

## DECISION MAKING AUTONOMY AND HEALTH OF WOMEN IN REPRODUCTIVE AGE IN PAKISTAN

**Altaf Ghani\***

PhD Student, University Malaysia Sarawak Malaysia  
[altafghani71@gmail.com](mailto:altafghani71@gmail.com)

**Zamri bin Hj Hassan**

Senior Lecturer, University Malaysia Sarawak Malaysia  
[hzamri@animas.my](mailto:hzamri@animas.my)

**Dolly Paul Carlo**

Senior Lecturer, University Malaysia Sarawak Malaysia  
[pcdolly@animas.my](mailto:pcdolly@animas.my)

### ABSTRACT

*For all individuals, regardless of their age, ethnicity or other attributes, reproductive health rights are everyone's right to make reproductive choices. Reproductive health privileges include the right to access RH related knowledge, insights and to encourage decisions along with the facilitation of reproductive health. The study focuses on the investigation of women's sovereignty in decision-making regarding their reproductive health. The data was collected through in-depth interviews and focus groups discussion to seek detailed information. A hybrid technique was used to figure out and analyze the data collected from 42 study respondents between age 15-49 years. Results reveal that husband's reported 47.61percent authority of decision making while the role of mother-in-law is reducing as the culture of nuclear family type is increasing. Women also are in a position to engage in decision making process. Patriarchal social practices, and polygyny marriages reduce the decision-making authority of women especially for their maternal health. Study is also backs up by existing studies showing that educational qualification improves the decision-making power of women. According to the Reproductive and Healthcare Rights Act 2013 by national policy of Pakistan, women have a right to reproductive health care information.*

**Keywords:** Reproductive health, women of reproductive age, decision making, reproductive rights, autonomy.

### INTRODUCTION

**Background:** A major international survey has revealed that nearly a quarter of women are unable to deny sex or make their own choices on receiving adequate health care. Most of the countries have legislation to ensure women's access to their sexual and reproductive health and rights. Yet the situation faced by women is not different. UNFPA has evaluated women's reproductive decision-making in 57 countries, sexual and reproductive health rights laws from 107 countries (UNFPA, 2005). The results, among other statistics suggest that women's reproductive rights are deteriorating in more than 40 percent of the countries. One woman out of four in the countries which in sampled is unable to make her own health care choices (UNFPA, 2020).

As for as the description of women's reproductive health decision- making worldwide is concerned, UNFPA (2020) also summaries that only 50% women have the right to decide on their sexual and reproductive health. About one fourth of women are impotent to make their own choices on access to health care. As accumulated, countries have 73% of the laws and legislation that are in need to make sure the complete and fair accessibility to sexual and reproductive health and rights. Many states try to put judicial restrictions on some communities including women and youth that slow down the access to sexual and reproductive health and rights (UNFPA,2020)

---

\* Corresponding Author

**Decision Making:** Three key definitions will classify the idea of decision-making, such as decision-making as a freedom (Koon, Nambiar and Rao, 2012), as an option (UNGA, 2000) and as a method (Reincke et al., 2000). Decision-making is a method that begins with the recognition of problems, the collection and compilation of data, data analysis, observations, and the development of an acceptable and most appropriate alternative solution and finally the assessment of the procedure (Reincke et al., 2000).

Socio-demographic characteristics such as the level of education (Exavery et al., 2012), the education of spouse (Darteh et al., 2014) and the family income (Ameyaw et al., 2017) have the ability to affect informed decision-making of an individual. A beneficial impact on decision-making is openness to evidence and information and the opportunity to care for individual's needs. By enhancement, the decision-making of a woman on her sexual and reproductive health can be successfully done based on the capacity to cater for her desires and her level of awareness.

Nevertheless, other context attributes such as religious orientation (Ameyaw et al., 2017), place of residence (Reincke et al., 2000) and cultural affiliations, may also have an effect on the decision-making process (Upadhya & Karasek, 2012; Oronjeet al., 2011; Haile & Enqueselassie, 2006). In specific, religious identity, socio-cultural aspects, place of residence and environments [e.g in sub-Saharan Africa] also influence women's decision-making for reproductive health (Darteh et al., 2014). The Pred's Behavioral Matrix is compatible with this statement (Reincke et al., 2000).

Keeping in mind the implicit assumption, men dominate women in their social class in most communities, especially in Asia-particularly in their households and families. In a developing country, women typically have inferior status in household. In turn, women are either jointly making decisions with their parents or depend solely on the decisions of the male partner on issues concerning their reproductive lives (Blanc, 2001). Hakim et al., proposed that stronger gender equity may foster the sovereignty of women and promote the adoption of contraceptives due to increased involvement of women in decision-making (Hakim et al., 2003).

**Reproductive Health:** Pakistan commits to working toward achieving universal access to reproductive health and raising the contraceptive prevalence rate to 55% by 2020 (Family Planning, 2020). The reproductive health initiative needs to be introduced in several ways and, thus, it is important to establish a cultural context that clarifies the relationship between global and local issues. Such a view would figure out that the idea of reproductive health itself is culturally formulated; thus, the introduction of the policy for reproductive health is as much a matter of pursuing a clear collection of cultural principles in different parts of the globe as it is a matter of management and scientific know-how (Obermeyer, 2013).

Healthy sexual and reproductive wellbeing is, according to the United Nations Population Fund, a state of full physical, emotional, and social well-being in all matters related to the reproductive system. This ensures that individuals will have a stable and healthy sex life, the desire to conceive and the right to determine whether, when and how much to do so (UNIPIN, UNPD, UNDESA and UNPF, 2007). Sexual and reproductive health problems account for more than one third of the global burden of diseases by women, according to the World Health Organization. In women, reproductive health issues such as infant death, maternal morbidity, and sexually transmitted infections account for 36 percent of lives being lost (WHO, 2007; Jose et al., 2019).

In the life of a woman, reproductive health plays a major part. Owing to the lack of awareness on reproductive health problems, women of child-bearing age groups in developing countries experience ill health (Jose et al., 2019). Medical literature describes reproductive health as an organizational structure that encompasses maternal and child health services, family planning, miscarriage, sexually transmitted infections, post-natal illness, maternal and child health are all linked with one another (Dudgeon & Inhorn, 2004). RH treatment is a set of strategies, approaches and behaviors for the well-being of both reproductive and sexual wellbeing by avoiding and addressing the challenges involved in strengthening reproductive and sexual relations (Khan et al., 2009).

#### **Overview of Pakistan in Relation to Health Reproductive**

The population of Pakistan is over 180 million (PRB 2009) consisting the ratio of 102 males per 100 females (NIPS and Macro international Inc;2014), 65% people are living in rural areas (UNDPESAPD,2008),20 % couples choose to delay or limit their birth and almost one in the total fertility rate 3.8 is unexpected pregnancy, with an average birth-spacing time of 28 months. The contemporary use of contraceptive methods is around 26% with permanent (female sterilization), less

successful (condoms) and traditional (withdrawal) perspectives being the most common (NIPS and Macro International Inc, 2014). The paternal system of society works all levels in Pakistan to put women in more unassertive role than men (Ali et al; 2010). Pakistan ranks nearly the lowest of the countries surveyed on gender inequality, ranking 134 out of 135 countries, according to the 2012 Gender Disparity Survey (Hausmann, Tyson, & Zahidi, 2012). In order to strengthen important maternal and reproductive health metrics, it is also recommended to discuss the problem of women's empowerment (Bhutta et al., 2013). Despite of regular development in several indicators of health, the population of Pakistan's reproductive health status remains below when it is compared with the similar countries having similar socio-economic aspects. Government of Pakistan in 2017 declared that despite of progress in population and health, Pakistan remains one of the poorest of the region performers against Millennium Development Goals (MDGs), targets.

Globally 292,982 women died in 2013 as the result of complications related to pregnancy and more than 50% of all maternal deaths were in only six developed countries, as well as in Pakistan (Hogan et al., 2010; Kassebaum et al., 2014). According to Pakistan's National Policy<sup>1</sup> Reproductive and Healthcare Rights Act 2013, women have a right to information on reproductive health care. Information on reproductive healthcare should be offered to women, which gives understanding of the emotional and physical health and well-being of individuals and communities. Under the Act, women have the right to ensure that choices on sexual life are taken with informed consent and the right to increase public awareness of the occurrence and effect of morbidity and mortality and the provision of medical research to prevent this misery.

Objective of the study was to explore the “culture of decision-making practices regarding reproductive health of women of age between 15-49 years”.

## **MATERIALS AND METHODS**

For this research, case study analysis was applied. The explanations for introducing a case study approach in particular are that: (a) the study identifies with rural native and disadvantaged women who have deep socioeconomic, cultural and religious values and are not interested to seek health care services; (b) it attempts to collect rich and high-quality data describing the phenomena, factors and meanings of their beliefs;

**Locale of study:** Field analysis was carried out in Punjab's area; Jampur which is in District Rajan Pur. Jampur is the tehsil headquarters in District Rajanpur, Punjab, Pakistan. The researcher chooses Jampur because Jampur is a backward area the people are less educated, and they have the lack of awareness regarding reproductive health. The other main reason is that they people blame women for infertility regardless it's in men. The research objectives are related to the issue of reproductive health and other knowledge associated to the resources accessible to the people of the same region.

**Research Design:** This research used a hybrid technique approach, [qualitative] for data processing and data interpretation. Between April-2019 and April-2020, field work was carried out and the duration was broken into two stages.

**Sampling:** To engage the participants for analysis, purposive and snowball sampling the researcher was carried out. Through snowball sampling his first respondent referred him to the next then with the help of purposive sampling the researcher selected those participants who actually were concerned to his research question and objective. The organized selection of participants came up to with a basis for the collection of ample information affiliated to the subject area of the study (Patton, 1990) and maximum diverseness among the participants of the study (Kielmann et al., 2011). Age and educational achievement levels of young people were used as sampling criteria in both rural and the urban areas as a sampling strategy for data collection. Through interviews, uneducated, less skilled and educated females aged 15-49 with at least one infant were selected on the sampling criterion.

**Tool:** i- Participant Observation, ii- Key informants, iii- Interviewing: formal and in-depth interviews, iv- Focus Group Discussion, and v- Field Notes, Daily Diary and other A.V. recordings were the main tools and methods used for data collection. In order to get data from the individuals in the community through first hand data gathering, the researcher used to observe community by living with the people in the same community. Key informant is a key person and a native of the research study area. Interview is used to gather data by face-to-face talk. It is also used for observing the talking expressions of the respondents. Through interviewing, ideas and opinions, behavioral traits and body language were observed. In the focus group discussion 7 to 8 people were involved in discussion at a

time and on one point. Field notes have been basically used to capture the main information and activities on the research area so that it could be memorized. These all tools play a vital role in this research and with the help of these tools, researcher cross check the data validity.

## RESULTS AND DISCUSSION

Decision making has an important role and a strong impact on sexual and reproductive health of a woman. To evaluate the direct involvement of women in decision making process or other authorities responsible for decision making about their sexual and reproductive health, the question had been set. Discussion made it clear that in the process of decision making, the roles of husbands, family heads, mother-in-law and grandparents were more obvious, and they seemed dominant in this perspective

The Study data also reveals that polygyny is also a main reason for less decision-making power of women related to their health. The results showed that women in polygynous relationships go through more difficulties while contributing to decision-making process related to access to maternal healthcare. Several healthcare providers that were interviewed reported that less involvement of women in decision making process related to the use of pregnancy or delivery care services is becoming a great challenge in improving maternal healthcare. The previous studies showed that age, education level, earning (Wahaga, 2018), living status as working or non-working (Moma et al., 2014) also affect the decision-making autonomy of women.

**Table No. 1 Decision Making Authority**

Final Decision-making authority	N	%
Husband	18	43
Mother-in-law	12	28
Husband and mother-in-law (Collective)	7	17
Traditional birth attendant	2	5
Self	3	7
<b>Total</b>	<b>42</b>	<b>100</b>

The responses were set categorically, keeping in mind which authorities can be involved in decision making process. About 43% respond that their spouse (husband) has the final decision-making authority. While 28% of the respondents that comprises 12 women respond that decision-making authority is their mother-in-law. 17% responded that the family took collective decision. Traditional birth attendant has also some involvement in the decision-making process related to the reproductive health. Two women (i.e., 5%) out of 42 were directly in decision making process related to their health and 7% said they decide their self. The analysis shows that the husband has more and a greater influence in the decision-making process. While mother-in-law is also considered a strong influence as a decision-making authority.

The system of decision making was badly male dominating, so it did not give timely access to health care of women. In addition, decision making was culturally rooted, therefore it caused a delay in health seeking. As a result, the mothers had to use traditional medicines, home remedies and spiritual methods as an alternative system. A woman told during the interview.

*“When I have to go for my check-up, I talk to my husband about it. If he cannot find time due to busy schedule, I go to the lady doctor with my mother or brother. I get checked up three to four times during pregnancy. Because the health of the mother will be good, the child will also be born healthy. But it is our tradition that permission must be obtained from the husband. If the husband is not at home, it is necessary to get permission from the mother-in-law or any elder of the home.”* (A educated urban woman age 29)

A woman told in FGD

*“It’s the part of our culture. If a woman goes to the lady doctor or hospital for a check-up, she has to tell, her husband or many other elders of the family because the husband is the guardian and responsible of a house. Acknowledging his decision is considered a sign of honor. That way, the woman is safe, because the family knows where she is and why”.* (A educated Rural woman age 28)

Some women had the point of view that there should have been no restrictions on health issues. According to them, there was a lot of change now women were aware of their health and could make their own decisions. A young mother said in this regard,

*“I live in a joint family. My husband works abroad. I make my own decision at home. My in laws do not interfere much. I tell my husband on the phone if I have to go to the doctor. I visit the hospital after getting permission from him. If there is a collective matter such as a marriage ceremony or to give something to someone on an occasion. I must consult my in-laws. But I decide for myself about my health and children.” (Matriculate Woman age 22).*

It was observed through this FGD that such behavior of men was normal thing for all those women because they considered it integral part of customs and traditions. The dominating role of men or joint family was daily routine for them. They did not take it as a discrimination against them. It was found that inequality and an imbalance existed in the society. A women should not exclude herself from this decision-making process especially in terms of health right. In short, if men were given the complete authority of decision making, it turned itself into gender inequality that is considered static feature of society and enforced by imbedded social structures and results in the construction of constraints associated with women autonomy (Ali, et al., 2011; Omer, Zakar, Zakar, & Fischer, 2021). In the same discussion a woman said,

*“If men forbid us to do something, we have no right to ask them why? Because in our culture, man is considered a virtual god. Therefor it is very bad to disobey his orders. That’s why women are not included in men’s decision making”.* (Uneducated Rural Woman age 37)

If their husbands could not afford their expenses, they also could not decide about their health independently. So, they had to obey their husbands and nothing else. In this way, traditional belief system of relying on family and adopting traditional treatments became stronger. It means economic rheostat of men and women dependency on men for economic purpose led to strengthen power of men in patriarchal system as well as women’s subordination and their dependent position too (Scott, 2009).

During the study, it was observed that man had a powerful role in household activities. A man had to perform his role in many aspects such as economically politically socially, culturally and spiritually. Besides this, he had the responsibility to take good care of his wife in prenatal, natal and postnatal periods. During the interview, when mothers were questioned how much their husbands were supportive in the maternal period. An aggregative response came in front through FGD and interviews. In that culture, a man played a supportive role regarding the Maternal health care in three ways: firstly, economical, logistically and thirdly through Decision Making. Economically and logistic support was the most important aid given by a man relating the maternal health.

A different point of view also emerged in this group discussion. Some mothers said their husbands did not facilitate them economically, so they had to bear the expenses of delivery themselves. There were marrying reason for this one was that their men did not work to earn. Secondly, despite working, their income was very low so they could not meet the expense of delivery. Those women said that they used to sew and embroider for earning or working women supported their husbands on this occasion. A mother shared her experience,

*“My husband is a laborer. His income covers the household expenses. When the time comes for the baby to be born. I do sew myself to save money and participate in a kitty in the village. This money comes in handy during delivery time.”* (An uneducated rural woman 34)

It was observed during the group discussion that overall pinion of women was that man had to fulfill the responsibilities outside the house therefore they did not help out in household chores especially related to kitchen. A woman told in an interview that her husband never helped in housework. A participant mentioned that in area of Jampur second marriage was a common practice. A woman shared her case study related to this point in FGD,

*“I am the first wife of my husband. He remarried although I have children, a son and a daughter also. But still he got remarried. The second wife lives separately. After the last pregnancy I gave birth to a son. In the early 2-3 months of pregnancy my husband visited me but after that he did not come back. He stayed with his second wife. I had a hard time to cope with daily routine. He came to me at the time of delivery. I am a working lady. He knows well that I can bear my expenditures. He visited me but spent no money. In those days when I suffered immense pain, I used to call my mother or sister for support. They also helped me out at the time of delivery. Two marriages can be beneficial for a man but not for wives. Jealousy arises between them no matter what.”* (Educated woman age 32)

During this study some educated women shared their point of view that these was nothing wrong with men helping their women for short time but ultimately, it was the responsibility of women

comparatively they could do house chores better. Overall, this point popped up that the duty was given to someone among the relatives of man or women to assist the pregnant women in this time period. During pregnancy a young sister or sister-in-law helped out while at the time of delivery and afterwards, the role of mother or mother-in-law proved effective and beneficial. And all this was done according to the man's decision. Generally, this wheel process was considered the essential part of culture which was happening from the far past. It was taken and followed as a good value in the community (Miranda, 2005) A woman supported this discussion and said,

*“Personally, I do not like my husband working in the kitchen and washing the clothes. It is in our culture that mothers or sisters help out in maternal period. I am in favor of this. We must uphold the good traditions of our elders on this occasion. Not that the house chore was given to husband”.*

(Rural Woman age 33)

It was observed during the study that the role of TBA was significant traditionally regarding the decision making, especially concerning maternal health care. Families consulted TBAs to take the decision about mother's prenatal and postnatal checkups. When would the checkup be made? Where and from whom it would be done etc. It was noticed that in this process usually mothers did not participate, and everything was discussed with husbands, mother-in-law and TBAs. This belief was found in the community that pregnancy should not be exposed in early 2-3 months so that mother could be protected from evil eye. Because some people could use amulets to harm the mother and the baby due to jealousy. One Mother told IDI,

*“Pregnancy is initially kept secret in our family and it is not allowed to go outside the house. These are precautionary measures taken to be safe against jealousy found in relatives and fear of black magic and demons. Actually early 2-3 months of pregnancy are most important for baby's development and these evil deeds can put the mother and the baby on the risk. We also do ultrasounds after three months because in there early months the rays of ultrasounds are harmful for the baby.”*

(An educated woman urban area age 27)

In interviews and FGD, many women said that they did not take prenatal care in early three months of pregnancy but stayed at homes. Attempts were made to minimize contacts with other homes. Every going to hospitals or clinics was feared of evil eye. During this time period TBA or mother-in-law took care of pregnant mother. It is customary belief to consult with spiritual healers to ward off evil eye or influence of evil spirits directed against pregnant women and elder of family, very often mother-in-law or any other female take, this responsibility (Odigbo, Eze, & Edem, 2016).

Many pragmatic studies in different background have examined the role of women's pregnancy and decision-making power is assisting access to skilled maternity care (White et al., 2013; Jensen & Thornton, 2003; World Bank, 2011; Bloom et al., 2001; Fotso et al., 2009; Woldemicael & Tenkorang, 2010; Hou & Ma, 2012). the decision-making power of women about their reproductive health and rights (RHR) was causal constituent to achieve reproductive well-being. Studies divulged those women with high decision-making power were more responsible to pursue health care services (Tadele et al; 2019)

Beside the restricted involvement of women in decision-making, in-depth interviews with healthcare providers and women highlight that for attending antenatal clinic or giving birth at a health facility outside the domestic sphere, the women had to seek permission from the husband or another male member of the family. This was a great restriction on women to access and avail the skilled maternal health services.

*“It is customary for men to decide. Because in our religion man has been given this responsibility. He is the owner of our everything. (It was described in local (Languages). Therefore, he has the right to make every decision. His decision is better in every way. If the husband is not at home, its father –in-law or elder brother decides because he is in the father's place. In most homes, men go to work out of city or abroad. In their absence, the decision rests with father-in-law or brother-in-law.”*

Earlier studies explain that in Pakistan, women are unable or restricted to take decision about their education, economical, and social activities, occupation, use of health and medical services. This is due to patriarchal system i.e., male dominance and the dominant customary and cultural barriers on women (Amin 1995; Hakim and Aziz 1998). If a woman has less participation in decision making process in her household, she will be refused to use maternal health services if she was disheartened by her husband or household head while using the health care services (Mumtaz and Salway, 2007). Results of present study are consistent with the findings of Mumtaz and Salway, (2007) who

suggested that except husband and wives who are personally and directly involved in the process related to pregnancy and antenatal care, the authority to make decision still lies with the elder lady of the family i.e. mother-in-law.

Most of the women observed during participant observation and their responses unfolded it that they suffer lot of problems while approaching skilled maternal health services at health facilities. It is the outcome of lack of freedom they have to take decisions even in the situations when they need and want to seek Medi-care. Furthermore, women expressed that though they were expected to upbring their pregnancies and give birth to normal babies, the right to take decisions related to pregnancy and birthing care is not wholly theirs. In consequence, these powers are distributed among intricated system of actors. Where husband and mother -in-laws have the ultimate decision-making authority.

A mother said,

*“My family is educated and I have passed matriculation myself. The mother in our family give birth the babies at home because in case of going to hospital, doctors do not wait for a normal delivery. They instantly switched to surgery which is costly for sure. It also affects mother’s health and cause pain in stomach and back. Once it is operated, normal delivery is not possible again.” (Urban women age 28)*

Results also showed that some women disobeyed the decisions posed by their husbands and mother-in-law in the scenario when they needed the health care services and they (husband or mother-in-law) were against the utilization of health facility. Others responded that they seek permission to access the health care services from their husband with the help of an honorable relative or a powerful member.

Most of the women who challenged the decision of their partner and mother-in-law were younger and between the age of 20-30 years. This is because they had some formal education level that made them aware of their health and healthcare services. They were somehow financially independent and involved in income generating activities which empowered them for decision making concerning their reproductive health. A study conducted on women’s autonomy in health care decision-making in developing countries concluded that educated women are more informed or aware about their health and are more confident than less or uneducated women (WHO, 2014).

A woman told during the interview

*“I am an educated mother and doing job in NGO. When I have to go for my check-up, I talk to my husband about it. If he cannot find time due to busy schedule, I go to the lady doctor with myself. I get checked up three to four times during pregnancy. Because the health of the mother will be good, the child will also be born healthy. (Urban women age 25)*

## **CONCLUSION**

Reproductive health of women and the decision related to it and about health care services are of high importance. The Pakistani society mostly practices the patriarchal system that ultimately shows that the male members have more decision-making power than females. Rather the women are also dependent on the male members for the decisions related to many aspects of their life and about their reproductive rights. The decision-making power is directly related to the reproductive health and access to the maternal health services. The decision-making authority is dispersed in a network. Few women have independence to take their decisions pertaining reproductive health. The analysis also figures out that husbands have a greater decision-making authority and then the mother-in-law has the authority to make final decisions. While mother and traditional birth attendant has a lesser role in decision-making. Besides patriarchal system, traditional religious and cultural barriers are also considered as a factor that lessen the utilization of modern health care services. The less involvement and dependency on other members in decision making process also contribute to the reproductive illness of women. Polygynous marriages that are highly practiced in the society also contribute to ignorance of reproductive health services and rights of women. Less involvement of women in pregnancy care services is also being a challenge for improving maternal health care. While decision making power of women about RHR is essential for their well-being.

**ACKNOWLEDGMENTS**

This paper is contributed by the first author (Altaf Ghani) and it is a part of his Ph.D. dissertation. The author is grateful to his research Supervisor Dr. Zamri bin Hj Hassan and Dr. Dolly Paul Carlo whose efforts enabled him to do such work

**FUNDING SOURCE**

No funding source is available for this manuscript.

**REFERENCES**

- Ali W, Fani MI, Afzal S, & Yasin G. (2010). Cultural Barriers in Women Empowerment: A Sociological Analysis of Multan, Pakistan. *European Journal of Social Sciences* 18: 147–155.
- Ali, T. S., Krantz, G., Gul, R., Asad, N., Johansson, E., & Mogren, I. (2011). Gender roles and their influence on life prospects for women in urban Karachi, Pakistan: a qualitative study. *Global Health Action*, 4(7448).
- Ameyaw EK, Appiah F, Agbesi CS, & Kannor P. (2017). Contraceptive Use in Ghana: What about Women Empowerment? *Advances in Sexual Medicine*. 7: 44–64. 10.4236/asm.2017.71004
- Amin S. (1995). *The Poverty-Purdah trap in rural Bangladesh: implications for women roles in the family*. Working Paper, Research Division. New York: Population Council.
- Bhutta ZA, Hafeez A, Rizvi A, Ali N, Khan A, et al., (2013). *Reproductive, maternal, newborn, and child health in Pakistan: challenges and opportunities*. Lancet.
- Blanc AK. (2001). The effect of power in sexual relationships on sexual and reproductive health: an examination of the evidence. *Stud Fam Plann*;32(3):189–213.
- Bloom SS, Wypij D, & Das Gupta M. (2001). Dimensions of women's autonomy and the influence on maternal health care utilization in a North Indian city. *Demography*, 38(1):67–78.
- Darteh EK, Doku DT, & Esia—Donkoh K. (2014). Reproductive health decision making among Ghanaian women. *Reproductive Health*. 11:23 (1–8).
- Dudgeon, M.R., & Inhorn, M.C. (2004). Men's Influences on Women's Reproductive Health: Medical Anthropological Perspectives. *Social Science & Medicine*, 59(7), pp. 1379-1395
- Exavery A, Kante AM, Jackson E, Noronha J, Sikustahili G., Tani K., et al. (2012). Role of condom negotiation on condom use among women of reproductive age in three districts in Tanzania. *BMC Public Health*. 12:1098: 1–11. 10.1186/1471-2458-12-1
- Fotso J, Ezech CA, & Essendi H. (2009). Maternal health in resource-poor urban settings: how does women's autonomy influence the utilization of obstetric care services? *Report Health*. 6:9.
- Haile A, & Enqueselassie F. (2006). Influence of women's autonomy on couple's contraception use in Jimma town, Ethiopia. *Ethiop Health Dev*. 20 (3): 145–151.
- Hakim A, & Aziz A. (1998). Socio-cultural, religious, and political aspects of the status of women in Pakistan. *The Pakistan Development Review* 37: 727–46.
- Hakim A, Salway S, & Mumtaz Z. (2003). Women's autonomy and uptake of contraception in Pakistan. *Asia Pacific Popul J*;18(1):63–82.
- Hausmann R, Tyson LD, & Zahidi S. (2012). *Insight Report: The Global Gender Gap Report 2012*.
- Hogan MC, Foreman KJ, Naghavi M, Ahn SY, Wang M, et al. (2010). Maternal mortality for 181 countries, 1980–2008: a systematic analysis of progress towards Millennium Development Goal 5. *Lancet* 375:1609–1623.
- Hou X, & Ma N. (2012). The effect of women's decision-making power on maternal health services uptake: evidence from Pakistan. *Health Policy Plans*. 42:1–9.
- International Labour Organization. (2009). *Global Employment Trends for Women*. p43.
- Jensen R, & Thornton R. (2003). Early female marriage in the developing world. *Gend Dev*. 11(2):9–19.
- Jose MJ, Fathima FN, Joseph SN, Fernandez AC, Siangshai S, Vadakkan N, and Agrawal T. (2019). Knowledge regarding reproductive health among women of reproductive age group in three sub-centre areas of a primary health center, Sarjapur, Bengaluru, Karnataka: a cross sectional study. *Int J Community Med Public Health*; 6:4082-7.
- Kassebaum NJ, Bertozzi-Villa A, Coggeshall MS, Shackelford KA, Steiner C, et al., (2014). *Global, regional, and national levels and causes of maternal mortality during 1990-2013: a systematic analysis for the Global Burden of Disease Study 2013*. Lancet.



- Khan, M. M., Zafar, M. I., Ali, T., & Ahmad, A. (2009). Effect of Socio-Economic, Cultural and Demographic Factors on Woman Reproductive Health. *Pak. J. Agri. Sci*, 46(4), 308-314.
- Koon AD, Nambiar D, & Rao KD. (2012). *Embedding of research into decision-making processes: background paper commissioned by the alliance for health policy and systems research to develop the WHO health systems research strategy*. Alliance Health Policy Res 2012
- Ministry for Foreign Affairs of Finland. (2010). *Freedom to Choose: Sexual and Reproductive Health and Rights in Finland's Development Policy*. p13.
- Miranda , R. L. (2005). *Impact of women's participation and leadership on outcomes*. Expert Group Meeting on Equal participation of women and men in decision-making processes.
- Moma C, Mfoumou C, Zibi M, & Lebailly P. (2014). Opportunities and challenges of women cassava producers inbityili (South-Cameroon) and the implications for gender roles. *Fifth Int Sci Agric Symp*. 6(10):1092–9.
- Mumtaz Z, & Salway S. (2007). Gender, pregnancy and the uptake of antenatal care services in Pakistan. *Sociology of Health & Illness* 29: 1–26.
- National Institute of Population Studies Pakistan and Macro International Inc. (2014). *Pakistan Demographic and Health Survey 2012–13*.
- Obermeyer C. M. (2013). *The Cultural Context of Reproductive Health: Implications for Monitoring the Cairo Agenda*. Retrieved from: <https://www.guttmacher.org/article/2013/11/cultural-context-reproductive-health-implications-monitoring-cairo-agenda> Access date: 28 10 2020
- Odigbo, B. E., Eze, F. J., & Edem, A. B. (2016). Social Marketing Tools Employed For Correcting Harmful Traditional Maternal Health Practices In Cross River State, Nigeria. *International Journal of Innovative Research and Advanced Studies*, 3(11).
- Omer, S., Zakar, R., Zakar, M. Z., & Fischer, F. (2021). The influence of social and cultural practices on maternal mortality: a qualitative study from South Punjab, Pakistan. *Reprod Health*, 18(97).
- Oronje RN, Crichton J, Theobald S, Lithur NO, Ibisomi L. (2011). Operationalizing sexual and reproductive health and rights in sub-Saharan Africa: constraints, dilemmas and strategies. *BMC International Health and Health Rights*. 11(Suppl 3): S8.
- Population Reference Bureau (PRB). (2009). *World Population Data Sheet 2009*.
- Reinicke WH, Francis MD, Jan MW (eds). (2000). *Critical choices: The United Nations, networks, and the future of global governance*. Ottawa: IDRC
- Scott, A. S. (2009). Patriarchy, masculinities and health inequalities. *Health policy and public health*, 23(2), 159-160.
- Tadele, A., Tesfay, A. & Kebede, A. (2019). Factors influencing decision-making power regarding reproductive health and rights among married women in Mettu rural district, south-west, Ethiopia. *Report Health* 16, 155. <https://doi.org/10.1186/s12978-019-0813-7>
- UN. (2017). *Unite to End Violence Against Women. United Nations Secretary General's Campaign* <http://www.un.org/en/women/endviolence/pdf/VAW.pdf> (Accessed March 21, 2017)
- UNFPA. (2020). *Women's reproductive decision-making worldwide - one quarter of women cannot refuse*. Retrieved from: <https://www.unfpa.org/press/unfpa-study-shows-limits-womens-reproductive-decision-making-worldwide-one-quarter-women>. Access date: 03-11-20
- United Nations Department of Economic and Social Affairs Population Division (UNDESAPD). (2008). *World Population Prospects: The 2008 revision*.
- United Nations General Assembly. (2000). *United Nations Millennium Declaration*. New York: United Nations. A/RES/55/2
- United Nations Population Information Network, United Nations Population Division, Department of Economic and Social Affairs with support from United Nations Population Fund. (2007). *Guidelines on reproductive health*. New York: POPIN/UNFPA; 2007. Available at: <http://www.undp.org/popin>. Accessed on 27 June 2019.
- Upadhyia UD, and Karasek D. (2012). Women's Empowerment and Ideal Family Size: An Examination of DHS Empowerment Measures in Sub-Saharan Africa. *International Perspectives on Sexual and Reproductive Health*, 38(2):78–89, 10.1363/3807812
- Wahaga E. (2018). The gendered nature of productive and reproductive roles in the agricultural sector. *Int J Dev Sustain*. 7(1):120–46.

- White D, Dynes M, Rubardt M, Sissoko K, & Stephenson R. (2013). The influence of intrafamilial power on maternal health care in Mali: Perspectives of women, men and mothers-in-law. *Int Perspect Sex Reprod Health*. 39(2):58–68.
- Woldemicael G, & Tenkorang YE. (2010). Women's autonomy and maternal health-seeking behavior in Ethiopia. *Matern Child Health J*. 14:988–98.
- World Bank. World Development Report. (2011). *Gender Equality and Development*. Washington, DC: International Bank for Reconstruction and Development and World Bank
- World Health Organization. (2007). *Introducing WHO's sexual and reproductive health guidelines and tools into national programs: principles and processes of adaptation and implementation*. Geneva. Available at: [https://www.who.int/reproductivehealth/publications/general/RHR\\_07\\_09/en/](https://www.who.int/reproductivehealth/publications/general/RHR_07_09/en/). Accessed on 27 June 2019.
- World Health Organization. (2014). *Trends in Maternal Mortality: 1990 to 2013: Estimates Developed by WHO, UNICEF, UNFPA and the World Bank*. Geneva: World Health Organization; 2014.