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# 'I never go anywhere': extricating the links between women's mobility and uptake of reproductive health services in Pakistan

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**Abstract**

An integrated analysis of large-scale survey data and detailed ethnography is presented to examine the patterns of women's mobility and their relationships with contraceptive and antenatal care use in Pakistan. Findings confirm that women's mobility is circumscribed but also illustrate the complex and contested nature of female movement. No direct relationship between a woman's unaccompanied mobility and her use of either contraception or antenatal care is found. In contrast, accompanied mobility does appear to play a role in the uptake of antenatal care, and is found to reflect the strength of a woman's social resources. Class and gender hierarchies interact to pattern women's experience. Poor women's higher unaccompanied mobility was associated with a loss of prestige and susceptibility to sexual violence. Among richer women, such movement did not constitute a legitimate target for male exploitation, nor did it lead to a loss of status on the part of their families. The findings caution against the use of western notions of 'freedom of movement' and associated quantitative indicators. At the same time, the wider impact of mobility restrictions on women's reproductive health is acknowledged and policy implications are identified.


*Keywords:* Women's mobility; Pakistan; Reproductive health services

## Introduction

An interest in women's seclusion and restricted mobility is central to much of the discourse concerning gender and health in South Asia (Dyson & Moore, 1983; Balk, 1994; Durrant & Sathar, 2000; Amin, 1995; Schuler, Hashemi & Riley, 1997). Women's inability to travel alone, as and when they wish, is viewed as an important barrier to improving their health. In this thesis, women's independent mobility is postulated to directly promote their health by enabling them to travel to service outlets to access health care (Cleland, Kamal, & Sloggett, 1996). Unrestricted, independent mobility is also thought to improve health outcomes indirectly via increased exposure to information, development of interpersonal skills, and greater self-confidence (Cleland et al., 1996). Such an analysis has important policy implications, and indeed, policy responses are clearly evident in most South Asian settings. Most notably, cadres of field-based workers, many of them female, have been introduced in an attempt to bring services within reach of women and thus circumvent the proscriptions against their movement.

However, despite this apparently reasonable analysis of the situation, an examination of the literature for Pakistan reveals a confused picture with remarkably little firm evidence of a link between women's mobility

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and use of reproductive health services (most commonly contraceptive use).

Some studies do suggest that geographical distance to a health facility is a barrier to uptake of services. A Population Council survey of Punjab found that the more time it takes to reach a family planning source, the less likely a woman is to adopt a family planning method (Population Council, 1997). Similarly, a situation analysis of a network of 1288 Family Welfare Centres found that the majority of service users lived nearby and travelled to the centre on foot (Cernada, Rob, & Ameen, 1993). A recent analysis of data from the 1996/7 Pakistan Fertility and Family Planning Survey found that contraceptive use rates were higher among women who lived in areas served by two or more community-level workers (who provide services to women in their homes) than among women living in less well-served areas (Sultan, Cleland, & Ali, 2002).

Recently, however, surveys that have attempted to measure women's mobility directly have produced very different conclusions. Sathar and Kazi (1997) found no association between women's mobility, as measured by a respondent's ability to travel *alone* to a health centre, and contraceptive use in Punjab. Similarly, researchers found no association between a woman's mobility, as measured by her ability to travel *alone* to six different locations, and contraceptive use in an urban squatter settlement in Sind (Fikree, Khan, Kadir, Sajan & Rahbar, 2001).

A focus on women's '*travel alone*' is located in the wider conceptual paradigm of 'women's autonomy' (Dyson & Moore, 1983; Jejeebhoy, 1995). Conceptualised largely by Western feminists, women's autonomy is understood as a key factor in improving women's reproductive health. Broadly described as 'control over their lives', women's autonomy has been viewed as a set of multiple inter-linked domains that usually include, but are not limited to, decision-making authority, economic and social autonomy, emotional and physical autonomy (Jejeebhoy, 1995). It is the last characteristic, physical autonomy in interacting with the outside world, that is the basis for the empirical focus on women's 'freedom of movement'. In Pakistan in particular, which is a context characterised by women's seclusion and restricted mobility, women's freedom of movement, to travel *alone*, as and when they wish, has been emphasised as a crucial factor in accessing reproductive heath services and thereby improving their reproductive health.

A review of the anthropological literature, however, suggests that women's mobility in Pakistan is more complex than a simple restriction of movement. Researchers caution us against the use of simplistic public-private dichotomies and draw attention to the fluid and negotiable nature of gender norms (Donnan, 1997). Norms relating to women's mobility are closely linked to notions of '*purdah*' and '*izzat*' (honour), with seclusion as the ideal (Khan, 1999). The control of women's mobility and their exclusion from public space is perhaps the most salient feature of *purdah* in Pakistani society. However, gender hierarchies interact closely with those of socio-economic class, resulting in diverse behaviours among different sub-groups of Pakistani women. In rural areas, the practice of secluding women within the home is more common amongst women from large land-owning families than among poorer groups where women are economically forced to leave the home for work. In contrast, in urban areas it is the middle-class women who are most visible and mobile outside the home (Sathar & Kazi, 1997).

Thus, it is important to recognise that seclusion has never been absolute, and that observed mobility outside the home cannot simply be equated with some notion of 'freedom of movement'. Some authors have recognised this diversity in patterns of women's movement (see for instance comparisons of Muslim and Hindu women in Northern India by Mandelbaum, 1986) and variation by the wider sociocultural context (Jejeebhoy & Sathar, 2001). Nevertheless, the dominant discourse within the demographic and reproductive health literatures remains one where independent, unaccompanied mobility is seen as the goal and is expected to be associated with greater uptake of health care services and positive reproductive health outcomes. The present study contextualises observed patterns of women's mobility and extricates the links between aspects of mobility and reproductive health service use. The paper thereby explores the appropriateness of the current conceptual emphasis of much of the reproductive health literature. A number of key issues that remain unclear are addressed below:

- What are the patterns of mobility of Pakistani women, and how do local constructions of space and movement compare to outsider definitions?
- What type of female mobility facilitates access to healthcare services? Is a focus on unaccompanied, unrestricted mobility appropriate to this cultural context?
- Does the importance of restricted mobility as a barrier to uptake of healthcare services vary between types of service, between groups of women, and between contexts? Under what circumstances and why are other factors more important barriers to the uptake of services?
- Where greater mobility is found to be associated with higher use of services, what explains the relationship? Does greater mobility directly lead to uptake of services? Does greater mobility act via other pathways, for instance via increased access to information? Or, does the relationship reflect the fact that mobility is merely a proxy for other important dimensions of women's position?