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REPRODUCTIVE HEALTH

GENDER ROLES AND RELATIONS AS PREDICTORS OF PRACTICING OF REPRODUCTIVE HEALTH RIGHTS AMONG MARRIED WOMEN AND MEN IN PUNJAB, PAKISTAN

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ABSTRACT... Practicing reproductive health rights is not an individual attribute but an outcome negotiated between partners. Large differentials can place the less powerful partner at risk by reducing his or her ability to negotiate safer sexual relations. Negotiation between partners is affected by material assistance which is given by men. Hence, the present study was designed to gauge the extent of practicing the reproductive health rights among married men and women and to see the relationship between respondents' characteristics and practicing of reproductive health rights by them. A cross-sectional survey was carried out from Punjab province. Well designed interviewing schedules were constructed in the light of research objectives and the conceptual framework of the study to collect data and draw inferences. A representative sample of 700 married women and 600 men were interviewed. The SPSS/PC+ 15.0 Statistical Package for Social Sciences were used for analyzing the data. A strong and positive association between the demographic characteristics of married men and women and their attitude towards the reproductive health behavior and those women who were currently engaged in paid jobs had highly favorable and consistent attitude towards RHR-Practices. It was strongly suggested that encourage women's employment by increasing their education level and creating jobs in every department and encourage women's participation in decision making process.

Keywords: Reproductive health rights, practicing, gender roles and relations, women status, married couples

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INTRODUCTION

Traditional gender roles, attitudes and norms that limit the gender equality are strongly associated with acceptance of intimate violence. Literature showed that about 25-40% of women agreed that a good wife obeys her husband, that it is important for a man to show his wife his power and authority. Evidence further showed that patriarchal values, women's lack of financial autonomy, low male socioeconomic status and alcohol consumption were associated with partner's aggression. It is also added that having more occasional quarrels with a partner or having refused a job because of a partner set a stage of traditional beliefs about wife-beating or partner's assault[1,2,3]. The evidence on immoral relations depicted that males involved in extra-marital relations and admitted that they had used some sort of coercion or bribery to get into these relations money and/ or gifts. Moreover, hitting is correlated with negative health outcomes including sexual dysfunction and unwanted as well as unsatisfying sex-and that these problems particularly affect women[2,3,4].

It is commonly assumed that marriage is a safe refuge for young women but marriage may increase the risk of sexual violence, or it may increase young women's risk of HIV infection. Traditionally, husbands cannot be charged of raping their wives because marriage is considered

as extensive approval to intercourse. More than one in five sexually experienced young women had had nonconsensual sex. The perpetrators were often the young people's intimate or their husbands. It reveals that non-consensual sex is a common-and often overlooked issue within marriage[5-7].

Reductions in maternal mortality and provision of pregnancy care are central objectives for all reproductive health services. By making maternal care as a key issue for a nation's economic and public health agenda would be helpful to ensure that millions of women and their children avoid the pregnancy-related death and problems that are still all too common. In developing countries 58% to 80% of pregnant women developed acute health problems and 8% to 29% went on to develop chronic health problems as a result of pregnancy. Use of contraceptives is inconsistent and men are often unwilling to use condoms with younger partners. Young women's power to negotiate condom use is compromised by age disparities and economic dependence within such relationships[8-11].

Working women more often use or intend to use contraceptive than do women who do not work for pay. The effect of work, however, inconsistent and vary in size. Women's wages and work within the home - both of which are dependent on women staying healthy- are increasingly important[8,12,13,14].

The consequences of poor maternal health have been documented as “the burden” and “the cost”. For women of reproductive age, pregnancy and childbirth are the leading causes of death, disease and disability. The consequences of the death of a woman when giving life to the next generation to her family and community are adverse. It has been also documented that a woman can never suggest to her spouse that he should use condoms as a protective measure, because of the unpalatable consequences that are bound to arise, including misunderstandings leading to mistrust between spouses; fighting with the family- particularly wife beating; and the men's becoming annoyed and initiating affairs with other women. Dissolution of marriages would be the consequence. Above to all, because of the social and economic disadvantages women face, a woman cannot refuse to have sex with her husband, even when she knows that he has other partners and is exposing himself and her to risk of HIV infection. Therefore, the prevailing socioeconomic situation was the principle influence on participants' practicing of reproductive health rights[8,15].

Practicing reproductive health rights is not an individual attribute but an outcome negotiated between partners. Large differentials can place the less powerful partner at risk by reducing his or her ability to negotiate safer sexual relations. Negotiation between partners is affected by material assistance which is given by men[16,17].

Based upon the above discussion it can be concluded that most women, lacking sexual decision-making power, take reproductive health risks because self-protection is likely to threaten their social and economic survival. Culturally based gender roles and relations, economic and social inequalities, and age disparity between partners combine to create a situation of unequal power for women in sexual relationships, which reduce their ability to negotiate on practicing their reproductive health rights. Therefore, literature suggests that a partnership between the two sexes must be created giving equal status to both within sexual relations[14]. For this, young women need a way to achieve status, define identity, and acquire resources. Hence, the present study was designed with the following objectives.

Objectives

1. To search out the socio-economic characteristics of married men and women.
2. To identify the gender roles and relations of married men and women.
3. To gauge the extent of practicing the reproductive health rights among married men and women.
4. To see the relationship between respondents' characteristics and practicing of reproductive health rights by

them.

5. To suggest measures to improve the practice of reproductive health rights by the couples

Conceptual Framework

Social research is to delineate the influence of people's perceptions and beliefs on their reproductive health behavior. Scientific evidence showed that these ideas beliefs, values, attitudes and perceptions of the reproductive health users are important predictors of

Figure 1 indicates that the independent variables i.e. socio-economic (women's economic status) and cultural (gender roles and relations) factors in social milieu directly influence the dependent variable i.e. married men and women's attitude towards the practice of RHR.

Practicing reproductive health rights[18-21]. Rights based approach emphasizes that services be offered to women, men, and adolescents with a special focus on fulfilling men and women's health needs, safe guarding their reproductive rights, empowering women, and involving men in reproductive decision making as equal partners in meeting the goal of responsible parenthood. Conceptual relationship between gender roles and relations with gender differentials in reproductive health rights (RHR) practices is shown in fig. 1.

In Pakistan, most people are member of a close social network, where primary relationships are important to both individuals and society. The family is prestigious because it is the only institution which provides the basic personal and social needs for its members; close kinship bonds prevail. Because of these close bonds, there is usually little or no individual decision making about reproductive and fertility regulating behavior in Pakistan. Reproductive health rights behavior is strongly influenced by the social pressure of senior family members such as parents, grandparents, and in-laws. Peers, reference groups, and neighbors are also important determinants of individual's attitude. Therefore, so far married women's and men's attitude towards practicing RHR is focused we cannot separate them from the existing values in the normative milieu of the Pakistani culture. Furthermore, the significance of social factors in determining reproductive and contraceptive behavior (reproductive health security) in Pakistan cannot be exaggerated[20,22].

Theoretical Structure

Theory of Reasoned Action and Planned Behavior

The Theory of Reasoned Action and the Theory of Planned Behavior place relatively more emphasis on the concept of "behavioral intention"[23]. Intention is based upon the individual's expectations for the results of three factors i.e. behavior, attitudes, and beliefs in terms of certain influences such as his/

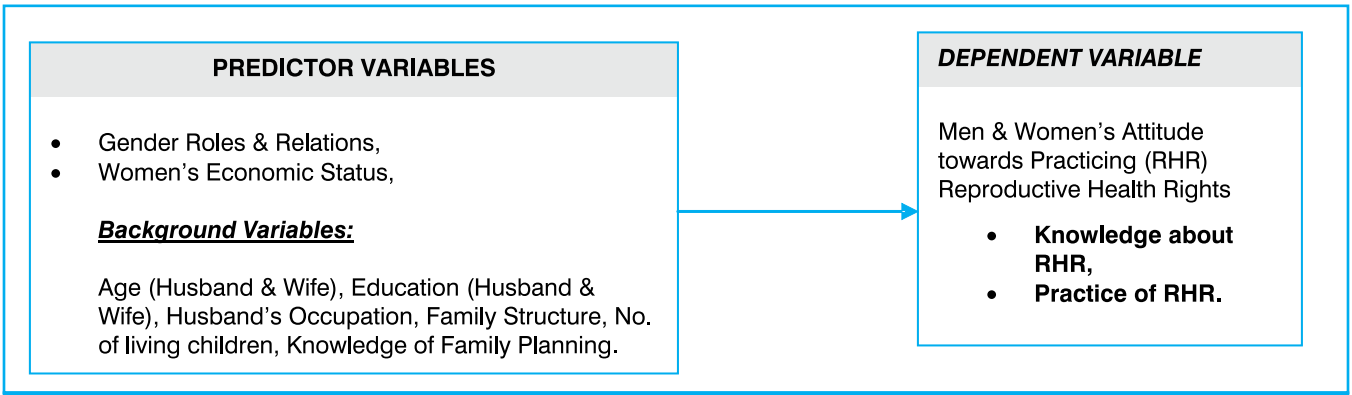

Figure 1: Relationship between Gender Roles and Relations with Gender Differentials in Reproductive Health Rights (RHR) Practices

her peer group in the practice of specific condition[24,25].

Hence, the theory of reasoned action explains that individual action of a given behavior is principally explored by an individual's intention to perform that behavior. This human intention is an outcome of by two important factors: the person's attitude toward the behavior (i.e., beliefs about the results of the behavior and the significance of these results) and the influence of the person's social environment or personal norm i.e. beliefs about what peer group think the person should do in the practice of specific situation, as well as the individual's motivation to act in accordance with the opinions of others).

MATERIAL AND METHODS

The materials and methods provide a path to researcher how to complete the process of collection, analyzing and interpretation of data. The research design is the "blueprint" that enables the researcher to come up with the solutions to the problems encountered during the research[26].

Research Design

A cross-sectional survey was carried out from Punjab province. Punjab is the most populated province of Pakistan, with 86,084,000 people in 2005[27]. The study was conducted in urban as well as rural areas of three districts; Toba-Tek Singh, Bahawalpur, and Rawalpindi of Punjab province in Pakistan. From each district respondents were selected proportionally for the given population size[28], using the formula:

$$n_k = n * N_k / N$$

Where n and N stand for the total sizes of the sample and population; and n_k and N_k represent the sizes of sample and population of k^{th} district. Multistage sampling technique was used to select the respondents. At the first stage, three districts, Toba Tek Singh, Rawalpindi, and Bahawalpur were selected through simple random sampling technique. The next lower level administrative divisions of districts are tehsils. Hence, at the second stage, from each district one tehsil was selected by *simple random selection*. At the third stage, three urban and three rural union councils were selected *randomly*. At the fourth stage, rural and urban localities were selected for the selection of household. From the selected urban and rural localities married men and women of age 15 – 49 years having at least one child were interviewed. A representative sample of 700 married women and 600 men were interviewed[29]. Well designed interviewing schedule was constructed in the light of research objectives and the conceptual framework of the study to collect data and draw inferences.

DATA ANALYSIS

The SPSS/PC+ 15.0 Statistical Package for Social Sciences were used for analyzing the data. Frequency distributions of the variables were first obtained and, where appropriate, cross tabulated; the Chi-square, Somers'd and Gamma test of significance was used for assessing the relative importance of each of the independent variables in relation to the dependent variable.

RESULTS AND DISCUSSION

The general objective of this study was to analyze the socio-economic and cultural characteristics of the respondents and to delineate the men and women's attitude towards reproductive health rights and behavior in the Punjab, Pakistan. In this section an attempt has been made to discuss, analyze and interpret relevant data for deriving conclusions and formulating appropriate suggestions in the light of the study results.

Demographic Characteristics

Demographic characteristics are important predictors of married men's and women's attitude towards the knowledge acquisition about reproductive health rights, type of RH-Method and adoption and practice of RHR.

A woman's age is a key determinant of knowledge acquisition and practice of RHR i.e. younger women might be more open to new ideas and better informed about RHR and RH-Services, but older women might have more control over household resources and a greater ability to make

and act on decisions about practice of RH-Method[30]. Other socioeconomic characteristics are also key determinants of the attitudes towards the knowledge and practice of RHR and RH-Services. For example, education may effect in multiple ways; it may expose women to modern ideas about the limitation of family-size, and it may enhance their ability to exercise control over their sexual relationships and childbearing preferences. Women with more schooling may be more comfortable in interacting with medical personnel, may have better access to RH-facilities and above all may have better negotiation power than women who have little education. In addition, better-educated women may be more likely than others to earn incomes, and thus may have greater economic resources that could improve their access to health facilities. Household economic resources also may affect access to modern RH-Services and methods, and regional areas dramatically unequally distribute them. Similarly, community conditions may influence the availability of modern contraceptives and the perceptions of potential users[31].

The variables concerning to socio – economic and demographic characteristic were operationalized as age of the respondents, husband's education, respondent's education, monthly income, and husband give specific amount each month for household expenditure.

The information presented in table 5.1 reveal that 37.7 Percentage of the respondents fall in the age

		Respondents		Husbands	
Current Age (in years)	**F**	**%age**	**F**	**%age**	
20 – 25 -	24 – 29	91	13.0	56	8.0
26 – 30	30 – 34	264	37.7	116	16.6
31 – 35	35 – 39	175	25.0	226	32.3
36 – 40	40 – 44	133	19.0	153	21.9
41 – 45	45 – 49	37	5.3	107	15.3
	50+			42	6.0
Age at Marriage (in years)					
15 – 19	18 - 22	273	39.0	90	12.9
20 – 24	23 - 27	350	50.0	323	46.1
25 – 29	28 - 32	67	9.6	248	35.4
30 +	33+	10	1.4	39	5.6
Mean = 27.52		S.D. = 3.92			
Mean = 22.25		S.D. = 3.99			
Education (years of schooling)					
Illiterate		119	17.0	52	7.4
1 - 4 Class		125	17.9	94	13.4
Primary		65	9.3	76	10.9
Middle		72	10.3	79	11.3
Metric		133	19.0	135	19.3
Intermediate		88	12.6	115	16.4
Graduate		81	11.6	112	16.0
Master		17	2.4	37	5.3
Monthly Income in Rupees					
Don't Know			5		.7
1,000 - 5,000			227		32.4
6,000 – 10,000			196		28.0
11,000 - 15,000			83		11.9
16,000 - 20,000			56		8.0
21,000 +			133		19.0

Table 5.1-: Distribution of the *Female* respondents according to their demographic characteristics (*n=700*)

category of 20 – 30 years. One forth (25 %) of the respondents were of age 31 – 35 years old and only small proportion (5.3 %) were from elderly age group (41 – 45 years old) . The average age of the respondents was 31-years. The finding of the present study was in accordance with the results presented[32]. They found the mean age of the respondents as 32.0 years where as the mean age of the husbands was 35.8 $\pm$ 1.05 years. It can be said that respondents of age bracket of 26 – 35 years were easily available in the four walls of their houses because elderly women were mostly busy in domestic activities. It is reflected from the information that half (50.0 %) of the Female respondents' age at the time of marriage, was 20 – 24 years a bit less than one tenth of the respondents were 25 – 29 years old at time of their marriage. The mean age at marriage was 20.1-years. Data depicts that monthly income of almost one third of the *female* respondents from all sources was in the range of Rs. 1,000 – 5,000 and a little less than one fifth (19.0%) of the *female* respondents had Rs 21,000 or more as monthly family income from all sources

Women Status

Johnsons (1997)[33] stated, that denying of reproductive health rights cuts across social and economic situations and is deeply rooted in cultures around the world - so much so that millions of women consider it a way of life. Worldwide, studies have shown a consistent pattern of events that generate aggressive responses[34-37]. According to UNFPA (2000)[38] violence in all its forms causes immense damage to the reproductive health and well-being of women and girls throughout the world, in direct and indirect ways i.e. unwanted pregnancies and restricted access to family planning information and contraceptives and psychological problems, including fear of sex and loss of pleasure.

Researchers have found that affected women tend not to use reproductive health services for fear that husbands would turn violent[34,36,39].

The variable on Women's socio-economic status was operationalized as currently working for a paid job and husband give some specific amount for her expenditures.

Work is a key transition in the lives of people. Work helps the people to earn livelihood along with a contribution to gain building life skill. Besides this, head of the family gets a unmatchable place due to work factor. The survey presented in Table 5.2 reflected those women who were working outside the home to contribute in their household. The information shown in Table 5.2 indicates that only less than one tenth (9.4% *female* and 9.5 *male*) of the respondents were economically independent while the remaining 90.6% of them were economically dependent to their husbands. The data clearly reflect the Pakistani/Punjabi culture that here majority people dislike and strictly condemn that their ladies go outside the four walls of their houses for earning purpose even

	***Female* Respondents (*n*=700)**		***Male* Respondents (*n*=600)**	
	Respondent is a Working women		Respondent's wife is a working women	
Response	**Frequency**	**Percentage**	**Frequency**	**Percentage**
Yes	66	9.4	57	9.5
No	634	90.6	543	91.5
Husband give specific amount each month for household expenditure				
	***Female* Respondents (*n*=700)**		***Male* Respondents (*n*=600)**	
Response	**Frequency**	**Percentage**	**Frequency**	**Percentage**
Yes	356	50.9	322	53.7
No	344	49.1	278	46.3

Table – 5.2 Distribution of the respondents according to economic dependence

though they faced tough economic situation[40]. The latest Labor Force Survey (LFS) 14% females involved in any kind of economic activity. Further they explained that there wasn't any significant positive change in female participation rates since the mid-sixties. Since now rate of female economic independence has varied from 10% in 1966-67 rising to 14% in 1991-92 and again falling to 11.4% in 1994-95. Likewise, when the male respondents were asked about the working status of their better halves surprisingly same results were drawn which are clearly reflected by data presented in Table 5.2 that is a great majority 91.5 percent of the respondent's wives was household women and only 9.5 percent of the respondent's wives were found to be the working women. Almost similar results were reported by Schuler (1992) that almost 87 percent of the women were housewives.

The data showed in Table 5.2 presented the analysis whether husbands gave some specific amount to their wives for monthly expenditures. The analysis presenting that about half of the respondents (50.9 % of *female* respondents and 53.7 percent *male* respondents) gave them some specific amount for monthly expenditures whereas the remaining respondents were not gave any of the amount to their wives.

Gender Roles and Relations

The international reproductive health community has acknowledged the importance of addressing gender disparities in reproductive health decision making as fundamental of improving the reproductive health and rights of both women and men. Gender-based power inequalities can contribute to poor reproductive health outcomes especially among women because gender inequality is a key element of the social context in reproductive decision-making. Women's sacrifice of their own wishes for their partner's desires is a result of nonconsensual sexual activity within marriage (a form of gender-based power inequality), is common in all societies. Furthermore, Erulkar (2004)[5] explored that it has long-term negative consequences i.e. lower chances of practicing RH-Methods and services; and a higher possibility of experiencing sexually transmitted infections (STIs) and unwanted pregnancy. Speizer et al (2005)[41] added that husbands have fear that if they approved of RH-Methods and allowed their wife to use it, they will lose their role as head of the family, their wife might be unfaithful. While conversely, women who have some decision-making power and autonomy often are better able than other women to meet their reproductive health goals.

In the present study gender role and relation was operationalized as the attitude of married women and men on their rights and behavior regarding mate selection, consultation in major family decisions, and conflict resolution between husband and wife, and decision relating to use of available RH-Methods for practicing reproductive health rights.

The largest proportion of marriages in Pakistan is among relatives. The majority of peoples are traditional and practice orthodox behavior, and marriages within the family is a norm. The respondents were asked about them being married within the family or not. The data displayed in Table 5.3 indicates that a large majority of male respondents i.e. 64.4 percent were married within the family and 35.6 percent were married out of the family. Likewise, 66.3% of the *female* respondents were familiar to their husband and their family before marriage by having family terms between two families e.g. cousins, friends, family friends, relatives etc and 33.7% of the *female* respondents 'did not know the husband' before their marriage. Similarly, 63.0 percent of the *male* respondents reported that the decision of their marriage taken by their parents. Correspondingly, data furiously reflect that in mate selection *female* respondents' opinion or choice was not considered by parents. It is obvious from the data that a very small proportion of parents considered the *female* respondents' opinion/choice at the time of marriage i.e. less than one percentage (0.9%) of respondents selected their spouse by

Marriage Within family	*Female* respondents (*n* =700)		*Male* respondents (*n* = 600)	
Yes	464	66.3	386	64.4
No	236	33.7	214	35.6
Respondent's Opinion Taken at the Time of Marriage				
Yes	-	-	325	54.2
No	-	-	275	45.8
Decision about marriage				
Personal choice	6	0.9	71	11.8
Parent's choice	534	76.3	378	63.0
Parents & personal choice	31	4.4	142	23.7
Relatives & parents Choice	119	17.0	9	1.5
Others	10	1.4		

Table 5.3 Distribution of the respondents according to the Gender Roles relations with their spouse

themselves and only 4.4% of the respondents' parents considered the opinion/choice of their daughter in mate selection. The information of this table is a true reflection of pure Pakistani/Punjabi traditional parents' role in mate selection for their daughters. Here in Punjabi culture it is a normative practice that parents select a spouse for their daughter according to their status & standard and daughter has to accept it without any hesitation.

The data presented in Table 5.4 show that almost two third of *female* respondents' husbands (63.4%) managed household expenditures by themselves according to the family requirements and occasional demands. This shows that males/ husbands in Pakistani society keep economic decisions in their own hands to keep an eye on expenditures done by wives by providing money on daily/ weekly basis as it is easier to keep record or eye about matter type of expenditures being made by family/wives.

The data given in Table 5.5 show the married women's and men's responses to gender role and its relations. It is obvious from the given information that both married men and women had favorable attitude towards all indicators of the importance of gender role in family with reference to reproductive health rights and behavior but breach lies in the intensity of their favorable perception towards the indicators. The percentage distribution of the respondents showed that almost all married women (99.1%) thought that a woman should always pay due respect to her husband and try to avoid a chance

Nature of Arrangement	Frequency	Valid Percentage
Self Done	218	63.4
Weekly	18	5.2
Daily	55	16.0
Others	53	15.4
Total	**344**	**100.0**
Missing System	**356**	
Total	**700**	

Table – 5.4: Distribution of the respondents according to the nature of arrangement made by their husbands to meet household expenditures

*356 respondents' husband gave them specific amount each month for household expenditure.

Statements	*Female* Respondents (*n*=700)			*Male* Respondents (*n*=600)		
	Agree	Neutral	Disagree	Agree	Neutral	Disagree
	Count N %	Count N %	Count N %	Count N %	Count N %	Count N %
A woman should take part in the decision of selecting her mate	200 28.6%	75 10.7%	425 60.7%	165 27.5	165 27.5	270 45.0
A woman should equally express herself about any affair of home's life	510 72.9%	50 7.1%	140 20.0%	247 41.2	299 48.8	54 9.0
A woman should take initiative in resolving conflict with her husband (if arises any)	523 74.7%	35 5.0%	142 20.3%	416 69.3	168 28.0	16 2.7
A woman should be encouraged to get higher education	629 89.9%	53 7.6%	18 2.6%	208 34.7	224 37.3	168 28.0
A woman should always pay due respect to her husband	692 99.1%	0 .0%	6 .9%	451 58.5	245 40.8	4 0.7
A woman should get a divorce if she cannot live with a man (Husband)	448 64.0%	26 3.7%	226 32.3%			

Table – 5.5 Distribution of the respondents showing variable responses to gender role and its relations

to annoy him on any matter of family development and management while a simple majority (58.5%) of male respondents had the same opinion. Similarly, almost three fourth of respondents (74.7%) agreed that a woman should take initiative in resolving conflict with her husband (if arises) similarly 69.3% married men were agreed that women should take initiative in resolving conflict with her husband. It can be assumed that women were in psychological pressure and accepted the male dominance of the society which was reflecting in their way of thinking and expressions that a woman should always pay due respect to her husband and a woman should take initiative in resolving conflict with her husband (if arises). This was a true reflection of Pakistani culture. The results of the present study were clearly supported by the theory of reasoned action and planned behavior presented[23]. According to this theory, individual performance of a given behavior is primarily determined by a person's intention to perform that behavior. Further they explained that this intention is unfolded by two major factors: (1) the person's attitude toward the behavior (i.e. beliefs about the outcomes of the behavior and the value of these outcomes) and (2) the influence of the person's social environment or subjective norm. Therefore, majority of married women took the husband's decisions as their own decision and claimed as an equal partner of her husband while taking decision over any domestic matter.

The information presented in Table 5.6 (A & B) indicates that there was a strong and positive association between the demographic characteristics of married men and women and their attitude towards the reproductive health behavior. It can be seen from the table 5.6 (A) that less than half (15.6%) of those married women who fell in age group 20–29 years were highly consistent in their attitude towards RH-behavior. Likely, almost the same proportion of those married women who were in the age group '30–39 years' (52.9%) were moderately consistent (24.7%) or highly consistent (22.8%) in their attitude. It is evident from the table that as the age of married women increased the proportion of those women who had highly consistent in their attitude towards RH-behavior

decreased but women entered in their late reproductive age i.e. 40 – 45 years again the proportion of those women who were highly consistent in their attitude towards RH-behavior was increased. Similarly found U-shaped rather than linear trend between women's age and the likelihood of non use of RH-Methods[42].

It is clearly reflected from the data that a clear majority (39.7%) amongst the literate married women (74.8% of total) were '*highly consistent*' in their attitude towards RH-behavior. The results of

(A) *Female* Respondents

Demographic Characteristics	Attributes	Respondents' Attitude towards Reproductive Health Behavior			
		Inconsistent	Moderately Consistent	Highly Consistent	Total
Age of Respondent	20 - 29 Years	41 7.0%	70 12.0%	91 15.6%	202 34.6%
	30 - 39 Years	32 5.5%	144 24.7%	133 22.8%	309 52.9%
	40 - 45 Years	24 4.1%	23 3.9%	26 4.5%	73 12.5%
	Total	97 16.6%	237 40.6%	250 42.8%	584* 100.0%
Statistics	Chi-Square ≤ 0.0001 (110.831) Somers' d ≤ 0.0001 (-0.239) Gamma ≤ 0.0001 (-0.569)				
Husband's Education	Illiterates	34 5.8%	35 6.0%	5 .9%	74 12.7%
	5 - 8 Classes	33 5.7%	57 9.8%	36 6.2%	126 21.6%
	9 - 12 Classes	26 4.5%	114 19.5%	95 16.3%	235 40.2%
	14 +	4 .7%	31 5.3%	114 19.5%	149 25.5%
	Total	97 16.6%	237 40.6%	250 42.8%	584 100.0%
Statistics	Chi-Square ≤ 0.0001 (159.847) Somers' d ≤ 0.0001 (0.429) Gamma ≤ 0.0001 (0.614)				
Respondent's Education	Illiterate	54 9.2%	75 12.8%	18 3.1%	147 25.2%
	Literate	43 7.4%	162 27.7%	232 39.7%	437 74.8%
	Total	97 16.6%	237 40.6%	250 42.8%	584 100.0%
Statistics	Chi-Square ≤ 0.0001 (100.528) Somers' d ≤ 0.0001 (0.372) Gamma ≤ 0.0001 (0.697)				
Monthly Income From All Sources (in rupees)	1,000 - 10,000	74 12.7%	165 28.3%	78 13.4%	317 54.3%
	11,000-20,000	13 2.2%	39 6.7%	79 13.5%	131 22.4%
	21,000 +	8 1.4%	32 5.5%	93 15.9%	133 22.8%
	Total	97 16.6%	237 40.6%	250 42.8%	581** 100.0%
Statistics	Chi-Square ≤ 0.0001 (109.433) Somers' d ≤ 0.0001 (0.369) Gamma ≤ 0.0001 (0.576)				

Table: 5.6 Associations between Respondents' Demographic Characteristics and their Attitude towards their Reproductive Health Behavior

* 116 Respondents did not practice RHR in their life.

** 3 Respondents have no knowledge about monthly income

(B) *Male* Respondents

Demographic Characteristics	Attributes	*Male* Respondents' Attitude towards Reproductive Health Behavior			
		Inconsistent	Moderately Consistent	Highly Consistent	Total
Age of Respondent	Up to 35	119 (66.1)	35 (19.4)	26 (14.4)	180 (30.0)
	36-45	111 (51.6)	55 (25.5)	49 (22.7)	215 (35.8)
	46 & above	31 (15.2)	49 (23.9)	125 (60.9)	205 (34.2)
	Total	261 (43.4)	139 (23.3)	200 (33.3)	600 (100.0)
Statistics	Chi Square value. 137.46** Gamma value. 0.246*		**. Highly significant *. Significant		
Age at marriage (years)	Upto 25	156 (66.6)	50 (21.4)	28 (11.9)	234 (39.0)
	26-30	70 (44.9)	34 (21.8)	52 (20.3)	156 (26.0)
	31 and above	35 (16.6)	55 (26.2)	120 (57.2)	210 (35.0)
	Total	261 (43.4)	139 (23.3)	200 (33.3)	600 (100.0)
Statistics	Chi Square value. 213.659** Gamma value. 0.707**		**.Highly significant **.Highly significant		
Male Respondent's Education	Illiterate	156 (76.0)	31 (15.1)	18 (8.7)	205 (34.1)
	Primary to Middle	69 (61.0)	16 (14.1)	28 (24.7)	113 (18.9)
	Metric to Inter	18 (16.5)	47 (43.1)	44 (40.3)	109 (18.2)
	Graduation and above	18 (10.4)	45 (26.01)	110 (63.5)	173 (28.8)
	Total	261 (43.4)	139 (23.3)	200 (33.3)	600 (100.0)
Statistics	Chi Square value. 206.087* Gamma value. 0.102**		*.Significant **.Highly significant		
Monthly Income From All Sources (in rupees)	Up to 10,000	185 (58.9)	117 (37.2)	12 (3.8)	314 (52.3)
	10,001-20,000	44 (39.6)	17 (15.3)	50 (40.04)	111 (18.5)
	20,001 and above	32 (18.2)	5 (2.8)	138 (78.8)	175 (29.2)
	Total	261 (43.4)	139 (23.3)	200 (33.3)	600 (100.0)
Statistics	Chi Square value. 299.56** Gamma value. -0.49 NS		**.Highly significant NS. Non significant		

this study were consistent with the results[12]. They found that literacy was broadly associated with current and intended use of contraceptive. According to them, literate women were more likely to discuss ideal family size and reproductive health methods with their husbands and were more knowledgeable about modern RH-Methods and their sources than were

Women's Economic Status	Attributes	*Female* Respondents' Attitude towards Reproductive health Behavior			
		Inconsistent	Moderately Consistent	Highly Consistent	Total
Currently working for paid job	No	96 16.4%	218 37.3%	212 36.3%	526 90.1%
	Yes	1 0.2%	19 3.3%	38 6.5%	58 9.9%
	Total	97 16.6%	237 40.6%	250 42.8%	584 100.0%
Statistics	Chi-Square ≤ 0.0001 Somers' d ≤ 0.0001 Gamma ≤ 0.0001 (0.51)				

Table: 5.7 Association between women's economic status and their attitude about reproductive health behavior

illiterate women.

It is evident from the information presented in Table-5.7 that those women who were currently engaged in paid jobs had highly favorable and consistent attitude towards RHR-Practices i.e. almost two third of those respondents who were currently working for paid jobs had highly consistent attitude towards the practice of RH-rights as compared to those married women who were currently not working. The value of Chi-Square, Somers'd, and Gamma shows a significant and positive association between the two variables; women's socio-economic status and practice of RHR. The difference in attitudes between the two groups of married women may be due to the difference in their exposure to practical environment. Those married women who ever worked for a paid job may be due to their practical experiences became more confident in their attitudes towards different aspects of life, more expressive and have improved their communication skills. The result of the present study is in line with the concept which is presented by Ajzen and Fishbein in 1980 in "Theory of Reasoned Action and Theory of Planned Behavior". According to them individual performance of a given behavior is primarily determined by a person's intention to perform that behavior. This intention is measured by two main factors i.e. the person's attitude toward the performance (i.e., viewpoint about the outcomes of the actions and the significance of these outcomes) and the influence of the person's social environment (i.e., beliefs about what other people think the person should do, as well as the person's motivation to comply with the opinions of others). The results of this study are also in harmony of the findings presented by Blanc in 1996. He suggested that women's social and economic vulnerability inhibits their ability to express and argue for their own interests with their partner.

The data presented in Table 5.8 reveal a highly significant and positive relationship between Respondents' perception about the importance of women's involvement in gender role and relations and their attitude towards reproductive health behavior. In simple words it can be said that as the role of women (in gender role & relations) is increased particularly in domestic activities their attitude toward RH-behavior would also be more consistent.

Statistically the value of Chi-Square ($p = 0.0001$) and correlation coefficient Gamma ($p= 0.001$) clearly indicating a positive and highly significant intensity of relationship between the two variables. Hence, it can be concluded that as the perception of married men and women become more positive for the importance of the involvement of married women in gender role and relations then their attitude towards the RH-behavior will be more consistent for the betterment of their own reproductive health. The findings of this study were supported by the results[12]. In their report they reported that involvement of women in domestic decision-making is consistently associated with women's fertility. Women who were highly involved in domestic decisions were more likely than those

Communication with wife	Males' attitudes towards practicing of reproductive health rights			
	Inconsistent	Moderately Consistent	Highly Consistent	Total
Low	187 (81.3)	35 (15.2)	8 (3.4)	230 (38.3)
Medium	67 (41.1)	44 (26.9)	52 (31.9)	163 (27.2)
High	7 (3.4)	60 (28.9)	140 (67.6)	207 (34.5)
Total	**261** **(43.4)**	**139** **(23.3)**	**200** **(33.3)**	**600** **(100.0)**
Statistics	Chi Square value. 297.35** Gamma value. 0.170**		**.Highly significant **.Highly significant	

Table 5.8 Association between perception of *respondents* about gender role & relations and their attitude towards reproductive health behavior

Gender Role & Relations	Attributes	Females' attitude towards Practicing of Reproductive Health rights			
		Inconsistent	Moderately Consistent	Highly Consistent	Total
Perception about importance of women's involvement in decision making	Disagree	26 4.5%	50 8.6%	7 1.2%	83 14.2%
	Neutral	36 6.2%	60 10.3%	34 5.8%	130 22.3%
	Agree	35 6.0%	127 21.7%	209 35.8%	371 63.5%
	Total	97 16.6%	237 40.6%	250 42.8%	584 100.0%
Statistics	Chi-Square ≤ 0.0001 (100.438) Gamma = 0.001 (0.574)		Somers' d = 0.001 (0.357)		

(B) Female Respondents *116 Respondents never practiced RHR

who were less involved to have discussed family size with their husbands, and were more likely to want to limit or space their births, more likely to be knowledgeable about RH-Methods and their sources than are those who were less involved.

CONCLUSIONS AND RECOMMENDATIONS

From the above discussion it can be concluded that though majority of women were of the opinion that women should equally express themselves about any affair of home-life and similar trend can also be seen in terms of response on getting higher education but majority of men were either silent or disagree on these issues. Likewise both women and men both are agreed that women should took initiative for resolving husband-wife conflict and also paid due respect to her husband. This all reflect that men are given more value, might and power for several decisions on issue related to women. It is interesting that in several cases this value, might and power for men is supported by females as well. This is important to keep in mind while making policies on human rights and more importantly for women rights in Pakistani society.

On the bases of above discussion the following suggestions are recommended:

- To encourage women's employment by increasing their education level and creating jobs in every department.
- To encourage inter-spousal communication particularly initiative by women. Community must be exposed to their rights (especially women's rights in every sphere of life) with the help of printed and electronic media, special lectures especially in educational institutions at all levels.
- To encourage women's participation in decision making process. For this purpose community must be made aware of the importance of participation of family members particularly the women in decision making process through media and special lectures in educational institutions at all levels.

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