Asesorías y Tutorías para la Investigación Científica en la Educación Puig-Salabarría S.C.
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RFC: ATI120618V12

Revista Dilemas Contemporáneos: Educación, Política y Valores.
http://www.dilemascontemporaneoseducacionpoliticayvalores.com/
Año: VII Número: Edición Especial Artículo no.:74 Período: Octubre, 2019.

TÍTULO: Impactos de la Supremacía Social Estructural de la Casta en la salud de la mujer en la sociedad paquistaní.

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RESUMEN: La casta se puede definir como "cualquier clase o grupo de personas que heredan privilegios exclusivos o son percibidos como socialmente distintos" (Lyon, 2004). La casta como sistema jerárquico, completamente endógamo, estado adscrito, conectado con los fenómenos de pureza y contaminación, se ha arraigado mucho dentro del sistema económico. En este contexto, la estructura de la jerarquía de castas está interrelacionada con cada esfera de la vida, como el acceso a las instalaciones de salud y las oportunidades laborales. Esta investigación explora patrones de estructura jerárquica basados en la casta, que limita el acceso de las mujeres a los centros de salud reproductiva. Esta investigación es puramente antropológica, cualitativa, bajo el método de investigación etnográfica. Los datos son compatibles con la literatura secundaria basada en métodos de investigación.

PALABRAS CLAVES: estructura de la casta, salud reproductiva, mujeres, identidad de la casta, acceso a la salud.

TITLE: Impacts of Social Structural Supremacy of Caste at women's health in Pakistani society.

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ABSTRACT: Caste can be defined as "any class or group of people who inherit exclusive privileges or are perceived as socially distinct" (Lyon, 2004). Caste as a system of hierarchy, completely endogamous, ascribed status, connected with the phenomena of purity and pollution, have much ingrained within the economic system. In this context, the structure of caste hierarchy is interlinked with every sphere of life like health facility access and occupational opportunities. The objective of this research was to explore hierarchal structure patterns based at caste that confines female access to reproductive health centers. This research is purely anthropological work, qualitative, conducted under ethnography research method. Data is supported with the secondary research method-based literature.

KEY WORDS: caste structure, reproductive health, women, caste identity, access to health.

INTRODUCTION.

This research describes the caste structure in general and in the particular context of Pakistan. This research explores the structural patterns that decide the ascribed status of caste. Aspects of ascribed structural patterns are covered that effect on the health access. Social determinants like poverty, access to health facility and behavior of doctors are described in this piece of work. Before exploring the link between health and caste, we need to understand background of caste evaluation and its occurrence in Pakistani community.

Understanding of Caste.

Anthropological studies raised a basic question of traditional understanding of caste. To define caste remained an evident problem. Certain features of caste system create understanding of caste. Caste is a socially closed stratification, in which every caste has interdependence on other caste in social structure for social survival, ranked hierarchy on the scale of ritual purity, differential access to religious privileges and social rights, endogamous, commonly exclusive, hereditary of crafts or occupation, closed organic segmentary stratification and non-mobility existence.

There are four referents of caste; firstly, classical division of society on the basis of *"vedic"(* religiosity) society; secondly, caste categories, aggregates of persons, usually in the same linguistic region, usually with the same traditional occupation, and sometimes with the same caste name; thirdly, caste association, the voluntary group which draws its membership from the inscriptive reservoir of traditional caste; fourth, is *"jati",* characterized by a system of segregation, interdependent for survival and hierarchy (Robert & Hardgrave, 1968).

There is a widely prevalent view that caste in the sense referred to above influences the distribution and the use of power and the 'ways and means of achieving it to a degree that vitiates the working of the system (Desai, 1967). The influence of caste in social and political structure is obvious. It is recognized mainly in society, by performing its traditional role which is mainly ceremonial and social. Power to a person of caste is geared on the basis of family status, age, knowledge and experience of traditional matters (Goyal, 1965).

Synonyms words for caste are from *"sansakarit*" language "*varna and Jati*" specific to Indian culture. Four primary professional divisions into which ancient Indian society was divided: *"Brahmanas"* (the intellectuals, teachers and priests), "*Kshatriyas"* (the warriors), "*Vaishyas*" (the trading, merchant and commercial class) and "*Shudras"* (the service class)(Vallabhaneni, 2015). There is no

universally accepted definition of caste. The English word “caste” is derived from the Portuguese word “*casta*” means breed, race or kind (Goli, Maurya, & Sharma, 2015).

Caste concept confined in hierarchy structure that widely prevails in Polynesia, Africa, Japan, Guatemala and Negro White relations in South of United States. It evidently proved that range of similarities between caste structure and race acceptability in America is remarkably parallel. Characteristics in cultural context are similar of both concepts. If caste of India is applied outside somewhere, the best option would be the name application of hierarchical structure at Southern United States, Endogamous subdivisions whose membership is hereditary and permanent, wherever they occur (Berreman, 1960).

Caste in Pakistani context denote class as exceptional rigid edifice prevailed in structural phenomenon of traditional community, that denote the general discussion regarding nature of close groups like race, ethnicity or any social group that based on discriminatory patterns and inequalities (Usman, 2017).

Under the light of Pakistani contextual understanding, definition given by Barth and Lyon describes the caste concept as “A hierarchical system of stable social groups, differing greatly in wealth, privilege, power, and the respect accorded to them by others. In any such system, the organization of one stratum may only meaningfully be described with reference to its relations to the other strata” (Barth, 1960).

“A hierarchical system of hereditary based and endogamous social groups, called *zat or quom*, with definite occupational specializations, differing greatly in privilege, power, and the respect accorded to them by others. In any such system, the organization of one stratum may only meaningfully be described with reference to its relations to the other strata” (Lyon, 2004).

Caste in the context of Pakistan, occupies hierarchal occupational positions on the basis of hereditary; it can be regarded as caste system practice in Pakistan. Above definition incorporates the factors like occupation, heredity, endogamy that contribute the conceptual understand of caste group. Barth presented wealth as main contributing factor to the concept of caste. Caste group associates with privilege of high status, elevated occupation, privileged, power and prestige. Service providing caste group face severe poverty and starvation and are reported as poorest people.

Understanding of caste attributes in context of Pakistan.

Caste is associated with occupations that determine the hierarchical status of people. Social position of person is determined by his ascribed caste group (Kalas, 1998).

Many writers deny the fact by contributing that the concept of caste hierarchy is exaggerated. Caste based ranking and positions are locally based and change with the passage of time. In modern times, the social status is the aggregate of a person's achievements and caste. In Pakistan, landowners and peasants' community depicts the hierarchy; owning land placed that caste at higher level (U. Sharma, 1999).

Endogamy is an important feature that protects the caste purity. According to the traditions of Pakistan, practice of endogamy is very strictly followed. In India, marrying with lower caste is considered a taboo, symbol of polluting blood of caste lineage, inter caste marriages is not liked even in the lower casts (Kalas, 1998; Kapadiya, 1966). Similarly, In Pakistan, inter caste marriages are avoided or not taken as preferred practice. Caste endogamy as an essential feature decides the future of people's life. The situation is worse in rural areas and traditional families of Pakista (Ahmad, 1970; Alvi, 1972; Blood, 1994).

Contrary to Hindu Caste structure, Pakistani Muslims have no commonalities regarding easting with lower caste. The people are free to eat and drink together or share any kind of food (Ahmad, 1970; Eagler, 1960). In Hindu caste system, Caste hierarchy restricts the social interaction with the lower caste; high caste people can accept food from same one's own. The conduct of commensality instigates from the ritual concept of purity or impurity in the Hindu caste system (Freitas, 2006; U. Sharma, 1999).

Un-touch-ability is practiced in few parts of India; upper caste people do not touch the lower caste people and keep them at certain distance. Due to urbanization, the concept is not strictly followed but still exits (U. Sharma, 1999). There are no such concept exits in Pakistani community (Eagler, 1960). Attributes of "Jati and Varna" system could be traced in the in the division of "*Quom,zaat zamidar, Kammi*". Occupational division, on the basis of four categories Brahmins, Kshatriyas, Vaishyas and Shudras, has structure similarities with *"zamidar*" and "kammi" in Pakistani society. Hereditary based occupations and membership are birth based ascribed statuses, service providing, laborer and artisan "*Quoms"* are grouped together as Kammis recognizes as Naaei[1], Tarkhan[2], Moochi[3] while land owning group people are known as zamindar known as Jatts, Rajpoot etc.

Every Kammi and Zamindar Quom is endogamous social group and form its self-recognition system of *Biradari system*, i.e., kinship groups (Ahmad, 1970; Alvi, 1972; Bhatty, 1996; Blood, 1994; Blunt & Blunt, 1969; Chakraborty, 2003; Domunt, 1980; Dutt, 1968; Eagler, 1960; Freitas, 2006; Ghurye, 1961.; Hooper & Hamid, 2003; Horton, 1951; Jodkha, 2004; Kalas, 1998; Kapadiya, 1966; Lal & Loon, 1969; Liddle & Joshi, 1986; Marriot, 1977; PlanningCommission, 2003; U. Sharma, 1999; Waber, 2009).

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[1] Barbers.
[2] Carpenters.
[3] Cooblers.

Caste-specificity in occupation has declined with passage of time, there is no evidence of dissolution of caste, since endogamy within the sub-caste remains resilient to change. This attributes in large part to the interaction of normative codes of caste and kinship at this local level, and to the distinction of cultural custom which exists between castes. Intermarriage between those who do not share a 'way of life' requires a reconciliation of 'us' and 'them', though it may not be relative ritual purity which is the fundamental distinction; the workshop succeeded in drawing together the themes of revision of past perspectives, and the apprehension of present fact. Of course, the two are intimately associated: ethnography is necessarily selective from a number of possible social realities (Rutter, 1993).

Institutionalization of caste through hierarchy-based structure is not unique to Pakistan but almost every society contains form of inequality, normative structure of reciprocity and interdependence that do not effect rich but only poor. In simple words, East is not mysterious due to caste, but the fact remains that caste is structure that supported to survival and embodiment of inequalities till to date. A universal factor that did not develop the social classes because the system clearly supported to sustain caste system hierarchy (Basham & Mencher, 1975).

Prejudice can be considered as key factor in intergroup associations, as what goes on in people's minds seldom escapes social expression. One caste group members keep biased viewpoints regarding other people associated to another caste. Such kind of perceptions generates inter-caste tension by promoting hostility and distrust. Personality factors combined with social traits generate a variety of responses to different caste groups and to the system in general (Cameron, 1995; Singh & Prasad, 1977).

Socioeconomic status impacts on health.

The certainty of the caste system is very complex, derives hundreds of sub-castes and various local gradations, which dissuaded official authorizes of policy making from studying the commonalities,

that influence demographic outcomes (Navvaro, 1990; Rogers, 1989). The socio- economic deprivation among low castes as foremost aspect governs the rest of life of inferior caste. Mortality rates differs from lower caste to higher caste, motivational factors are quite similar with race and class. Mahadev argues, if socioeconomic differences are tried to control, the lower caste mortality would diminish. By seeing the historical understanding of caste and its exhibition, Substitutability of class for caste, if consider tantamount, appears unwise (Mahadeven et al., 1985).

Dumont claimed in his work titled "Homo Hierarchicus", hierarchy based on caste is not identified through material objects but on status. Caste systems determine the social status of an individual in the social hierarchy, that is essentially dependent on the economic system (Dumont, 1980). The high incidence of poverty amongst small caste, is intensified by professional discrimination by caste. Influence of social status on the health has been widely discussed through different angels; some suggested that social status that a person occupy in society is due to health (Sapolsky, 2004; Singh-Manoux, EAdler, & GMarmot, 2003).

Few researchers argue that social capital as a mechanism to health (Kawachi, Kennedy, & Stith, 1987). Researcher specialization in ethnic and racial differences presented the argument that there are several impediments in access to health services for members of historically disadvantage groups. Spatial distribution of health facilities, non-availability of proper health facility in the congested area of lower caste and low status, badly affects the health maintenance of the residents. In other situation, when the health facilities are available but insulting and discouraging behaviors by service provider would significantly limit the utilization of those facilities by low caste women (Frisbie, Song, Powers, & Street, 2004).

Incorporating ideologies under the sense of superiority, negative behaviors due to beliefs of racial and ethnic ideology, differential treatment as part of social mythologies from individuals and social institutions made the lower caste people suffer. Evidenced noticed such discrimination in the

treatment of lower caste. low caste groups may lack social capital that would facilitate them to access new technologies or through which acquaintance of knowledge could be gain regarding methods of preventing child illness and death. Such differences reflected in poorer usage of antenatal and delivery care services (Borooah, 2005; Burgard, 2002; Dumont, 1980; Hummer, 1993; Kawachi et al., 1987; Mahadeven et al., 1985; Navvaro, 1990; Rogers, 1989; Singh-Manoux et al., 2003; Williams & Collins, 1995).

Belonging to lower caste, as an ascribed status, brings disadvantages affecting life opportunities, like education, job opportunity and income. Education attainment among lower caste is average, perpetuated by structural barriers, less opportunities, lack of resources and most important, internalizing of low self-worth (Hoff & Panday, 2004).

Poor people share disproportionately sufferings in health dimensions regardless of age gender and age, cultural hominid group of people with rife of ethnic identity, under public or private credos. Development of class-based stratification is a quite new idea in the history of hominids. "*There is nothing in the world of nonhuman sociality involves such an utterly, psychologically permeating sense of subordination as does the human invention of poverty"* (Dommaraju, Agadjanian, & Yabiku, 2008). Socioeconomic factors such as education, income exert powerful influence on the heath of people. Proxies of social status exert baneful influence to those that are in bottom of social hierarchy. Social factors determine material welfare of individuals.

Material welfare has ability to decrease or maintain the health through different casual pathways of lifestyle and access to reproductive health facility. Inequality is crucially formative factor in maintaining health, might be not at absolute level but to some extent. Material welfare and social status have strong correlation with better health access, high status individual enjoys better health facilities, better nutrition, living in less polluted environment, freedom of social pressure and better working conditions (Mellor, 1998).

Cultural disparities that create discriminatory attitude towards the expectation for anti-natal care, ethical differences, biased behavior of treating patients, negatively affects the health of lower caste community, which do not distress those of higher caste or higher social status people. Discrimination in quality care provision makes the situation worse. Women of lower caste if do not receive her right of treatment, information and quality care at public health center, they may avoid visiting next and would not be able to protect her reproductive health rights. Poorly treating behaviors towards lower caste women by clinic staff create hurdles of equality of seeking health behaviors(Becker & Tsui, 2008).

Gender health and caste intersection.

Health inequalities does not exist among different statuses but also between two sex, called gender health inequalities, derived through the different statuses of male and female at same level of socioeconomic status. Gender health equalities encompass the concepts that men and women lives at different social and economic positions in a society, this social structure-based disparity gives birth to the health different, women are treated as socially biased values that are unavoidable and unjust system, supported by norms.

In spite of obvious similarities man and woman from same social group, marked difference are traced in the well-being concept of health priority, access to health facility and freedom to choose the health facility center with one own will (Doyal, 2009). Gender inequalities in health were address in widely in 1970, that addressed the effects of patriarchy on women health, their life and well-being, disparities in the structural pattern were identified that make vary the morbidity and mortality among male and female. These idea were inspired under the concept of liberal feminism, (emphasizing the possession of social roles) and radical feminism (emphasizing role of gender and patriarchy in production of

inequality at deferent phases of social society) (Crenshaw, 1991; DeCola, 2012; Hunt & Annandale, 2000; Smith, Nish, Harding, Nazroo, & Williams, 2010).

This sophisticated analyses based on differential life experience of females and males in the field of salaried and domestic labor Work, consequential access to health improving facilities and resources, in defining co-relationship among gender, women's tripartite roles, pre-determined by patriarchal structures (presented by Caroline Moser as productive, reproductive and community), and women's physical and psychological health (Avirgan, Bivens, & Gammage, 2005; Doyal, 2009). Feminist drawn the attention towards the invisibility of women at work place, employment opportune, male biasness in health of female, diminished attention of women health despite the increasing participation in labor market (Doyel, 1994).

Gender and socioeconomic position were explored, and traced those differences of income as a larger impact on the wellbeing of women as compared to men. The gender differentiation effects health in labor markets has constant implication in the contemporary framework of economic globalization. Studies argue that women tend to employed in comparatively segregated lower paid, less safe and casual work, with wobbly occupational conditions, minimal instruction and communal protection (Abihwj, 1997; Barbeau, Krieger, & Soobader, 2004; Baru, Acharya, Acharya, Kumar, & Nagaraj, 2010; Cleak, 2005; R.Bauer, 2014).

Caste as long-understanding determinants of socioeconomic inequalities are affecting wellbeing of south Asia. Caste-based violence is oppressive not only in south Asia but Diaspora of South America and Europe. Caste remained most marginal account of health discussions. Caste as a system of hierarchy, surety of pollution and purity, division of labor based discriminatory structural patterns, customs to control over resources and knowledge the way of exploitation and maintain it. Lower caste in hierarchy as a symbol of socially segregated and economically disadvantage occupations, mostly landless, laborers and engaged in ritually polluted occupations(Bob, 2007; Borooah, 2010). Control

over sexuality through endogamy marriage pattern supports the maintenance of caste system(Bob, 2007). Gender health system is incomplete without the understanding of patriarchal structure of certain caste and class. Caste and class cannot bind in same category but caste is intrinsically and inherently tied with class system (Kabeer, 1994).

Lower caste female faces the duel structural discriminatory pattern. First as being female, faces the patriarchal structure of same group, second, being female of oppressed lower caste. literature reports that mal nutrition than average female at national level, less resources to income generation resources, severe threats of violence, poverty, social humiliation from both male and female of high caste groups, poor access to reproductive health facilities not welcoming attendant visits from doctors increased the morbidity of as compared to higher caste female (Cornwall, 2000) (Chakravarti, 1998).

Health determinants among lower caste women.

Maternal and reproductive health is not only remedial event but also a social phenomenon. Socially defined cultural factors define the access and utilization of reproductive health care facilities. Failure to meet the targets of reduction in Maternal death, is prominently linked and analyzed with a terms of equality in access the reproductive facilities, a great emphasis is needed in understanding of the patterns of discrimination in health within different social contexts (Östlin et al., 2011; Say & Raine, 2007).

Culyer has recommended that because of susceptibility, deprived and underprivileged groups should be identified on priority basis, toward rectifying inequities in health (Culyer, 2001). Further, there is need to look beyond the prominent factor of income inequity at societal level, correlative social and structural determinants towards suppressed groups illuminate the interrelationship in access to equity in health (Östlin et al., 2011). Inadequate health services are not only the reason of unequal distribution of health, but also the unfair allotment of health services, because of unfair or inadequate

social arrangement, key determinants of health inequities are, that they are socially created, systematic production in their distribution across the population, unjust and inequitable (Whitehead & Dahlgren, 2006).

Correlation of poverty and health is evidently proved, health care access is commonly reliant on the ability to pay for the medication, poor women in absence of financial resources rely on government-funded social-welfare programs to attain access to health care. Health gap among poor and rich is derived from absence of economic resources and all other aspects that are required to access health facilities. Poor gets poorer and sicker. Reproductive health is determinant factor of next generation health that need to be dealt with transcend notion of caste and class differences (McBarnette, 1987), chronic diseases, urinary tract infection, menstrual cycle disorders, hypertension, diabetes, osteoporosis, arthritis, eating disorder that negatively affect the eminence of women life severely in absence of medical health services. Multiple roles associated to female, work stress as contributing labor force are detrimental factors of health quality of women at surface. Physiologic, psychosocial, and economic discriminatory factors mutually act negatively to pull down the health of women (Leslie & Swider, 1986).

To define the unfair distribution of health facilities, WHO anticipated, phenomenon involves analysis with respect to collective justice and the social determinants of health. To enhance the understanding of health, how inequalities are supported by social structure, the commission presented a conceptual framework.

“Conceptual farm work is based on three basic elements correlation. Firstly, socioeconomic and political context; secondly, structural determinants; thirdly, intermediary determinants. First, framework model includes fowling aspects of socioeconomic and political context, consist of governance, macroeconomic, social, public policy; cultural and societal values; and epidemiological conditions. The second constituent, structural determinants of health, refers to the interplay between

socioeconomic and political context, where structural mechanisms in the society generates a social stratification, which, in the end, results in the socioeconomic position of individuals. The third factor, the concept of social determinants of health inequities is used to conceptualize the socioeconomic and political context and structural determinants when understood jointly. The structural determinants, or the social determinants of health inequity, operate through a series of intermediary social factors. These intermediary factors include material circumstances such as housing quality and physical environment, psychosocial circumstances such as stressful living conditions and relationships, (lack of) social support and coping styles, and behavioral and biological factors such as lifestyle and genetic factors" (Sanneving, Trygg, Saxena, Mavalanka, & Thomsen, 2013; Solar & Irvan, 2010).

This framework is an action-oriented, applicable to categorize ingress points for intercession and policy formation, that could diminish inequities in health within a specific social structure setting. It is based on the impression that health inequities materialize through systematic unequal circulation of power, prestige, and material resources among suppressed groups of society (Ahluwalia, 2009; Balarajan, Selvaraj, & Subramani, 2011; Solar & Irvan, 2010). (Clift, 2012; LaMothe, 2013; S. K. Sharma, Sawangdee, & Sirirassamee, 2007; Shpungin & Lyubansky, 2006).

Analytical aims.

The study aimed to provide evidence for assistance of caste disparities to maternal health access. We accomplish the study by examining the disparity in effectual relation of caste with socio-economic status in accessing to anti-natal and delivery assistance.

Locale of the study.

According to the information provided by the inhabitants, "*Rasool Park*" was developed in 1980. The name of the town was named after Rasool (PBUH). "Rasool[4]" is Arabic word that means messenger of God. The area is also known as the "Mustafae Park". "Mustafa" is one of the names of Prophet (PBUH). Name of the town was kept with the belief that "Rasool Park" housing society would relieve the people from sorrows and grief. Small housing scheme was introduced for the families with lower income. Majority of the inhabitants are engaged manual labour, they work on daily wages and provide a large share of labour force to the industries of the vicinity.

Data analysis.

Our field work revealed that structure of community was based on occupational hierarchy on caste system. Suburban area of city consists on the labor class inhabitants, migrated from nearby villagers to work at cities for better earnings.

The lowest caste kammi made up almost half of total population of the area. Migrated inhabitants from villages to suburban area, largely landless, hardly access to income generating opportunities, less educated or illiterate and possess long term intergenerational poverty. Before migrating to city side areas, they were serving high caste people of villages. Among highly asymmetrical system of caste hiarchary, lower caste known as Kammi[5], devided into several categories of service providers entitled due to their profession as *Maashqi[6], Naai[7], Kumhaar[8],Lohar[9], Meerasi[10], Julaha[11],Teelie[12]*

[4] It is especially important for Muslims due to the prophet (PBUH) whom they call Rasool, the messenger of God who conveyed the message of God to the Muslims. Prophet Muhammad (PBUH) is the most respectful and important personality for Muslims.
[5] Local term for lower caste.
[6] Water fetcher.
[7] Barber.
[8] Pottery maker.
[9] Blacksmith.
[10] Messenger and social mobilizer.
[11] Waiver.
[12] Oil Maker.

and massali[13]. They are known by their professions and looked due to work distain. Lower castes are socially tied with higher caste through structural economic setup known as "*saphi*" system. "*Saphi*" is kind of payment of services provided by lower caste, usually given in the form of kind, given at harvesting season of crops. Life survival of kammi mostly depends on the payments of the landowners. Health emergencies, social issues, accommodation and food like grain, vegetable, milk are gained with resources of the landowner.

"We stayed the lands for several years; Chaudhary gave us place to live, food, money and everything. In return we have to work at his fields, take care of his cattle's and also have to perform the household chores".

Low caste is recognized as the belonging of higher caste landowner. Low caste entitlement is unobvious and uncertain. People get better chances of generating income and comparatively life of freedom at cities.

"Due to low income and high debits, we have decided to come to the city. A better job opportunity gives more return. Domestic labor at rich people home generates more money on monthly basis as compared to village. Moreover, our kids can work at hotels, factories and houses, earning are better".

Although low income is perceived an essential dimension in the life of lower caste, but economic poverty cannot be consider the alone factor contributing the poor health of women of lower caste. There is interlinked course of actions contributing to the economic and social marginalization of lower caste women like consideration towards the female health, timely access to reproductive health center, skilled birth attendant, attitude of practitioners with females of lower caste. We discuss following aspects by highlighting their possible proposition for interventions anticipated to enhance maternal health care use among alike marginalized groups of lower caste women.

[13] **Service providers of landlords.**

Social inferiority and stigma associated with caste.

Social status is higher among high caste, lower caste like kammi is identifying as stigma and identity of lower social status. Lower caste women are considering less honored and respectful. Members from high class do not respect the female of lower caste. They are considered most vulnerable persons to blame. Even in the structure of suburban community of Pakistan, it is widely believed that these women possess less virtue, less sanctimonious and less followers of moral ethics settled by the society to keep the strong character of women. It is frequently observed, Derogatory terms are used while describing any women from lower caste.

Another consequence factor comes up in the treatment of health practitioners. The lower caste women when do not have high social status, less resources of income, consequently, she cannot go to private doctors for health services. Government health care providers do not treat them properly and also misbehave them. Stigma of lower caste made women to suffer disrespect from the health practitioners at government hospitals. The lower caste women are well aware with the benefits of biomedicine and trust the use of medicine, but at the same time, they are not satisfied with the treating behavior of health practitioners. These women would prefer to deliver their babies at local birth attendant called "dae". Trust maintained on "dae" is due to less payments, more care as compared to government service centers, to stay at home in pains, most important factor towards home-based delivery is that "dae" is experienced and behaves politely, which particularly compels these women.

"Government hospitals birth attendants are butchers. I know it is safe and hygienic to go hospital, but there is not any difference of expenses. We buy our medicine by ourselves and also bear the misbehavior of staff. Staffs at government hospitals do not consider the pain of female in labor, they shout, some-time slap on face due to screaming in pain. While on contrary basis, It is nothing like that with local birth attendant. "dae" is experienced, she handles the complications with a smile on her face".

Our field observation revealed that patients counts and values the behavior of practitioners particularly during antinatal and labor services. *"Half of the disease disappear when Dae talks with care and satisfy us regarding our problems".* (A woman from lower caste talks about the practitioner.)

A local health practitioner talked about the ignorance of women of lower caste. "*A woman was expecting twins, she came here at health facility center, we refer her to district headquarter for better services and care. Her life would be at risk if we try for normal delivery labor. After that day, she disappeared and never came back to the health center, after seven weeks when she returns, she was carrying babies which she delivered at home with the help of low skilled traditional birth attendant. Prolong delivery and complication occurred but the woman was happy that she delivered at home without expense*".

Dae has threshold to maternal health risk by putting female into labour without knowing fetus situation. Take risk of breach presentations, without knowledge of feto pelvic, disportion, put women into risk by taking trial of labour with previous C section and pre- eclampsia. These entire risks factor increase the maternal deaths chances during labor.

Technical staff provision would not be the enough beneficial for up gradation of health services development until the behavior of practitioners is not improved through proper check and balance.

Limited access of lower caste women towards poverty reduction opportunities.

Employment options to the women of lower caste are very limited. They experience intergenerational poverty, less education and daily wage-based jobs in their lives commonly. Landless community spends their monthly earnings on house rent, shelter, food and other daily expenses. They remain unable to keep cash reservoirs. Long term poverty limits the access of woman to seek some public facility center. Behind the scene of all scenario, in case of public sector health service utilization,

women have to bear the expense of medication, transportation and payments to service providers (Local term use is mubaraki[14]). If these women have to take to local public health facility, the family members rush for the arrangement of money first. Lower caste people took amount on debits with interest to tackle the emergencies.

If we refer to the patient to district hospital, the family members took a long time in arranging money and put women into risk of maternal deaths (local LHV taking about the preparation to tackle emergency).

It is widely observed during interview that women were well aware for the arrangement of money and transportation to tackle the emergency situation. In spite of knowledge, lower caste women rely on their faith that nothing will happen and God will help bless to deliver baby normally at home. Additionally, Kammi women leave the delivery matter on the husband as they are going to deliver his baby.

This is the time, when husband meet the demands, otherwise we have to handle every spheres of life by our self (A kammi woman talking to make the husband realizes of his responsibility of her gossip).

Comparatively women from higher caste with better resources, saves money, gives importance to her health and get the help of lower caste women to perform her daily household chores. Lower caste women not only bear the burden of household chores, victim of malnutrition and also suffer the complicated situations during labor.

Lower caste women are excluded from formal transfers aimed to help the poor, to enhance the economic security funds to the poor's. low ranked social status women, working at domestic level do seek support from their masters, but all they get is either in form advance seller or loan on interest.

[14] Payment to service providers after the delivery of baby safely.

Banks do give loans for different purposes, but banks do not give loans to the lower caste, landless people who have nothing to present anything in the form of guarantee. Banazir income support programs started by previous government to help those jobless poor people who deserve. But this fund is allocated to those people only who have access to official authorities. Names of poor and deserving people from the area are chose by the union council members. Union council officers choose the members on the basis of personal relations with the people. Poor people who actually deserve remain unattended.

Denial of identity.

Every woman, who belong to the lower social caste, is not agree to admit that she is from "*kammi"* family. Every woman argues constantly that she belongs to honorable family based on higher caste. While the caste of the same category is considered low by these women. Women refer the other occupational based caste as low caste based Kammi.

Several reasons came forth to hide the reasons of caste, first, colony was established only 23 years before, and people were mostly migrated from different areas. They do not know the background of other community inhabitants. Majority kammi, shows their association with some high caste or considered their caste as socially prestigious. In this way, they try to get better identity and honorable place in society. Secondly, women of "kammi" lower castes are considered more vulnerable to moral corruption. Higher caste people and masters of workplace try to utilize them physically in return of very cheap amount. So women who want to maintain their dignity, shows her association with some high caste. On the other side, situation is different. People of high caste claimed that the moral ethics and living styles reveal the family background of women.

View of factory masters are different, women from some good family would never come out to work in factory.

“She will bear the hardship quietly at home and work from home (factory master expressing views regarding the recognition of high caste women)”.

Denial of deprivation of lower caste.

“How they could be poor”, although lower caste people do not own the farming land, work on daily basis and lives hand to mouth in a single room. Still they are not considered poor. It is believed commonly in the society regarding others that they have money, but do not spend and saves.

If one lower caste is serving to the masters of higher caste, they are considered self-sufficient and well earned.

“Kammi are not as poor as they show, people of lower caste have association with high class masters, who pay them to meet the need. If master do not pay, he would be accountable on doomed day”.

Lower caste people were found to emphasize the dependency on the upper class hierarchy. Lower caste women admit they are exploited and kept oppressed in access to social and financial resources, but they cannot challenge the structure of society. On the other hand, high caste people with better resources of earning denied the fact by stating.

The time is changed, now a day’s intergeneration poverty is no more structural supportive, if persons work even on daily wages, they will bring three hundred in the evening, that would help reduce the poverty.

Government policies developed with intention to target the deprived, most disregarded category known as population of women must be identified that the social constructions that define their social status are deeply drive in, maintained by an ideology that promotes their demotion, and legitimize of other sections of social hierarchy of society. It is necessary to break the social constructed status quo in order to improve the living standards of these women, most likely in comparison of powerful groups, (Mumtaz et al., 2014).

Discussion on findings.

This study aimed to think beyond the correlation of material aspects and provision of health care services. Health disparities still exist in spite of policies aimed to reduce health care facility obstacles, this paper research finding suggest until the socioeconomic obstacle and demands of lower caste are not understand, the policies would not be applicable successfully. This research suggests that there is no system is traced to reduce the economic obstacle of lower caste women. They have no options except to indulge them in social fabricated system of inequality and associate themselves with some better resource master of high caste.

Low caste women poverty is determined by her birth at lower status as an ascribed status. The income resources base on low-self-esteem, uncertain and tentative characteristics. Her inferiority also pervades of statuary services, poor treatment at public health care centers, and socially systematic exclusion from poverty reduction policies. All of these assessed combination consequences consequently paid by poor lower caste women in the shape of suffrages of her body health. The women do not afford the private doctors' clinic expenses; they do prefer to get services by unskilled traditional birth attendants. If any complications came forward during emergency, they try to grasp their possible resources for loans to access better care of health.

If the policy makers want to make effective results towards better health, need to care following aspects while implications policies.

Explicit knowledge of lower caste social fabricated dispraise and health demands of poor lower caste females, interrelation of socio-economic hierarchy and gender differences introduce extremely drawbacks. Utilization of resources to identify most disadvantage group, largely invisible stigmatized women. This should be acknowledged in policy documents, so far the policy makers, front line health service managers and health care providers can get knowledge that how caste system effects the health determinants and how structurally excluded people could met better access to health services. The

trainings should be included as part of continuing professional development for health care professionals and become an obligation for replenish credentials.

Make sure that health services provision at public sector should be free. Birth preparedness constrain from saving, barrier is unequal distribution of wealth. Social structure needed modifications to make every ethnic group ready for emergency obstacle of life. Any health loan access should be easy and deliver directly to the person in need via direction transaction based on technology. Vouchers of poverty reduction scheme distributions should be based on social indicator that proved the right person for the fund, transactions on direct basis rather than indulging the local authorities make the situation better.

Maternity's service providers should be bound to provide good level of quality, supportive attitude to suppressed women would enhance the trust these lower caste women at public health centers.

Proper monitoring of access to services by indicators of caste status as well as income and wealth. Targets for equity should be developed and monitored for performance. Meeting equity targets should be incorporated into a provider's evaluation of performance. Acknowledge that the responsibilities of those charged with improving maternal health extend beyond the provision of services to ensuring their equitable uptake as well as to working with other sectors to address the wider determinants of poor maternal health.

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RECIBIDO: 2 de septiembre del 2019. **APROBADO:** 11 de septiembre del 2019.