39.7 percent respond about female health service provider.

The above table evident that in Pakhtun society women were not permitted for treatment with out a male company if health service provider/doctor was male .

Table No. 4.34. Age of health service provider/doctor.

Age of health service provider/doctor	Frequency	Percent
31-40 years	111	35.2
Above forty years	204	64.8
Total	315	100.0

Table No. 4.34 Shows the age of the health service provider/doctor. Among the total respondents a maximum 64.8 percent respond about the category of above than forty years of age of service provider/doctor while the minimum 35.2 percent respond about the category of 31-40 years of age of health service provider.

The above table highlighting that women in Pakhtun society permitted for treatment to male doctor if his age above than forty years because women's visit to young doctor in Pakhtun society making negative image about the women character.

Table No. 4.35. Language of health service provider/doctor

Language	Frequency	Percent
Pushto	306	97.1
Urdu	9	2.9
Total	315	100.0

Table No. 4.35 Shows the language of the health service provider/doctor. Among the total respondents a maximum 97.1 percent respond about the Pushto while the minimum 2.9 percent respond about Urdu language of health service provider.

The above table evident that most of the women checkup restricted by their male member to doctor who speaking local language.

Table No. 4.36. Attitude of health service provider/doctor

Attitude of health service provider/doctor	Frequency	Percent
Cooperative	129	41.0
Encouraging	97	30.8
Humanitarian	67	21.3
Bad	22	7.0
Total	315	100.0

Table No. 4.36 Shows the attitude of the health service provider/doctor. Among the total respondents a maximum 40.0 percent respond about cooperative attitude of the health service provider/doctor while the minimum 7.0 percent respond about bad attitude of the health service provider.

The above table shows that in Pakhtun society women for checkup & treatment permitted mostly due to cooperative attitude and older age of the doctor.

Table No. 4.37. Person explaining health issues/problem to doctor

Person explaining health issues/problem to doctor	Frequency	Percent
Mother in Law	133	42.2
Father in law	24	7.6
Husband	62	19.7
Sister in Law	36	11.4
Brother in Law	22	7.0
Father	13	4.1
Mother	12	3.8
Sister	10	3.2
Any other	3	1.0
Total	315	100.0

Table No. 4.37 shows about respondent's explanation to doctor regarding illness. Among the total respondents a maximum 42.2 percent respondents shared about mother in law and 19.7 percent respond regarding husband talking with health service provider/doctor, while 7.6 percent respond toward father in law talking with health service provider/doctor.

The above table evident that due to Pakhtun tradition and restriction on women talking with out side male only 01 percent women talking to doctor regarding their illness.

Table No. 4.38. Physical examination at the time of checkup

physical examination	Frequency	Percent
Yes	134	42.5
No	181	57.5
Total	315	100.0

Table No. 4.38 shows about the physical examination of the respondent by doctor/health service provider. Among the total respondents a maximum 57.5 percent respondents answered "No" about physical examination of the health service provider/doctor, while the remaining minimum 42.5 percent respondents answered "Yes" to physical examination.

The above table evident that most of the women not permitting doctor for physical examination due to strict parda in Pakhtun society

Table No. 4.39. Asking about follow up visit by doctor/health service

Asking about follow up visit by doctor	Frequency	Percent
Yes	315	100.0

Table No. 4.39 indicate about the asking of follow up visit to the respondent by health service provider/doctor. All of the 100.0 percent respondents answered "Yes" to the follow up visits by health service provider/doctor.

The above table evident that all the respondents were asks for follow up visit but due to work load and non seriousness of the male family members they not revisit for checkup.

Table No. 4.40. Pattern of taking medicines

Pattern of taking medicine	Frequency	Percent
Regularly	215	68.3
Casually	87	27.6
Not at all	13	4.1
Total	315	100.0

Table No. 4.40 shows the pattern of taking medicine by respondents. Among the total respondents a maximum 68.3 percent respondents were taking medicine on regular basis and 27.6 percent respondents taking medicine casually while 4.1 percent respondent's not taking medicine.

Table No. 4.41. Follow up visits

Follow up visit	Frequency	Percent
Yes	132	41.9
No	183	58.1
Total	315	100.0

Table No. 4.41 shows about the follow up visits of respondents for checkup. Among the total respondents a maximum 58.1 percent respondents have no follow up visits for checkup while the remaining minimum 41.9 percent respondents follow up visits for check up to health service provider/doctor

The above table evident that due to women work load and non seriousness of the male family members they not permitted for follow up visits.

Table No. 4.42.A Pakhtun Culture/codes

Statements	Frequency and Percentage		Total
	To great extend	To some extend	
Observe strict parda	125(39.7)	190(60.3)	315 (100%)
Remain in home	153(48.6)	162(51.4)	315 (100%)
Strictly adhere to her husband	123(39.0)	192(61.0)	315 (100%)
Restriction on alone traveling	131(40.6)	184(58.4)	315 (100%)
Accompany of male member	176(55.9)	139(44.1)	315 (100%)
Not talk to male doctor	105(33.3)	210(66.7)	315 (100%)
Obedience to her husband	125(39.7)	190(60.3)	315 (100%)
Sacrificing for family	128(40.6)	187(59.4)	315 (100%)
Subordinate role in family	127(40.3)	188(59.7)	315 (100%)
Abide the rules made by male	127(40.3)	188(59.7)	315 (100%)
Abide the decision taken by male	127(40.3)	188(59.7)	315 (100%)
Maintaing the supremacy of her husband	126(40.0)	189(60.0)	315 (100%)
Not bother about her husband	127(40.3)	188(59.7)	315 (100%)
Bear the problem alone	128(40.6)	187(59.4)	315 (100%)
Not sharing own health issue with male	126(40.0)	189(60.0)	315 (100%)

Table No. 4.43A shows the opinion of respondents regarding remains in home to great extend or to some extend. Among the total respondents a maximum 51.4 percent respondents remain in home to great extend while the remaining minimum 48.6 percent respondents agree to some extend. It shows the opinion of respondents regarding observance strict parda. Among the total respondents a maximum 60.3 percent

respondents observe strict parda to great extend while the remaining minimum 39.7 percent respondents observe parda to some extend. It shows the opinion of respondents regarding strictly adhere to her husband. Among the total respondents a maximum 61.0 percent respondents respond to great extend while the remaining minimum 39.0 percent respondents respond to some extend. It shows the opinion of respondents regarding restriction on traveling to great extend or to some extend. Among the total respondents a maximum 58.4 percent respondents restriction on traveling to great extend while the remaining minimum 41.6 percent respondents restriction to traveling to some extend. It shows the opinion of respondents regarding accompany of husband or male family member in traveling. Among the total respondents a maximum 55.9 percent respondents accompany in traveling by husband or some male family member to some extend while the remaining minimum 44.6 percent respondents accompany in traveling by husband or some male family member to great extend. It shows the opinion of respondents regarding the restriction on respondents in talking with doctor/health service provider. Among the total respondents a maximum 66.7 percent respondents were not allowed to talk to doctor/health service provider upto great extend while the remaining minimum 33.3 percent respondents were allowed to talk to doctor/health service provider upto some extend. shows the opinion of respondents regarding obedience of husband. Among the total respondents a maximum 60.3 percent respondents answered that women were obedient to husband to great extend while the remaining minimum 46.7 percent respondent answered to some extend. It shows the opinion of respondents regarding sacrificing for family. Among the total respondents a maximum 59.4 percent respondents answered that they were sacrificing for family to great extend while the remaining

minimum 46.7 percent respondent answered their sacrificing for family to some extend. It shows the opinion of respondents regarding subordinate role in the family. Among the total respondents a maximum 59.7 percent respondents answered that they were subordinate role in the family to great extend while the remaining minimum 40.3 percent respondent answered their subordinate role in the family to some extend. It shows the opinion of respondents regarding abide the rules made by the male member. Among the total respondents a maximum 59.7 percent respondents answered that respondents abide the rules made by the male member to great extend while the remaining minimum 40.3 percent respondent answered that respondents abide the rules made by the male members to some extend. It shows the opinion of respondents regarding abide decisions made by the male member. Among the total respondents a maximum 59.7 percent respondents answered that respondents abide decisions made by the male member to great extend while the remaining minimum 40.3 percent respondent answered that respondents abide decisions made by the male member to some extend. It shows the opinion of respondents regarding maintaining the supremacy of her husband. Among the total respondents a maximum 60.0 percent respondents answered maintaining the supremacy of her husband to great extend while the remaining minimum 46.0 percent respondent answered to maintaining the supremacy of her husband some extend. It shows the opinion of respondents regarding not bother about her health. Among the total respondents a maximum 59.7 percent respondents answered not bother about her health to great extend while the remaining minimum 40.3 percent respondent answered not bother about her health to some extend. It shows the opinion of respondents regarding bear the problem alone. Among the total respondents a maximum 59.4 percent respondents answered bear

the problem alone to great extend while the remaining minimum 40.6 percent respondent bear the problem alone to some extend. It shows the opinion of respondents regarding not sharing about her health problems with male members. Among the total respondents a maximum 60.0 percent respondents answered that they were not sharing about her health problems with male members to great extend while the remaining minimum 40.0 percent respondent answered not sharing about her health problems with male members to some extend.

The above table evident that in Pakhtun society women remain in home even at the time of serious illness they waiting for male member permission. The above table evident that in Pakhtun society women strictly observe parda at the time of checkup/treatment due to which they were not physically examine by the doctor. The above table evident that in Pakhtun society women strictly adhere to her husband decision in all kind of activities what ever related to her health or some thing else . The above table evident that in Pakhtun society women was restricted to travel alone out side the home. In Pakhtun society that women was considered bad character especially in rural areas. The above table evident that in Pakhtun society women was restricted to travel alone out side the home. In Pakhtun society the women were permitted to travel along her husband or other male members in time of traveling. The above table evident that in Pakhtun society women were not permitted to talked to doctor. Only the accompany person whatever her mother in law, husband or any other male member were talked. The above table evident that most of the women in Pakhtun society follow the order of the husband whatever he said. The above table evident that most of the women in Pakhtun society sacrificing in kind of obedience to her husband and family male members, caring and nursing of old

persons, cooking and keeping good quality food for male, collecting wood for cooking and following all those rules which were form by male member of Pakhtun society. The above table evident that in Pakhtun society women were play subordinate role and follow the order and decision of male members. The above table evident that in Pakhtun society women's were followed the rules, order and decision of male members. The above table evident that in Pakhtun society all the rules made by male members and the women were bound to follow these rules what ever for their better health and empowerment or not. The above table evident that husbands in Pakhtun families have supremacy over wife and wife were followed and accept husband supremacy. The above table highlight that women in Pakhtun family utilize her energy for the family and in Pakhtun society women realize that their health not important that other family matters.The above table evident that women in Pakhtun society bear their problem alone not shares with husband and other male members because that woman not want to show her weak to her husband. The above table describes that woman in Pakhtun society not sharing health problem with male due to their subordinate role in family.

Table No. 4.42.B Pakhtun Culture/codes

Statements	Frequency and Percentage		Total
	To great extend	To some extend	
Discussing only serious issues	126(40.0)	189(60.0)	315 (100%)
Telling only her mother in law	126(40.0)	189(60.0)	315 (100%)
Restriction on alone visit to doctor	128(40.6)	187(69.4)	315 (100%)
Not taking medicine regularly	125(39.7)	190(60.3)	315 (100%)
Consultation with local healer	129(41.0)	186(59.0)	315 (100%)
Not taking with doctor	129(41.0)	186(59.0)	315 (100%)
Not telling detail to doctor	128(40.6)	187(69.4)	315 (100%)
Women not allow doctor for physical examination	129(41.0)	186(59.0)	315 (100%)
Women consultation with TBA	129(41.0)	186(59.0)	315 (100%)
Dislike modern technology foe physical examination	128(40.6)	187(69.4)	315 (100%)
Not bother her husband again and again for checkup	129(41.0)	186(59.0)	315 (100%)
Delivery at home	126(40.0)	189(60.0)	315 (100%)
Local remedy at home	125(39.7)	190(60.3)	315 (100%)

Table No. 4.43 B shows the opinion of respondents regarding discussing only serious health problems. Among the total respondents a maximum 60.0 percent respondents answered that they were discussing only serious health problems to great extend while the remaining minimum 40.0 percent respondent answered discussing only serious health problems to some extend.

It shows the opinion of respondents regarding telling only her mother in law regarding her serious health problems. Among the total respondents a maximum 60.0 percent respondents answered that they were telling only her mother in law regarding her serious health problems to great extend while the remaining minimum 40.0 percent respondent answered telling only her mother in law regarding her serious health problems to some extend. It shows the opinion of respondents regarding restriction on her alone visit to doctor. Among the total respondents maximum 59.4 percent respond that they were restriction on her alone visit to doctor to great extend while the remaining minimum 40.6 percent respondents answered restriction on her alone visit to doctor to some extend.

It shows the opinion of respondents regarding local remedy at home. Among the total respondents maximum 60.3 percent respond that they were local remedy at home to great extend while the remaining minimum 39.7 percent respondents answered local remedy at home to some extend. It shows the opinion of respondents regarding not taking medicine regularly. Among the total respondents maximum 60.3 percent respond that they were not taking medicine regularly to great extend while the remaining minimum 39.7 percent respondents answered not taking medicine regularly to some extend. It shows the opinion of respondents regarding consultation with local healers. Among the total respondents maximum 59.0 percent respond that they were consulates with local healers to great extend while the remaining minimum 41.0 percent respondents answered consulates with local healers to some extend. It shows the opinion of respondents regarding not talking with doctor. Among the total respondents maximum 59.4 percent respond that they were not talking with doctor to great extend while the remaining minimum 40.6 percent respondents answered not talking with doctor to some extend. It

shows the opinion of respondents regarding not telling the detail to health service provider/doctor. Among the total respondents maximum 59.4 percent respond that they were not telling the detail to health service provider/doctor to great extend while the remaining minimum 40.6 percent respondents answered not telling the detail to health service provider/doctor to some extend. It shows the opinion of respondents regarding not allow a male doctor to examine physically. Among the total respondents maximum 59.0 percent respond that they were not allow a male doctor to examine physically to great extend while the remaining minimum 41.0 percent respondents answered not allow a male doctor to examine physically to some extend. It shows the opinion of respondents regarding consultation first with Traditional Birth Attendant (TBA). Among the total respondents maximum 59.0 percent respond that they were consultation first with Traditional Birth Attendant (TBA) to great extend while the remaining minimum 41.0 percent respondents answered consultation first with Traditional Birth Attendant (TBA) to some extend. It shows the opinion of respondents regarding dislike use of modern machinery of examination for treatment/checkup. Among the total respondents maximum 59.4 percent respond that they were dislike use of modern machinery of examination for treatment/checkup to great extend while the remaining minimum 40.6 percent respondents answered dislike use of modern machinery of examination for treatment/checkup to some extend. shows the opinion of respondents regarding not bother her husband again and again for checkup. Among the total respondents maximum 59.0 percent respond that they were bother her husband again and again for checkup to great extend while the remaining minimum 41.0 percent respondents answered bother her husband again and again for checkup to some extend. It shows the opinion of respondents

regarding delivery at home. Among the total respondents maximum 60.0 percent respond that they were deliver at home to great extend while the remaining minimum 40.0 percent respondents answered were deliver at home to some extend. It shows the opinion of respondents regarding local remedy at home. Among the total respondents maximum 60.3 percent respond that they were local remedy at home to great extend while the remaining minimum 39.7 percent respondents answered local remedy at home to some extend.

The above table highlights that women in Pakhtun society only sharing their serious problems like pregnancy in the family and the other illness ignored which have bad impact on their health. The above table evident that women's in Pakhtun families have sharing about their serious problems only to mother in law because male not considered women health as serious issue for them. The above table evident that women's in Pakhtun society restricted by rules made by male family members from alone visit to doctor for checkup. In Pakhtun society all those women's considered bad character who visiting alone for doctor or any other health service provider and they were considered the violator of the rules and code of Pakhtun society. The above table evident that women's in Pakhtun society taking some local remedy at home when they fell ill and they were not permitting by their male member on any reason. Some time the health facility not available in local area so the male member giving them the medicine at home level. The above table evident that women's in Pakhtun society were mostly illiterate that's why they not taking medicine regularly and at once they recover from illness they leave the completion of taking medicine course due to which they face same illness after some time. The above table evident that women in the Pakhtun families not permitted

by male members to visit doctor for treatment especially when the doctor faraway that's why the women consulting the local healer for recovery from illness. The above table evident that women in Pakhtun society were observe strict parda and under rules made by male the women have no right to speak openly regarding her illness to doctor. The above table evident that women in Pakhtun society were bound under rules made by male the women have no right to telling openly regarding her illness to doctor. The above table evident that a male doctor in Pakhtun society was with out permission not allowed to examine women physically. Physical examination of women considered the violation of the Pakhtun codes and leads to dangerous results for doctor. The above table evident that in Pakhtun society at time of pregnancy most of the women consulted Traditional Birth Attendant (TBA) because of unavailability of women doctor. No male want under the Pakhtun traditions that a male examine or consulted for pregnancy. The above table highlight that women in Pakhtun society dislike modern technology especially ultrasound for treatment. They considered it as the violation of privacy and parda. The above table evident that Pakhtun women not bother her husband again and again for checkup because they considered male and their work superior than own health and indicate that in Pakhtun society male have restriction on women's mobility even for their health checkup that's why the delivery take place in home. The above table evident that women's in Pakhtun society taking some local remedy at home when they fell ill and they were not permitting by their male member on any reason. Some time the health facility not available in local area so the male member giving them the medicine at home level.

Table No. 4.43. Religious Codes

Statements	Frequency and Percentage		Total
	To great extend	To some extend	
God controlling the whole universe	129 (41.0)	180(59.0)	315 (100%)
God made the women subordinate	127(40.3)	188(59.7)	315 (100%)
God controlling health and illness	128(40.6)	187(59.4)	315 (100%)
God cure even incurable diseases	130(41.3)	185(58.7)	315 (100%)
God loves the ill person	132(41.9)	183(58.1)	315 (100%)
God listen the ill person	137(43.5)	178(56.5)	315 (100%)
God dislike women who alone travel	136(43.2)	129(56.8)	315 (100%)
God dislike women who disobey husband	139(44.1)	176(55.9)	315 (100%)
God dislike women who discussing openly	132(41.9)	183(58.1)	315 (100%)
God dislike women who talk to doctor openly	139(44.1)	176(55.9)	315 (100%)
God order women to keep secret your illness	132(41.9)	183(58.1)	315 (100%)

Table No. 4.44 shows the opinion of respondents regarding God controlling of the whole universe. Among the total respondents maximum 59.0 percent respond that God controlling the whole universe to great extend while the remaining 41.0 percent respond that God controlling the whole universe to some extend.

It shows the opinion of respondents regarding God made the women subordinate. Among the total respondents maximum 59.7 percent respond that God made the women subordinate to great extend while the remaining 40.3 percent respond that God made the women subordinate to some extend.

It shows the opinion of respondents regarding God controlling the health and illness. Among the total respondents maximum 59.4 percent respond that God controlling the health and illness to great extend while the remaining 40.6 percent respond that God controlling the health and illness to some extend. It shows the opinion of respondents regarding God cure even incurable diseases. Among the total respondents maximum 58.7 percent respond that God cure even incurable diseases to great extend while the remaining 41.3 percent respond that God cure even incurable diseases to some extend.

It shows the opinion of respondents regarding God loves the ill persons. Among the total respondents maximum 58.1 percent respond that God loves the ill persons to great extend while the remaining 41.9 percent respond that God loves the ill persons to some extend. It shows the opinion of respondents regarding God listen the ill persons. Among the total respondents maximum 56.5 percent respond that God listen the ill persons to great extend while the remaining 43.5 percent respond that God listen the ill persons to some extend. It shows the opinion of respondents regarding God response to women who go alone out side the home. Among the total respondents maximum 56.8 percent respond that God response to women who go alone out side the home to great extend while the remaining 43.2 percent respond that God response to women who go alone out side the home to some extend. It shows the opinion of respondents regarding God dislikes women who disobey the husband. Among the total respondents maximum 55.9 percent respond that God dislikes women who disobey the husband to great extend while the remaining 44.1 percent respond that God dislikes women who disobey the husband to some extend. It shows the opinion of respondents regarding God dislikes women who discuses openly. Among the total respondents maximum 58.1 percent

respond that God dislikes women who discuses openly to great extend while the remaining 41.9 percent respond that God dislikes women who discuses openly to some extend. It shows the opinion of respondents regarding God dislikes women to consult male doctor. Among the total respondents maximum 55.9 percent respond that God dislikes women to consult male doctor to great extend while the remaining 44.1 percent respond that God dislikes women to consult male doctor to some extend. It shows the opinion of respondents regarding God order women to keep secrets. Among the total respondents maximum 58.1 percent respond that God order a women to keep secrets to great extend while the remaining 41.9 percent respond that God order a women to keep secrets to some extend.

The above table shows that in Pakhtun society male belief that God controlling the whole universe so they not taking women illness serious especially of pregnancy and they realize them to belief on God.

The above table evident that in Pakhtun society men blackmailing by misinterpretation of religious statements regarding women were made subordinate by God.

The above table evident that male realize to women regarding their health that God cure even incurable disease due to that statement men giving less importance to women health.

The above table evident that male realize to women regarding God loves the ill person due to that statement men ignoring the illness of women. The above table evident that male realize to women regarding God listen the ill person due to that statement men ignoring the checkup of women.

Testing of Hypothesis

Hypothesis No. 01. Higher the sharing regarding illness with mother in law higher will be the company of women to doctor

Table No. 4.82. An Association between sharing about illness in the family and company to doctor by family member

Sharing Person	Who company you to doctor									Total
	Mother in Law	Father in law	Husband	Sister in Law	Brother in Law	Father	Mother	Sister	Any other	
Mother in Law	99	15	24	19	11	--	--	--	--	168
	58.9%	8.9%	14.3%	11.3%	6.5%	--	--	--	--	100.0%
Father in law	12	3	5	5	2	--	--	--	--	27
	44.4%	11.1%	18.5%	18.5%	7.4%	--	--	--	--	100.0%
Husband	17	5	31	11	6	--	--	--	--	70
	24.3%	7.1%	44.3%	15.7%	8.6%	--	--	--	--	100.0%
Sister in Law	3	1	2	0	3	--	--	--	--	9
	33.3%	11.1%	22.2%	.0%	33.3%	--	--	--	--	100.0%
Brother in Law	1	--	--	1	--	--	--	--	--	2
	50.0%	--	--	50.0%	--	--	--	--	--	100.0%
Father	1	--	--	--	--	--	--	1	2	4
	25.0%	--	--	--	--	--	--	25.0%	50.0%	100.0%
Mother	--	--	--	--	--	13	12	9	1	35
	--	--	--	--	--	37.1%	34.3%	25.7%	2.9%	100.0%
Total	133	24	62	36	22	13	12	10	3	315
	42.2%	7.6%	19.7%	11.4%	7.0%	4.1%	3.8%	3.2%	1.0%	100.0%

Chi-square = 4.663 E2 Significance = 0.00 Lambda = 0.42 Gamma = 0.050

The above table indicates the association between sharing of illness by respondent in the family and company to respondent for checkup and treatment from doctor. The sharing of illness by respondent was measured in seven categories; Mother in law, Father in law, Husband, Sister in law, Brother in law, Father, Mother. The company of respondent to doctor was measured by nine categories; Mother in law, Father in law,

Husband, Sister in law, Brother in law, Father, Mother, Sister and Any other. The result in the above table indicated that among 168 respondents 59 percent respondent sharing regarding their illness with mother in law who company her to doctor for checkup or treatment, among total 27 respondent 44.4 percent women sharing with her father in law and company her to doctor, among 70 respondents 44.3 percent women sharing with husbands who company her to doctor for checkup or treatment, among 9 respondents 33.3 percent sharing with sister in law who company her to doctor, among 2 respondents 50 percent sharing brother in law who company her to doctor, among 4 respondents 25 percent sharing and company by her father to doctor for checkup and among 35 respondents 34.3 sharing with her mother who company her to doctor. Thus among the total 315 respondents majority of the respondents share about their mother in law regarding their illness and she company her to doctor for checkup and treatment.

The chi-square value (4.66) at 0.000 level of significance indicated that sharing of illness with women in Pakhtun families were high and the women were company the respondents for treatment and checkup. There is highly significant association between the two variables.

Basic reason behind that in Pakhtun culture women are considered subordinate to their husband. This subordinate role of women does not allow her to share regarding their illness with their husband or any other male member of the family. Mostly women share about their illness to other women in the family and especially elder women company her to doctor.

Hypothesis No. 02. Lower level of education of the respondents lower will be the checkup during pregnancy

Table No. 4.83. An Association between educational status and checkup in pregnancy

Educational status	Checking regularly in pregnancy		Total
	Yes	No	
Illiterate	3	160	163
	1.8%	98.2%	100.0%
Primary	2	62	64
	3.1%	96.9%	100.0%
Middle	2	21	23
	8.7%	91.3%	100.0%
Metric	7	10	17
	41.2%	58.8%	100.0%
Intermediate	6	1	7
	85.7%	14.3%	100.0%
Graduate	9	4	13
	69.2%	30.8%	100.0%
Post graduate	19	9	28
	67.9%	32.1%	100.0%
Total	48	267	315
	15.2%	84.8%	100.0%

Chi-square = 1.825 Significance = 0.00 Lambda = 0.46 Gamma = 0.037

The above table indicates the association of educational status of the respondent which was categorized in seven levels; Illiterate, Primary, Middle, High, Intermediate, Graduate and post graduate.

The respondent checkup regularity in pregnancy period was the second variable measured in two categories; Yes & No.

The result indicated that among 163 illiterate respondents 98.2 percent not checking regularly in pregnancy period while 1.8 percent illiterate respondents checking regularly in pregnancy. Among 64 primary educational level respondents 96.9 percent respondent

not checking regularly in pregnancy while 3.1 percent respondents checking regularly in pregnancy. Among 23 middle level educated respondents 91.3 percent respondents not go for checkup of pregnancy while only 8.7 percent respondents checkup regularly in pregnancy period. Among 17 metric level respondents 58.8 percent respondents no checkup regularly in pregnancy while 41.2 percent respondent checkup in pregnancy period. Among the 7 intermediate level educated respondents 14.3 percent respondents not checkup regularly in pregnancy period while a major proportion 85.7 percent respondents checkup regularly in pregnancy period. Among 13 graduate level educated respondents a major proportion 69.2 percent respondent checkup regularly in pregnancy period. Among the 28 post graduate level respondents 32.1 percent respondents not checkup regularly in pregnancy while a major proportion 68 percent respondent checkup regularly in pregnancy period. Thus from above detail description of cross tabule it become clear that majority of illiterate respondents not taking checkup regularly in pregnancy period and majority of educated respondents especially from intermediate to onward checkup regularly in pregnancy period.

The chi-square value (1.825) at 0.000 level of significance revealed that there is a high significant and positive relation with the variable level of education and checkup in pregnancy period by the respondent.

Basic reason behind that is Pakhtun culture has strict traditions regarding parda for their women. This does not allow women to get education and to visit for checkup during pregnancy on regular basis to doctor except Traditional Birth Attendants (TBAs) which are available at village level.

Hypothesis No. 03. Strict parda observance restrict women to talk to doctor

Table No. 4.84. An Association between custom of parda and practice of health seeking

Custom of parda	practice of health seeking		Total
	Some extend	Great extend	
Some extend	103 82.4%	22 17.6%	125 100.0%
Great extend	2 1.1%	188 98.9%	190 100.0%
Total	105 33.3%	210 66.7%	315 100.0%

Chi- square = 2.245 Significance = 0.00 Lambda = 0.42 Gamma = 0.003

The above table indicates the association between Pakhtun women should observe strict parda and Pakhtun women should not talk to male doctor at the time of treatment or checkup. The Pakhtun women observe strict parda was measured in two levels; to some extend and to great extend and a Pakhtun women should not talk to male doctor was also measured from to some extend and to great extend.

The data indicate that 210/315 respondents 66.7 percent respondents observe strict parda and not talk to doctor at the time of checkup and treatment to great extend while only 105 (33.3%) respondents observe strict parda and not talk to doctor at the time of checkup and treatment to some extend. Thus the above table indicate that a majority proportion observe strict parda and not talk to male doctor at the time of checkup and treatment.

The chi-square value (2.24) at 0.000 level of significance indicated highly significant and positive association between these two variables.

Basic reason behind that in Pakhtun culture women are observe strict parda and no women is allowed to go out side the house with out parda even in an emergency and

mostly they are restricted to their houses and they only follow those rules made by male members. The women in Pakhtun society are not allowed to visit lonely for checkup and they are permitted only some elder women company her. As Pakhtun culture women have no right to talk regarding her illness to male doctor only the elder women talk regarding her illness to male doctor.

Hypothesis No. 04. There is strong link between cultural interpretation of pakhtun traditions and religious teaching

Table No. 4.85. An association of cultural codes and religious codes doctor

Cultural Cods	Religious Cods		Total
	Some extend	Great extend	
Some extend	125 97.7%	3 2.3%	128 100.0%
Great extend	14 7.5%	173 92.5%	187 100.0%
Total	139 44.1%	176 55.9%	315 100.0%

Chi-square = 2.506 Significance = 0.00 Lambda = 0.31 Gamma = 0.003

The above table shows the association between cultural interpretation of pakhtun traditions and religious teaching. The Pakhtun women should not talk to male doctor was measured by two levels; to some extend and to great extend while the God does not like women to consult male doctor for checkup or treatment was measured by to some extend and to great extend.

The table indicate that 176/315 respondents which is 56 percent of the total respondents not talk to doctor and they have strong belief that God does not like those women who consult with male doctor for checkup and treatment while 44 percent respondents not talk to doctor and answered that to some extend God does not like women who consult the male doctor for checkup or treatment at the time of illness.

The chi-square value (2.506) at 0.000 level of significance indicated highly significant and positive association between these two variables.

Basic reason behind that in Pakhtun society male mostly the women are uneducated and unaware regarding Islamic values thus male member preach them that God also not like those women who talk to male doctor or any other male out side the family. In Pakhtun culture those women are considered bad character who talking to male out side the family. As in Pakhtun culture women have no right to talk regarding her illness to male doctor only the elder women talk regarding her illness to male doctor.

Hypothesis No. 05. Lower the monthly income of the respondents lower will be eating of enough food during pregnancy

Table No. 4.86. An Association between the monthly income and eating of food required in pregnancy

monthly income in Rupees	Enough food during pregnancy		Total
	Yes	No	
0001-5000	7	38	45
	15.6%	84.4%	100.0 %
5001-10000	15	81	96
	15.6%	84.4%	100.0 %
10001-15000	17	75	92
	18.5%	81.5%	100.0 %
Above 15000	51	31	82
	62.2%	37.8%	100.0 %
Total	90	225	315
	28.6%	71.4%	100.0 %
Chi-square = 61.638	Significance = 0.00 Lambda = 0.047 Gamma = 0.077		

Above table shows that there is a high level of significant association between the respondent total monthly income in rupees and their eating of enough food during pregnancy period.

The family monthly income from all sources was measured in four levels; 0001-5000 R/m, 5001-10000 R/m, 10000- 15000 R/m and above than 15000 R/m. The respondents eat of enough food which is required in pregnancy period was categories at two level; Yes and No.

The above table indicates that among 45 respondents which fall in first category 0001-5000 R/m a majority proportion 84.4 percent respondents not take enough food in the

pregnancy period while only 15.6 percent respondents taking enough food in the pregnancy period. Among 96 respondents a majority proportion 84.4 percent fall in category 5001-10000R/m not take enough food in pregnancy period while only a limited 15.6 percent respondent eat enough food in pregnancy period. Among 92 respondents which fall in 10001-15000 R/m category 81.5 percent respondents not eat enough food in time of pregnancy while the reaming 18.5 percent respondents eat enough food in the time of pregnancy period. Among 82 respondents which fall above 15000R/m from all sources 37.8 percent not take enough food in the pregnancy period while majority proportion 62.2 percent respondents eat enough food in the pregnancy period. Thus the above table indicate that majority proportion which monthly income above than 15000 R/m eat enough food in pregnancy period while majority proportion which fall in category 0001-5000 R/m not take enough food in pregnancy. Thus monthly income strongly affect eat of enough food in pregnancy period.

The chi-square value (61.63) at 0.000 level of significance indicated highly significant and positive association between these two variables.

Basic reason behind that is Pakhtun society women have no such importance as compare to male members of the family and male members are considered the earning hand so they have right to eat good quality and healthy food as compare to women whatever she is in pregnancy period.

CORRELATION

		Women's Access to Health	Socio-Cultural Constraints
Women's Access to Health	Pearson Correlation	1	0.932**
	Sig. (2-tailed)		.000
	N	315	315
Socio-Cultural Constraints	Pearson Correlation	.0932**	1
	Sig. (2-tailed)	.000	
	N	315	315

(**Correlation is highly significant at the 0.01 level (2-tailed), r (315) =0.932; p<.01. r^2=0.93) (Since 93% of the variance is shared, the association is obviously a strong one)

The above table indicates the association between independent variables that is Socio-Cultural constraints and dependent variables (Women's Access to Health). The result of the correlation demonstrate highly significant relationship as (**Correlation is highly significant at the 0.01 level (2-tailed), r (315) =0.932; p<.01. r^2=0.93)(Since 93% of the variance is shared, the association is obviously a strong one)

Further it authenticates the proposed hypothesis as valid that there is strong connection and association between dependent and independent variables.

CHAPTER FIVE
CONCLUSION

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CONCLUSION

5.1. Summery

Despite the fact a lot of socio-cultural issues in Pakhtun society are still there in women's access to health despite the fact women's still remain a lot of socio-cultural issues in Pakhtun society to access health facilities. While many factors restricted women's access to health facilities in Pakhtun society. The women subordinate role in the family, lack of transportation, unavailability of health facilities, women have no decision making power, early marriages, Pakhtun women's observe strict parda, disapproval of physical examination by male family members, sharing of health condition by women's mostly with their other women members of the family, lack of privacy, restriction on women mobility, non seriousness of male member in women health condition, male are the decision maker of the family matters, women's role as house wife, women's not taking their health issue serious, lack of use of maternal health care services during pregnancy, delivery mostly concluded by Traditional Birth Attendants (TBAs) at clinics or homes, avoiding modern technology for checkup, male family recommending women for faith healer, self mediation, lack of equipped medical professionals these above are important factors contributing to lack of women's access to health facilities in Pakhtun society.

Women in Pakhtun society are more likely to have births delivered at home.

> *"Traditional birth attendants (TBAs) still play a major role in assisting the delivery and in some hilly areas the percentage of using unskilled birth attendants is very high.*

The Provincial government has made several attempts to improve health condition of the women's by making health facilities in the area more accessible and by improving service quality. However, the utilization of the health care requires voluntary participation from the male members of the Pakhtun society themselves to decide if they want to employ these services or not."

Thus, underutilization of women's access to health facilities, particularly the lack usage of delivery care is perhaps related not only to accessibility but also acceptability and affordability by the Pakhtun families. Accessibility, affordability and acceptability of women are related to their male member's attitudes, social influence and their self efficacy towards health care usage. The attitudes, social influence and self efficacy of a woman depend on her family environment, traditions, values, demographic characteristics, economic, culture and most important the approval of male members of the family.

The preceding chapters of this study have discussed and examined the patterns of women's access to health facilities and their socio-cultural determinants. This last chapter presents a summary of the major findings and some implications of the results in order to give suggestions for future research and program strategies needed for the improvement of women's access to health in Pakhtun society.

As stated in Chapter One, this study has four objectives. The first objective is to identify the socio-economic characteristics of respondents in Pakhtun Society to examine the influence of women's and their husband's characteristics as well as the women's household variables on their access to health facilities in Pakhtun society. The second objective is to identify the socio-cultural constraints to women's health access in Pakhtun society. In addressing the first and the second objectives, bivariate analyses have been

used. The bivariate analysis has been based on tests of association (Chi-square tests). The third objective of the study is to identify the availability of health resources/facilities in the area. This objective focusing on the available resources for women's in health sector in the area. The fourth objective of the study is to suggest policy measures to address the issue of women health in Pakhtun society. Last objective focused that to provide implications for future research and improving policies and programs for improving women's access to health care in Pakhtun society. With reference to the first, second and third objectives, the major findings are presented in the first section of this chapter. The research and policy implications are presented in a separate section in order to address the fourth objective.

5.2. Major Findings

1. Majority proportion i.e. 50.7 percent of the respondent's belonged to age group 26-30 years. This finding shows that most of the respondents were young married women.
2. Majority proportion i.e. 47.9 percent of the respondent's was housewife. This finding shows that most of the respondents were not permitted to do job or any work out side the family in Pakhtun society.
3. About one third proportion i.e. 34.3 percent of the respondent's was helping their husbands in farming. This finding shows that most of the respondents were only allowed for farming with their husband permission in Pakhtun society.
4. About one third proportion i.e. 30.5 percent of the respondent's monthly income was between 5001-10000 rupees per month.

5. Majority proportion i.e. 93.3 percent of the respondent's was living with their husband.
6. About half of the respondents 48.9 percent married under 18 years of age. This finding show that culture of early marriages is prevailing in pakhtun society.
7. Majority of the respondents 92.1 percent marriage was arranged. The table shows that in Pakhtun society women marriage decisions are taking by the male family members.
8. Majority proportion 84.8 percent respondents were not consulted for their marriage decision. This table shows that in Pakhtun society women are the subordinate and property of male family members and they have full right to take future decision of their women.
9. Only 8.3 percent respondents was consulted by the male members in their marriage decision.
10. Majority proportion 55.6 percent respondents were living in joint family system. The table shows that in Pakhtun society joint family system strongly prevail and male members lead the families.
11. All most half 51.8 percent respondents were illiterate. This table shows that right of basic education for women is exploited in Pakhtun society.
12. Majority proportion 98.4 percent have female and 94.3 percent have male children. This table shows that in Pakhtun society preference given to large family size and most of the respondent living in joint family system.

13. Majority proportion 85.7 percent respondent feel there health condition average because of there subordinate position and domestic workload in joint family system.
14. Majority proportion 63 percent respondent feel mostly illness in their health condition. One of the reasons is women in Pakhtun society ignoring their illness in respect of domestic work.
15. Majority proportion 66 percent respondent feel illness some time in their health which mean they only considered the main illness as illness. The main reason is their less importance to health condition.
16. In response to chronic diseases majority 84.1 percent respondent answered that they have no chronic disease.
17. In response to parental family chronic diseases majority 80 percent respondent answered that their parental family have no chronic disease.
18. In response to husband family chronic diseases majority 87.6 percent respondent answered that their husband family have no chronic disease.
19. Half of the respondents 53 percent respondent's share about their illness with mother in law in the husband family. The main reason is that in Pakhtun family with in home the representative of the women is mother in law.
20. Almost one third of the respondent 34 percent seeking their health from Traditional Birth Attendants (TBAs). This is because of the distance of health facilities, retraction on mobility and less expensive as compare to other service providers.

21. Majority proportion 42.2 percent respondents company by mother in law for checkup or treatment at the time of illness because of sharing their illness with mother in law in Pakhtun families.
22. Majority proportion 73.3 percent respondents not affording the medicine price because of poverty. In Pakhtun society women considered less important as compare to male members of the family that's why the family male considered investment on their health as the waste of money.
23. Majority proportion 62.2 percent respondent sharing about their pregnancy to mother in law. In Pakhtun society women have no right to share about pregnancy with male member of the family. The male feel sham when women become pregnant till their delivery.
24. Majority proportion 80 percent respondents not checkup in pregnancy period. In Pakhtun society the women who are pregnant and going out side the home male of that family feel sham in the society.
25. Majority proportion 74.1 percent respondents not taking enough food in pregnancy period because in Pakhtun society women are not aware that in pregnancy what need to eat and how much need to eat. The women giving preference that male member of the family eat good, healthy food because they are the master of the family.
26. All most one third proportion 36.2 percent respondent last delivery takes place in home. The main reason is the observance of strict parda, lack of transportation, lack of women gynecologist and un-availability of health facilities, equipments in the health center and the expenses.

27. One third 30 percent of the respondents answered that parda is the reason of delivery at home. In Pakhtun families women are not allowed to go out side the family with out male member permission and company of any one from the family. In Pakhtun society women observe strict parda.
28. One of the forth proportion 24 percent respond that there is BHU facility available in the area but with out adequate equipments and women doctor due to which they are not permitted for treatment in BHU.
29. Majority proportion 59 percent respondents answered that health facilities available faraway from their area where all health facilities available and they cover more than 30 minutes traveling. The women in the area consult with TBAs because of available at door step with less expense.
30. One third proportion 39 percent women respond that pregnancy is the main illness which compels them to consult doctor or other health services provider. This result shows that the other illness are not considered illness as much pregnancy.
31. One third proportion 30 percent respondent answered that they visiting BHU for treatment with mother in law or any other male family member but due to unavailability of health equipments and medicine the treatment is not satisfactory and no women health service provider available.
32. Majority proportion 60 percent respondents answered that male doctor available in health facilities. Thus in Pakhtun society women are not permitted for treatment from male doctor.

33. Majority proportion 65 percent respondent share that the age of the male doctor matter very much at the time of checkup and treatment like they are permitted for checkup to those male doctor whose age more than forty.
34. All most all the respondents 97 percent respondents answered that doctors language is Pushto. In Pakhtun society women are mostly un educated and they don't know any other language rather than Pushto so Punjabi, Urdu and other language doctor cant survive in the area.
35. One third proportion 40 percent respondents show the result that doctor behaviour is cooperative in the sense to attract patient next time.
36. In response to talking with doctor 42.2 percent mother in law talking with doctor regarding women illness while the patient have no permission to talk to male doctor in Pakhtun society.
37. A limited respondent visiting to male doctor for checkup and treatment among those limited 43 percent respondent were physically examine by the doctor.
38. Hundred percent respondent answered that health service provider ask for regular visits and re checkup.
39. Majority proportion 68 percent women respondent taking medicine regularly till there recovery when the women recover their health then they not completing and finishing the medicine.
40. Majority proportion 58 percent respondent not re visiting for checkup. The main reason of not re visiting is domestic work load and mobility restrictions in Pakhtun society.

41. Majority proportion 60.3 percent respondent observe strict parda. Due to their strict parda they are not permitted to go out side the family even in time of serious illness.
42. Half of the respondents remain in home. In Pakhtun society women are responsible for overall management of the home affaires thus their home management more important than their own health.
43. Majority proportion 61 percent respondents in Pakhtun society strictly adhere to her husband because husband is the Majazi Khuda of wife.
44. Majority proportion 58 percent respondents in Pakhtun society restricted to their home and no permission of mobility.
45. Majority proportion 55.9 percent respondents were accompany by other family member for treatment or checkup thus when someone not free in the family she suffer seriously from illness.
46. Majority proportion 66.7 percent due to Pakhtun codes not permitted to talk to male doctor.
47. Majority proportion 60.3 percent respondent must be obedient to her husband due to Pakhtun traditions.
48. Majority proportion 59.4 percent respondents sacrificing in kind of health for family. She doing work and managing family affaires despite their illness.
49. Majority proportion 59.7 percent respondent play their subordinate role in the family as declare by the rules made by male members
50. Majority proportion 59.1 percent respondent abide the rule to great extend Formby male members for them.

51. Majority proportion 60 percent respondent abide the decision to great extend taken by male members for them.
52. Majority proportion 60 percent respondent maintaining the supremacy of her husband.
53. Majority proportion 59.7 percent respondent not bothering to her husband regarding her health.
54. Majority proportion 59.4 percent respondent bear the problem alone.
55. Majority proportion 60 percent respondent not sharing about her health with male members of the family.
56. Majority proportion 60 percent respondent discussing only her serious illness with in family.
57. Majority proportion 60 percent respondent telling her mother in law regarding their illness because in husband families mother in law is the elder women and responsible for other women in the family.
58. Majority proportion 59.4 percent respondent answered that in Pakhtun families they are restricted from mobility by male members because they are our master.
59. Majority proportion 60.3 percent respondent taking local remedy at home due to restriction on mobility.
60. Majority proportion 60.3 percent respondent not taking medicine regularly once they recover from illness.
61. Majority proportion 59 percent respondent consulting local healers because the male are the earning hand and they considered the high treatment an consumption of money that's why the women consulting local healer for treatment.

62. Majority proportion 59.4 percent respondent were restricted by Pakhtun rules that they not talk to male doctor.
63. Majority proportion 59 percent respondent were not telling detail regarding their illness to male doctor due to privacy in Pakhtun traditions.
64. Majority proportion 59 percent respondent answered that due to rigid and strict Pakhtun rules male doctor not allowed to physically examine the women and if male member of the family know such kind of act from doctor it leads to death penalty from the male members of the family.
65. Majority proportion 59 percent respondent consult TBAs for delivery because of unavailability of women gynecologist. The delivery with TBAs mostly leads to other physical complications in women body but in Pakhtun society women have no permission to deliver with male doctor.
66. Majority proportion 59.4 percent respondent were dislike the use of modern technology for treatment due to Pakhtun code restriction and privacy.
67. Majority proportion 59 percent respondent were not bother her husband again and again for checkup which leads to more bad health condition in women.
68. Majority proportion 60 percent respondent was delivered at home in Pakhtun society due to privacy, unavailability of women gynecologist, lack of transportation, strict parda and poverty.
69. Majority proportion 59 percent respondent were strong belief that God controlling all the matters so He do better for us in illness.
70. Majority proportion 59.7 percent respondent were strong belief that God made women subordinate for their husband and other male have superiority over them.

71. Majority proportion 59.4 percent respondent were strong belief that God controlling illness with out treatment as well.
72. Majority proportion 58.7 percent respondent were strong belief that God cure even incurable diseases.
73. Majority proportion 58.1 percent respondent were strong belief that God love the ill person.
74. Majority proportion 58.5 percent respondent were strong belief that God listen the ill person.
75. Majority proportion 56.8 percent respondent were strong belief that God dislike those women who go alone for checkup and treatment at the time of illness.
76. Majority proportion 55.9 percent respondent were strong belief that God dislike those women who disobey the husband order whatever the order by husband.
77. Majority proportion 58.1 percent respondent were strong belief that God dislike those women who discuses openly her illness to male doctor.
78. Majority proportion 55.9 percent respondent were strong belief that God dislike those women who consult to male doctor.
79. Majority proportion 58.1 percent respondent was strong belief that God order women to kept secret her illness and obey the order of husband.

5.3. Recommendation & Policy Implication

It has been concluded from the above study that women's access to health in Pakhtun society is constrained by socio-cultural factors. The following recommendations are suggested by the researcher to overcome the socio-cultural constraints on women's access to health facilities in Pakhtun Society.

- Government should focus on missing facilities in the hospitals. There is dire need to appoint new doctors, placement of fresh medical graduates in far flung areas, provision of modern diagnostic and treatment equipments in the hospitals.
- Pakhtun culture represents the traditional outlook and appreciate the role of TBA in the culture, the emphasis should be laid to give them proper training regarding hygiene and efficient use of modern equipments.
- Media, civil society, community groups, academia and religious leaders should join hands with government to bring a change in the Pakhtun culture.

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APPENDIX. A.

INTERVIEW SCHEDULE

Socio- Cultural Constraints to Women's Access to Health in Pakhtun Society

The interview schedule will be used for academic purposes and the information given kept secretes and will be useful to reach to the facts.

***The Researcher*_____**

1. Name of District _____ Tehsil _____

   U.C _____

2. Age of the respondent in complete year? _____

3. What is your occupation?

   1. Business □ 2. Government Job □ 3. Farming □ 4. Doctor □ 5. Engineer □

   6. Lawyer □ 7. Self Employ □ 8. Housewife □ 9. Any other □

4. What is your Husband occupation?

   1. Business □ 2. Government Job □ 3. Farming □ 4. Doctor □ 5. Engineer □

   6. Lawyer □ 7. Self Employ □ 8. Any other □

5. What is your family Monthly Income from all sources in Rupees?

   1. 0001 – 5000 □ 2. 5001—10000 □ 3. 10,001-15000 □ 4. Above 15000 □

6. What is your current marital status? 1. Separated □ 2. Divorced □ 3. Widow □

7. What was your age at time of marriage?

1. 10 – 12 years of age □ 2. 13 — 15 years of age □

3. 15 — 18 years of age □ 4. Above 18 years of age □

8. What was your type of marriage?

1. Arranged □ 2. Choice □ 3. Any other □

9. In case of arranged marriage were you consulted? 1. Yes □ 2. No □

10. If "Yes" who consult with you?

1. Father □ 2. Mother □ 3. Brother □ 4. Sister □ 5. Close family member □ 6. Any other □

11. What is the Type of family you are living in?

1. Nuclear □ 2. Joint. □ 3. Extended □

12. What is your educational status?

1. Illiterate □ 2. Primary □ 3. Middle □ 4. Metric □ 5. Intermediate□ 6. Graduate □ 7. Any other. □

13. How many children do you have?

1. Number of male children _____

2. Number of female Children _____ 3. Non □

14. How do you rate your own health?

1. Excellent □ 2. Average □ 3. Poor □

15. What do you think what illness is?

1. Lazinessо 2. tirednessо 3. Sleeping long time □ 4. Disability □ 5. Any other □

16. How often you feel ill?

1. Very frequently □ 2. Some time □ 3. Never □

17. Do you have some chronic diseases? 1. Yes □ 2. No □

18. Do your parents have some chronic diseases? 1. Yes □ 2. No □

19. Does your husband's family have some chronic diseases? 1. Yes □ 2. No □

20. Whom do you share about your illness in family?

1. Mother in law □ 2. Father in law □ 3. Husband □ 4. Sister in law □ 5. Brother in law □ 6. Father □ 7. Mother □ 8. Sister □ 9. Any other □

21. What is the method of treatment at time of illness?

1. Doctor □ 2. Hakeem □ 3. Faith healer □ 4. Self medication □ 5. Traditional birth attendant (TBA) □ 6. Any other □

22. Who company you to the doctor?

1. Mother in law □ 2. Father in law □ 3. Husband □ 4. Sister in law □ 5. Brother in law □ 6. Father □ 7. Mother □ 8. Sister □ 9. Any other □

23. Whatever the price of medicine affordable for you? 1. Yes □ 2. No □

24. When you become pregnant whom did you inform?

1. Mother in law □ 2. Father in law □ 3. Husband □ 4. Sister in law □ 5. Brother in law □ 6. Father □ 7. Mother □ 8. Sister □ 9. Any other □

25. Did you checking regularly in pregnancy? 1. Yes □ 2. No □

26. Are you eating enough food which required in pregnancy period? 1. Yes □ 2. No □

27. Where your last deliveries take place?

1. Government hospital □ 2. Private maternity home □ 3. Home □ 4. Any there place □

28. If delivery take place in home what was the reason?

1. Lack of transportation □ 2. Due to privacy □ 3. Due to confidentiality □ 4. Due to expenditure □ 5. Traditions/customs □ 6. Parda □ 7. any other □

29. Do you know any facility available in your area?

1. MCHC □ 2. BHU □ 3. Civil Dispensary □ 4. DHQH □ 5. THQH □ 6. Private clinic □ 7. Any other □

30. How much distance in minutes you have to cover for treatment?

1. 01 - 15 □ 2. 16 - 20 □ 3. More than 20 □

31. What type of diseases forced you to consult doctor?

Name of diseases

1)_____2)_____3)_____

32. Where you go for checkup?

1. BHU □ 2. Civil Dispensary □ 3. DHQH □ 4. THQH □ 5. Private clinic □ 6. Any other □

33. What was the gender of health service provider at time of treatment?

1. Male □ 2. Female □

34. What is the age of doctor/ health service provider in complete years?

1. Below 30 year of age □ 2. 30 – 35 years of age □ 3. 36 — 40 years of age □

4. above 40 years of age □

35. What was language of doctor/ health service provider?

1. Pushto □ 2. Urdu □ 3. English 4. Punjabi □ 5. Any other □

36. What was the attitude of the doctor/ health service provider?

1. Cooperative □ 2. Encouraging □ 3. Humanitarian □ 4. Any other □

37. Who talked to doctor regarding your illness?

1. Mother in law □ 2. Father in law □ 3. Husband □ 4. Mother □ 5. Father □

6. Sister □ 7. Sister in law □ 8. By self □ 9. Any other □

38. Doctor physically examine you during you visit? 1. Yes □ 2. No □

39. Did health service provider ask for follow up visit? 1. Yes □ 2. No □

40. How regularly you took medicine? 1. Regularly □ 2. Casually □ 3. not atoll □

41. Did you re visit to doctor? 1. Yes □ 2. No □

42. upto what extend do you agree or disagree with the following statements of Pakhtun Culture/codes which constraint women's access to health facilities

Statements	**Some extend**	**Great extend**	**Not At all**
1. A Pakhtun women should observe strict Parda			
2. A Pakhtun women should remain in home			
3. A Pakhtun women should strictly adhere to her husband			
4. A Pakhtun women should not travel alone			
5. A Pakhtun women should accompany her husband in case she has to travel			
6. A Pakhtun women should not talk to some male			

7. A Pakhtun women is a

symbol of chastity

8. A Pakhtun women should be

an obedient

9. A Pakhtun women should be

sacrificing

10. A Pakhtun Women should

play a subordinate role in the

family

11. A Pakhtun Women should

only abide by the rules made by

the male members

12. A Pakhtun Women should

abide by the decisions made by

male members

13. A Pakhtun Women should

maintain the supremacy of her

husband

14. A Pakhtun Women should

not bother about her health

15. A Pakhtun Women should

bear the problem alone

16. A Pakhtun Women should

not share her health problem

with male member/s

17. A Pakhtun Women should

only discus the serious health

problems

18. A Pakhtun Women should

only tell her mother in law

19. A Pakhtun Women should

not visit doctor

20. A Pakhtun Women should

try some local remedy at home

21. A Pakhtun Women should

not take medicine

22. A Pakhtun Women should

consult some local healer

23. A Pakhtun Women should

not talk to doctor

24. A Pakhtun Women should

not tell the details to doctor

25. A Pakhtun Women should

not allow a male doctor to

examine physically

26. A Pakhtun Women should

consult TBA first	
27. A Pakhtun Women should avoid modern machinery of examination	
28. A Pakhtun Women should not bother her husband again and again for check ups	
29. A Pakhtun Women should be delivered at home	

45. Upto what extend do you agree or disagree with the following religious statement which constraints women's access to health facilities

Statements	**Some extent**	**Great extend**	**Not At all**
1. God is controlling the whole universe			
2. God has made the women subordinate			
3. God is controlling the health & illness			
4. God can cure even incurable diseases			
5. God loves the ill person			
6. God listens ill persons pray			

7. God does not like a women to

go alone

8. God does not like a woman to

disobey the husband

9. God does not like women to

discuss openly

10. God does not like women to

consult male doctor

11. God orders a women to keep

secrets