An Ethnographic Look At The Status Of Health Of Women Living In An Urban Squatter Settlement Of Karachi

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Abstract

Pakistan is a populous country with an estimated population of 180,808,000. The high increasing growth rate plays a negative role in the development of Pakistan. Karachi, principal urban has an estimated population of 15 million, which is at present growing at about 5% per year, mainly because of rural-urban internal migration. Poor people have less income to spend on nutritious food, clean water, adequate clothing, shelter and education. This paper is an ethnographic study analyzing the status of married women's health, of all age groups, living in Ghazi Goth – the squatter settlement. Self reported monthly income was positively related to decreased incidence of illness, cooking frequency per day and self and spousal literacy. Income was dependent on non income factors such as reproductive health status, educational status and nutritional status of women- determinants of health.

تلخیصِ مقالہ

پاکستان ایک کثیر آبادی والا ملک ہے جس کی کل آبادی ایک اندازے کے مطابق ۱۸۰۸۰۸۰۰۰(ورلڈ ہیلتھ آرگنائزیشن ۲۰۱۰)۔ زیادہ شرح نمو اور تیزی سے بڑھتی ہوئی آبادی پاکستان کی ترقی پر منفی اثر ڈالتی ہے۔ صاف پانی، اچھی خوراک، مناسب کپڑے، گھر اور تعلیم کے حصول میں غربت ایک بڑی رکاوٹ ہے۔ عورتوں کی معاشرہ میں غیر رعایت یافتہ حیثیت کا تعلق ان کی خاندانی اور گھریلو اقتصادیات سے ہے۔ جس کی بناء پر ان کا اچھی تعلیم، صحت اور خوراک کا حصول مشکل ہو جاتا ہے۔ زیر نظر تحقیق غازی گوٹھ کچی آبادی میں مرتب کی گئی ہے۔ یہاں رہنے والے خواتین (علاوہ بیواؤں) کی علم الاقوام کی تشخیص ہے۔ علم انسانی تشخیص اور تحقیق کا ایک طریقہ کار ہے۔ زیر نظر تحقیق علم انسانی کے طریقہ کار کے ذریعے غازی گوٹھ کے مکینوں کا بہت قریب سے اور ذاتی تجربے کی بنیاد پر کی گئی تحقیق پر مبنی ہے۔ محققہ نے ان کی روزمرہ زندگی کے معمول میں نہ صرف حصہ لیا بلکہ ان کا بغور مطالعہ کیا۔ محققہ اپنے ذاتی تجربے اور آنکھوں دیکھا حال بیان کرتی ہیں۔ یہ تشخیص اور تحقیق سوانح حالات، ملاحظات اور سوال نامے کی بنیاد پر ایک احوال بیان کرتی ہے۔ غازی گوٹھ کی رہائش پذیر خواتین کی از خود بتائی ہوئی آمدنی کا مثبت تعلق ان کے شوہر کے تعلیمی معیار، صحت اور روزمرہ کے معمولات کھانے پکانے سے تھا۔ خواتین کی خواندگی اور ان کی غذائیت کا براہِ راست تعلق ان کی آمدنی سے تھا۔

Introduction

Pakistan is one of the most populous countries with an estimated population of 180,808,000. [1] Karachi has an projected population of 15 million, which is at present growing at about 5% per year, mainly because of rural-urban internal migration.[2] Karachi accounts for the majority share of national GDP and revenue. Seventy percent (70%) of income tax and 62% of sales tax collected by the Government of Pakistan comes from Sindh Province and of this 94% is generated in Karachi, while it produces about 42 percent of value added in large scale manufacturing. In its formal sector, the city has 4,500 industrial units. However, there are no estimates available for the informal sector. However, 75% of the working population is employed there (Hasan, 2003).

The high increasing growth rate plays a negative role in the development of Pakistan. Poor people have less income to spend on nutritious food, clean water, and adequate clothing, shelter and education. Engaged in a daily struggle to meet basic needs, the poor often cannot avail themselves of health care and preventive health care, or save for the exigencies of unexpected illness.[3] And they have less access to social tools, such as education and sanitation, needed to improve and safeguard health (WHO,1987). As well as being a major determinant of health, gender also influences the access of individuals to health care through a number of different routes. In many households there is evidence of gender bias in the allocation of resources. Females of all ages may be assigned a lower status and will have less entitlement to food and health care (ADB, 1992). According to the World Health Organization, this bias will be especially damaging in poor communities where there is little state provision and care has to be bought with cash (Ayub, 1994). Economically and politically weak, squatters provide crucial inexpensive labour for the development of booming Asian economies (Siddiqui, 1998). According to estimates, 57.1% of the informal sector labour force in the manufacturing sector is comprised of women. 42% of these women have complained of suffering from health problems (Hasan, 2007).

In 1978 the katchi abadi population was 55 per cent of the total population of Karachi (Shah, 2010). According to Demographic Health Survey 1990-91, in 1980 it was 43 per cent. This decline was due to the social housing policies of the Bhutto government in the 70's. In 1998 it was 50 per cent (700,152 households) and in 2006 it was 61 per cent (1,200,000 households) (DHSP, 1990-91). For katchi abadis this figure is 89 per cent of which 54 per cent are the chronic poor. These figures show a major increase from previous surveys (PIHS, 1998-99). In addition, in the 1980 Housing Census, houses with separate latrines were 74 per cent, separate kitchens 65 per cent and separate bathrooms 69 per cent (LFS, 1999-2000). In the 1998 Census, these figures have fallen to 47 per cent, 48 per cent and 34 per cent respectively.

The Karachi Strategic Development Plan 2020 survey shows that 34.4 per cent of households earn less than Rs 5,000 and 41.4 per cent earn between Rs 5,000 and Rs 10,000 per month. It is estimated that these households spend 75 per cent of their earnings on food items and 18 per cent on utility bills.[4] Karachi, Bombay, Delhi all aspire to become world class cities like Dubai. In an attempt at establishing this image, poverty is pushed to the periphery and already poor unfriendly bylaws are made even more unfriendly (Hasan, 2009). Asian Development Bank figures indicate that 50.5 per cent of Karachiites live below the poverty line (Srinivas).

Laws for the Right of Adequate Housing

Pakistan has ratified the Universal Declaration of Human Rights, Article 25. In July of 1985 Pakistan ratified Convention on the Elimination of All Forms of Discrimination against Women, Article 14. In April of 1996 Pakistan ratified the Convention on the Elimination of All Forms of Racial Discrimination, Article 5. Convention on the Rights of the Child, Article 27 was ratified in 1990 (Scholz, 1983).

The initiative of improving and regularizing Katchi Abadis as a solution for the low income housing shortage first came into existence in the UNDP Master Plan for 1974 to 1985 (the plan was developed between 1968-1974). As a result, the Karachi Metropolitan Programme (KMP) was set up by the Master Plan Department and given the responsibility for providing housing for low income groups. [5]

Understanding Ghazi Goth at a Glance

Definition of a squatter settlement varies widely from country to country and depends on a variety of defining parameters. In general, it is considered a residential area in an urban locality inhabited by the very poor who have no access to tenured land of their own, and hence "squat" on vacant land, either private or public (Gazdar, 2009). For numerous people in Sindh, urban areas have always been a means for improving their quality of living by, in addition to getting better jobs and incomes (Turner, 1968). This has generated a considerable flow of migrants to the major city of Karachi. Priorities of these impoverished urban migrants change over time, depending on various conditions in which they find themselves (Sheikh, 1995).

The history of the settlement dates to an initiative to colonize the area around a *'madrassa'* (religious school). The initiative was led by Ghazi Abdullah, a cleric heading his own small '*madrassa*' built on state land in this area during the late 1990s.

According to the residents of Ghazi Goth, it has been there since 1990's. It started out as a small squatter settlement. It comprises of multi ethnic population. Being located

alongside the main University road,[6] surrounded by residential, educational and recreational areas, residents of Goth found it easier to commute to find daily wages (Figure 1).

Despite repeated attempts to dislodge the Goth and its people, the Goth slowly kept growing (URC). It has always been an illegal settlement, with a high rate of turnover of population. Very poor people live here. They look for ways to support themselves, either by begging, street vending, scavenging or working as house maids (James, 1979).

Ghazi Goth has been removed, or let's say demolished, several times. Some time completely demolished, other times most or few of the shacks survived and then multiplied. However, it acquires new settlements soon afterwards. Its diversity of Sindhis, Punjabis, Pushtoons, Baluchi, Saraiki and other ethnicities is very interesting, resulting in a blend of cultures, practices and diversities. The population of Ghazi Goth was estimated to be around 3870 inhabitants in 2004 till 2006. The population has been much greater and also less than 3870, depending how long the Goth was left in place at period in time without being demolished by the government. The Goth was majorly vacated / removed in 2001[7] and then repeatedly again after every few years.

The residents have not paid anything to live here, and there has been no transaction of a possession. The only formal recognition of the existence of the settlement is that many residents have given Ghazi Goth as their residential address for their national identity cards, and this address has been accepted by the citizenship registration system. These people then rent or sub let a room or two rooms in their '*juggis*' to other informal settlers. These "new" informal settlers are the new migrants from other provinces coming to the city for employment or medical treatment. The land on which Ghazi Goth is settled belongs to the city authorities. Nearly every year, authorities would raid the Goth and attempt to evict residents.[8] Although, such incidents were common, a few families always waited for the KDA authorities to leave, and without any shelter or protection, and then would start rebuilding new shacks.

Ethnography

One of the earliest definitions of ethnography was provided by A.H. Beatty in 1896, who wrote, "Ethnography is purely descriptive, dealing with characteristic social and political conditions of people, irrespective of their possible physical relations or affinities". The definition sounds old fashioned formal, and somewhat unclear, but it serves as a starting point.

Ethnography is a special science research method which relies heavily on up close, personal experience and possible participation (that is not just observation), using a blend

of historical, observational, and interview methods, with an end product of a narrative description of the group studied (Emerson, 1995).

Typical ethnographic research employs three kinds of data collection:
1. Interviews,
2. Observations, and
3. Documents.

Ethnography is a long-term investigation of a group (often a culture) that is based on immersion and optimally, participating in that group. One of the primary tools of ethnographic study is the use of field notes. Observers may simply begin with a blank notebook and write down everything that goes on. Others may use audio or video tapes. Some observers begin with a list of categories of behaviour to be noted, as I did. This approach works best when the research question is already defined; however, categories should be flexible and modifiable throughout the study (Patton, 1990).

Methodology

Study Method

This is an Ethnographic study, a qualitative research. This non participatory method of study relies on observation and taking notes by semi structured questionnaires, in depth interviews, focused group discussions and documentary review. Unlike quantitative methods of research, ethnography relies on longer responses rather than simple “yes” or “no” answers of study participants.

Two questionnaires were designed. One was for the key informants and the other was for the sample of women, which comprised of open ended answer options regarding antenatal care utilization. Key Informant Interviewing: Key informant questionnaires were unstructured, narrative interviews in which the respondent talked at length and in detail. The key informants described the demographics of the community. They introduced me to women and explained to them the purpose of this research. This helped build trust between the interviewer and the respondent, which is imperative for ethnographic data collection.

Sample

A randomly selected sample of 100 married women, residing in Ghazi Goth, participated in the quantitative survey. Informed consent was obtained from the women, to be a part of this study. The main inclusion criterion for the in-depth interviews was the age (should

have crossed menarche), marital status (married women). Widows, unmarried women and those who did not give consent, were excluded from the study.

Study Period

The study period was 14 months. Some women dropped out of the study and some moved away during the study and were lost to follow up sessions.

Method of Data Collection

My supervisor seeked permission from the leader of the Ghazi Goth, to carry out this study at the field site. Data was collected by pre tested questionnaires. The questionnaire was developed after working in Ghazi Goth for two weeks and identifying two key informants. Key informants were women living within Ghazi Goth since over two years and who knew the local people and had information about the demographics of the place. The role of key informants was to help the interviewer to participate in daily data collection within the local population. Key informants accompanied the interviewer during the first visit of every shack, and introduced her to the residents. An initial survey of the Goth took two weeks. Then a sample of 100 women was selected randomly. During the study period, 12 women left study as they moved away and 2 dropped out. However, we recruited 14 more and maintained the sample of a 100. We picked a married woman of reproductive age group, from every third shack, who gave consent to be a part of the study.

A calendar helped keep a chart of daily activities such as meeting with key informants, scheduled interviews with the sample, pre tests, themes and focused group discussions. Informed consent was seeked verbally from the women included in the sample. They were explained the purpose of the research and asked if they understood their role as participants. Confidentiality was assured to the participants and has been maintained. Thematic data was collected by semi structured questionnaires.

If at any given point, the woman felt uncomfortable, she was not pursued any further for the study. Respondents' habits, customs, and cultures were observed and noted. Contextual Inquiry was done. Semi structured questionnaires had open ended answers which were in their regional language and in sentences, rather than a 'yes' or a 'no'.

Data Recording

Data recording for this Qualitative research took many forms: notes in my files, tape recordings, photographs and maps. Tried making verbatim transcripts, however, this was

too time consuming, so this practice was stopped. Tape recorders were too distracting particularly when women were interviewed with other family members around her. Many researcher keep a running log at the end of the day (Jackson 1990b:6), however, I chose to take notes simultaneously as I observed or interviewed. Developing a conversation was the most helpful. The key informant was useful in starting a general conversation and then asking the theme related questions. I could cross check, when I felt some responses were not clear. I managed this qualitative data in such a way that it could be easily and efficiently searched during analysis. I interviewed my key informants separately. I held two focused group discussions. I observed behaviours, clothes, eating habits and events. I looked at secondary data (such as participants' clinical records). Themes were identified. Once the data was collected as notes, the two researchers studied the notes and identified headings and sub headings. Colour pencils and high lighters were used to identify themes in the notes. We wrote in the margins, point collected through clinical records and other supplementary material shared by the participants. Some information was related to more than one theme. So it was marked accordingly.

Photographs were taken at the sixth month of the data collection. The key informants, who were community members always, accompanied me while taking photographs, we explained to them why photographs were being taken and how will they be used and obtained verbal consent.

Data Management and Storage

All the questionnaires, consent forms and notes were stored in a safe location. Initially there was the study proposal which helped develop the key informant's questionnaire. Key informant responses helped design a pilot questionnaire for the sample of women. This was pre tested and editions were made. Filed notes, hand drawn maps and illustrations and a satellite image of the location of the Goth was stored. Data management also required topic guides which helped plan the conversations. All this was transferred to data sheets. Data was coded to maintain anonymity. Interview transcripts of focused group discussions were maintained.

Results and Discussion

Self-reported monthly income was positively associated with gravidity, decreased incidence of illnesses, cooking frequency per day and self and spousal literacy; it was negatively associated with number of occupants per room, wood used as cooking fuel, and spouse in a skilled occupation. Income is dependent on non-income factors such as literacy, and the nutritional and reproductive health status of women.

Ghazi Goth was unique in the fact that Muslims and Hindus both lived here. 47% of the population of Ghazi Goth was Sindhi. 36% was under the age of 12 years. 66.9% of the population were Muslims. 19 % were Hindus. Average family size of a Muslim family was 6.7, Hindu family was 5.98, and Christian family was 5.6. The population of Ghazi Goth was estimated to be around 3870 inhabitants in 2004 till 2006. The Goth was vacated / removed in 2001 and then again nearly once every year.[9] During this study, total number of shacks was 604.The population was not static and according to the residents varied in numbers over years. Sindhis formed the major bulk of the population. Followed by Afghanis and Punjabis at 19 % and 12% respectively. A significant number of people living in the Goth had been there since less than 6 months. The turnover rate was high. They moved when evicted or they found jobs elsewhere. 56% of the population of Goth was estimated to be females. Mean family size of the Muslims was 6.7; Christians was 5.6 and Hindus was 5.98 and most families had extended family members residing with them. 54% of the families had between 6 to 10 children. 35% of the families had between 1 to 5 children. Inhabitants found it much easier to take public transport. 68% of the respondent sample size travelled by public transport. Which was easy to access as the Goth is right adjacent to the main arterial road (Figure 1). 8% walked to their work. The average monthly income of the participant sample showed that 56% earned in between rupees 10,000 to Rupees 15,000. Only 11% of the participants earned between Rs 15,000 to Rs 20,000. What was so surprising was 6% said they earned less than Rs 5000.

It is noteworthy to see that 71% of the respondents had been married to either their first or second cousins. The practice of consanguineous marriage is very common in Pakistan. The Pakistan demographic health survey showed that two thirds of the marriages in the country were consanguineous. In this qualitative study, it became clearer that such marriages are common across ethnicities and religions. However, it was primarily the parents who made the decision of choosing the life partner. Either it was exchange (wata sata) marriage or a brother and a sister marrying another pair of siblings. This solved their economic problems of giving no dowry to the woman. 77% of our sample population of women reported that they were between 10 to 20 years of age at the time of marriage. This compares favourably with the mean age of 19.1 years at marriage for half the women, according to the PDHS, 2006-07.

In-depth interviews with these women showed that sexual intimidation and non-consensual sex were common and not limited to violent relationships. Difficulties in negotiating safe sex resulted in unwanted pregnancies, some leading to unsafe abortions. This case was similar to findings in other research studies as well (Hussain, 2008, Khan, 2004). The girl being very young at the time of marriage has no say and does not understand her role as a wife.

Self rated health: I had asked the 100 respondents: "Would you say your health in general is excellent, very good, good, fair, or poor? "Overall 71 % participant women rated their health as poor or fair. Another study has shown that evidence suggests that women in the developing world report more ill health (Asfar, 2007). This study did not compare the responses of women with responses from men. When we talk about health seeking behaviour of women at the Ghazi Goth, we saw that 41% of our respondents went to *Dum Walay Baba* (Spiritual healer). 24% went to the hospital. 17% went to lady health visitor. 14% went to the doctor and 4% received no treatment (Table 1). In 43% of the cases, the husband was the decision maker about where the delivery of the baby should take place. However, 31% of the respondents also reported that their mother-in-laws were the decision makers for the baby's delivery. Only a mere 3% reported a self-decision (Lee, 1999).

Our study revealed the 41 % of the women did not receive antenatal care (ANC) because of lack of financial support. 13 % said transportation was an issue. 33% said family did not support the decision to get ANC.

Diets in low income areas are poor, especially for the women. This research showed that only 8% had meet in their daily diet. 30% said they either had Dal (lentil) or vegetables in their daily diet. A proper meal is required for the healthy development of the body and mind. 26% of the respondents' diets did not consist of fruits. 56%, however, said that sometimes they ate fruits. It was too expensive and not on their priority list. What we noticed was that a significant part of the population believes in avoiding certain kinds of foods because they feel them either hot or cold or because their family does not eat it. Some foods were believed to be *"Baadi"*, that is gastric problem producing.

Socio-economic and cultural reasons decide the nutritional preferences. From the 26% who believed foods to be hot or cold or 24% who believe that food is *baadi* (indigestion inducing) ,the percentages of respondents believing that some foods were hot, cold and *baadi* were 82%, 43% and 91% correspondingly. The other foods like rice, yogurt, banana, watermelon, milk and cold drink were also thought to be cold by many of the respondents. Cabbage, cauliflower, potato, rice, gram and mash pulses (*chane and mash-ki-dal*) were highly rated as *baadi* foods. Beef, fish, chicken and egg, were perceived as hot by majority of the respondents. The majority of vegetables were perceived as cold foods. Educational levels showed no bearing on this belief. Such a belief system is quite common in our society as depicted by other studies (Ali, 2003, Bukhari, 2002).

58% of our respondents said that earning male members get priority when food is served. 21% said that female working members get priority. However, when asked about male and female children, a majority said that the male child gets priority. When asked specifically about their health and their children's health, 17% said their husbands were

concerned about their health. 42% said not at all concerned. 22% said poorly concerned. And 5% just did not know the answer to this. Considering that infectious diseases continue to be a major public health problem in rural Pakistan, the need for a sound health policy that is primarily focused on preventive medicine, especially health education is apparent.

Self-medication with medicines provides 20% to 26% of participant's health care . Only between 8% and 10% of patients are seen by the public sector, hospitals and community health centres. Another study (Zaidi, 2006) done in Karachi slums noted that self medication with medicines accessible in the home or explicitly bought for the illness episode from a drug vendor combined provides 13% to 18% of health care. Merely between 11% and 13% of patients are seen by the public sector, hospitals and community health centers.

Expanded health services usually reach the better-off groups prior to being of service to the underprivileged ones. Rendering it improbable for the deprived people to be the foremost beneficiaries of efforts to hasten development towards the MDGs by providing additional resources to the health sector, as presently constituted. More conceivable is quicker progress among advantaged groups and an increase in poor-rich health disparities. Such an outcome is not unavoidable; but achieving quicker progress for poor populations will require reorientation in addition to expansion of health activities (Gwatkin, 2005). This would enhance inequity. This was proven by the results of the MDGs being unmet (Waage, 2001).

Limitations

Qualitative study samples can result in reliable data which can be applied to broader populations (Steckler, 1992). Patton (1990) also argued that even though, the small sample design can yield contextually rich data, however such designs are generally not appropriate when seeking statistical accuracy. Due to the high turnover in Ghazi Goth population, a greater sample size was not within the scope of this research. For ethnographic study, I needed to collect textual data. I had no micro computer based system of textual management and no text retrieval and management software programs such as ZyINDEX dtSearch, GOFER,NOTEBOOK PLUS< TEXTBASE ALPHA and ETHNOGRAPH . I wrote notes and took pictures, hence then developed a pattern of observation. This was time consuming.

Recommendations

Few recommended strategies adapted from the Jakarta Declaration on Leading Health Promotion into the 21st Century from July 1997 are as follows. These would assist in

promoting health for all (World Health Organization, Geneva, 1984) - including women. Hence, render them able to lead economically and socially productive lives as their status of health permits them to.

1. More focused group discussions should be done within the settlement. It helps the community to come together and share their views. This approach would inject a "we" feeling between the trainers and community. Major emphasis should be on practising better sanitation habits, storing of food, sending children to school and getting ANC.
2. Health Promotion. Challenge is that population is enormous and cost of providing all this is high. Hence, train the trainers. Instead of relying solely on government to fulfil the State's role, some Non- governmental organization could make an agenda to addressing the worst – offs, through a number of its projects. NGO people can visit Goths and ask the residents what they need and how would they arrange it. Enable the resident's to increase control over their health and improve it (Ottawa Charter for Health Promotion. WHO, Geneva, 1986) . NGO would support economically and if the program has successful outcomes than they can lobby to get the Government to adopt it on a wider scale. They can train the residents of the Goth to become community health workers. May be train them once a week for 10 months. Pay them a stipend and incentivize to learn. Empower them. They can refer the patients to the Basic health units or district hospitals.
3. The number of these Goths can be taken up by medical colleges and as a part of curricular training , health care people from the department of community medicine could make once a week visit to these settlements and treat patients and make referrals to other government hospitals. Pharmaceutical agencies could donate medicines to such medical camps as a part of corporate social responsibility for various corporations. This would develop the ability of the staff and a support system to address the health needs of the marginalized population. Primary Care doctors training in urban city, should include once a week, two hour clinic at one of these Goths.

   Complying with the Alma Ata Declaration, WHO, Geneva, 1978, activities such as nutrition, sanitation, immunization, treatment of common diseases and provision of essential medicines all would be addressed. The rest of the week, peripheral health houses (physician assistant, CHW, LHW, Health logistician) can check on patients and maintain community alliance.
4. Develop the infra structure to integrate these people into the system. Government could help enrol them in some program (public or private) designed especially for the irregular settlement people. This program could give them a computerized ID card and a medical cover. A program similar to like Benazir income support program (BISP) or BISP itself can make a sister program for the urban poor living in irregular settlements. With the computerized card, these people would know

where to go for treatment. This could be a form of social health insurance extended to marginalized poor who are the worst off.

The utilization of a health care system, public or private, formal or non-formal, may depend on socio-demographic factors; infra structure structures, educational status, culture, and gender bias, status of women, economic and political systems, environment, the disease pattern and health care system itself. There is an under utilization of the PHC in Pakistan (Sabih, 2010). Access to health could be improved if we find a way to refer these patients to the district health system in Pakistan. Which is organized into a network of public service delivery outlets of Health Houses such as LHW and CHW, first-level care facilities, district and sub district hospitals. The district health system also includes a system of private providers inclusive of general practitioners, clinics, hospitals and pharmacies and numerous alternative care providers including hakims, homeopaths and for Yunani and eastern medicine [(39)] . Policy makers need to comprehend the motivators of health seeking behavior of the low income population in a pluralistic health care system.

5. Health development: Greater concerted effort is necessary for facilitating behavioral health promotion campaigns via inter-sectoral collaboration, closely monitoring the disadvantaged population. Besides media health promotion campaign, doing small skits, with students from the university across the road, could highlight the importance of the girl child and encourage the community to participate. Similarly, such plays could be enacted with stories addressing early marriages, cousin marriages, domestic violence, attitudes towards a pregnant female; all issues could be addressed to raise health literacy. Attitudinal change is a slow process. By reaching out, understanding residents and their needs and then slowly, without offending or mocking their customs, we can induce change.
6. Government funded evening schools and drop-in-centers with provision of skills based education, basic health facilities, food and bathing facilities would be an ideal solution for the urban impoverished. This could be a public – private partnership which could find various stake holders like local and internal NGOs. There needs to be ownership of the drop-in-centre idea and an agreement.
7. More vocational training centres should be set up where these people can get some sort of professional skills. This way earning better would become a possibility for these urban squatter settlement dwellers. Karachi industrial area could set up an employment exchange program which is linked to all urban squatter settlements and helps recruit groups of labourer, guards, cleaning personnel from these squatter settlements. Financial independence goes a long way in promoting confidence and hence rendering women capable of making better choices for themselves.
8. It is interesting to note that television sets are present in these shacks. It shows their priorities. TV can be used to promote and advocate behavioural change. This

is a strong medium and has been used extensively for HIV prevention and family planning, hence can be used further.

9. Researchers, scientists and social workers could try and study the habits of the urban squatter settlement dwellers in more detail. This study focused on one settlement. More such studies should be done in order to form a data base on which health policy planners and government officials could rely. Without authentic data sets being made available, it is cumbersome to design any policy changes.

Conclusion

The representative sample of this study shows that in low income areas such as slums and Goths in countries like Pakistan, women are trained to be submissive to their husbands and hence have little say in choices of health seeking, education attaining and maintaining healthy sanitation behaviour. This is largely due to poverty and gender bias which translates into lack of choices for environmentally, economically and mentally healthier living. This has turned into economics of submission on the part of these women. New methods need to be devised which enables women to recognize this lack of choice in seeking better health care, more education and better sanitation for themselves and their children, and lead way to empower them to make healthier choices. The challenge is in designing community based inter-sectoral strategies that can engage and petition for the attention of the community and government sectors for joint actions, where every partner has something to gain.

End Notes

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Acronyms

Afghani	Refugees from Afghanistan
ANC	Ante Natal Care
Baghee	Hindus
Balouchi	People from Baluchistan Province
CHW	Community Health Worker
Dai	Un Trained Birth attendant
Dam walay Baba	Religious healer
Goth	Squatter settlement
Juggi	Shack, informal, make shift home
Karachites	People who live in Karachi
Katchi Abadi	Squatter settlement
KDA	Karachi Development Authority - Government
Kunda	Illegal connection for electricity
LHW	Lady Health Worker
Madrassa	Religious school
NGO	Non Governmental Organization
PDHS	Pakistan demographic health survey
Punjabi	People belonging to the Province of Punjab (one of the four provinces of Pakistan)
Saraiki	Ethnic group in Pakistan
Sindhi	People belonging to the Province of Sindh (one of the four provinces of Pakistan)
TBA	Traditional Birth Attendant
Wata Satta	A brother and sister married to another brother and sister. In exchange of each other
WHO	World Health Organization

Table 1
Health Seeking Behaviour of Women (Preference)

Health Seeking Behaviour of Women	N	%
Go to a Dum Walay Baba	41	41.00%
Visit a Hospital	24	24.00%
Seek advice from LHV	17	17.00%
Go to a Doctor/ Private practice clinic*	14	14.00%
No Treatment	4	4.00%
Total	100	100%

*Medical Private Practice is very diverse in Pakistan with charges varying across socio economic strata (SES). Charges mainly depend upon the country/region and level of training of the doctor.

Table 2
Daily Diet Consist of Staple

Daily diet of Staple	N	%
Roti/Bread	36	36.00%
Dal/Lentil	30	30.00%
Rice	26	26.00%
Beef/Poultry	8	8.00%
Total	100	100%

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