Infertility in Pakistan:
Experience and Health Seeking Behavior among Baloch Women in a Karachi Slum

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Experience and Health Seeking Behavior among Baloch Women in a Karachi Slum

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Note on Transliterations

For this thesis, I have translated Balochi and Urdu terms in a simple way, therefore I have made no distinction between long and short vowels and between dental and retroflex consonants.

According to Axmann, the ethnonym „Baloch“ has been transliterated in different ways, the most common being „Baluch,“ but from 1990 „Baloch“ has became the accepted standard in Pakistan since this was decreed by the provincial government of Balochistan as the official English spelling (2009: ix), therefore it will be used in this form throughout this thesis.

Summary

This thesis explores the experiences, health seeking behavior and ways of coping among Baloch infertile women in a Karachi slum from a narrative perspective. In addition, the validity of current official epidemiological definitions which are based only on the clinical aspects of infertility is questioned, arguing that the experiences of infertility vary from them, and that they are a form of social suffering that needs to be understood in a broader context. It also proposes that the neglect of infertility in public health is rooted not only in its inadequate definitions but also in the reinforcement of ideas related to biopolitics by international organizations that stress the importance of demographic control and that reduce reproductive health to family planning and maternal health care.

Following research questions will be answered: what are the experiences and health seeking behavior regarding infertility in among low-income Baloch women? How do women seeking medical attention regarding infertility define and cope with their condition? For this purpose, an eleven-weeks fieldwork was conducted in a slum called Yusuf Goth in order to collect life histories of infertile women in form of interviews which portray experiences in their complexity. It will be argued that narratives construct the meanings of illness, and therefore they are essential to understand experience.

Epidemiological literature was reviewed arguing that its problems are based on the inconsistency of the infertility definition as well as on the epistemology of epidemiology, which has been criticized in the last decades for its behavioralist tendency and the insufficient inclusion of broader contexts in the study of infertility. Differently, anthropological works are centered in the experience of the infertile and claim that infertility is not only a physiological condition, but also a dialectical process shaped by the social, economical, political, and religious environments in which the sufferers give meaning to their experience. Drawing on these findings, infertility will be considered here as a form of social suffering embedded in everyday life, arguing that its study requires the inclusion of so called „axes of suffering," which in the case of infertile women in Yusuf Goth, include Baloch ethnicity, history

and politics; the health system and biopolitics; kinship and familial structures; Islam and gender; and labor migration and the economical situation.

Ethnographic material and life histories will show that infertility is a negative experience manifested also in domestic violence and gossip, and that its suffering is exacerbated through economical deprivations, the malfunctioning health system, marginalization on the basis of ethnicity, and through the failure to fulfill the expected role of mothers. Infertility, therefore, is considered a social problem which involves the whole family, friends, and neighbors. Similarly, the importance of health seeking behavior is rooted in the expectations set on women to do something about their situation; it will be argued that health seeking is also a way in which women reaffirm themselves and disclaim responsibility for the failure to conceive. Women rely on three broad categories of healers, doctors were always consulted whereas spiritual healers were considered only a last resort. The women usually consulted *dais* or doctors in the first two months after marriage if they had not become pregnant, and they continued trying different therapies for years until they quit because of their inefficacy and the huge expenses on the long term. Women declared to have spent enormous amounts in their quest to achieve birth, especially if compared with the monthly incomes in their households, and that it is often relatives who decide regarding which resort to use and when. Ethnographic data also revealed the complaints toward different healers for the lack of transparency regarding their consultations, therapies, and manners toward infertile women. The coping strategies mentioned by the women included the importance of faith, blaming the husband, talking to relatives and friends, among others. They agreed that although these ways of coping help them to carry on better with their situation, they did not reduce significantly their suffering, nor they diminished their wish to have an own child.

Finally, this thesis suggests that a structural change in the health system through a change of discourse regarding reproductive health and reproductive rights should enable poor infertile women the access to a dignifying health care system where they should be properly informed about their condition and the possibilities of treatment, and that this would contribute to relieve those whose suffering is already ingrained in other aspects of everyday life.

1. Introduction

> *Only through the concrete understanding of particular worlds of suffering and the way they are shaped by political economy and cultural change can we possibly come to terms with the complex human experiences that underwrite health.*
>
> Arthur Kleinman, 1995: 89.

It is generally accepted that around 80 million couples in the world are affected by involuntary infertility, most of whom live in so called developing countries where infertility services and artificial reproduction techniques are not widely available (Vayena *et al.* 2002: xv). Although infertility is not a public health priority in many countries, it is a central issue in the lives of the affected, whose experience is usually a negative one, often shaped by marital problems, domestic violence, stigmatization, and even ostracism, especially for women (ibid.).

In South Asia, fertility plays a central role for the construction of gender identities: often women only attain a status of sexual and social maturity after bearing a (male) child, being birth a critical event that signifies the empowering of both parents, but especially of the mother (Patel 2007: 141). Therefore, the inability to conceive incites in many infertile women a feeling of failure to fulfill the gendered role expected by society and is accompanied by a myriad of social, cultural, economic, and health consequences, including discrimination from family members and neighbors, negative mental health consequences, and even murder and suicide (Daar and Merali 2002: 16, Lavania 2006: 96, Sääväla 2001: 78f., Van Balen and Inhorn 2002, Vayena *et al.* 2002: xv, Widge 2002: 62ff.).

Although infertility poses a big problem for its sufferers, it still remains widely neglected as a public health issue. In India, for example, little attention has been given to infertility since it is considered not to threaten life, and its policy has rather focused on the managing of the population size of the country (Daar and Merali 2002: 16). Similarly, in Pakistan infertility is often not regarded as a problem, but as a „bless“ helping to achieve goals of population control: „Why are you researching

on infertility? This is not the problem of this country, you should conduct research on fertility, we have too many people over here, that‘s our problem. We should be grateful to have some infertility cases at least!“ This sort of reaction, which I encountered often while conducting fieldwork in Karachi, seems to reflect the mainstream neglect of infertility as a public health issue, highlighting the importance of economic aspects over the everyday suffering of thousands of women and men who are not able to have children in spite of their wish. According to the discourse of demographics, development is hindered through the high population number of poor countries (ibid.), therefore fertility control and the neglect of infertility can be seen as mechanisms used to exercise biopower, i.e. the adjustment of human accumulation to capital accumulation (Foucault 1983: 136, see section 4.2). This neglect, as I will argue through this thesis, does not only take place at the state level, but also on international levels where the discourses of international organizations fail to address infertility as a reproductive health issue related to reproductive rights.

The World Health Organization (WHO) defines infertility in its International Classification of Diseases (ICD) as „the inability to achieve pregnancy, sterility“ (ICD-10, http://apps.who.int/classifications/apps/icd/icd10online/). The ICD-10 is the worldwide standard for the diagnostic and classification of all epidemiological works, standard foci, and clinical uses, and it is solely based on the clinical manifestations of diseases, not taking into account their social meanings. Infertility, therefore, is only classified according to its disease dimension. Helman used Cassell‘s definitions of illness and disease to distinguish between a doctor‘s and a patient‘s perspective of a disorder (2001: 83). The experience of an affliction by the patient, therefore, is more the experience of illness and not of disease, considering that illness is defined as:

> the subjective response of an individual and those around him to his being unwell; particularly how he and they interpret the origin and significance of this event; how it affects his behaviour and his relationship with other people; and the various steps he takes to remedy the situation. It not only includes his experience of ill health, but also the *meaning* he gives to that experience (ibid., emphasis in original).

Illness, therefore, encompasses more than the mere manifestation of a disorder in an individual. Its dimension includes the social environment and the response toward it; the experience of and the meaning given to an affliction. Epidemiology, as it will be argued through this thesis, has failed to address infertility from an illness perspective, since it still continues to work predominately with the „disease“ category, especially regarding definitions.

According to Good and Del Vecchio Good, narrative practices construct the meanings of illness (1994: xiii). Since these narratives have different authors, including the sufferers, their families, healers, and others, their meanings are social products (ibid.). In this context, I will argue that the meanings of infertility are socially constructed and that the official, standard clinical definitions, such as those used by the WHO, are unsuitable if not inaccurate to conduct research on infertility.

The aim of this thesis is to gain a deeper understanding of infertility, elaborating its social meaning and the ways in which it is socially constructed in a section of Pakistani society. For this purpose, I conducted an eleven-weeks fieldwork in Yusuf Goth, a slum in Karachi[1], including participant observation and the collection of life histories of childless, low-income Baloch women in order to answer following two connected research questions: What are the experiences and health seeking behavior regarding infertility in Yusuf Goth? How do women seeking medical attention regarding infertility define and cope with their condition?

Through answering these questions, I expect to prove that current official and standard definitions of infertility are not universal and that true working definitions cannot be solely based on clinical manifestations. For this purpose, I considered „infertile“ those childless women seeking health for infertility, regardless of if it is them or their husbands who are clinically infertile, giving priority to their own self-definition and experience.

Infertility, as aimed to reflect, must be studied in its context. In the case of low-income women in Yusuf Goth, infertility can be understood as a form of social

[1] The fieldwork research for this thesis was financed through a scholarship from the German Academic Exchange Service (DAAD), for which I am very grateful.

suffering which „results from what political, economic, and institutional power does to people and, reciprocally, from how these forms of power themselves influence responses to social problems“ (Kleinman, Das, and Lock 1997: ix). In other words, the experience, health seeking behavior and the ways of coping with infertility are the product of different, interconnected domains in which the everyday lives of childless women take place.

The beginning of this thesis deals with the research and the methods selected for it. I will portray Yusuf Goth, the locality chosen as field and the setting where the everyday lives of the interviewed infertile women take place. Here, the importance of illness narratives and life history research for the study of experience, as well as the benefits of focused ethnographic studies (FES) for a short-term ethnographic research will be outlined. I will also explain who constituted the sample for this study and how I conducted interviews and participant observation.

In chapter three literature on infertility, both from epidemiology and anthropology will be reviewed. Here I will suggest that epidemiology has failed to address the question of definitions in a proper way, and that the inclusion of broader contexts has taken place mostly on behalf of psychological and behavioralist approaches, which have been criticized by different authors who proposed new epidemiological approaches in which the epistemology of epidemiology, i.e. its methods and scope, but also its claims of validity, are questioned. The second section presents a review of anthropological and sociological works on infertility which are centered in the experience of the infertile, arguing that infertility is a dialectical process shaped by the social, economical, political, and religious environment in which the sufferers give meaning to their experience, and that the physiological aspects of it do not determine the course of its experience. Here, I will also draw on the anthropology of suffering, arguing that infertility is a form of social suffering and that its experience is shaped by many different aspects embedded in everyday life.

Chapter four draws on Farmer‘s idea of “axes of suffering“ (1996: 274) in order to portray the context of infertility in Yusuf Goth. First of all Baloch ethnicity, history and politics will be covered, arguing that the marginalization of Baloch people

contributes to deepen the suffering experience of infertile Baloch women. The second section of this chapter deals with the health system and biopolitics, here the problems of the health system in Pakistan will be discussed, arguing that its negative influence on the experience of infertility draws upon corruption and the failed conception of the system, and that the neglect of infertility as a public health issue is also rooted in the reinforcement of ideas related to biopolitics by international organizations, who stress the importance of demographic control and who reduce reproductive health to family planning and maternal health care. The third section of this chapter portrays familial and marriage structure among Baloch people in Yusuf Goth, arguing that the endogamic marriage pattern has rather a positive influence regarding the infertility experience, but stressing that it does not hinder women from being exposed to domestic violence due to their condition. In the fourth section, which deals with Islam and gender, I will argue that Islam has both a positive and a negative influence on the infertility experience: on the one hand, it defines womanhood through motherhood, thus the gender identity of infertile women is confronted by themselves and their environment; on the other hand, Allah is believed to have put infertile women in their situation, and faith on God is also a source of relief and a way of coping with it. The last section of this chapter deals with labor migration and the economical situation. Here I will argue that extreme poverty is a major source of suffering in the everyday lives of people in Yusuf Goth.

Chapter five presents ethnographic material to portray the everyday suffering of infertile women in Yusuf Goth. Here I will discuss the social aspects of infertility experience, like the importance of children, the threats to which infertile women are exposed to, and how domestic violence and gossip contribute to shape the own perception of it. It will be concluded that infertility is a social problem which involves the whole family, friends, and neighbors, and that it is experienced as a negative situation which constitutes an additional form of suffering in the everyday lives of poor Baloch women.

Chapter six deals with health seeking behavior, I will start with a narrative to later discuss the importance of *'ilaj* (getting treated) for infertile women, being this a central concept in their lives and a way of reaffirming themselves and stand in front

of others. Medical pluralism in Yusuf Goth will also be portrayed through the description of three different and broad categories of healers that women consult for infertility: *dais*, doctors, and *mullas*. In the third section of this chapter, I will describe the patterns of resort of infertile women in Yusuf Goth, suggesting that they vary enormously and that it is difficult to establish clear patterns. This section also deals with complaints toward the medical system and the different practitioners, an aspect that influences health seeking behavior and also adds to the suffering of being infertile. The fifth and sixth sections of this chapter deal with financial matters and decision making, here the influence of costs and money availability as well as who decides on health seeking behavior regarding infertility will be discussed.

In the last chapter of this thesis I will deal with the ways of coping, portraying the importance of faith, blaming the husband, talking to relatives and friends, as well as other ways of coping, arguing that although they do help women to carry on better with their situation, they do not reduce significantly their suffering, nor they diminish their wish to have an own child.

I am in debt with many persons who made this research possible. I would like to thank Bilqis Nadir and her family, the non-government organization (NGO) All Pakistan Women‘s Association (APWA) and the staff of its clinic in Yusuf Goth for their kind support and help, and especially the infertile women in Yusuf Goth who let me in their homes and confided me their joys and sorrows. Their names have been changed in order to ensure anonymity.

2. Research and Methods

2.1 The Field: A Slum Called Yusuf Goth

After a forty minutes ride from APWA‘s office in Saddar, Karachi‘s city center, and shortly before reaching the border with Balochistan, the NGO‘s car arrives three days a week in Yusuf Goth, on the right side of the road. Trucks are parked there waiting to get fixed or to get new colorful designs and shapes in their exterior, most of them come from Las Bela and Quetta, both cities in Balochistan. There is a also a bus-stand offering services to that area, therefore it is a place where many Baloch living in Karachi meet.

According to some inhabitants, the settlement is around 20 years old, but most of the houses, small two to three-room buildings made out of concrete, without windows but with a patio, have been built in the past couple of years. In fact, I noticed the expansion of the built areas since my first visit to Yusuf Goth in 2007 to the time of my fieldwork, in August 2009. Still, there is no official data available about the number of inhabitants of the settlement: despite the obviously growing population of Yusuf Goth, there are no public primary health care facilities, nor are there public schools. There is also no tap-water supply, no proper streets, and, ironically, no waste-disposal-system, even though the waste of Karachi is put at around only two kilometers away from Yusuf Goth, outside Karachi, across the Balochistan border.

The times I was in Yusuf Goth, it looked like a squalid village with urban architecture, with piles of litter outside the houses. Dirty dogs and cats would be walking around the streets full of kids, who would be playing barefoot with whatever they might have found. Also a few women would be walking around, covering their colorful Baloch-dresses with black *burqas*, and some men would be sitting outside the truck workshops, their *kurtas*, arms and faces would be blackened with motor-oil and dust. Most of the people in Yusuf Goth are Baloch, but according to APWA‘s staff Pushtuns (usually from Balochistan), Sindhis, Punjabis, and Siraiki-speaking people also live there.

The jurisdiction of the settlement is unclear, some people said that it as a part of Keamari Town, others considered it as part of Baldia Town. No official map of Karachi mentions Yusuf Goth, it is as if it was non-existent. It is impossible to get any official information about the area, therefore I had to work with estimated numbers given by inhabitants of the settlement. Being no hospitals nearby, most of the births take place at home and therefore no registration of births is made, and because there are no public schools there is also no data regarding the children. The residents remain invisible for the authorities.

APWA is the only NGO working in Yusuf Goth, it has run a primary health care center for women and children since 1994. The centre was closed in December 2008 due to lack of funds, but since the opening of APWA‘s girls‘ school in June 2009, the clinic reopened in the second floor of the new school building. The clinic staff includes a doctor from Quetta, a female and a male assistant who have been working in the clinic since its beginnings; both are Baloch and live in Yusuf Goth. A ladies health visitor (LHV) conducts ultrasounds once a week in the clinic, though she is also well known in the community because she used to run the clinic before the doctor joined. The staff is completed by a sweeper who is also Baloch. It was in this small clinic where I conducted participant observation while I waited for being brought to the houses of infertile women.

2.2 Illness Narratives, Life History Research, and Focused Ethnographic Studies (FES)

Since the main aim of this thesis is to portray experience and health seeking behavior in a holistic way, it was important to choose methods that allow the positioning of the individual experience of infertility in a broader context. For this purpose I used the narrative method in form of life history research.

From the late 1980s a narrative turn took place in scholarship, which, according to Sandelowski (1993: 2), was part of a larger change in the social and behavioral sciences „toward interpretive methods and away from conventional research

strategies that fail adequately to represent personal meaning and the varieties of reality.“ Narratives have been used in medical anthropology since then because they allow us to learn about beliefs, perceptions, actions, and experiences not only of the ill, but also of their families and of the healers (Mattingly 1998: 7). If we agree with Good and Del Vecchio Good, illness narratives are neither simply accounts of experience nor cultural fictions; moreover, they formulate reality and an attitude toward it (1994: 841). Kleinman also pointed out that narratives create, control and give meaning to life problems (1988: xiii). For him, meaning is the central aspect of illness experience, he criticized the fact that the interpretation of narratives of illness experiences has been neglected by medical doctors, although it should be a central task in their practice (ibid.).

The most important characteristic of the narrative method is the focus on the individual and the complexity of his or her experience. According to Cole and Knowles, life is considered to be lived as a whole set of complexities which are constituted by personal, temporal, and contextual connections and relationships (2001: 19). The difference between narrative research and life history research is that the latter relies, according to them, on the placing of the narrative accounts in a broader context, including the familiar, political, educational, and religious spheres, in other words: „Whereas narrative research focuses on making meaning of individual‘s experiences, life history research draws on individual‘s experiences to make broader contextual meaning“ (2001: 20).

The importance of the context for experience was also acknowledged by Kleinman, according to whom human conditions constrain lived experience (1995: 98f.). He criticized psychological approaches arguing that „the flow of experience is not the product of a human nature (personality, instinct, etc.) but the condition for its emergence as both shared and culturally particular, and therefore far from the determinative agency“ claimed by behaviorists and other psychological theorists (ibid.). Kleinman concluded that ethnography offers a better alternative to gain a valid knowledge of the „dialectical structure and contingent flow of lived experience“ than other reductionist forms of knowing like behavioralism and psychology (1995: 99). We can conclude, therefore, that in order to get closer to the

ideal of a complete description of social experience, it is necessary to analyze both the experiences as lived by the subjects and the conditions in which the experiences take place, and that this analysis is possible and should be carried out through ethnographic fieldwork.

Due to the limited period I was given to conduct this research, I opted for a methodology called focused ethnographic studies (FES), which seemed to be the best alternative to the long-term, classical ethnographic research. FES differs from classical ethnography in that it is focused on specific questions and provides clear target areas for the process of data collection (Campbell *et al.* 1999: 54). Following this methodology, first I conducted interviews with health professionals in order to get some views on structural determinants for health seeking behavior from their perspective. Because these views can be biased, they were only used as a staring reference before conducting interviews with infertile women.

Another important aspect of FES was participant observation, which in the case of this research took place mainly at one primary health care center (PHCC) run by the APWA, where I sat either in the waiting room, observing and interacting with the patients and staff coming, or in the doctor‘s room, where I could observe doctor-patient interactions. I could conduct most of the interviews with childless women, except for one, at their own homes. Since the visits were only reduced to the purposes of interviewing, I acknowledge that these observations were limited; nevertheless, they were useful to gain insights of the living conditions, the familial relations, and everyday lives and routine of infertile women in Yusuf Goth.

2.3 Building the Sample, Conducting Interviews

I conducted open interviews with a total of twelve infertile women in two PHCCs, but for this thesis only seven of them where analyzed closely.[2] The sample was finally constituted by six Baloch women and one Sindhi woman married into a

[2] I also conducted fieldwork in another PHCC in Golimar, but for this thesis I only analyzed data of women from Yusuf Goth living in Baloch households. Other interviews, where women were reluctant to talk openly, were also excluded from this thesis.

Baloch household, all between 18 and 33 years old who had not given birth to a child yet, though some of them had been pregnant but had miscarriages. All the interviews were conducted by myself in Urdu and each lasted from 30 to 70 minutes, in order to guarantee privacy it was ensured that the interviews take place in a separate room where only the interviewee and I could sit and talk. The interviews were recorded with the consent of the interviewees and were later transcribed and translated into English by myself. Whenever understanding difficulties arose I asked native speakers for help.

The fact that Yusuf Goth is mostly inhabited by Baloch people offered me the opportunity to conduct research among a quite homogenous group of women who share, as it will be discussed later, a same language, a more or less similar patterns of marriage and kin relations and also a system of values, especially regarding family, children and religion. All the women are Sunni Muslims and five of them belong to the so called ‚Makrani Baloch', i.e. descendants of black slaves (see section 4.1). These patterns became visible at the time of talking about the perception and experience of childlessness. On the other hand, conducting research in Yusuf Goth offered me the possibility of access a number of informants who, apart from sharing the above mentioned cultural understanding and values, also share the same deprivations regarding the deficient infrastructure of the area described above.

I was fortunate to have been two years earlier in Yusuf Goth researching health seeking behavior of women regarding reproductive health, this allowed me to observe some changes and continuities, meet informants again and get easily accustomed in a rather harsh locality.

3. Studying Infertility: A Matter of Scope

3.1 Infertility in Epidemiological Research

Epidemiology, „the study of the distribution and determinants of the various forms of disease in human populations“ (Helman 2007: 372), focuses not on individuals but on groups of people, both the healthy and diseased. In order to find patterns of disease and connected behavior to make their findings comparable, epidemiologists have been looking for standard definitions and forms of measuring. The study of infertility in epidemiology has been characterized by the inconsistent definition of the terms infertility, sterility and infecundity, which are used interchangeably without a clear definition according to their context of usage (demographical or medical) and to the language in which they are expressed (Rutstein *et al.* 2004: 3). On the other hand, these standard definitions are also re-interpreted and differently used by medical staff worldwide, as could be observed during fieldwork.

Epidemiologists have been trying to establish a single definition for infertility since several studies revealed that the different usages lead not only to different research findings but also influenced the probability of future conception in the patients, having therefore a direct impact on them (Marchblanks *et al.* 1989: 259). These authors blamed the lack of a standard definition of infertility for deterring efforts to characterize the epidemiology of infertility better (ibid.: 260), therefore recognizing the fact that the problem of defining infertility is also decisive for the neglect it is given in public health. Although this critique is concerned with an improvement of research and, therefore, the further involvement with infertility from an epidemiological perspective, it still failed to offer a true solution, and, on the other hand, it is still only focused on clinical definitions. As Marchblanks *et al.* concluded, the differing definitions determine who is classified as infertile (ibid.: 264). Since the aspect of experience is neglected, the subjective perception of the condition remains, therefore, irrelevant.

Schmidt and Münster agreed that the usage of different definitions poses a problem to the comparison of studies on infertility, thus they suggested the application of

identical terminology in epidemiological and demographical studies, ideally the definition proposed by the WHO (1995: 1407). The WHO recommends the calculation of the prevalence of infertility in women as „[t]he percentage of women of reproductive age (15–49 years) at risk of becoming pregnant (not pregnant, sexually active, not using contraception and not lactating) who report trying for a pregnancy for two years or more“ (WHO 2006: 49). This indicator includes both primary and secondary infertility.[3] Again, we are confronted with an insufficient answer to the problem of definition since the WHO does not take the subjective perception into account to define who is infertile, nor does the international classification of diseases (ICD-10) include the aspect of experience since it is solely based on clinical aspects, thus remaining inadequate. Such definitions and classifications constitute enormous biases for research, especially regarding health seeking behavior. Moreover, the lack of attention put on suffering can be blamed as one of the reasons why infertility has been so neglected in public health.

The aspect of experience in epidemiological research on infertility tends to be considered only in relation to mental health aspects. Epidemiological work mainly focuses on the causes of infertility and on the impact it has for the patients in their mental health (Fisher 2009: 129ff.). It is only in the latter works that the aspect of experience is also researched by epidemiologists who either believe that psychological factors are the cause (psychogenic hypothesis, now mostly rejected) or who investigate the adverse psychological consequences of being infertile (Greil 1997). Greil criticized this approach, arguing that:

> Instead of asking how the infertile experience infertility in their everyday lives, the psychological literature asks whether they are more or less distressed than other groups of people. Instead of viewing the experience of infertility as a socially constructed life crisis, the psychological distress literature transforms it into an individual trait [...] Until research is guided by a more holistic and sophisticated theoretical framework, the results of efforts in this fields will remain disappointing (ibid.: 1700).

Since the 1960s, anthropological methods and theories have been used in epidemiology; today, it is generally recognized that human diseases and disorders are

[3] These terms are also problematic because they are also defined in different ways, Fisher defined primary infertility as „the inability to conceive at all“ and secondary infertility as „those who have at least one living child but are unable to conceive again.“ She added a third category called sub-fecundity, which is „the capacity to conceive but not to sustain a pregnancy to term“ (2009: 128).

the products of many factors between the „causal web“ or „web of determinants“[4] including exogenous, demographic, and cultural factors (Dunn and Janes 1986: 3). Dunn and Janes also agreed that „[b]ecause all diseases are caused, at least in part, by the behavior of individuals, groups or communities, epidemiology must be a behavioral science“ (ibid.). This behavioralist approach, which was initially seen as the main commonality between anthropology and epidemiology (ibid., Fleck and Ianni 1957: 38), has been contested in the last two decades by many scholars who criticized the decontextualization of exposure to risk factors and individual behavior, specially regarding women‘s health (Farmer 2005, Inhorn and Whittle 2001, Inhorn 2006, Krieger and Zierler 1995). The behavioral approaches, the authors argue, blame individuals by portraying risks as lifestyle, being research based on them biased through the neglect of social organization and hierarchies, global political economies, and nation state policies (ibid.).

Inhorn and Whittle proposed a synthesis of what they called the „new epidemiologies,“[5] focusing on the elimination of anti-feminist biases through the questioning of assumptions like the understanding of reproductive health as „women‘s health,“ which reduced women to a „reproductive sex“ that has to be „controlled“ (2001: 556ff.). It was these two authors who explicitly called against the biological essentialization of women in epidemiology and public health, appealing for the inclusion of social science approaches and theories in order to transform epidemiology into an emancipatory discipline. This approach, called „feminist epidemiology,“ is based on epistemological approaches that are closely related with anthropological research and that emphasize the multivocality of women, the record of everyday life experiences, and the recognition of various forms of political, social, and economic oppression to which they are subjected.

The critique on the classical epidemiological approaches, therefore, is not only directed towards the problem of definitions, as discussed above, but also against the

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[4] These terms were introduced by MacMahon *et al.* in their epidemiology textbook (1960, cit. in Krieger 1994: 890). For a critique on their concept and its poor elaboration in epidemiology see Krieger 1994.

[5] Here the authors make reference to the critical epidemiology of Krieg and colleagues (1994, 1995, 1996), the popular epidemiology of Brown (1992, 1997), and the alternative epidemiology of Wing (1994) and Thursen (1984) (cit. in Inhorn and Whittle 2001).

methods used in epidemiology, which are mainly quantitative and are applied to the study of occurrence and determinants of diseases in given populations (Weiss 2001: 6). Although methods are central for epidemiological research, Krieger argued that:

> [E]pidemiology is more than a mere amalgam of methods and study designs. Whether explicitly articulated or not, epidemiologic research embodies particular ways of seeing as well as knowing the world, with the express intent of analyzing and improving the public‘s health“ (1994: 888).

The methods of epidemiology had, therefore, to be „turned on their head“ (Inhorn and Whittle 2001: 553), and the epistemology of epidemiology had to be questioned and reformulated in order to remain valid. Cultural epidemiology can be seen as one step towards the incorporation of social science methods in epidemiological research, tough it has not remained uncontroversial (DiGiacomo 1999, Weiss 2001).

Although the inclusion of experience in epidemiological studies has increased (e. g. Bhatti *et al.* 1999), and nowadays more and more epidemiologists include broader social contexts in their research on infertility (Greil *et al.* 2009: 1, Trostle 2005), the importance of anthropological studies on the topic remains a necessity since it is only through ethnographic research that we can gain a deeper understanding of experience and suffering (Kleinman 1995: 99).

3.2 Medical Anthropological Perspectives

In the early 1990s several scholars from the anthropological and sociological fields published works on infertility, first focusing on the west and later all around the world (Van Balen and Inhorn 2002). What is characteristic for these studies, specially if we contrast them with works of epidemiological nature, is the definition of infertility as a dynamic social construct which is not necessarily related to the physiological definitions criticized in the previous section. Many of the studies came out as a consequence of the growing use of new reproductive technologies. In this section I will review only those studies focused on experience of infertility, specially among women.

Sandelowski criticized feminist critiques that blamed infertile women in the west for subjecting themselves to the pronatalist environment in which they live, being the

authentic desire of women to become mothers and their agency reduced to a patriarchal mandate (1990: 6). Sandelowski is one of the firsts scholars concerned with the experience of infertility from the perspective of the sufferers, she described it as a „painful fact for their existence and not just a socially constructed or culturally prescribed reality“ (ibid.). This statement is very important because it reminds that infertility is not only a construct of medicine or a failure to fulfill expectations in society, but it also signifies, on an individual level, the constrain to decide about the own fertility according to the own wishes and plans in life.[6]

Greil‘s monograph *Not Pregnant Yet: Infertile Couples in Contemporary America* (1991) explores the experiences of infertile couples in the United States. Greil attempted to study infertility in its social context, he distinguished between „reproductive impairment“, which is infertility as medically diagnosed, and infertility as a social constructed reality which is experienced by couples (1991: 6). He made following important point, which is central to this thesis:

> The experience of a physiological impairment in one or both partners does not in and of itself determine the course of couple‘s experiences of infertility. Rather, the process of infertility is dialectical; husbands and wives interpret, respond to, and give meaning to physical symptoms and physiological conditions (ibid.).

Greil stressed that the role that medical technology, the functions of marriage and family in society, the role expectations for women and men, and the social value of children are central in the shaping of infertility experience. He concluded that, in the context of the United Sates, infertility has become defined by the biomedical profession, being concerns about feelings and perceptions of failure rarely addressed. He also assumed that infertility can be seen as a chronic illness which is still experienced as a liminal state by most of the couples he studied, hence the title of his book.

Other anthropological works on infertility have dealt with the social construction of it, the perceived role of failure, the stigmatization of the infertile (women), and the construction of gender identity (Becker 1994, Feldman-Savelsberg 1994, Kohler

[6] On the debates of reproductive choice and reproductive rights as human rights see for example Petchesky (1980) and Freedman and Isaacs (1993). These discussions, nevertheless, failed to address the problem of infertility, being reduced to the free choice for the use of contraception and abortions.

Riessman 2002, Neff 1994, Papreen et. al 2000, Sandelowski 1993). These studies focused on the importance of the different contexts in which infertility is experienced, arguing that class differences, access to medical care of different kinds, kin structures, political situation, gender roles and expectations, and other cultural factors influence the infertility experience. All concluded that infertility is perceived as a negative experience, especially for women, who suffer the most.

Inhorn‘s ethnography on poor infertile women in urban Egypt (1996) is perhaps the most comprehensive work on infertile Muslim women. According to her, it is the patriarchal structure of Egyptian society, where women are subjected to domination and their role reduced to a reproductive one, which intensifies the problem. According to her, infertile women were particularly disadvantaged because they were subjected to a triple social stigmata: femaleness, poorness, and barrenness (ibid.: 2). Thus, the experience of infertility is a suffering that is not only based on the nonfulfillment of the expected course of marriage, but also on the whole set of consequences that the social, economical, political and the religious environment imposed on infertile women.

Through this thesis, I will agree with Inhorn and will regard the experience of infertility as a form of social suffering. According to Young, suffering is not only related to somatic pain, but it also involves a moral or social dimension since it is locally understood in terms of a group of people or society with a certain system of values (1997: 245). Farmer and Kleinman defined suffering as „a culturally and personally distinct form of affliction of the human spirit“ (1989: 138). This definition is ideal for the study of infertility because suffering and its experience is understood as interpersonal or intersubjective (Kleinman 1995: 15), meaning not only studying personal suffering but, in Kleinman‘s words, „social suffering“, i.e. what institutional, economic, political, religious and other forms of power do to people and how people respond to them (Kleinman, Das, and Lock 1997: ix). According to Inhorn, „[...] understanding the infertility experience can reveal a great deal about the nature of human suffering, particularly in the absence of physical pain“ (1996: 40). Following this line, I will portray the experience of infertility in Yusuf Goth in a broader context, because, as I will show, it is only in this way that this suffering can

be better understood. Only through a deeper exploration of the suffering of infertile women will it be possible to shift attention to this topic, which has been widely neglected in public health.

4. Infertility and the Axes of Suffering

The individual experiences and narratives in Yusuf Goth are embedded in a broad and complex system of structures that need to be introduced in order to be able to understand the ethnographic material in a better way.

According to Farmer, suffering is a manifestation of large-scale social forces through different mechanisms, as illustrated in his „multiaxial models of suffering“, in which different factors, or social „axes,“ as Farmer calls them, operate simultaneously within the large-scale „historical system“, i.e. the same social and economic nexus (1996: 274). Here, the weight of the social axes varies in particular settings and times, but their consideration is indispensable in order to give meaning to suffering through personal experience (ibid.). Though Farmer‘s description of social axes is rather vague, and he only applies it to „extreme human suffering“ (ibid.), it still seems to be a useful model to begin with the task of situating the meaning of childlessness among Baloch women in Yusuf Goth. It is necessary to stress that I make use of Farmer‘s axes of suffering as a model, i.e. as a simplified representation created to facilitate understanding of a complex phenomenon. The most important aspects that seemed to play an important role, whether positive or negative, in the infertility experience among Baloch women in Yusuf Goth, are discussed below.

4.1 The Marginality of Baloch People: Ethnicity, History, and Politics

Even though the present research was conducted within the official boundaries of Karachi, and therefore Sindh, given that Yusuf Goth‘s population is mostly Baloch, it is important to get an idea about the historical and political situation of Balochistan and Baloch people who, in Karachi, identify themselves strongly with the conditions faced by those living in the province, keeping strong kin and tribal links to people living there (Slimbach 1996: 141). The history and politics of Balochistan began before the creation of Pakistan, and even today the idea of a Greater Balochistan

Baloch 1987). This section cannot do justice to the extensive history of Balochistan, therefore my aim is to briefly address the question of marginality of Baloch people at the local (Yusuf Goth) and broader (especially Balochistan and Pakistan) levels, arguing that Baloch people and their demands as an ethnic group have been systematically neglected in the wider context of the politics of the centralized Pakistani state.

Given the fact that the Baloch have traditionally inhabited a region characterized by numerous invasions, the origins and histories of Baloch people are very diverse. Still, a distinctive Baloch language and culture emerged and, in spite of regional variations, it has served as a self-consciousness basis for ethnical identification and, later, also for ethnic-nationalism (Lewin 1996: xv). Lewin argued that ethnicity, whatever its basis, has been a solid and very real source of identity for the people of Balochistan (ibid.).

Balochistan has a long history as a tribal borderland and internally it has been characterized by unstable alliances based on personal rule rather than state boundaries (Titus and Swindler 2000: 63) which has historically enabled its inhabitants a certain degree of autonomy. This situation has been changed in the post-colonial era since people had to face the incorporation into the nation-states (Afghanistan, Iran and Pakistan) into which Balochistan was divided (Titus 1996: x). The borders of Pakistan‘s province Balochistan make it the biggest province in the country, though it has the smallest population, a factor also influenced by labor migration (ibid.). Titus and Swindler stated that Balochistan has and continues to be the least-developed province in Pakistan (2000: 63.). According to Titus, closer ties to the centralized state have increased the sense of marginalization among many Balochs, who find themselves in a position of a „subsumed minority“ (1996: x).

Either real or perceived, marginality remains at the root of Baloch ethnic consciousness, legitimating the demands of ethnic nationalists in the modern era (Lewin 1996: xxviii). Slimbach argued that the Baloch‘s experience of economic dependency and status domination has lead towards their sense of subordination at national and local levels, and many Baloch accuse the state apparatus to protect the

Punjabi hegemony through discriminatory policies and by claiming that expressions of ethnic grievance are anti-national and subversive (1996: 140f, Binder 1986).

Many people living in Yusuf Goth, and most of the infertile women interviewed, looked clearly different because of their African origin. People call them „Makranis“ because they are the descendants of black slaves that were brought to the coast of Makran via Oman and Iran during the eighteenth and nineteenth century (Sultana 1996: 30). Though they are also identified as „Baloch,“ they are situated at the bottom of the Baloch clear-cut hierarchy based on tribal affiliations and bilateral kinties in which groups are ranked according to genealogical characteristics, socio-economic strength, and physical traits (ibid.).

Following the handful of scholars working on Balochistan and its people as well as the claims of ethnonationalists about their marginal position, infertile Baloch women in Karachi can be consequently understood as among the most neglected and vulnerable in Pakistan. If compared with the poor, infertile Egyptian women Inhorn described in *Infertility and Patriarchy* (1996), we find more than a „triple social stigmata“ (femaleness, poorness, and barrenness) which makes women stand in a „particularly devalued and disempowered position in a society that, by all definitions, can only be seen as patriarchal“ (1996: 2). Infertile women in Yusuf Goth are encountered with a fourth and even a fifth level of social stigmata which is related to their own ethnicity and the history of politics of Balochistan. They are marginalized in the context of the nation state, and as black Baloch they are marginalized among their own ethnic group. Swindler put it: „While scholars, Baloch and anthropological, speak of and for Baloch, the still mostly silent Baloch themselves go about the task of making their lives between the constraints of local, national, and global forces“ (1996: 188).

Nevertheless, given that Yusuf Goth‘s population is constituted mainly by so called Makrani Baloch, the interviewed women only seem to face these fourth and fifth levels of stigma when they go outside their own community, as it is the case when they visit some hospitals in other areas outside Yusuf Goth. Marginality is relational (Ecks and Sax 2005: 208), and in the micro-context of everyday life Baloch ethnicity

was not perceived as a health endangering factor by the interviewed women, but in a broader context the marginalization is clearly manifested in the neglect of the population of Yusuf Goth by local authorities and the state‘s health policies, which will be discussed in the next section.

4.2. The Medical System and Biopolitics

This section will outline how the health system is organized and how does it influence the infertility experience. I will argue that the failures of the health system are both based on structural deficiencies that hinder the creation of adequate health policies as well as on problems regarding the implementation of health policies, especially corruption, and that the neglect of infertility in the public health agenda is a symptom of the biopolitics followed by the Pakistani state and also by international organizations: although the allocation of resources for reproductive health policies has increased in Pakistan (Siddiqi *et al.* 2004: 124), most of it is spent on maternal and child care and birth control, thus infertility remains neglected, being usually completely absent from the public health agenda promoted both by private and public initiatives aiming to promote health and well-being.

According to Udink, the Pakistani medical system is the worst in South Asia (2007: 40). Although the organization of health care delivery in Pakistan is stratified into different levels, the provincial and district levels have factually neither decision making power nor influence on determinations regarding program budgeting and finance, which are restricted to the top levels of the provincial and federal hierarchies (Khan and Van den Heuvel 2007: 283). The delivery of health care at the national level is the responsibility of the National Health Policy, i.e. the Ministry of Health, in Islamabad (Akran and Jehangir Khan 2007: 1), though the responsibility for family planning services relies on the federal Ministry of Population Welfare. Siddiqi *et al.* argued that the division of authority regarding reproductive health services in two ministries is responsible for the duplication of efforts and blame this segregation for the poor coordination regarding service delivery, monitoring and supervision (2004:

119). Besides, it is the Ministry of Finance who often has the last word regarding the allocation of resources of the National Health Policy (ibid.).

Other authors focused their critique on the marginal expenditure on the health sector and the failure to allocate resources properly, especially during the military governments, which resulted in a constant contrast between economic growth of the country and the government expenditure on health (Khan and Van den Heuvel 2007: 282). As an example, during 2005 and 2006 the Pakistani government spent only 0.75% of the GDP on the health sector, meaning yearly approximately USD 4.2 per-capita, a minimal amount compared to the USD 34 per-capita recommended by the WHO (Akran and Jehangir Khan 2007: 1ff., Khattak 2006: 516). Regarding this picture, it is not surprising that the private sector plays a central role in the provision of health care, covering between 70% and 80% of the outpatient services without any regulatory framework (Akran and Jehangir Khan 2007: 12, Siddiqi *et al*. 2004: 119).

Yusuf Goth is an example for the failure of the Pakistani health system: First of all, no official data about Yusuf Goth is available because, and perhaps this is also why, there is not a single governmental health care service provider and APWA is the only non-profit organization covering primary health care for women and children, leaving men completely out of coverage free of cost. Other private service providers include biomedical and non-biomedical practitioners. The first work in small clinics and, according to APWA‘s staff, are dubiously qualified. These private clinics open during the evenings when the weather becomes mild and the women are more or less freed from domestic responsibilities. According to informants, the charges of private clinics in Yusuf Goth are reasonable, though the service is reportedly bad.[7] Non-biomedical practitioners offering services include *dais*, and *mullas* (see chapter six).

For more complicated issues, the nearest private hospital is Murshid Hospital, some 5 km away from Yusuf Goth. The nearest public hospital is the Lyari General Hospital, situated some 10 km away. Since Lyari is well-known for its predominant Baloch population, and since many of the women I talked to or their families came from Lyari, these naturally mentioned the hospital as one of the most important

[7] I was not able to visit them in order to inquire more about them. All the informations regarding these clinics are based on conversations with informants and APWA‘s staff.

places to seek medical treatment for infertility and other ailments. Although the Lyari hospital is a public one, women complained of the high fees and long waiting queues. Corruption practices by doctors and hospital staff in Pakistan have been described in a draft document brought out by Heartfile and Transparency International (n.d.), they include the refusal of seeing patients in the public facilities and referring them to private clinics, the provider-driven over-consumption of health services, over-prescription, and over-use of diagnostics These are the same practices encountered by many women from Yusuf Goth, also in private clinics. One woman explained the problems she faced at the Lyari General Hopsital:

> These are no doctors. They take the salary from the government and the very good medicines they‘ve got there, they sell them outside, they are not for the patients here. If you go there, if you go to Lyari Hospital, the patient will be at a certain distance [from the doctor], and the medicines will be the same, only the same, they have cough syrup, syrup for pain, that‘s it, no other thing [...] and it is a big hospital!

The allocation of state resources destined for the health sector, and particularly for reproductive health, is not well documented in Pakistan (Siddiqi *et al.* 2004: 124). Although it is still possible to distinguish an increasing trend, this remains very low, and most of it has been financed through external donor support in the frame of the Millenium Development Goals (MDGs) (ibid.). In the MDGs, reproductive health is reduced to maternal health and family planning, and the diagnostic and treatment of infertility are not included in their reproductive health plan. Similarly, the latest available Pakistan Demographic and Health Survey 2006-07 (NIPS 2008), which is concerned with several reproductive health issues such as fertility and its determinants, family planning, maternal mortality, and reproductive health in general, does not include a single section dealing with infertility in its whole 407 pages.

The lack of interest on infertility as a public health issue is not only a problem of the Pakistani authorities but also a problem of international organizations and donor agencies whose primary goals and targets are to reduce poverty and assure universal access to health services through the reduction of population in developing countries (see the MDGs homepage: http://www.un.org/millenniumgoals/). If we agree with Foucault‘s concept of biopower, then we will understand the neglect of infertility, not

only in Pakistan but in all poor, so called developing, countries, as a political maneuver that acts according to the adjustment of human accumulation with capital accumulation, of population growth with the expansion of productive labor and the allocation of profit (1983: 136). Hereby we can identify a conflict that takes place between the economical interests of a country, international agencies, and private partners in the frame of modernization and neoliberalization, and the establishment of „rights“ that, following Foucault, protect life, health and happiness in the era of biopower (ibid.). Hence, although nowadays reproductive rights are recognized as human rights, what is understood under ‚reproductive rights‘ or ‚reproductive health‘ has not been clearly defined yet (Petchesky 2003: 35) and it remains open to interpretation. Here I suggest that the neglect of infertility as a public and international health issue is a response not only to the lack of awareness related to the suffering experience of it, but also to economic and modernization goals that poor countries are expected to meet and which are more likely to be achieved through the reduction of population growth, hence the stress on family planning.

4.3 Kinship Structure and Familial Relationships

Baloch families in Yusuf Goth are commonly patrilocal structured, and the marriage arrangements, taken over usually by the parents, take place when they children have not reached puberty yet, sometimes right after birth. Most of the women I talked to were married before menarche, and their marriage was consummated directly after it. According to informants, there are no strict rules regarding marriage among Baloch people in Yusuf Goth, though the marriage of six out of seven women was endogamous and only one marriage was an exogamous one between a Sindhi woman and a Baloch man, an arrangement based on the friendship of their parents.

Most of the women married closed relatives, preferably cross-cousins, and a bilateral cross-cousin marriage was also observed (see diagram 1). Endogamy has been described as characteristic of different groups of Baloch people in connection to their economic and political organization (Pastner 1979 and 1981, Salzman 1992 and

2000). Here, I will not discuss why these marriage patterns take place but more how they affect the familial relationships and women‘s everyday lives, particularly regarding infertility.

According to Salzman, the recognition of kin ties among Baloch people is not limited to the patrilineal descent, he explains several terms generally used for kinsmen of all varieties including male and female links, whereby *peskom* (referring to kin through the father) and *maskom* (kin through the mother) are the most important (1992: 11). The significance of the latter, according to him, is explained through the preferred endogamic pattern, especially bilateral endogamy, through which *maskom* is, back to a certain point, also *peskom*, therefore it would make no sense to down-grade *maskom* (ibid.). This marriage structure appears to have a positive impact in the everyday life of infertile women: first of all, most of the interviewed already knew their husbands since childhood because they were related and, secondly, the natal family comes more often to visit. Finally, women are not strangers when they move into their in-laws‘ place. In the case of bilateral endogamy, the mother-in-law is actually the *phuphi* (FZ), and the father-in-law is the *mamun* (MB). Abida explained:

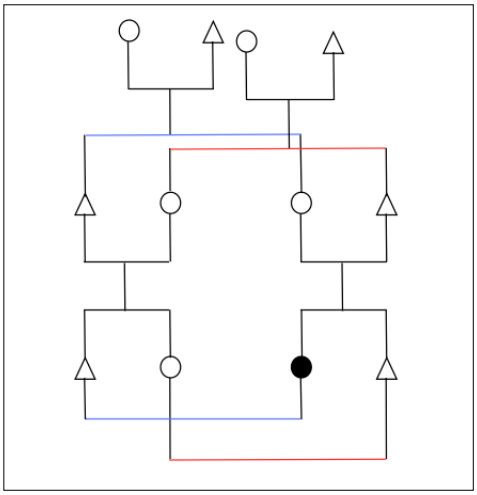

Diagram 1: Bilateral cross-cousin pattern, ego = Abida.

> My mother in-law, right, she is my father‘s sister, and my father-in-law, he is my mother‘s brother, therefore my mother-in-law is my *phuphi* [FZ] and my father-in-law is my *mamun* [FB]. Then, I am not an outsider, we are related [...] It is the same with my brother, like my *bhabhi* [BW], she is my *nand* [HZ] also [...] Like I am myself her *bhabhi* and her *nand*, the marriage of my parents took place like that, ours also.

Since affinity is backed by kinship, women tend to be in a better position in their *susral*. This, nevertheless, does not signify that women immediately feel at home at their husband‘s place. A woman narrated:

> It took me three years to feel that this place is good. After three years I liked this place, after that I became happy at my home... after leaving my mother, my siblings, that was very difficult

> for me, but my in-laws have never complained to me. The one sitting there [shows her father-in-law], he has never said anything to me, neither him, nor my husband, not even my *nand* [HZ].

Being away from the natal family is still problematic for many women. Other women accounted that in spite of being among relatives, they did suffer from verbal and physical violence due to their childlessness (see chapter five).

Another aspect worth mentioning is the lack of male preference for children among Baloch women in Yusuf Goth. Only one of the interviewed women declared to wish a male child, the rest declared that gender is not important, and many stressed the equality of boys and girls in God‘s eyes, this might be due to the fact that *maskom* is also important if compared with *peskom,* thus Baloch women do not feel pressurized to give birth to male children.

I will agree that the marital structure has rather a positive influence on the experience of infertile women regarding infertility, though it does not nullify their problems (see chapter five). Therefore, I believe that women would be in an even more disadvantaged position if they would be married to strangers. Familial structures are are also important to analyze the process of decision making regarding health seeking behavior and coping with infertility, these topics will be discussed more deeply in chapters six and seven. The importance of children and the family conflicts that arise due to infertility are discussed in chapter five.

4.4 Islam and Gender

Gender in Pakistan is usually discussed along with Islam, which is done here due to the limited size of this thesis. Islam, as the raison d‘être of the Pakistani state, plays a central role in the everyday lives of people. The use of Islam as a unifying force is not only evident in the legal system of the country, but also in the social and familial relations which are under its influence. In the case of infertile women, Islam is both a source of threat and of relief: On the one hand, Islam emphasizes the importance of offspring and motherhood, intensifying the feelings of incompleteness, whereas on

the other hand infertile women rely on their faith as a way of coping with their situation, which is considered to be Allah‘s will (Inhorn 1996: 82, see chapter seven).

Motherhood, through childbirth, is considered the natural outcome of marriage and it is glorified in the Islamic scriptures. The role of an adult woman is primarily the role of a mother who is naturally affectionate and generous toward her children (Degand 1988: 50f., Inhorn 1996: 82, Schleifer 1996: 47). Moreover, according to Schleifer, pregnancy, childbirth, nursing, and rearing have to be seen by Muslim women as spiritual acts because „it is her exclusive opportunity to obtain Allah‘s blessings and rewards, as the difficulty of pregnancy and childbirth is a way which Allah has allocated only to the female sex“ (Schleifer 1996: 51). After analyzing different passages from the Quran, the Hadith, and the Sharia, Schleifer concluded that „although in Islam, there are many ways to open the doors of Paradise, the vehicle especially chosen for the woman is that of pregnancy, childbirth, nursing and conscientious rearing of her children“ (ibid.). Motherhood, therefore, represents one of the only ways through which a woman can achieve spiritual salvation. In Yusuf Goth, although women are usually not knowledgeable about the specificity of the Islamic scriptures, they still have the notion of the praise of mothers by Allah.

Since Pakistan is an Islamic republic, the laws and the social order are regulated according to Islam. Polygyny and divorce, both allowed in Islam, constitute two main threats to which infertile women are potentially exposed to. Though endogamy might operate as a protective factor against these practices, some women might be confronted at least with the possibility of become second wives or to be divorced because they cannot bear a child (see chapter 5). This threat is very present in Pakistan, as Chaudhry, drawing from the findings of her ethnographic research in rural Sindh and Punjab, argued: „The primary purpose of women is to bear children and provide sexual services, therefore, she can be divorced if she cannot perform those duties due to health limitations“ (2006: 477).

In women‘s everyday lives, Islamic practice -reflected in their narratives regarding the belief on Allah- represents the central aspect of their faith, and also of their lives. All the women I talked to regarding their infertility mentioned constantly the name of

Allah. God is regarded as the as the giver (*Allah dene vale*) and as the boss (*malik*), having all decisions, also that of procreation, in his hands. Baloch women in Yusuf Goth shared the same views on God regarding infertility as those observed on Egyptian women by Inhorn (1996: 76ff). The power and omnipresence of God was mentioned by all the women, who strongly believed God to had put them in the situation of being childless. Infertile women in Yusuf Goth did not fear a spiritual sanction due to their childlessness, but contempt from society in form of gossip, tension in the familial relations, and, in the worst scenario, becoming second wives or even being divorced (see chapter 5).

4.5 Labor Migration and Economical Situation in Yusuf Goth

Yusuf Goth is the result of the settlement of labor migrants and their families from the past twenty years, some of them either came directly from Balochistan searching for better working opportunities in Karachi, or, like most of them, they belong to the second and third generation of immigrants who initially settled in other areas of Karachi like Baldia or Lyari Town. These towns, especially Lyari, have been known as poor Baloch settlements since decades and are so congested and affected by criminality and inter-ethnic tensions (Slimbach 1996: 142f.) that many prefer to move to Yusuf Goth in spite of its greater distance from Karachi city and the lack of facilities. A woman who settled in Yusuf Goth after marriage said:

> Yusuf Goth is fine, Lyari is not fine... there are so many conflicts in Lyari, right? [...] There are shootings, that happens over there, conflicts... Here, in Yusuf Goth, that is fine. If anything happens here or if nothing happens, you can just sit at home...

People, therefore, hazard the consequences of leaving a dangerous environment which, nevertheless, offers more facilities and job opportunities than the more quiet Yusuf Goth.

All the husbands of the interviewed women were daily-wage laborers, having no regular income to support their families. Some women did not know how much did their husbands earn, but others mentioned amounts between Rs. 50-300 (approx.

0,40-0,90 Euro) a day and Rs. 1000-8000 (approx. 8,70-70 Euro)[8] a month. These amounts are clearly below the international poverty line,[9] especially if we consider that these earnings are supposed to support entire families between three and fourteen people. The maximum amount of men providing for a household was three, so even if the men help out each other, the income remains very low. Though the living expenses are very little, the earnings often remain insufficient to cover the basic needs, and the interviewed women often expressed that in bad times they do suffer from hunger.

Women, nevertheless, are not supposed to contribute with income in their households, even if that would be strikingly necessary. A woman put it: „Here they don‘t let the girls work, no matter if they have eaten or if they haven‘t. The girls don‘t work.“ Though women are not allowed to work outside home, they do contribute to the household economy by performing activities that save extra costs, like sewing clothes for the family members.

Besides the extreme low-incomes, poverty is further evident in the infrastructure of the area. As described at the beginning, the area lacks of proper roads, sanitation, public schools and medical facilities as well as public transport. Another problem is posed by the many electricity connections, which have been illegally stretched into the households and which, in rainy days, have cost the lives of several children. Besides these problems, pollution due to lack of sewerage systems and the lack of a waste deposit constitute serious hazards to which the inhabitants are daily exposed to.

To conclude, we can say that the inhabitants of Yusuf Goth live in extreme conditions of poverty, and that due to the lack of interest of the local authorities in the area, the situation does not seem likely to change in the near future. Yusuf Goth remains on the periphery of Karachi‘s geography, economy, and social structure, and their

[8] Rs. meaning Pakistani Rupees. The currency rate dates from February 13th 2010, being 1 Euro equivalent to Rs. 115,49.

[9] This is, according to the World Bank (http://www.worldbank.org/, last accessed: February 13th 2010), USD 1 a day.

inhabitants, especially infertile women, are among the most neglected people in Pakistan.

5. „I know the hardships of a childless woman, I know the pain of a childless woman:“ Infertility and Everyday Suffering

5.1 Fatima‘s Story

Fatima‘s life has been surrounded by death since her childhood. Without previous knowledge of any disease, her mother died suddenly when Fatima was in the 4th class. Eleven months later, her father suffered a heart attack and passed away, leaving her and her four brothers and four sisters on their own. Fatima is 29 years old now and has been married since 9 years, she has not got an own child yet. She is Sindhi, but was married into a Baloch household, to the son of her father‘s friend. The marriage was arranged by her mother before she died, and it was consummated when Fatima was 20 years old.

In the first months after marriage Fatima became pregnant. Suddenly, after completing the fourth month, she felt very sick. She went to the doctor, who prescribed an ultrasound which showed that the fetus was not healthy, Fatima remembers the doctor saying that it was either dead or malformed, so the doctor‘s advice was to get a dilation and curettage (D&C)[10] done. Fatima followed her advice, but since then she has been having pain and has not been able to become pregnant again. She developed a cyst in her reproductive tract, though she could not recall where exactly.

A year ago she was operated at the Lyari General Hospital to remove the cyst, but few days after her condition worsened. She was admitted at the hospital three times after the operation but she has not recovered fully until the time I met her. She had been to several doctors, before and after the operation, both in order to treat her pain and to become pregnant again. The new reports showed that the cyst reappeared. In spite of her diagnosis, Fatima believes that this is not the cause of her infertility:

[10] D&C is a procedure which consists in opening of the cervix and the surgical removal of uterine walls and or contents of the uterus, it is also a widespread technique used for abortions in Pakistan (Misbah Shabbir, personal communication, August 21st 2009).

> The doctors kept on saying that it can be that with the defect you have, you still can get pregnant, that is not a reason for not getting pregnant [...] Four or five years she [the doctor] said that you are fine and that you can conceive, but then my husband never got tested, he could also not afford it [...] So because of this is that, maybe... we could not find out why we cannot have children.

Fatima‘s husband works as a conductor. His earnings are irregular, and when he earns good, he is beholden to contribute to the household where his two unmarried brothers, also daily-wage laborers, live. When one of them does not have work, they financially help out each other. Fatima‘s husband has paid for her medical expenses as long as he has been able to. Still, Fatima claims that lack of money is not a reason for her husband not to get tested, assuring that even if he had the money he would not do it. Still, she loves him and affirms that he is a good husband; indeed, he has never pressured her to have children because, she believes, he understands her suffering and feelings towards their childlessness.

Four years earlier, Fatima‘s youngest sister died. They were very close, her sister used to accompany her to the doctors. Fatima‘s sister had a son, and was expecting twins. She had fatal complications during labour, only one girl survived. Fatima had to struggle to adopt both children, the brother of the children‘s father was also interested in keeping them. According to Fatima, her brother-in-law could not afford to feed the children, so finally they agreed that she takes them.

Fatima and her husband had considered adoption even before her sister‘s death. She recalls:

> Like, you know, nowadays, you know that you have the children of others if you don‘t have children on your own. I thought about that and went to see how much is for that, that maybe I could save for that. [Adopting her sister‘s children] was better than take to from someone else.

Before her sister died, Fatima approached an institution in order to adopt a child, but the bureaucratic procedures, a talk with her in-laws, and, mostly, the fear from what people might say, abstained her from it:

> [T]he ones who give, those from Edhi,[11] they said we will go to your home, we will talk, and then we will give, that means that they will give us a child that has no home. To look what is

[11] Edhi foundation is a well-known non-profit organization that provides social services in Pakistan.

> behind all this, after seeing that we will give [they said]. That is why we left it. Also, people started talking, this and that, that this is wrong... this happened. So we also talked with my in-laws, and they said what the people were talking about us. So that is why I left it, because, it is our life, the only thing we want is to have a child, we would have brought a child, but then people would have started talking, so how could we live like that? So that is why we thought we better leave it.

Fatima‘s in-laws died about four years back. Her mother-in-law had diabetes, her condition worsened from one day to another and the next day she passed away. Her father-in-law lost his voice one day, and then he stopped eating and drinking. Fatima believes that he might have suffered from cancer because he used to smoke the *huqqah*, take *charas* and drink tea, not eating properly from the past 25 to 30 years before he died. She felt sad about their death because they treated her well, she missed them. She is the only woman in her household since her sister-in-law was married and moved out, so after the death of her own sister she goes everywhere on her own if her married sisters have no time.

Fatima and her husband love their adoptive children. Both are attending school, they even moved from Manchar Colony to Yusuf Goth in order to be able to send the children to the school in the neighboring Baldia Town. This is similar to what Fatima‘s father did when she and her siblings were little, they moved to Baldia Town. He strongly encouraged education for his children, specially the education of his daughters in order to provide them a good future. Fatima remembers: „He pressured us. We also had tuition classes, so that no human can do us anything, because we were poor.“ Still, Fatima was not able to complete her education. After her parents died there was no money to pay the tuition fees. She attended a sewing course later on, now she sews cloths for her husband, her children and herself, so there is no need to buy them.

Fatima worries about her adoptive children. She does not want them to know yet that they have been adopted. The girl, who is just four years old, has not asked about it yet, but her brother did. Fatima narrates:

> The elder one, sometimes people talk in front of him, about his nose, about his face... so he sees that and then he comes and sometimes asks about it... he is my son, right, he is quiet but still he listens and remembers, then he repeats that [what he heard] when he comes back home.

> In front of others he does not ask why I do look different, we say you look like my brother, or like the son of my *mamun* [MB], or of my *khala* [MZ], that is why you got this color.

Fatima goes alone to the doctor in order to avoid her children to listen about her infertility. She even feels uncomfortable in social events like weddings that she avoids because relatives come and ask her about her infertility. She will tell the children about their real parents in due time, when they are mature enough to understand: „Yes, *insha'allah*, when he becomes mature and with understanding, then it will be fine when I say this to him, so that he understands that ‚my parents did not do any mistake, that they did it for our sake, for our benefit.'"

Despite the love for her adoptive children, and that they are treated as they were her own, Fatima still wants own children. With tears in her eyes, she said that she wants a child, and that it does not matter if it is a girl or a boy, nor does it matter if it is only one. Fatima's faith relies on God, who will decide how many children she will get as well as the gender of them. It is for this child desire that she has been going from hospital to hospital and from doctor to doctor since the first failed pregnancy, sometimes it was frustrating for her to pay and get nothing:

> One time, I went to some hospital, there was a doctor sitting, she charged Rs. 500 [approx. 4 Euro] fees, I was with my sister. I paid it, I gave it, so that she can say something and give me some good advice of why is my condition affected, so she says that I have an allergy or I don't know, she said „they did not operate properly, so now we cannot treat you" [...], the doctor said that it is of no use [to get operated again]... if she had said yes, get the treatment, it will be very beneficial for you... well, the problem was that she answered like that, this is why I told her, the fees I paid you, give them back, but... if she had given good advice... but she didn't want to.

Later on, after being to different private practitioners, Fatima came back to the Lyari Hospital. They prescribed her medicines which she took during one month, but nothing improved. She got an ultrasound done and, according to the hospital staff, she had to get treated again, but this time she could not afford it anymore. She has not been back to the hospital:

> I could not afford so many medicines, my husband said „so much expenses we are having nowadays..." Then we talked again, he said it is OK, the proper medicines... now, after the operation, I do not take [medicines]. If I have a lot of pain like I am having now, I come here [to APWA's PHCC], then I will take painkillers and then I will go.

She does not know how much money she has spent on getting treated, but she said that she had to stop treatments because she had no money. In spite of the inefficiency of biomedicine in her case, Fatima claimed to have never been to any *dai* or *mulla*.

Fatima has not given up her hope to become pregnant again and give birth for the first time, she prays for getting a child: „Allah is the giver, and my husband, he has given me so much attention so that when he is giving some step I am going on his side. I hope that the future will be good, that‘s it.“

Fatima‘s story does not only narrate the experience of not having own children, it also narrates how infertility is embedded in the suffering of her everyday life. The inability to conceive merges with other causes for suffering, i.e. poverty, death of close relatives, lack of proper medical attention, and the early abandonment of studies. Though the adoption of children has ended with her childlessness, she is now confronted to the fear of her adoptive children to know the truth too early. Besides, her desire to become a biological mother is still not fulfilled.

In the case of Fatima, like in the lives of other infertile women in Yusuf Goth, infertility is not an isolated clinical condition whose perception can be studied abstractly, her suffering is accentuated through everyday deprivations. Health seeking behavior as well as ways of coping and the experience of infertility are all a product of a group of experiences that merge into a blurry total which can be called the suffering of everyday life.

5.2 Women in the Household: Everyday Life in Yusuf Goth

The activities of women in Yusuf Goth take place mostly within the walls of the house. There, through daily interaction with family members and, occasionally, neighbors and friends, women grow up and are socialized according to the expectations of the clearly established gender roles.

Adult women distribute household activities among themselves according to hierarchies, skills, and preferences. In an average household, in which besides the

woman with her husband also the parents-in-law, brothers-in-law and their wives and children live, the activities are divided among those who serve the whole household (i.e. cooking, cleaning the patio, fetching water, taking care of the children) and those who are only for the nuclear family, like cleaning the own room, and sewing and stitching cloths.

Infertile women take part in household activities doing their assigned tasks, like cooking and washing clothes, after which many declared to bore themselves. In their spare time they watch television, take a nap, sew some cloths, and if they can, they go to visit neighbors or relatives living nearby. The husbands usually work the whole day outside the house, some of them come back home very late at around 1 or 2 a.m., the wives wait for them in order to eat together before going to sleep. Without own children, women described their daily routines as boring and insipid. The days are long and there are not so many things to do to occupy those hours which would be invested in the bringing up of children. The lack of children is also perceived as the lack of a reason to be.

When a woman does not have own children, she looks for affection and leisure activities in others‘ children, childless women take in their arms the baby of their neighbors or relatives. Although they are allowed to play and take care of other‘s children, they might not be allowed to interfere in the upbringing of them. Ayesha, who married before menarche at the age of 13, some five years ago, explained:

> Before marriage I didn‘t want children, but then I got married. At home there is only one child, it is the one of my *devarani* [HBW], so I call him to come and talk to me. When there is any quarrel, if he has been involved and I defend him, then they say to me „Is it your child? You don‘t even have children!“ That is why I say „Allah, please give me a child!“

Not having any children means for Ayesha not having any authority to interfere in matters regarding the only child of the house. She did not want to have children until she got married and realized the importance of having children for establishing herself in the new household. Children, therefore, are also a source of power for their mothers, who can only establish their role through giving birth. Like in most parts of South Asia (Lavania 2006: 96, Sääväla 2001: 78f., Widge 2002: 62ff.), in Yusuf Goth womanhood is defined through motherhood, and, like in Patel‘s example of

Rajasthan, women only acquire a status of seniority through childbirth (2006: 77). A wife is only considered a good wife by the family when she brings offspring, only through the children does a married woman receive consideration and is regarded as having honor. Ayesha said that „those who do not have got children, they don‘t have honor at their in-laws‘ place,“ meaning that they are not respected and not taken into account as adults, therefore, their opinions are not considered in matters regarding the extended household.

Another case supporting this argument is Mumtaz‘, she married about 14 years ago and, after several miscarriages, is still hoping for a child. She also talked about honor related to children: „Look, we are poor people, our wealth: the children. It is because of the children in the house that a person gets honor. If there are no children, then a person does not have honor.“ Her statement is particularly interesting because she considers children not only to be a source of honor but also a form of wealth which specially applies for poor people, like another woman said: „When we get old, someone will take care, the own children will take care, there is no one else behind to take care, but the own children.“ Additionally, Mumtaz also mentioned the importance of continuing the line with the name: „My only worry is that of the children. That is the problem, the name is the sign of a person, a person leaves but the name remains with one‘s children.“ Securing the continuity of the family name seems to be a matter of crucial importance. A woman not giving birth is considered to be responsible of discontinuing the line. Although these statements stress the importance of male children, according to Mumtaz a child brings honor to its family regardless of its gender because, she explained, there is no difference between girls and boys since both are human and give honor to the family. Childless women in Yusuf Goth wish to have a child and it does not matter if it is a male or a female one. For them, a child, regardless of his sex, will bring them honor, respect and recognition as fully adults, as one woman said: „I would be very happy to have a child, no matter if it is a boy or a girl.“

5.3 „The problem of children“: Missing Motherhood[12]

Childlessness was considered by all women a source of tension and arguments in the household, not only between wife and husband, but also with the in-laws, and even with neighbors and acquaintances. Often, the family does not speak openly about childlessness, though infertile women do perceive the real origin of some arising conflicts in themselves and their condition. When asked about family conflicts because of childlessness Ayesha explained:

> Tension, within the family, sure. They don‘t say it directly, still I understand that for them, as for me, it is a huge worry: because of me all my family has some worries, there is tension... „I don‘t know why she still hasn‘t got a child“... they pray for me and they are making a big effort, but, well, Allah is the boss [...] If I get a child everyone would be so happy!

She also spoke about the situation of a friend:

> I have a friend, her wedding took place I think some 15 years back, and she has no children. [...] Sometimes there are quarrels, sometimes she is beaten, sometimes she goes to her mother‘s place, because if there is any problem it is exactly that: the problem of children. And there is no other reason because they are angry at her, for not to be at home, just the child, that‘s it. The problem is that there is no child. She says „Allah please don‘t do that, before doing that I prefer my honor to become less [by going to her mother‘s place]“, but that‘s it. I was born once in the household of my mother and once I left, I cannot go back there, now I have my home with my in-laws. My in-laws place is my place now.

The in-laws‘ place is for some infertile women a place to be humiliated for not fulfilling their role, a place where upset is responded with harsh comments, insults, and physical violence. „The problem of children,“ i.e. the problem of missing motherhood, means for women a negative experience in which they do not only suffer for not fulfilling their own wish to have child, but also for the abuses of relatives, specially the in-laws, for not fulfilling the main expectation for a *bahu*: To give birth to a healthy child.

A woman named Rashida explained how people received her at home after one of three miscarriages:

[12] The term „missing motherhood“ goes back to Inhorn (1996).

> What happened in my heart? What happened to one? I said, the child has to be alive, I prefer to die but the child has to be alive in order to face those people, they beat me. I was uselessly sitting [in the hospital], then I went home. Then my husband came and I talked to him, then the people at home said that there is no child, there is no this, there is no that. One gets angry, right?

This situation is a good example of how women and their bodies are thought as child-producing machines, she was not consoled by the people at her home because she lost her pregnancy, instead she was beaten and had to suffer from verbal abuse for failing in producing a child directly when she came back from the hospital.

Another problematic situation, as exposed in section 4.4, is polygyny: when a woman does not give birth, the husband can take another wife. Some women fear that this might happen, this fear, however, is not only based on affection toward the husband, but also on respect and honor and, moreover, on the economic consequences it would have, especially in a poor household. One woman said:

> Now, his mother is saying that he should marry another one, he should do this and that, and my husband says no. I am his cousin, but still she doesn‘t care about that. In this house I am sitting in, I have endured a lot, hunger, thirst... I have endured everything. If another wife comes, I will not be able to endure that [...] What an imprisonment this is! And if I tell this to anyone... I just don‘t tell this to anyone. I have had thirst, hunger in this home. There was no roof, I had to made it myself, I did all myself [...] There was no roof, I spent four or five years like that. After that I stopped sleeping, I closed the roof, I did it myself. Now, I sleep with some fear.

Another wife would mean another economical burden, but a child would not. Children are considered to enrich life in the household, and instead of contributing to aggravate the tensions, they would decrease them. Children are expected to improve the marital relations of a childless couple, as a woman explained: „There would be no discussions when a child stands between the parents, there will be not so much tension.“ Similarly, another woman said: „If there was a child in this house then it will be no trouble, if there was a child... there are discussions, it is difficult, there would be no tension. If I get a child I would enjoy it a lot, I like children!“

5.4 „People talk...“ Intrusive Questions and Gossip

One of the major sources of hassle is related to intrusive questions regarding why women have not gotten children yet. A woman experienced this as a very problematic situation, because after the people asked, she also started asking herself about her situation:

> [People say] „infertile, she will not become pregnant and if she does, her blood will turn bad.“ [...] Yes, they ask, „why not?“ [meaning why she has not get children yet], they say. When they see that my heart has become excited, when they see me they bring it out. They talk a lot, before, they talked a lot. When strangers spoke there was not so much trouble with it, but when I spoke [to myself] it meant a lot of trouble. When strangers ask, then I also ask myself „why haven‘t you become pregnant yet?“

The same happened to another woman:

> After my marriage, everybody was asking „why aren‘t you pregnant? why aren‘t you pregnant yet?“ so that one‘s heart breaks... Then I started asking myself why I am not getting pregnant, that is why, only one thing made me sad, why I have not become pregnant.

Gossip by strangers was also a matter of concern for infertile women, who repeatedly mentioned that „people talk“ and that it would be good if the whole world could see them with children. Gossip and the intrusion of others is an important issue because their identity is defined by what others say about them since they lack children who could make them be recognized as adult women. The importance of gossip, therefore, sustains that infertility is a social issue, and that its experience is shaped by the social environment.

5.5 The Amalgamation of Infertility with other Afflictions

As seen before, infertility in Yusuf Goth is considered a disruption in the natural course of a married woman‘s life. This disruption, however, is not necessarily identified by women as directly associated with other physiological causes which might be considered, by professionals in the health sector, the actual causes of infertility.

In their narratives, the women tended to give a rather blurred account of their physical afflictions (*taklif*) related to childlessness. They talked about tension, menstrual problems, heart disease, blood pressure, cysts, a „closed“ uterus, lower back pain, and other disturbances, either while recounting their visits to the doctor or while talking about their personal problems. Many women did not give credit to the diagnostics from doctors and *dais*. Ayesha, for example, declared never to have been pregnant even though the *dai* and the doctor said so. Irregular menses and even amenorrhea are very common, both were mentioned by five out of seven women; nevertheless, they did not considered menstrual irregularities to be directly related to their childlessness.

Another woman associated stress with her childlessness. For her, this was a vicious circle, she had tension because she had three miscarriages. The doctors said to her that if she takes out her tension, then she will be cured and able to become pregnant an give birth, and if she had no tension then she would not have had the miscarriages.

Despite mentioning other afflictions and also complaining about their poor economical situation, many of the interviewed women explained that their only worries are all related to their childlessness. The narratives of infertility are life histories. The perceptions and experience of infertility are, as Greil argued, dialectical processes in which the infertile interpret, respond and give meaning to their condition (1991: 6). The condition of childlessness is translated into suffering in everyday life, and women themselves do not separate their infertile condition from other forms of suffering in their narratives, they neither do so while consulting different kinds of healers. This aspect is central to the analysis of health seeking behavior, which will be discussed in the next chapter.

6. „It is Allah‘s will, but he want us to make an effort:“ Health Seeking Behavior

6.1 Fozia‘s Story

Fozia is 25 years old, she married some six years ago, at the age of 19. After the second or third month of marriage she did not become pregnant, so she decided to visit a *dai*. The *dai* treated Fozia and told her that she is fine and that she will be soon expecting a baby. Later on, the *dai* informed her that she was pregnant. Fozia then, under the advise of the *dai*, underwent an urine pregnancy test, which also showed positive. Soon she menstruated again. Worried, she asked her mother. She recalls:

> So then I had my period, so I thought if I am pregnant, how does it come that I‘ve got my menses now? Then my menses came, I told my mother and said I have this little bit [of bleeding], and she said that this should not happen, that during pregnancy you don‘t have your period, it stops, you will not have it. So I worried that it will happen every month. Then, my mother said come to my place, I will take you to the doctor.

Fozia went with her mother and her *khala* (MZ) to see a doctor, who prescribed some tests which confirmed that Fozia had a miscarriage. She was under treatment afterwards, but she had to discontinue it due to lack of resources. Fozia narrates:

> [The doctor] made some tests and everything, and she said „you are not pregnant, there is no baby.“ And I said what is the problem, she said that „there is a small piece of flesh and it dried up inside your womb. It dried up, but there is not such a thing like a baby in it.“ So then I got treatment for that, three months I was under treatment, and... it was so costly, the medicines, the pills, so then I discontinued it.

After breaking the doctor‘s therapy, Fozia tried everything she could:

> Then, in those places where I got to know that they give treatment, I also tried. First I went to the doctor because my mother said „child, I will take you there!“ Then I got treatment in form of medicines, after taking these medicines I will be fine, they said. After that I did not conceive, so then, again, I discontinued it, in every place where I got treatment I discontinued it afterwards, I did not become pregnant, so I stopped it. [...] It was of no use. Two times, three times I got an ultrasound done, they said you are clean, the only thing, the only disease is my period, that my menses do not come in a proper way.

Fozia went to different doctors. One prescribed her a homeopathic medicine[13] to regulate menstruations, but she stopped taking it because se could not afford it anymore and also because the treatment was not effective: neither her menses normalized nor did she become pregnant. Fozia spent three years looking for treatment before she stopped doing it regularly. She still complains about irregular menstruations, but the inefficacy and cost of the different treatments have made her lost her patience. Now she only relies on Allah:

> I like children so much that I asked wherever I go that they should treat me, that why I haven‘t become pregnant yet [...] Then I did not become pregnant, like all this money... she said [the *dai*] I had a miscarriage, then I quit [the treatment], Allah will give.

After trying the *dais* and the doctors Fozia also visited two *mullas*, one said she was pregnant when she was not, the other said that she was alright and that she will become pregnant. Both gave her a potion with something written on it, but afterwards she did not become pregnant. Then she quit the treatments again. Although she had tried anything and almost gave up, she recently went to a *dai* again:

> I went to every place! To every place where they say they get treatment there, I went. Now, a month ago, there is a *dai* here, I went to her to get treatment, she said „you are pregnant“, after that my menses came, and with my broken heart I stopped getting treated, I said what is the use of spending money like that, going here and there... and maybe from getting medicines inside my illness even worsened from inside... if there is an illness or not, they [*dais*] introduce medicines and the disease worsens inside, so I stopped, that is why.

Now Fozia does not believe so easily in those who say that she will get a child, she even blames the *dai‘s* treatment of being prejudicial and worsening her disease. She is sick of looking for treatment and she is not looking for it constantly anymore, hoping that pregnancy will happen „on its own“:

> Well look, until now my hopes were broken by doctors and *dais*, wherever I went for treatment they said yes, you‘ll become pregnant, you‘ll become pregnant this month, you‘ll become pregnant next month. I also went to *dais*, they said this month will happen, next month. It is because of this that my heart broke. So if it happens, it will happen on its own, I will not get more treatments.

[13] Fozia showed me the medicine, it was a syrup whose active component was called *aletris farinosa.*

If her word is final cannot be known, but she, like most of the childless women in Yusuf Goth, has tried all that she could and is tired of it. She feels that healing practitioners abused her hopes, and this has broken her heart. Now, Fozia still worries because of her childlessness:

> I only have worries regarding a child, but no, besides that I don‘t have any other worries. Now, we cannot go to these expensive doctors, because of the money, that is why we can‘t go. How much poverty we had, and my husband still gave me money for my treatment. Now the problem is my husband, he said „I‘ll better get tested myself, maybe it is me who has some disease“, my husband said that. Two thousand, three thousand would it cost to test my husband, that is why... my husband said „That‘s enough, now you sit and I am going to the doctor myself... maybe it is a husband‘s disease, husbands could also have a disease, so after going myself, if I have no disease, then you can go for treatment.“

Even though Fozia‘s husband, who is also her cousin (the son of Fozia‘s *phuphi* [FZ]), is ready to get tested and assumes that he could be infertile, the huge costs impede the couple to pursue examinations and treatment. Their economical situation does not enable them to look for treatment with the „expensive doctors“, thus constraining their choice. In their case, money it is also the reason why the man has not been tested yet.

Fozia‘s story exemplifies why women visit so many practitioners in their quest to become mothers. The inefficacy of treatment, the promises of hope that she heard again and again, a decision of her mother and economical concerns are all factors which have influenced Fozia‘s health seeking behavior. It also portrays the ways in which health practitioners abuse of their power in order to obtain more money, and how women react to this. Fozia‘s story portrays medical pluralism, patterns of resort, financial matters regarding healing, the process of decision-making and the importance of getting treated. All these aspects will be discussed in the following sections.

6.2 The Importance of *`ilaj*

`Ilaj,* an Urdu word of Arabic origin, means medical treatment, medicine, and cure (Ferozsons‘ Urdu-English Dictionary: n.d.), but its use encompasses a wider concept: Under *`ilaj, women in Yusuf Goth refer to all the matters regarding health seeking behavior. *`Ilaj karna* means to visit the different practitioners, to get tests done, to take medicines, to use amulets, and so on. *`Ilaj* is central in the lives of infertile women because they spend a lot of time and money on it in the hope to give birth to a child.

`Ilaj karna,* i.e. „to do *`ilaj“, is not only desirable among childless women but it is expected by those around them. It is the evidence that women really like and want to have children and that they do everything within their limits to achieve a successful pregnancy. The receipts of doctors and the reports of tests constitute for many women a concrete and visual attestation that they have done all what they could and that if it has not worked, it is not their fault. Mumtaz told me about her urine and other tests:

> I got them from everywhere, there are many slips of paper here, aren‘t they? If anyone says that I did not get treated to get children, I have proofs. If you ask me, I will bring you the ultrasound. I could go fast to any doctor and bring the result with me, this happens.

In the same way Mumtaz used the doctor bills and test reports to proof her efforts to get a child, she condemned her sister Bilqis, who is also childless, for the lack of those as an evidence for her indifference regarding childlessness:

> Yes, she [Bilqis] has never got children. She was pregnant once and the child got lost in her womb. Now, if you go to her home you can ask her about this. [...] She went to a *dai*, I don‘t know if she went to the doctor or not... now look, I told her to come here to our house, but she doesn‘t like children. You see, how many times did I look for treatment [*`ilāj kyā*]? But she... now you can ask her, ask her if she has done any ultrasound or any test and you will see if she shows that to you or not.

The importance of doing *`ilaj* is a performative one, it is the most important thing to do regardless of its success. By this I do not mean that childless women are indifferent to the success of their treatments. On the contrary, what I mean is that even if they have personally given up the hope that any treatment will work, though

they never give up the hope to become pregnant and give birth, as it will be discussed later, they still keep on trying different practitioners and their therapies in order to demonstrate that they do their best to achieve pregnancy, that they are not indifferent to their childlessness and that they do something about it. In other words, a childless woman who has done many *`ilaj* cannot be blamed for her condition. The fact that she remains childless is shown to be not due to a lack of initiative, but to Allah‘s will.

`Ilaj is not only important to demonstrate the family and the acquaintances that a woman does something to change her situation, it is also perceived as something that God expects childless women to do. A woman explained:

> He [husband] keeps on saying that Allah will give, Allah will give, but it means that if you get treated Allah will give, Allah will not give just like that. It would be a matter of luck if maybe even without getting treatment Allah would give. It is Allah‘s will, but he want us to make an effort.

Getting treatment is therefore fulfilling the expectations of God. He decides, but still expects women to get *`ilaj*. In other words: it is in *Allah‘s* hands, but his decision depends on the health seeking behavior attitude of the childless women.

The concept of *`ilaj* is therefore central to explain why women keep on trying the same treatments again and again, and why they can be so easily exploited by some unscrupulous practitioners.

6.3 Medical Pluralism

The concept of medical pluralism goes back to Kleinman, who saw healers, like patients, as basic components of health systems which, like other cultural systems, integrate health-related components of a given society (1980: 24). As already mentioned, women in Yusuf Goth rely on a series of different healing practices when they seek treatment for infertility. Biomedical, homeopathic, spiritual and religious healers along with *dais* were the practitioners mentioned by the women.

This section describes the different practitioners as they were described by the women. Since they highlighted the treatments the practitioners gave them, I will also do so. For a better understanding I divided the healing practitioners into three categories corresponding to the kind of healing they offer. This distinction was made by the women themselves.

The category „doctor“ is a very broad one. In Yusuf Goth, any person practicing not only biomedical but also homeopathic medicine is called a doctor. The doctor can also be a nurse or a LHV. Women characterized doctors as the practitioners who conduct exams like ultrasounds, blood and urine tests, and whose treatments consist of syrups, tablets, injections, dilation and curettage (D&C) and, in extreme cases, operations. Childless women visit only female doctors, this is so self-evident for the women and so established in Pakistan that they never commented on this. Many of the women referred also to the LHV as „the doctor.“ Scholars and health professionals studying health seeking behavior should be aware of the fact that when a woman says that she went to the doctor, her categorization does not necessarily correspond to that of the fieldworker. Even a deeper inquiry about the „doctor“ women talk about does not always throw enough light to discern which kind of practitioner they referred to. All the involved women went to at least one doctor because of their childlessness.

A *dai* is what has been called a „traditional birth attendant“ (Jeffery et al. 1989: x), in Yusuf Goth they do not only attend births but are generally speaking specialists for reproductive and children‘s health, therefore they also treat cases of infertility. Here, *dais* are always women, they do not have a recognized training in childbearing, and they commonly learned through observation and practice from someone in the family. Although their practice is non-biomedical in nature, they do base their work sometimes on biomedical tests, such as urine tests and ultrasounds, which some of them also prescribe, this might suggest that some *dais* have acquired some kind of biomedical training, though I was not able to prove this. In the case of infertility, their treatment consists of introducing herbs and other medicines through the vagina of the infertile women.

The *mullas* (also *mullahs* in the literature) here can be regarded as spiritual healers. Women in Yusuf Goth used the term interchangeably with *maulavi, maulana,* and *pir*, thus the categorization is, like that of the doctors, very broad and unspecific. In the case of infertility, *mullas* are demanded when the doctors‘ or *dais‘* treatments have been ineffective, because they treat diseases whose origins are in the spiritual and religious world. A woman explained:

> Whenever I went to the doctor the doctor would say to me that the reports are O.K., so go to the *mulla*! There are these *mullas*, right, *maulavis* and so on, to them I should go, to these people that make conception possible, that‘s how we call these people [...] To them, because the reports are alright, so it is in Allah‘s hands.

The *mullas*, therefore, act as intermediates of God and spirits who are able to treat infertility when it is not originated by physiological causes, i.e. when its etiology is beyond the *dais‘* doctor‘s scope. Therefore, the treatments prescribed by *mullas* vary substantially from those prescribed by *dais* or doctors: they do not prescribe medicines, instead they prepare amulets that are worn by the patients, or they write Quran verses in paper and put them in water which is subsequently drunk by the women, or they perform ritual healing, which was described by a woman as placing Quran verses and amulets on the body for five minutes and then taking them away. It was not possible for me to estimate the number of *mullas* practicing in Yusuf Goth since there are also *mullas* who wander around from place to place offering their healing services. Besides, some women declared to have visited different *mullas* outside Yusuf Goth, most of them in different parts of Balochistan, including Quetta.

Generally speaking, it is possible to say that the doctors and the *dais* are healing practitioners who base their work on the possible physical origins of infertility, whereas the healing practices of the *mullas* are based on religious and spiritual grounds. Nevertheless, it is important to say that these categories are not as exclusive at they might seem to be. They mix elements and even refer patients to each other: *dais* use biomedical tests to assess diseases, doctors suggest to visit a *mulla* when the tests seem normal, and *mullas* might refer to the doctors or *dais* when they think they can offer a more effective treatment.

6.4 Patterns of Resort

The strategies used by people to decide which option to employ and when are called ‚patterns of resort' (Hardon et al. 2001: 35). In his model of patterns of resort, Kleinman related the use of certain medical care to the beliefs of patients regarding the etiologies and the characteristics of the diseases (1980: 184ff.). Later on he criticized his own model, arguing that the characterization of distinctive types or resorts seems „overly mechanical" nowadays (1995: 9). This critique can be applied in this thesis, where the different narratives of getting '*ilaj* made it impossible to establish a clear pattern of resort due to the high variation in health seeking behavior. Nevertheless, it is possible to distinguish some commonalities regarding the beginning of health seeking and the length of it.

Since women are expected to become pregnant soon after marriage, some of the women started worrying because they did not become pregnant in the first months of their married life. When pregnancy does not occur immediately, it means that something is „wrong," either with the wife or the husband. Still, the woman is the first, if not the only one, who is blamed and expected to seek health care as soon as possible.

All the interviewed women sought treatment the latest two months after marriage, either because they had a miscarriage or because they were not becoming pregnant. The practitioner chosen, however, varies: five women visited a doctor first, whereas two opted for a *dai*. Bhatti *et al.*'s (1999) qualitative study on infertility in Karachi's squatter settlements also threw out that doctors are preferred instead of *dais* because, as they suggested, women in slums are exposed to an urban lifestyle and have generally more information regarding the medicalization of infertility.

The infertile women had already consulted so many practitioners that they could not recall the exact numbers of *dais,* doctors, and *mullas* they have been to. All women turned to doctors, according to their estimations they had been to seven to three different doctors. Two women declared that they had been neither to a *dai* nor a *mulla*, while one went to a *dai* but not to a *mulla*. Women did not specify on an etiological basis about why they visited a certain practitioner. The decision which

resort to use seemed to be more based on the decision of the mother, the mother-in-law and other relatives and on the fees that each healer charged as well as the assessment of the condition (hospitals were chosen for emergencies and when the condition was perceived as serious). Nevertheless, *mullas* were always consulted only after having visited *dais* or doctors. Assumably, *mullas* are considered an option only when treatment based on the physical causes had failed.

The continuity of treatment by each practitioner varied as well, women declared to have quit therapies either because they did not seem to be effective or they could not afford them anymore. The definite interruption of health seeking, which was the decision of five women out of seven after three to thirteen years of seeking treatment, had many reasons, the most important being inefficacy, but also the cost of the treatments on the long term. It is because of this that women who have visited many healers are tired of not achieving the expected results. Additionally, all the woman, also those still pursuing treatment, feel upset since they have the impression that doctors and other practitioners are not honest and do not tell them the truth. A woman who stopped consulting healers put it:

> No one told me anything. That is why I am not going anywhere. They should know the truth, the *dai*, the *mulla*, the doctor, they all have the certainty, but they don‘t say anything, so what is the use of consulting them?

Women may also criticize the manners of doctors, as one complained:

> It is because of that that my heart breoke from the treatments... some said this, others said that... I say if there is any doctor who talks in a nice, tranquil, and tender way, I would understand [...]. Then the doctor went on my nerves, I said no, I will not come to you... like normally I fear when I go to the doctor, they don‘t explain the patient what is it, which illness do I have, they only make the patients fear.. that is why I am afraid.

Also Fozia suspected that the *dai‘s* treatment (introducing herbs through the vagina) worsened her condition, as she experienced.[14] Fear and suspicion of different practitioners might play a role on the resorts used in the next stage. They also portray the plurality of the perceptions and experiences of *‘ilaj* in Yusuf Goth.

[14] For a discussion on both the negative assessments and the romanticization of *dais* by the WHO, doctors, and anthropologists see Jeffery and Jeffery 1993.

6.5 Financial Matters

As already seen, infertile women in Yusuf Goth have usually no own income, therefore they rely on the support of their husbands and other family members. Healing regarding infertility always carries economic expenses with it because in Yusuf Goth only private practitioners are accessible by feet and public services like the Lyari Hospital, are too far away, involving always transportation costs. Besides, as discussed in chapter four, public services are not always for free due to the widespread corruption of the health system.

The allocation of money for medical purposes varies from household to household. Whereas some women declared to obtain a certain amount of „pocket money“ from their husbands for the whole week and finance from this amount the service‘s fees, other women were accompanied by their husbands who paid the bills. Because childlessness affects the whole family, in some cases the whole household contributes to finance health care, especially in the case of greater costs for operations or expensive exams. Given the degree of poverty of the women, it was impressive to hear how much the couples and families had spent in treatments and exams, some of them costing more than three or four monthly incomes for a family of four or five. Although the women could not recall any exact amount regarding their total expenses for treatment, they all were sure that it was a lot. One woman declared that her husband borrowed Rs. 15,000 from different persons in order to pay, among other services, a blood test at the Lyari General Hospital costing Rs. 10,000. In order to cover the whole sum, her husband took a loan and, additionally, borrowed money from her mother-in-law and her *devar* (HB).

The women also declared that the doctors were the most expensive of the healers, followed by *dais* and *mullas*, because the biomedical tests and examinations as well as the prescribed medicines are much more expensive than those provided by *dais* and *mullas*. These declarations, notwithstanding, are contradictory with other statements made by the women themselves, therefore it always depends on each individual practitioner and hospital, being generalizations difficult. For example, in APWA‘s clinic consultations are free of costs, but ultrasounds and procedures like

D&C are charged (Rs. 100 and Rs. 1,000, respectively), whereas one woman declared to have paid a *dai* Rs. 500 for a consultation. The cost of the different healers, therefore, varies enormously.

A woman suggested that the biggest problem to obtain a proper treatment is money. When asked if she assess the expenditures as useful, she said:

> Not until now, what should I do? The biggest problem is money, the problem of money, with money you get everything, if there is no money there is nothing, like when you have money you have everything, but when you don‘t have... we will ask our mother, our brother and sister...

The women perceived their economical situation as a burden to achieve proper medical treatment. Lack of money is therefore not only a reason to quit treatments, but also a reason not to pursue potentially more effective treatments. This is a reason why women in Yusuf Goth have never heard about new reproductive technologies: they are so away from their economic realities that they do not even know about their existence.

6.6 Decision Making

Although it is the childless women who go from practitioner to practitioner looking for treatment, it is often not themselves who take the decision where to go and when. Being childlessness a matter of concern for the whole family, the same applies for the decision of obtaining treatment.

The first person most women in Yusuf Goth approach when they have any problem related to reproductive health is the mother-in-law. Many women considered shameful to discuss such issues with their own husbands. When the mother-in-law does not live anymore, the women would confide their problems to their husbands or to their sisters-in-law if also married. The own mother is also informed when women have the chance to, and especially if there are no other female relatives nearby. Often it is others who impose their opinions on the women, deciding where they should go to get treated. One woman declared that she does not believe in amulets, but still used one because her mother-in-law insisted.

Generally speaking, women need permission to go to the practitioners, and they also need a companion so that they do not go alone. Only if they are the only women in the house, as in Fatima‘s case, they do go alone and do not need to ask anyone. But usually it is the husband or a female relative who goes with the women to the different healers.

Health seeking behavior for infertility is thus a familiar matter, and it is not possible to study it without taking this fact into account. The choice of one or the other practitioner is subjected to many factors which make it difficult to establish a clear pattern. Each woman showed peculiarities in her health seeking behavior history based on her own and her relative‘s beliefs.

Further, the early health seeking by infertile women is central to explain the problem of epidemiological definitions of infertility: women who already seek health a couple of months after marriage define themselves as infertile through this attitude, but they would not be considered infertile under the current epidemiological definitions because at least one to two years need to have been passed without achieving conception or birth to be considered infertile (see introduction), constituting a major problem to explain early health seeking behavior. Experience and the own perception of the condition should also be included in epidemiological definitions in order to avoid biases in the study of health seeking behavior.

7. Coping with infertility

7.1 „As long as there is life, hope remains“: Faith and Hope

Infertile women in Yusuf Goth considered their condition to be a temporary one, they never talked about barrenness but only about childlessness. In other words, they all maintained the hope that they will get, soon or later, at least one own child.

Most of the interviewed women had already given up treatments of different kind and all their hopes were placed on God, as a woman said: „Yes, there is hope, it [pregnancy] will happen, *insha'allah*.“ They felt that they have done their part and now God has to do his own.

„God praises the hope of humans“ said another woman, that is why women do not give up her hopes and are usually convinced that God will help them, as another one told me: „I say that Allah will give, he will give for sure! I am sure about that, he will give me [a child], he will...“ Her sister, also childless, said: „As long as there is life, hope remains. When one dies, then it is over!“

Women often recall stories of acquaintances and relatives who, after many years of trying unsuccessfully to give birth to a child, they finally achieved pregnancy and birth. These stories reaffirm the belief that patience and hope pay off. Fozia said:

> My sister-in-law, my brother's wife, right? She also couldn't become pregnant after six years of marriage. My marriage took place two years after theirs, and I had so many treatments [`ilāj] but she had not. I said to her I am getting treated, I love children, therefore I am so much looking for this to happen, but she said she will not [get treated], „I will become pregnant on my own, yes.“ Six years after her marriage, she got a girl. Yes, six years after her marriage she got a girl, but I haven't got any child yet. I asked my mother, I also asked her, „Why haven't I become pregnant yet?“ „Because it was the same for me,“ my mother said, „three years after marriage, three years passed and I got a boy,“ so I asked „is it like this in the family?“ and she said „Yes, it is like this in the family,“ so after six years I haven't got a child yet, but I have been to every place, I have told you I looked treatment in every place, but it is God's will, as a human you can do anything but still... isn't it?

The fact that her sister-in-law became pregnant after so many years even without seeking medical attention is a source of hope for Fozia. Moreover, since her own mother also waited three years before her first pregnancy, she believes that her destiny is the same. Exaggerating the story of her sister-in-law, she told me later: „In our family, it happens that for ten years you don‘t have children, but after that it happens, after that children [are born]. [...] Yes, this happens often.“ Another woman recalls the story of her own mother: „Still I think that Allah gives favors, Allah will give, he gave to my mother after twelve years. My mother said I [eldest child] came after twelve years.“ It is due to these stories of long wait and success that women are convinced that God will give them a child.

7.2 Blaming the Husband

Within the family, women are the first to be blamed for the childlessness of a married couple, but the women themselves tend to blame their husbands. Most men do not undergo any infertility test, out of the seven women only one declared that her husband had been tested. Not having the proof that men are not responsible for infertility allows women to speculate about the origin of the „failure“ and to stress the fact that the problem is not necessarily theirs. When asked about why she thinks that she does not get a child, a woman answered:

> I think that after four years, four years I have been married and I don‘t have a child yet, and when I get tested the reports show that everything is normal, so it‘s not me. My husband will maybe have some problem, but he hasn‘t got any test made, he has not been tested. That is the problem, if he would get tested then we would come to know what is wrong, if he had some problem or if the problem is inside me... with the test, but he has not been tested yet. He doesn‘t care, he doesn‘t care if I am tested. How much effort have I done in order to get tested, but he just doesn‘t want to, he says that it costs too much... I do this for the sake of a child, not as a recreation, but he doesn‘t care... I got tired of talking and talking to him. I said „I want a child, if you don‘t want, I still want.“ The miscarriage and the childlessness, for a person... like... I would become very happy [with a child].

The uncertainty of where the „problem“ really comes from is ambivalent: On the one hand, as long as pregnancy and birth is not achieved, women tend to keep on seeking

treatment with the consequence of spending large amounts of money and, of course, getting tired from it; on the other hand, as long as the clinical cause is not determined, women can always blame their husbands, arguing that they have already done all what they can, so now it is not in their hands to change the situation.

Even when the possible explanation for infertility seems to be more or less clear, for example when women were already pregnant and had miscarriages or in the case of women with amenorrhea and irregular menstrual cycles, those whose husbands haven not been tested yet will still argue that maybe it is „his“ problem, as a woman explained:

> I think that it could be because of the [irregular] menses, or perhaps my husband has some disease and he is not well...[...] I said, right, to each and every place I went for treatment they said you are clean, you are completely alright, so maybe it is because of my menses, or maybe because of my husband, that is why, both reasons.

Blaming the husband is a way of disclaiming responsibility on the failure to fulfill the expected role in the family and society, but also an excuse for themselves: Convincing themselves that it is probably the husband is a way of coping with the own situation and a way of reaffirming the own honor and identity as a woman in a society where femaleness is defined primarily by motherhood.

7.3 „Someone to talk to...“ Friends and Family

Although friends, family and other acquaintances play a big role in making childless women feeling bad about their situation by asking them why they have not born a child yet, women still use conversations as a way of coping with infertility. In some cases it is about discussing their hardships, also those related to infertility, whereas in other occasions, especially with those who are not so close friends, it is more about chatting about all the world and his brother in order to forget the own problems.

Due to the patrilocal organization of Baloch households, married women are far away from their mothers, sisters, and friends from the natal place, therefore some

women regret not having anyone to talk to at home. A woman complained that not even the children at home are willing to chat with her, as she explained:

> People know what is the mother-in-law‘s house like, sometimes it is fine, sometimes it is absolutely bad. There is my nephew, there are my [younger] brothers-in-law, but there is nobody I can talk about my feelings. Now, all have their children, if anyone is beaten, if any of them starts crying, after coming back home they will come to the *bahu* [daughter-in-law], children are like that. If I call the boys they will not come, nor the people working, nobody. I talk to nobody, the whole day I sit in front of the television, I watch, and I stitch. I have [friends], but I had to leave them with my people at [the natal] home, there is my cousin, there is my *khala* [MZ], there is my mother... [...] Thank God they are there, but they cannot come [here] and go all the time.

Talking to those relatives who really care was avoided by a woman, who explained: „I don‘t talk with my mother about that because she thinks a lot [about it], that is why I talk to my mother-in-law.“ She preferred to spare her own mother from her suffering so that she does not have to worry. Although women usually have neighbors with whom they can have some small talk, often infertile women wish they had someone to talk about their feelings. One woman said:

> I have a lot of hardships, but I can‘t tell anyone, but in front of you I am telling this. The ones whom I talk to, I can‘t tell them... there is my mother-in-law, my *nande* [HZs], my *jetani* [HBW], but I can‘t tell them. What is the use of telling? When a person talks, then it becomes lesser.

Talking about the own problems is perceived as a form of relief, though only a light one. A woman said she talks often to other infertile women whose hardships are similar. She explained: „They say ‚I can understand your troubles, ‚I have also them, a lot, I am also like this, I am also like that.‘ I talk to them and they talk to me, then the sadness becomes slightly less.“

Through communication women look for understanding to their situation and also for consolation. Nevertheless, talking as a way of coping does not really alleviate women from suffering.

7.4 Adoption

In an article titled *Why adoption is not an option in India*, Bharadwaj argued that adoption is a last resort option for infertile couples because „it is an open and public declaration of failed fertility, not to mention the fears of failed sexuality“ and, more importantly, because the adopted child, or „third party“ signifies a break of the link between the body and the progeny where, as opposed to artificial donor insemination, it is impossible to maintain silence (2003: 1875). As one of Bharadwaj‘s informants said, „[an] adopted child is a bastard child!“ (ibid.), this sentence reflects the assumption that adopted children come usually from a „dubious“ background (pre- or extra-marital relationship), and, in case to opt for adoption, they would prefer a child coming from the own family.

The view of Indian couples can be applied for the context of Yusuf Goth. When we recall Fatima‘s story (section 5.1), who adopted her deceased sister‘s children, we will remember that she initially thought about adopting a homeless child, but the comments of others restrained her from it. Finally, she had the opportunity to adopt children from within the family, to what her husband and in-laws agreed. The adoption of „stranger‘s“ (*ghair* in Urdu) children is not accepted, whereas taking children from relatives seems to be a common practice. A woman narrated:

> My younger *nand* [HZ], right? She adopted the child of my big *nand*. Twelve years have passed since her marriage and she has not given birth to a child yet, not until now, so she took the daughter of my *nand*, they gave her to them, and they adopted her.

As an accepted practice, some had thought about it. A woman told that she would adopt a child with the consent of her husband, but she still has not found a relative to give her a child yet. She tells:

> It was me who told him [husband] to take another‘s child, to keep it with us, to take care of it, „do as you wish“ he told me sincerely, „if you want to keep someone else‘s child, if you get it to keep it, to take care of it“. He does not forbid it, because he also likes [children], right?

Another woman who has thought about keeping someone else‘s child as an option claimed that her husband stood against it. When I asked if she had considered adoption, she said:

> Yes, but I have not done it, my husband doesn‘t want to. [...] Yes, I want, my husband doesn‘t want, so how could it happen? He says that if he gives, it will be his own, and if he does not... I have told my husband, I have told him several times that I don‘t have children, that we could take someone else‘s child at least, but he said no.

That the child should come from „his own“ seems to be another reason for which a husband might oppose adoption. Nevertheless, not all women would like to adopt, like Ayesha, who associated adoption with „tension:“ „Ayesha should also be given a child [to adopt], but if I get one it is like... I mean, tension, I say no.“ Although she did not specify what kind of tension she refers to, it would be thinkable that either she means tension with the biological parents, if the child is adopted from relatives, or tension from outsiders who will gossip, if it is the child of a stranger.

Although adoption is considered as a way of coping, it is considered a last resort by infertile women in Yusuf Goth. Nevertheless, in the case of Fatima, adoption did not damp down her desire to get an own child, for which she is still looking for treatment.

7.5 Other Ways of Coping

Besides the coping strategies described above, the women talked about other practices that make them „forget“ or feel better with themselves. One woman explained that she goes often to visit Sufi shrines, but surprisingly these trips have no religious significance for her, instead they are regarded as a kind of holidays. She narrated:

> We use to go there [Sehvan Sharif, a Sufi shrine in Sindh] a lot. Since my marriage took place... we do not go as going for pilgrimage, how do you say? No, we just go to enjoy ourselves, as a trip. To Sehvan Sharif, Thatta [another place of pilgrimage], and to a lot of shrines in different areas of Sindh, we go there and we stay for one or two days there. Now, this *Eid*, we will go to Sehvan for a couple of days... my mother-in-law and my father-in law said „you are sitting so bored, let‘s go in a trip,“ so that is the intention. We do go to the shrines, yes. When one is away from home then the tension is reduced a little bit [laughs]. Yes, when you sit the whole day at home you get tension.

Other ways of coping mentioned by infertile women included keeping oneself busy with domestic activities like stitching, and also taking care of other‘s children. Although these women try to cope with their situation, they will be restless until they get the much desired child. As a woman said:

> Angry comes, but toward whom? I get angry, everybody gets angry, I get very angry at myself because this is what Allah has given to me. I am a woman, but not like a woman is supposed to be. I am married, but I haven‘t got any child yet. When I sit alone, well, then I think about these things. About why has this happened to me, why is it like this, why I don‘t have that? Allah knows!

8. Conclusion

Through this thesis I argued that the meaning of infertility is only understandable if we include the aspect of experience, and that experience can only be understood in the context in which it is embedded.

In order to gain a deeper insight into the everyday lives of infertile women in Yusuf Goth, I collected interviews which are not only illness narratives, but also life histories. In them, women could express themselves not only about their worries regarding their infertile condition, but, moreover, about their everyday life and suffering, aspects that are part of a dialectical process taking place in the shaping of the perceptions and experience of infertility for their sufferers. The lack of separation between these elements by the women themselves makes clear that infertility cannot be understood in vacuum, and that it cannot be measured only with numbers, therefore the inclusion of qualitative studies in epidemiological research remains strikingly necessary.

Infertility is perceived and experienced as a negative situation that is related to tension within the family, expenses that accentuate poverty, constant health seeking and disappointments regarding treatment and their outcomes as well as the confrontation with their own identity due to the failure to fulfill the role expected in society. Moreover, the intrusive questions of others and the cases of domestic verbal and/or physical violence related to infertility make it clear that being infertile is not only an individual matter concerned with the legitimate personal wish to have an own child and experience motherhood as a reason in life: childlessness in Yusuf Goth is experienced as a social matter, a fact also reflected through the importance of health seeking (*'ilaj*). The inclusion of the social environment is, therefore, central for the understanding of the infertility experience.

Infertile women defined their condition, as shown, as a temporary one, therefore they never perceived themselves as „barren" or „sterile" (*banjh*), but only as „childless" (*beolad*), no matter how long they have been trying to achieve pregnancy

and birth. Their perception on the condition varies, therefore, enormously from the WHO‘s definitions and classifications which have been suggested as standard without considering any inadequacy: the complexity of the experiences cannot be grasped through current epidemiological definitions. Moreover, since the health seeking behavior takes place independently from epidemiological definitions, I suggest that the clinical explanations and definitions of infertility do not play any role in it because the women are often not informed by healers about their actual condition and also because of the amalgamation of infertility with other afflictions, as seen in chapter six. This fact is also reflected through the parameter recommended by the WHO for the calculation of infertility prevalence, which only includes those women who have been trying to give birth for at least two years, a definition that leaves out all those women who seek health for infertility after the first months of marriage. Unless the experiences of infertility are included in epidemiological research, I suggest, its findings cannot be considered valid, and infertility will hardly gain priority as a public health issue.

Although women find different ways to cope with their situation, their statements revealed that these activities do only contribute to alleviate their suffering to a small extent. On the other hand, infertility being a social condition, the strategies to cope with it do not really help women to live as normal married adults, this is reflected by the fact that even after adoption the wish to have an own child does not diminish. Nevertheless, some ways of coping, like blaming the husband when he has not been tested, do help women to reassure their gender identity. This is clearly a form of agency, where infertile women make use of an ambivalent situation, usually depicted as negative for the women, for their own benefit.

Because the suffering of infertile women in Yusuf Goth is rooted primarily in their condition and its social reject, but also on the failures of the economical and health systems, a change on the policy level could contribute to an improvement in their situation. I suggest that a structural change in the health system, which could be achieved more easily through a change of discourse regarding reproductive health and reproductive rights on the level of international actors, especially donor organizations, should enable poor infertile women and their husbands to be checked,

tested and treated in the way they estimate as more convenient. Although treatment is not a guarantee for success and the achievement of birth, a dignifying health care system in which women and their husbands are informed properly about their condition and the procedures they are subjected to, where transparency discourages practices such as the unnecessary repetition of exams, and where accessibility and affordability are ensured, would signify a big relief for those whose suffering is already ingrained in so many other aspects of everyday life, especially poverty and marginalization on the basis of ethnicity.

9. Bibliography

Akran, M. and Jehangir Khan, F. 2007. *Health Care Services and Government Spending in Pakistan*. Islamabad: Pakistan Institute of Development Economics.

Axmann, M. 2009. *Back to the Future. The Khanate of Kalat and the Genesis of Baloch Nationalism 1915-1955.* Karachi: Oxford University Press.

Baloch, I. 1987. *The Problem of „Greater Baluchistan": A Study on Baluch Nationalism.* Stuttgart: Steiner Verlag Wiesbaden.

Becker, G. 1994. Metaphors in Disrupted Lives: Infertility and Cultural Constructions of Continuity. *Medical Anthropology Quarterly*. 8 (4): 383-410.

Bharadwaj, A. 2003. Why adoption is not an option in India: the visibility of infertility, the secrecy of donor insemination, and other cultural complexities. *Social Science and Medicine*. 56: 1867-1880.

Bhatti, L. I., Fikree, F. F., and Khan, A. 1999. The quest of infertile women in squatter settlements in Karachi, Pakistan: a qualitative study. *Social Science and Medicine*. 49: 637-649.

Binder, L. 1986. Islam, Ethnicity, and the State in Pakistan. An Overview. In Banuazzi, A. and Weiner, M. (Eds.), *The State, Religion, and Ethnic Politics. Afghanistan, Iran, and Pakistan.* Syracuse: Syracuse University Press, pp. 259-266.

Campbell, O., Cleland, J., Collumbien, M., and Southwick, K. 1999. *Social Science Methods for Research on Reproductive Health*. Geneva: World Health Organization.

Chaudhry, L. N. 2006. Salient Contours of Structural Violence in the Lives of Rural Women: From Fieldwork in Sindh and Punjab. In *Seventh Sustainable Development Conference (SDC) held from 8-10 December 2004 in Islamabad, Pakistan.* Karachi: Sustainable Development Policy Institute, pp. 460-482.

Cole, A. L. and Knowles, J. G. 2001. *Lives in Context. The Art of Life History Research.* Walnut Creek: Altamira Press.

Daar, A. S. and Merali, Z. 2002. Infertility and Social Suffering: The Case of ART in Developing Countries. In: Veyena, E., Rowe, P. V., and Griffin, P. D. (Eds.), *Current Practices and Controversies in Assisted Reproduction. Report of a meeting on „Medical, Ethical and Social Aspects of Assisted Reproduction" held at WHO Headquarters in Geneva, Switzerland, 17-21 September 2001.* Geneva: WHO, pp. 15-21.

Degand, A. 1988. *Geschlechterrollen und familiale Strukturen im Islam; Untersuchungen anhand der islamisch-juristischen Literatur 7./13 bis 9./15. Jahrhunderts.* Frankfurt a.M.: Peter Lang.

DiGiacomo, S. M. 1999. Can there be a ‚cultural epidemiology'? *Medical Anthropological Quarterly*. 13: 436-457.

Dunn, F. and Janes, C. R. 1986. Introduction: Medical Anthropology and Epidemiology. In James, C. R., Stall, R., and Gifford, S. M. (Eds.), *Anthropology and Epidemiology*. Dordrecht: Reidel, pp. 3-34.

Ecks, S. and Sax, W. S. 2005. The Ills of Marginality: New Perspectives on Health is South Asia. *Anthropology and Medicine*. 12 (3): 199-210.

Farmer, P. and Kleinman, A. 1989. AIDS as Human Suffering. *Daedalus*. 18 (2): 135-160.

Farmer, P. 1996. On Suffering and Structural Violence: A View from Below. *Daedalus*. 125 (1): 261-283.

Farmer, P. 2005. *Pathologies of Power. Health, Human Rights, and the New War on the Poor.* Berkeley: University of California Press.

Feldman-Savelsberg, P. 1994. Plundered Kitchens and Empty Wombs: Fear of Infertility in the Cameroonian Grassfields. *Social Science and Medicine*. 39 (4): 463-474.

Fisher, J. 2009. Infertility and assisted reproduction. In *Mental health aspects of women's reproductive health. A global review of the literature.* Geneva: WHO, pp. 128-146.

Fleck, A. C. Jr. and Ianni, F. A. 1957. Epidemiology and Anthropology: Some Suggested Affinities in Theory and Method. *Human Organization*. 16 (4): 38-40.

Foucault, M. (1976) 1983. *Der Wille zum Wissen. Sexualität und Wahrheit 1*. Frankfurt a.M.: Suhrkamp.

Freedman, L. P. and Isaacs, S. L. 1993. Human Rights and Reproductive Choice. *Studies in Family Planning*. 24 (1): 18-30.

Good, B. J. and Del Vecchio Good, M. J. 1994. In the Subjunctive Mode: Epilepsy Narratives in Turkey. *Social Science and Medicine*. 38 (6): 835-842.

Greil, A. L. 1991. *Not Pregnant Yet. Infertile Couples in Contemporary America.* New Brunswick and London: Rutgers University Press.

Greil, A. L. 1997. Infertility and Psychological Distress: A Critical Review of the Literature. *Social Science and Medicine*. 45 (11): 1679-1704.

Greil, A. L., Slauson-Blevins, K., and McQuillan, J. 2009. The experience of infertility: a review of recent literature. *Sociology of Health and Illness*. 32 (1): 1-23.

Hardon, A. *et al.* (1994) 2000. *Applied Health Research Manual. Anthropology of Health and Health Care.* Amsterdam: Het Spinhuis.

Helman, C. G. (1984) 2001. *Culture, Health and Illness. 4th Edition.* London: Arnold.

Helman, C. G. (1984) 2007. *Culture, Health and Illness. 5th Edition.* London: Hodder Arnold.

Inhorn, M. C. 1996. *Infertility and Patriarchy. The Cultural Politics of Gender and Family Life in Egypt*. Philadelphia: University of Pennsylvania Press.

Inhorn, M. C. and Whittle, K. L. 2001. Feminism meets the „new“ epidemiologies: Toward an appraisal of antifeminist biases in epidemiological research on women‘s health. *Social Science and Medicine*. 53: 553-567.

Inhorn, M. C. 2006. Defining Women‘s Health: A Dozen of Messages from More than 150 Ethnographies. *Medical Anthropology Quarterly*. 20 (3): 345-378.

Jeffery, P., Jeffery, R., and Lyon, A. 1989. *Labour Pains and Labour Power. Women and Childbearing in India.* New Delhi: Zed.

Jeffery, R. and Jeffery, P. M. 1993. Traditional Birth Attendants in Rural North India: The Social Organization of Childbearing. In Lindenbaum, S. and Lock, M. (Eds.), *Knowledge, Power, and Practice. The Anthropology of Medicine and Everyday Life.* Berkeley: University of California Press, pp. 7-31.

Khan, M. M., Van den Heuvel, W. 2007. The impact of political context upon the health policy process in Pakistan. *Public Health*. 121: 278-286.

Khattak, F. H. 2006. Health Care Financing: An Overview and Prospects for Pakistan‘s Forthcoming Five-Year Plan (2005-2010). In: *Seventh Sustainable Development Conference (SDC) held from 8-10 December 2004 in Islamabad, Pakistan.* Karachi: Sustainable Development Policy Institute, pp. 515-524.

Kleinman, A. 1980. *Patients and Healers in the Context of Culture. An Exploration of the Borderland between Anthropology, Medicine, and Psychiatry.* Berkeley: University of California Press.

Kleinman, A. 1988. *The Illness Narratives. Suffering, Healing and the Human Condition.* New York: Basic Books.

Kleinman, A. 1995. *Writing at the Margin. Discourse Between Anthropology and Medicine.* Berkeley: University of California Press.

Kleinman, A., Das, V., and Lock, M, 1997 (eds.). *Social Suffering*. Berkeley: University of California Press.

Kohler Riessman, C. 2002. Positioning Gender Identity in Narratives of Infertility: South Indian Women‘s Lives in Context. In Inhorn, M. C. and van Balen, F. (Eds.), *Infertility around the Globe. New Thinking on Childlessness, Gender, and Reproductive Technologies.* Berkeley: University of California Press, pp. 152-170.

Krieger, N. 1994. Epidemiology and the Web of Causation: Has Anyone Seen the Spider? *Social Science and Medicine*. 39 (7): 887-903.

Krieger, N. and Zierler, S. 1995. Accounting for health of women. *Current Issues in Public Health*. 1: 251-256.

Lavania, V. 2006. *Childless Couples. Social Consequences of Sterility and Infertility.* Jaipur: Rawat.

Lewin, C. McC. 1996. Introduction. In Titus, P. (Ed.), *Marginality and Modernity. Ethnicity and Change in Post-Colonial Balochistan*. Karachi: Oxford University Press, pp. xiii-xxviii.

Marchbanks, P. A., Peterson, H. B., Rubin, G. L., Wingo, P. A., and The Cancer and Steroid Hormone Study Group 1989. Research on Infertility: Definition Makes a Difference. *American Journal of Epidemiology*. 130 (2): 259-267.

Mattingly, C. 1998. *Healing Dramas and Clinical Plots. The Narrative Structure of Experience.* Cambridge: Cambridge University Press.

Neff, D. L. 1994. The Social Construction of Infertility: The Case of the Matrilineal Nayars in South India. *Social Science and Medicine*. 39 (4): 475-485.

N.N., n.d. *Ferozsons‘ Urdu-English Dictionary. Revised Edition.* Lahore, Rawalpindi, Karachi: Ferozsons.

Papreen, N., Sharma, A., Sabin, K., Begum, L., Ahsan, S. K., and Baqi, A. H. 2000. Living with Infertility: Experiences among Urban Slum Populations in Bangladesh. *Reproductive Health Matters*. 8 (15): 33-44.

Pastner, C. McC. 1979. Cousin Marriage Among the Zikri Baluch of Coastal Pakistan. *Ethnology*. 18 (1): 31-47.

Pastner, C. McC. 1981. The Negotiation of Bilateral Endogamy in the Middle Eastern Context: The Zikri Baluch Example. *Journal of Anthropological Research*. 37 (4): 305-318.

Patel, T. (1994) 2006. *Fertility Behaviour. Population and Society in a Rajasthan Village.* New Delhi: Oxford University Press.

Patel, T. 2007. The Mindset behind Eliminating the Female Foetus. In: Patel, T. (Ed.), *Sex-selective Abortion in India. Gender, Society, and New Reproductive Technologies.* New Delhi: Sage, pp. 135-174.

Petchesky, R. P. 1980. Reproductive Freedom: Beyond ‚A Woman's Right to Choose." *Signs: Journal of Women in Culture and Society*. 5 (4): 661-685.

Petchesky, R. P. 2003. *Global Prescriptions. Gendering Health and Human Rights.* London, New York: Zed Books in association with United Nations Research Institute for Social Development.

Rutstein, S. O. and Shah, I. H. 2004. *DHS Comparative Reports No. 9. Infecundity, Infertility, and Childlessness in Developing Countries*. Calverton: U.S. Agency for International Development (USAID).

National Institute of Population Studies (NIPS) [Pakistan], and Macro International Inc. 2008. P*akistan Demographic and Health Survey 2006-07*. Islamabad: National Institute of Population Studies and Macro International Inc.

Salzman, P. C. 1992. *Kin and Contract in Baluchi Herding Camps.* Naples: Instituto Univesritario Orientale.

Salzman, P. C. 2000. *Black Tents of Baluchistan.* Washington: Smithsonian Institution Press.

Sandelowski, M. 1990. Fault lines: Infertility and imperiled sisterhood. *Feminist Studies*. 16 (1): 1-15.

Sandelowski, M. 1993. *With Child in Mind. Studies of the Personal Encounter with Infertility.* Philadelphia: University of Pennsylvania Press.

Sääväla, M. S. 2001. *Fertility and Familial Power Relations. Procreation in South India.* Richmond: Curzon.

Schleifer, A. (1986) 1996. *Motherhood in Islam.* Louisville: Fons Vitae.

Schmidt, L. and Münster, K. 1995. Infertility, involuntary infecundity, and the seeking of medical advice in industrialized countries 1970-1992: a review of concepts, measurements and results. *Human Reproduction*. 10 (6): 1407-1418.

Siddiqi, S., Haq, I. U., Ghaffar, A., Akhtar, T., and Mahaini, R. 2004. Pakistan‘s maternal and child health policy: analysis, lessons and the way forward. *Health Policy*. 69: 117-130.

Slimbach, R. A. 1996. Ethnic Binds and Pedagogies of Resistance: Baloch Nationalism and Educational Innovation in Karachi. In Titus, P. (Ed.), *Marginality and Modernity. Ethnicity and Change in Post-Colonial Balochistan*. Karachi: Oxford University Press, pp. 28-50.

Sultana, F. 1996. Gwat and Gwat-i-Leb: Spirit Healing and Social Change in Makran. In: Titus, P. (Ed.), *Marginality and Modernity. Ethnicity and Change in Post-Colonial Balochistan*. Karachi: Oxford University Press, pp. 28-50.

Swindler, N. 1996. Beyond Parody: Ethnography Engages Nationalist Discourse. In Titus, P. (Ed.), *Marginality and Modernity. Ethnicity and Change in Post-Colonial Balochistan*. Karachi: Oxford University Press, pp. 28-50.

Titus, P. (Ed.) 1996. *Marginality and Modernity. Ethnicity and Change in Post-Colonial Balochistan*. Karachi: Oxford University Press.

Titus, P. and Swindler, N. 2000. Knights, not Pawns: Ethno-Nationalism and Regional Dynamics in Post-Colonial Balochistan. *International Journal of Middle East Studies*. 32 (1): 47-79.

Trostle, J. A. 2005. *Epidemiology and Culture*. Cambridge: Cambridge University Press.

Udink, B. 2007. *Allah & Eva. Frauen in Pakistan.* Bonn: Bundeszentrale für politische Bildung.

Van Balen, F. and Inhorn, M. C. 2002. Introduction. Interpreting Infertility: A View from the Social Sciences. In Inhorn, M. C. and Van Balen, F. (Eds.), *Infertility around the Globe. New Thinking on Childlessness, Gender, and Reproductive Technologies*. Berkeley: University of California Press, pp. 3-32.

Vayena, E., Rowe, P. J., Griffin, P. D., van Look, P., and Türmen, T. 2002. Foreword. In Vayena, E., Rowe, P. V., and Griffin, P. D. (Eds.), *Current Practices and Controversies in Assisted Reproduction. Report of a meeting on „Medical, Ethical and Social Aspects of Assisted Reproduction" held at WHO Headquarters in Geneva, Switzerland, 17-21 September 2001.* Geneva: WHO, pp. xv-xvii.

Weiss, M. G. 2001. Cultural epidemiology: an introduction and overview. *Anthropology and Medicine*. 8 (1): 6-29.

Widge, A. 2002. Sociocultural Attitudes Towards Infertility and Assisted Reproduction in India. In Vayena, E., Rowe, P. V., and Griffin, P. D. (Eds.), *Current Practices and Controversies in Assisted Reproduction. Report of a meeting on „Medical, Ethical and Social Aspects of Assisted Reproduction" held at WHO Headquarters in Geneva, Switzerland, 17-21 September 2001.* Geneva: WHO, pp. 60-74.

World Health Organization 2006. *Reproductive Health Indicators. Guidelines for their Generation, Interpretation and Analysis for Global Monitoring.* Geneva: World Health Organization.

Young, A. 1997. Suffering and the Origins of Traumatic Memory. In Kleinman, A., Das, V. and Lock, M. (Eds.), *Social Suffering*. Berkeley: University of California Press, pp. 245-260.

Online Resources

Heartfile and Transparency International, n.d. *Pakistan's Health Sector: Does Corruption Lurk?* Online available from: www.u4.no/...open/pakistan.../health-sector-corruption-pakistan.pdf (Last accessed: January 30th, 2010).

International Classification of Diseases, ICD-10, World Health Organization's homepage: http://apps.who.int/classifications/apps/icd/icd10online/ (Last accessed: January 28th 2010)

Millennium Development Goals, United Nations' website: http://www.un.org/millenniumgoals/maternal.shtml (Last accessed: January 30th, 2010)

10. Appendix

10. 1 Glossary of Balochi and Urdu terms

bahu: Daughter-in-law (SW).

bhabhi: Brother‘s wife (BW).

banjh: Sterile, barren.

burqa‘: A kind of mantle or veil covering the body, usually from the head to the feet.

beolad: Childless.

charas: Hashish.

dai: A traditional birth attendant.

dene vale: The giver (meaning God).

devar: Husband‘s youngest brother (HB).

devarani: The wife of the husband‘s youngest brother (HBW).

Eid: Two Muslim festivals, one at the end of the fasting month of Ramadan (*Eid-ul-fitr*), the other celebrated to commemorate Abraham‘s willingness to sacrifice his own son to God (*Eid-ul-adha*).

ghair: A stranger.

huqqah: A water pipe.

‘ilaj (karna): medical treatment, medicine, cure (used in Yusuf Goth also for health seeking, getting tests done, etc.).

insha‘allah: God willing.

jetani: Husband‘s elders brother‘s wife (HBW).

khala: Mother‘s sister (MZ).

kurta: A knee-long shirt.

malik: The boss, a sovereign (meaning God)

mamun: Mother‘s brother (MB).

maskom: Kin through the mother.

mulla: A spiritual healer (used in Yusuf Goth interchangeably with *maulana, maulavi*, and *pir*).

nand: Husband‘s sister (HZ).

peskom: Kin through the father.

phuphi: Father‘s sister (FZ).

susral: The father-in-laws‘ house or family.

taklif: Affliction, trouble, hardship.

10.2 List of Abbreviations and Acronyms

APWA All Pakistan Women‘s Association.

D&C Dilation and Curettage (see footnote in p. 37).

FES Focused Ethnographic Studies.

GDP Gross Domestic Product (the total market value of all final goods and services produced in a country in a given year).

ICD International Classification of Diseases.

LHV Ladies Health Visitor (A women trained in biomedicine to provide health services for women. The training does not allow her to work as a doctor but it is a level higher than nurses and midwives).

MDGs Millennium Development Goals.

NGO Non-government organization.

PHCC Primary Health Care Center.

Rs. Pakistani Rupees.

USD U. S. Dollars.

WHO World Health Organization.