Asian Journal of International Peace and Security (AJIPS)

Vol. 5, No. 1, (2021, Spring), 129-144

Women's Autonomy in reproductive health decision making: A comparative study of Working and Nonworking Women

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Abstract:

The current investigation aimed to explore the autonomy of working and non-working women in decision-making about reproductive health by concerning demographic characteristics. The study also tried to identify family and societal pressures faced by women within Pakistani society. The current study used a quantitative research design. A cross-sectional survey comprising a sample of 200 women (n=100 working and n=100 non-working women) between the age of 15-49 years was recruited from different areas of Lahore through the convenient sampling technique. A self-built scale containing 91 elements created on the Likert scale was used to quantify women's autonomy. It was hypothesized that there was a relationship between the autonomy of women and the work status. It was also hypothesized that autonomy has a relationship with the women's decision power about reproductive health. The outcomes show an inverse relationship between autonomy and work status of women. Moreover, even a negative association was visible between decision-making on reproductive health and autonomy of women. Limitations and suggestions are also discussed in the study.

Keyword: Autonomy, decision making, reproductive health, working women, family, societal

INTRODUCTION

The Pakistani society is patriarchal with traditional cultural beliefs and values, which has perpetuated gender attitudes and beliefs in people (Sathar et al., 2015). In patriarchal beliefs, women are given less control over their surrounding situations in which they breathe, while men enjoy all the authority to decide in all spheres of life (Ali et al., 2011). Men work in formal settings and fulfill the financial responsibilities of their families therefore, they have a dominating role in decision-making inside and outside the home, while women are restricted to the home for its maintenance and child-rearing practices (Kuo, Volling, & Gonzalez, 2018). The patriarchal system has some standards and values that often create hurdles for females to visit health care providers and restrain their maternal health care needs (Chowdhury et al., 2007; Rahman et al., 2011). Decision-making authority can affect the lives of women and other family members. Individuals

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can determine their well-being by gaining bargaining power through their capacity of autonomy (Buller et al., 2016). Autonomy means the autonomy of women and their ability to decide at large, the ability to influence and control at the domestic level (Peterman et al., 2015), or the capability of the person to get information and to decide about individual secluded and one's intimate matters (Agarwala & Scoot, 2006; Jejeebhoy & Sartre, 2001; Sathar, & Casterline, 2001).

In Pakistan, women's autonomy is influenced by factors associated with reproductive health decisions that include the birth of many children due to preference of son, which may cause high infant/child mortality (Guilmoto & Tove, 2015; Basu & De Jong, 2010; Saeed, 2015). Consequently, if women have little power to decide her domestic sphere, but her spouse or the family head does not allow her to decide about their maternal health, so she is not likely to avail the anti-natal care during pregnancy (Mumtaz & Salway, 2007). Pakistani families are mostly based on the joint family system, which always involved the elder's communication and decision-making (Peterson & Green, 2009). Communication plays a vital role in family planning decision making (Rimal et al., 2002).

With the latest advancement in societies and the introduction of more development programs for the empowerment of women, it was seen that in urban areas, there are diverse job opportunities available for women. This situation should have more possibilities to bring in better perfections in the position of women and even in their autonomy and decision making. The ability to make a decision is more specifying the women's position at domestic setup (Mumtaz & Salway, 2007). With education, job, and better economic independence, women might be given the power to decide on their reproductive health (De Silva, 2000). The demographic features like age, education, occupation, income, family system type of women bring in better autonomy and decision-making power (Sathar & Shahnaz, 2000; Murarkar & Soundala, 2011).

The previous research that worked on the autonomy of women revealed that women's autonomy is associated with certain attributes which might be important for women in using contraceptive methods. On the other hand, few dimensions of autonomy did not find any obvious relationship with contraceptive usage (Rastogi & Nguyen, 2005). Khan and Ram (2009) have seen the autonomy of females in households that involved the ability to decide, permissive mobility, and entrée to financial assets. It was determined that the partner's awareness about their autonomy in the specific area never affects their reproductive behavior as it was well-thought-out that the husband's awareness about the autonomy of their wives may significantly have a stronger impact on the behavior of females related to fertility decision. Bloom et al. (2001) explored different measures and dimensions of the relationship with maternal health care utilization. It showed that higher economic status influenced the women in getting a higher level of antenatal care, and a significant difference was identified at the level of pre-birth maintenance for women either they had faced one or more child death previously.

LITERATURE REVIEW

Sociodemographic factors and women's decision-making authority.

Kinoshita (2003) in his mixed-method approach study, discovered that females have little control to decide about their well-being due to their deprived economic position and the control of men on both secluded and communal areas. Thus, the use of contraceptives was linked to the lack of power of women to make decisions and their socio-demographic factors. It was determined that the

power of females to make decisions in the family was directly associated with the authority to make decisions about family planning, which no one could address exclusively. Therefore, if a female has little decision power in the domestic sphere but is not allowed to decide about the maternal health services, she will be doubtful to practice those services (Mumtaz & Salway, 2007).

According to Woldemicael (2007), based on Demographic and Health Surveys (DHS) of Eritrea and Ethiopia (2002; 2005), opined that most of the indicators of autonomy were imperative interpreters of health care services used by mother and child. Women's autonomy to make decisions about maternity health consumption was greatly impacted by social and economic issues. According to Hindin (2000) while considering the Demographic and Health Survey (DHS) in Zimbabwe, women, who have no autonomy to decide, ought to have more offspring than those females with some autonomy; females' autonomy is important to regulate the fertility process and behavior. Chavoshi et al. (2004) indicated that schooling is a critical variable of females that could predict fertility and contraceptive usage. In contrast, it appeared that both women's autonomy and reproductive behavior are significantly influenced by sociocultural context.

Hou and Ma (2013) used the Pakistan Social and Living Standards Measurement Survey (PSLM) 2005–06 and initiated that the decision power of women had a noteworthy, and helpful association with reproductive health services. While the male domination to take decisions had a different result of her autonomy, following the control of social and financial indicators. The level of education of community members has also played a significant role in making sound and effective prescriptive decisions (DeRose & Ezeh, 2010). They felt that normative decision-making models measured less traditional gender roles to support more innovative fertility behaviors. Abadian (1996) believed that women's autonomy was enhanced due to factors like education and age at marriage; the age gap between spouses and income level harmed fertility and the infant mortality rate, within which urbanization and family planning played a vital role. Women's autonomy varied with more money, more healthcare facilities, and vice versa.

Fotso, Ezeh, and Essendi (2009) conducted interviews with women in Kenya to observe their autonomy and concluded that though family income, education, and demographic predictors are strongly linked with the delivery place, the autonomy of women in decision making and mobility was weaker. Autonomy may not be an important negotiator in developing a relationship between education and the place of delivery. According to Saleem and Bobak (2005), there is no reliable connection between women's mobility, independence, and the use of the family planning process. A strong association has been identified between female education and the use of contraceptives. Sharan, Ahmed, and Strobino (2005) indicated a substantial positive correlation between women's autonomy and utilization of all maternal health care that included pre-birth maintenance, medical delivery place, and postpartum upkeep. Women with high independence from women with low independence had developed opportunities to obtain care in hospitals under the measured impact of social and community variables.

Women's autonomy when it comes to reproductive health.

Many inquiries have investigated the impact of women's autonomy on their multifaced health matters like fertility, birth control, and contraceptive use (Feldman et al., 2009; Furuta & Salway, 2006).

Al Riyami et al. (2004) took help from a national study (2000) in Oman and indicated that 25 percent of women conceived as their husband did not allow them to use contraceptives while this percentage declines significantly when women got the paid jobs and education. Working women utilized more birth control devices, and education of females was a healthier indicator that helped to guess about the importance of birth control devices rather than their autonomy. At the same time, there is a stronger influence of family and society on the use of contraceptives. On the other hand, Ward, et al. (2004) found that the decision of women on largest household expenses was the only significant variable of autonomy in the presence of potential threats, while it also had a weak association with contraceptive use.

Haile and Enqueselassie (2006), based on the opinion of interviews conducted with couples, believed that the variables related to the autonomy of uneducated females did not have any important role in the use of contraceptive devices. Bloom et al. (2001) stated that gynecological visits were carried out more by rich women. Some differences have been observed in the maternity care of working women and contraceptive practices. It has been shown that women who have the freedom of movement use more prenatal care and practice benevolent childbirth care.

To support the argument of autonomy of employed and non-employed women, Paudel and Pitakmanaket (2010) revealed that women who were not doing jobs utilized more health services than working women. There was a great linkage between services related to mother-child care and high educational background, between higher social family position and urbanized household. On the other side, Darteh et al. (in 2014) while working on women's contraceptive decision-making has found a healthier link between the demographic variables of residence, age, educational status, religion, occupation, and education of partners.

The current research seeks to identify and compare the level of autonomy of women in general and working and non-working women in particular after marriage. This work attempts to stimulate further inquiry along the line of action and also to target the overall decisions of women regarding reproductive health including contraceptive use/family planning and maternal health care, in the socio-cultural domain of Pakistani society. Even the impact of demographic factors on the autonomy and decision-making of women was also studied to fill in the knowledge gap in the Pakistani context.

Many previous studies conducted on women's autonomy, did not represent Pakistani culture.This research is carried out in Lahore, the second-largest city in Pakistan. It deeply explored pragmatic facts about the perception of family and the societal pressure that may suppress the autonomy and choices of women in reproductive health decisions. Data were collected from different areas of Lahore, where there was a gap in knowledge about the problems and obstacles associated with autonomy. It will be fruitful for future directions as no significant work has been done in this domain.

Hypotheses

- There is a significant relationship between the autonomy of women and their work status
- There is a significant difference between the autonomy of employed and unemployed women

- There is a significant difference between the decision-making power of working and non-working women and family or societal pressure.
- There is a significant relationship between the decision-making power of working and non-working women about reproductive health.
- Age has a significant impact on the autonomy of both working and non-working women.
- There is a significant difference between a family system and the decision-making power of women about reproductive health.

METHOD

This research was quantitative and selected a survey method to contact respondents. It was a cross-sectional research design. This study approach needs limited resources to gather more information speedily, and it preserves the value of distinguishing the uniqueness of the bigger mass with a small group of contributors (Creswell, 2011). Two hundred respondents, both married working (100) and married non-working women (100) formed the study sample. Respondents were within childbearing age (15-49 years). These sample proportions displayed an equal representation of the whole population.

Measures Demographic Information Sheet

The socio-demographic information was utilized to quantify autonomy among women in the present study.

An instrument to measure autonomy

A self-built questionnaire was utilized to measure women's independence in the current study by using the literature review and help from doctors working in green star centers. This questionnaire contained 91 statements and three sub-sections. The socio-demographic section comprised nine items:age, occupation of women and husband, education of women and their husbands, family income, family system, number of children, and women's work status. The autonomy section contained 12 items to govern the level of autonomy, the power to take economic and movement decisions, and the power to negotiate. The following section was related to identifying decision power for maternal wellbeing with 24 matters, to elucidate when to bear child, contraceptive use, the decision to do child spacing, and decision about general health. The factor connected to the household or social handles that affect device to control birth is also part of the questionnaire with six statements measuring influence of family size, and decisions about the maternal health. The last section contained 30 statements that clarify awareness of the role of norms linked to society and the culture of the female childbearing process in Pakistan. It is five points Likert type scale which is scored according to the following five response categories 1 as strongly disagree, 2 as disagree, 3 as neutral, 4 as agreed, and 5 as strongly agree. The reliability and validity of the questionnaire were checked. The validity of the study tool discussed the competencies of the questionnaire to quantify a hypothesis or variable to be measured (Cresswell, 2011). The Cronbach alpha reliability value of the scale was .75, .75, .80, for the level of autonomy, decision-making power, and perception about sociocultural norms respectively.

Procedure

A self-constructed questionnaire was used to gather data. The first step was to conduct a pilot study with the respondents to check the designed questionnaire for any ambiguity. That sample was not included in the final sample. In the light of participants' opinions, a questionnaire was modified. Then permission was taken from family members to allow women to participate in the investigation. It was ensured to maintain confidentiality and anonymity of data and participants. A total of 200 married women from Lahore was visited and briefed about the aim and purpose of the research after seeking their consent form and gathered demographic data. Then a questionnaire was administered to the participants. The concerns of the participants were addressed while filling out the questionnaire. In the end, the participants were thanked for their cooperation in the study. The result was interpreted and discussed in detail. Respondents took a time duration of 15-20 minutes to fill in the questionnaire at an average. The data was entered, screened, and analyzed by using Statistical Package for Social Sciences for the possible results. The statistical tests like t-test, One way ANOVA, and Pearson Correlation Coefficient were used to find out the mean difference and relationship.

RESULTS

The current research is designed to explore the autonomy of employed and non-employed females in decision-making about pregnancy and childbearing and also tried to identify the family and societal pressures within the Pakistani Society. It also tried to find the impact of age and family system on the autonomy and decision-making power of women regarding reproductive health. The autonomy of women is an important aspect of decision-making. Mean, Standard Deviation, Alpha Reliability, Pearson Correlation, and t-test were used in the present study. The socio-demographic characteristics of the respondents are displayed in table 1.

Table 1

Socio-Demographics of Participants (N=200)

Age of working women	**N**	**Percentage**
15-25 yrs	12	12%
26-30 yrs	28	28%
31-35 yrs	35	35%
36-49 yrs	25	25%
Age of nonworking women		
15-25 yrs	17	17%
26-30 yrs	35	35%
31-35 yrs	14	14%
36-49 yrs	34	34%
Education of working women		
Matriculation	12	12%
Intermediate	18	18%
Graduation	30	30%
Post Graduation	40	40%

Education of nonworking women		
Matriculation	28	28%
Intermediate	22	22%
Graduation	25	25%
Post Graduation	25	25%
Occupation of women		
government job	30	30%
business/commercial	22	22%
doctor/engineer/professor	48	48%
The educational level of the husband		
Matriculation	42	42%
Intermediate	48	48%
Graduation	51	51%
Post Graduation	59	59%
Occupation of husband		
Government Job	44	44%
Business/commercial	48	48%
Doctor/ engineer/ professor,	36	36%
Job abroad	34	34%
Other	38	38%
Number of children of working women		
1-2	70	70%
3-4	30	30%
Nonworking		
1-2	35	35%
3-4	65	65%
Women income		
10,000-20,000,	13	13%
21,000-50,000,	45	45%
51,000-70,000	22	22%
70,000 plus	20	20%
Family system of working women		
Nuclear	45	45%
Joint	40	40%
Extended	15	15%
Family system of nonworking women		
Nuclear	18	18%
Joint	55	55%
Extended	27	27%

Table 1 displayed the demographic data of the respondents. Out of the total 200 samples, 12 working women and 17 non-salaried women were within 15-25 years age bracket. Majority of working women 28 and (35) non-working women belonged to the age group of 26-30 years. While 25 and 34 employed and non-working womenfolk fell in the age bracket of 36-49 years respectively. The majority of employed women (40) did post-graduation while only 20 non-working women did masters. While the majority of non-working women (30) and 25 working women were graduates. The majority of the educational levels of husbands of (59) women were post-graduate. A small proportion of working women (20) were earning more than 70,000 rupees per month while working women (45) were earning less than 50,000. The majority of working women (45) were living in the nuclear family, 40 in a joint family, and 15 in the extended family system. While the mainstream of non-employed females (55) resided within the joint family system. The majority of working women (70) have two children while 30 have more than two children and 35 non-working women have two children.

Table 2

Alpha Reliability of Scales

Autonomy Scale	**Cronbach Alpha**
The determinant of the level of women's autonomy	.75
The determinant of women's decision-making capacity	.75
The determinant of role of sociocultural norms and women's decision making	.80

Table 2 shows Cronbach alpha reliability of the subscales of the Autonomy Scale. The outcomes show that all the subscales have acceptable alpha reliability, hence the subscales in this study have internal consistency and are very reliable.

Table 3

Mean, Standard Deviation and t values of the variance between the autonomy of employed and non-employed women and their decision making in reproductive health (N=200)

	Working women (n=100)		**Non-working women (n=100)**				***95% CI***		
Variables	*M*	*SD*	*M*	*SD*	*t (200)*	*p*	*LL*	*UL*	*Cohen's d*
Level of Autonomy	22.84	4.15	27.36	3.69	-6.56	.001	-5.65	1.49	.49
Decision making power for RH	92.57	14.52	66.31	16.10	9.79	.001	-3.80	5.36	.78
Influence of Family and	51.02	10.34	55.88	11.46	-2.537	.012	-4.76	.684	.35

Societal Pressure	

P< 0.05

1. Table 3 depicts the mean, standard division, and t-test value for the hypothesis that working women are significantly different in autonomy from non-working women. The outcome revealed that non-salaried females (*M*=27.36, *SD*= 3.69) were statistically significantly high on the level of autonomy than employed women with a mean as 22.84 and standard deviation as 4.15 at *t*=-6.56, level of significance as P= .001. The outcomes represented that employed females did not enjoy high autonomy as compared to non-employed women.

2. To regulate that employed females have the power to decide on reproductive health that is significantly different from non-employed women, outcomes showed that working females with *M* as 92.57, *SD* as 14.52 were statistically significantly high in their decision-making power on reproductive health than non-employed women (*M*=66.31, *SD*=16.10) at (*t*=9.76, *P*= .001).

3. A significant difference was visible in the effect of the pressure of household and society in the decision of childbirth and control as faced by both salaried and non-employed females. The results exhibited that there is a significant difference in the scores for employed women with a mean of 51.02 and standard deviation as 10.34 and non-salaried females with *M* as 55.88, *SD* as 11.46) at *t* (128) = -2.537, $p < .012$. The outcomes showed domestic and society pressure impacted the decision about the pregnancy of non-employed females more than the working females

Table 4

The table depicted the Pearson Correlation Coefficient values of the association between autonomy level of women and work status (N=200).

	Women	1	2
Women			
1.Level of autonomy-work status	.496**		
2.Women's level of autonomy- decision making power in reproductive health matters	-.488**	.001	

**. Correlation is significant at the 0.01 level (2-tailed).

Table 4 depicts the r value for the hypothesis that showed an optimistic relationship between the women's autonomy and their working position. Outcomes displayed that there existed a significant relationship between the level of autonomy of women and their work status (r (200) = .496, P<.001). The findings demonstrate that the association between autonomy level of females and their work position appeared as noteworthy at 0.01 α-level. As for the autonomy level and power to decide, the connection was inversely significant (r(200)=-.488, P<.001).

Table 5

Difference between Age and the autonomy of working and nonworking women by focusing on the values of degree of freedom, Sum of a square, Mean square, f distribution, level of Significance

Outcomes	***df***	***SS***	***MS***	***F***	***P***
Effect of age on autonomy of working and non-working women	1	980.1	982.2	0.016	.001
Effect of the family system on the decision-making power of women	1	34479.3	34470.4	146.7	.001

(N=200)

1. To test the hypothesis that age has a significant impact on the autonomy of working and non-working women, a one-way ANOVA was carried out. Table 5 shows a statistically significant impact of age on the autonomy of women [F (1, 197) = 0.016, P=.001]. To see which group has more significance than the other, a Post Hoc comparison was done. Post hoc comparisons using the Tukey HSD test specified that the mean score of the age group (31-35) is significantly different than the age groups (15-25), (26-30), (36-49). Precisely, study outcomes recommend that women within the age group 31-35 show better autonomy than other age groups.

2. To test the hypothesis that there is a significant difference between the family system and decision-making power of working and non-working women about reproductive health, ANOVA was carried out. Table 5 shows that there is a statistically significant impact of the family system (nuclear, joint, and extended) on the decision-making power of women [F (1, 198) = 146.7, P=.001]. To see which group has more significance than another group, a Post hoc comparison was done. Post hoc comparisons using the Tukey HSD test specified that the mean score of the extended family system is significantly different than the nuclear and joint family systems. Precisely, outcomes recommend that women who belong to the extended family system show the power to decide for their reproductive health.

DISCUSSION

The objective of the current research was to explore the difference between the level of autonomy and the decision-making power of reproductive health in women. The three self-structured sub-scales for a level of autonomy and decision-making were used to investigate the autonomy of working and non-working women. Since Pakistan is a patriarchal society where men have all the power to take decisions, while women have little social status, autonomy, and consideration to decide about their family. It is a significant feature that the independence of women to decide when to conceive is tremendously vital for improved mother-child health. So feminist theorists suggest that disparities in societal-level power within a patriarchal society used to produce such a traditional mindset that plays a direct or indirect role to legalize a male-dominated family structure. As a result, males exercise the power and control over women in several ways (Antai, 2011).

The Cronbach alpha reliability of the subscales of the self-constructed autonomy scale used in the current investigation was computed. It varied from .75 to .80, which proved that all subscales had internal reliability and consistency to use.

The first hypothesis was to see the difference between the autonomy of working women and non-working women. The results of this survey showed that female employees and non-employees differed considerably in their autonomy from each other. Nonworking women showed more autonomy than working women. This finding was contrary to the outcomes of Jejeebhoy (2000) who believed that the education and job status of women helped to enhance women's autonomy.

The second hypothesis was to see the difference between the level of autonomy and working status. A significant relationship was evident between women's level of autonomy and their professional status. Nonworking women showed more autonomy in decisions regarding reproductive health than working women. Existing research has revealed that women enjoy greater autonomy and self-awareness in family matters in the modern era. Female autonomy did not change the power of women to make decisions about pregnancy and restriction, while the level of autonomy had a lasting associative status with the women working position. The result was supported by Heaton et al., who inferred that whatever type or form of autonomy, has a significant influence on the social, economic, education, and job position of females (Heaton et al., 2005). The autonomy level is impacted by the awareness about who has the authority to decide for household, for instance, the authority to do expenses, liberty to move outside, and the power to negotiate in homes. Women who do not work, used to breathe in inadequate limits and usually have marginalized authority to decide between homes, so they appreciate being independent enough in such a limited domain. In contrast, employed females with enough awareness about their basic rights are outbound and desired that they must be consulted on every domestic matter in such households where husbands are subjugated.If employed women reside in a joint domestic sphere where other members also retain their influence, they have little independence. This finding was in line with Abadian (1996) work, in which he revealed that enhanced autonomy of women slows down fecundity, infant death, development, but an important role was also exercised by family planning. In the existing investigation, the cause for such a conflicting relationship between autonomy and decision about procreative stuff is the pressure of society and households on females that handled their ability to make a decision. Although being aware of their autonomy to make pregnancy and childbirth decisions, they were unable to exercise their authority to decide due to male-controlled setup**, a** strong society, and cultural factors. Hou and Ma (2011) discovered an encouraging and noteworthy linkage among the power of women to decide on reproductive domains, but dominating authority of male to take a decision produced opposite results.

This finding is contrary to the West (2006); Susilastuti (2003), both opined in their inquiry that the autonomy of women is affected by work status, and their contribution to household income, which made them more important in family and got them more bargaining power. Female participation in fruitful actions also offers openings for women to enjoy more autonomy and improve their decision-making in birth spacing or small family size (Hadi, 2001). This finding is also contrary to Al Riyami et al. (2004) who believed that educated working women did take a decision about their reproductive health than nonworking uneducated women and utilized more birth control devices. Ward, et al. (2004) found that the power of women on decision-making had a weak association with contraceptive use.

The current inquiry tried to differentiate between the power of employed and non-employed women to make decisions about reproductive wellbeing. The results specified that salaried women

exhibited greater power to decide when to conceive, child spacing, and childbirth as compared to non-salaried females. It was proved that despite having great autonomy to make decisions in the family, it did not show any effect on the power of women to take an independent decision about their pregnancy and childbirth. As society and family pressure is less on employed women so they have more power to take their reproductive health decision because they enjoyed independence outside home due to their work position. Whereas women who stayed at home and did not work outside, are financially deprived, and rely on their spouses and others to fulfill their requirements; therefore, their authority to decide when to conceive or bear a child is restricted. Woldemicael (2010) believed that the autonomy of women to decide on their and child health was powerfully influenced by society and the financial position of their husband. Frankenberg et al. (2003); Belch and Willis (2002) also supported that working females played a great role in domestic decision-making. As their work status played a significant role to do the decision-making about reproductive health and childbearing than non-working women.

The findings explored the pressure of household and society on the employed and unemployed women in the current research. The results have proven that the decision of unemployed educated women about when to conceive or bear child often encountered domestic and social pressure as compared to employed females. This outcome was in line with Mumtaz and Salway (2007), who stated that the decision about women's use of health care facilities during pregnancy is mostly taken by the husband, mother-in-law, and society at large.Consequently, the wellbeing of female lies in her linkage to these key domestic relatives. According to Matsumura and Gubhaju (2001) in Pakistan, usually, the males and elderly members of the family enjoy the decision-making authority, and women have little say in it. According to Drennan (1998), there should be a consultation between husband, wife and other family members regarding reproductive health decisions, as it is positively associated with fertility behavior and helps to promote women's involvement in reproductive health decisions that lead to improving health care practices.

The outcomes of research show that there is a significant impact of age and family system on the autonomy and decision-making power of working and non-working women. A significant difference was observed between age and autonomy. The result matches Sathar ant Shahnaz (2000), that age of women and family system structure are the main factors of women's decision power. Older women in the households are more expected than other age groups women to contribute to family decision makings. This finding is in line with Sharma et al. (2012) who observed that women in their middle age were more inclined to use contraceptives as having the power to decide. It is contrary to another study by Murarkar and Soundala (2011) that showed that women in their middle age have more autonomy to use family planning methods than women in their young and old age.

A significant variance was seen among the family system type and the decision-making power of women. The extended family system was a prominent sphere where women exhibited more power to decide on their contraceptive use. This outcome is contrary to the findings of Sathar and Shahnaz (2000), which stated that women in nuclear families are more expected to take part in decision-making about reproductive health and others practices as compared to women in other family systems (joint and extended).

Limitations and Suggestions

The researcher encountered some inadequacies during this research due to methodology and conceptual issues. Results of this study cannot be generalized to the whole population owing to meager sample size. A large sample size to represent the population should be taken to generate a convincing result that could be generalized to the total population. As it was a quantitative study, so misinterpretation of the questions is visible in respondent's responses. It would have been effective to do qualitative research by using interviews and focus group discussions to gather sufficient data from the participants about the variables to guide the credibility of the results. There could be a greater possibility of biased responses as people used to hide the truth-based facts about reproductive health decisions. The research used cross-sectional information, with only difference and the relationship was established. This study could be supplemented by a qualitative study to explain the social settings with types of social and family pressures that influenced the phenomenon under study.

CONCLUSION

It is imperative from the outcomes of this research that improving autonomy and decision-making of females about when to bear a child or use contraceptives could help to lower down the unmet desires. All hypotheses were accepted in the current inquiry. The results showed better autonomy among non-working females and better decision power among working women about reproductive health because working women have more awareness about family planning. The decision making is still the domain of male/husbands in our society about birth-control, household size, and when to visit the family planning. Though women have better job opportunities and education, society and family still have a strong hold and pressure over them. The family system is strong in Pakistan but the traditional mindset about the decision on reproductive health still hindered women's power to decide for their pregnancy or childbirth, to visit a health care facility or not, birth care, and the pregnancy linked decision. It is high time to spread awareness among the community that giving freedom and power to women to decide about their mate and about reproductive health does not mean to shatter the real essence of Pakistani culture and tenets of the religion.

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