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Understanding The Lived Experiences of Women on Reproductive Empowerment in District Mansehra

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ABSTRACT

This study investigates the lived experiences of women regarding the reproductive autonomy and empowerment in District Mansehra of the Khyber Pakhtunkhwa province of Pakistan. Qualitative research paradigm was used wherein in-depth interviews of 20 women purposively selected in rural health center, Basic health unit and hospitals were conducted. The data was thematically analyzed revealing that patriarchal norms, traditional male machismo and dominancy were found as crucial factors potentially determining reproductive empowerment. Economic independence of women and educational attainment of male and female were found as positive contributors to women sexuality, bodily autonomy and reproductive choices. It is concluded from the study although reproductive health, choices, and empowerment is culturally sensitive dimension of society, but these could be negotiated with social indicators including education, financial autonomy and community level awareness. The present research presents crucial insight into how to improve reproductive autonomy of women by formulating evidence based policy recommendations and stakeholder sensitization.

Introduction

Reproductive empowerment can be defined as the right of people and notably women to make informed and voluntary choices and decisions concerning their reproductive health such as birth control, pregnancy, birth spacing and abortion. It is considered as one of the critical dimensions of gender equality and women empowerment that has developed over centuries in legal discourses and socio-political struggle (Gammage et al., 2019). Reproductive empowerment as a gender justice issue was reshaped with the help of feminist movements that took place in the 1960s and

1970s. Planned Parenthood and activists such as Margaret Sanger focused on the accessibility to birth control as the key to women liberation. According to the argument by the feminist scholars, reproductive control was at the heart of financial autonomy of women, educational achievement and political involvement (Ginsburg & Rapp, 1995). Reproductive justice is a term coined by women of color in the 1990s, which broadened the discussion to cover the social, racial, and economic factors capable of influencing reproductive decisions (Ross, 2006).

Reproductive empowerment of women has been remained on the central stage as the Sustainable Development Goals (SDGs 5) specifically aim to empower women, making it a top priority for national and international development (Roy & Xiaoling, 2022). Although international forums and organizations have advocated reproductive empowerment of women however the policies are not being executed in letter and spirit thus demanding for more practical interventions in this regard (Dwivedi et al., 2022).

Pakistan being a country of over 240 million people have witnessed poor results in the arena of gender equality especially the reproductive autonomy and empowerment of women significantly affecting health and social indocators. In this regard, the rural, poor and conservative segment of population in the country are worsely affected. Male family members, including as spouses, fathers, and in-laws, frequently make important reproductive decisions on behalf of women where gendered inequality of power frequently affect women health, body and sexuality.

According to Pakistan Demographic and Health Survey (2017), contraception and family planning remains low especially amongst the rural communities. The using of contraception is much lower in rural districts in Pakistan in comparison with cities. This is in addition to the inaccessibility to the services of reproductive health aggravated by the societal judgment that forces the women not to use contraception due to concerns about religious values or fear of getting labeled as inappropriate. The findings of study by Fikree et al. (2005) revealed, rural Pakistani females do not consult family planning units due to cultural beliefs that support large families and view the practice of contraception as unsolicited or invalid. Furthermore, sexual abuse, coercion to have a child, and prevention of birth control are common to women in communities dominated by men where conservative thinking about gender stereotyping of women tends to thwart women choices (Dyson, 2022). Besides compromising reproduction rights of females making, it difficult to take decisions in relation to fertility, such forces of violence also increase other mental dysfunctions detrimental to human health such as stress, anxiety, and despair. According to the United Nations Population Fund (UNFPA, 2019), reproductive compulsion where women are threatened or otherwise forced to get pregnant or not get pregnant using contraception is still a massive gross violation of gender human rights and a great challenge to the realization of the equal opportunity in the reproductive arena.

Literature Review

Reproductive violence against women is a complex and widespread issue that requires a comprehensive understanding and effective solutions (Lewis et al., 2022). Studies have shown that reproductive violence can take many forms, including pregnancy coercion, contraceptive sabotage, reproductive exploitation, and denial of reproductive healthcare (Pakistan Demographic and Health Survey, 18). Research has also highlighted the role of intimate partners or family members in perpetrating reproductive violence (World Health Organization, 2013).

Reproductive violence is described by many scholars who outlined that any form of pressure or dissolution of reproductive health, including forced pregnancy and rejecting contraception and unwanted sex (Moulton et al., 2021). Reproductive coercions have been linked to increased rates

of unwanted pregnancies, illegal/ unsafe abortions and poor maternal health conditions (Gage & Hutchinson, 2006). Reproductive empowerment (RE) is a significant and broader concept within the domain of women's empowerment (Vizheh et al., 2021). It refers to a dynamic shift where individuals strengthen their ability to make independent and informed choices concerning their reproductive health and future (Kabeer, 1999). This empowerment includes engaging actively in conversations about reproductive matters, exercising autonomy over personal decisions and achieving reproductive goals without experiencing intimidation, coercion, or violence (Malhotra et al., 2002).

Autonomy during reproduction is meant to ensure that women exercise their control over their bodies without fear, discrimination or then coercion. It extends to the power of making own choices concerning reproduction (O'Brien & Newport, 2023). Besides leading a healthier life and being more educated on physical and mental health, empowered women who choose reproductive options to reflect their desires and medical requirements are also freer and more autonomous in their everyday lives (Wilson, 2015). Access to modern family planning is crucial for promoting reproductive health, yet millions of women worldwide lack this essential healthcare service. Family planning plays a vital role in minimizing maternal deaths by preventing unintended pregnancies, eliminating unsafe abortion practices, and encouraging healthy pregnancy outcomes (Singh et al., 2019).

Reproductive empowerment of women reproductively is affected by many factors such as socio-cultural norms, education, economic independence, family support and access to healthcare (Gilani et al., 2022). Up-to-date figures and facts involving the topic of reproductive health in Pakistan are as follows: Contraceptive Use: The present rate of contraceptive use in Pakistan stands at 35% with an unmet demand of family planning at 20 percent. The number of children born per women is approximately 3.8 (National Institute of Population Studies, 2020). Institutional Delivery**:** A study revealed that the rate of institutional delivery in the countryside is approximately 44.82 percent. Better educated women have higher chances of institutional delivery and the ones who have done antenatal visit (Ahmed et al., 2021). Antenatal Care**:** Approximately, 50.54 percent of women fail to contact antenatal care in time and 49.46 percent have at least four antenatal visits (Pakistan Demographic and Health Survey, 2017-18). Access to Healthcare: In Gilgit-Baltistan, Pakistan, almost 64.6% of the deliveries are carried out in the health facility. The postpartum hemorrhage and late neonatal mortality decrease when Lady Health Worker (LHW) makes home visits (Rizvi et al., 2021).

Purpose of the study

The overarching goal of this study is to understand the lived experiences of women on reproductive autonomy, empowerment and choices. Further, this will also docuemnt the underlying factors reinforcing the reproducitve violence and coercion. The study also aim to underscore the impact and barriers in the way of reproductive empowerment of women in the targeted locales.

Research Method

A qualitative research paradigm was used to carry out an in-depth exploration of ideas, experiences, knowledge of women with regard to reproductive health, choices and practices. In the context of this study, qualitative paradigm specifically provides a better understanding about the knowledge, experiences, impact and nature of the reproductive violence and reproductive empowerment of women.

Study Locale

The broader locale/universe of this study is district Mansehra within Hazara Division of the Khyber Pakhtunkhwa province of Pakistan. In this connection, two public sector hospitals were selected including King Abdullah Teaching Hospital, Mansehra and Tehsil Head Quarter Hospital in Balakot. Furthermore, rural health centers including Khawajgan Road Mansehra, Rural Health Center Hussainabad Mansehra alongwith basic health units Baffa, Basic Health Unit Jabri. 2) Rural health center Attershisha. Those sites were selected purposively because of the large number of women attending these health sites on daily basis and it was easier for the researcher to conveniently access the study participant. Data collection procedure was facilitated by female field workers.

Sampling and Sampling Size

Purposive and snowball sampling were used to select responedent in the targeted locales. A total of 20 women were Interviewed until data saturation, or when no new information was discovered. Women between the ages of 18 and 45 were included in the sampled respondents especially those willing to participate vulunteerly in the study. Furthermore, key respondents such as midwives, community health professionals, or local female leaders were included in the study.

Data Collection and analysis

Data was obtained through qualitative semi-structured interviews. The interview with open-ended questions was convieneniet for participants to share their ideas, feelings, and experience freely. Some interviews were audio recorded with the consent of the interviewee and subsequently transcribed. Key Informant Interviews (KIIs) was used to gather more data, depending on participant comfort. Female researchers and students were hired to collect the data for which they were specifically trained. The collected data was analyzed while using thematic analysis of six-phase method suggested by Braun & Clarke (2006): Data familiarization, preliminary coding creation, seeking and common trends, examining the topics, characterizing and identifying themes and assembling the report.

Results and Discussion

This section contains in-depth accounts, sociocultural notes, and theoretical remarks as it explores further into the seven sub-themes that emerged during the interviews. The enlarged dialogues which will hereto follow will give us a clearer picture about the reproductive freedom of women within Hazara Division.

Autonomy in Contraceptive Decisions

Ability to select a mode of birth control is probably one of the most blatant signs of reproductive autonomy. However, there are major barriers in the way of women trying to exercise this choice despite increased awareness of contraceptive methods currently available. As per the interviews, most women were aware of contraceptive methods but due to cultural, familial, and societal pressures they were not able to practice them again and again. One of the studies participants, e.g., discussed how punishing it was to her when she was unable to decide regarding contraception:

> *After having my second child, I intended to have my children well-spaced through family planning. I thought that it was essential to the health of my family as well as myself. My husband however disagreed because according to him we were not supposed to limit our family size to a meager number of children and that more children is a blessing. He keeps saying that the bigger the number of children in a family, the better it is. He insisted that we*

> *should have more children as it would make our life happier despite the fact, I wanted to oversee my reproductive health and ensure that I can spaced out my children to develop a better family life.*

Another participant talked about the stigma attached to using birth control:

> *I discussed family planning with some of my close friends. They all agreed that it's best to keep the conversation to ourselves because people will judge us if they hear. According to them, contraception is for people who don't want children, and in our society, that is seen as humiliating and self-centered. When society and my husband's family make me feel awful for thinking about it, it's difficult to make the proper choice.*

These answers highlight how men's power and traditional cultural beliefs shape women's reproductive choices. These results are consistent with the Power and Control Theory, which holds that the more powerful household members—usually men—frequently have the last say over reproductive choices. The idea that "more children are a blessing" perpetuates patriarchal standards that drive women to make choices that suit men's tastes at the expense of their own desires and well-being.

Right to Refuse Sexual Activity

Reproductive autonomy encompasses the training to refuse sexual behavior. A lot of women mentioned, though, that this freedom could not be realized by them as they were bound by their marriage and society and could feel only helpless and stressed. The inability of most of the women to say NO to sexual associations reflected greater equity imbalances between women and men.

One of the participants said the reason behind the emotional burden of having to meet the sexual demands of her husband was because of having to constantly adapt to her husband’s sexual expectations:

> *I need to be available, even when I am not feeling well or when I am so tired. In the opinion of my husband, declining him is impolite. He thinks he is being deserted and starts accusing me that I do not love him when I do reject. This makes me feel so compelled to reply yes even when I do not feel like doing it, always. I think this powerlessness makes me feel out of control in my own body, and it gets to be tiring. Apparently, my emotions do not matter in matters relating to intimacy.*

The more optimistic sexual autonomy perspective in a core supportive partnership was presented by another participant:

> *My relationship with my hubby is very respectful and very open. He does not mind my decision when I am exhausted or do not feel good. We do not hide what we want, and he does not pressurize me to indulge in sex. Due to our equality of respect, I feel secure and comfortable in such an environment. I feel empowered because I have power over my body, and everyone understands that my emotions matter within the relationship.*

Even the experiences of women in supportive marriages and those whose marriages were controlling were rather different, and this is why emphasis should be put on the role of communication, respect, and joint decision-making in enhancing reproductive autonomy. Such findings cohere with the feminist theory, which acknowledges the ownership of females to their bodies and the usefulness of consent in both partners in any intimate association.

Supportive and Controlling Relationships

The dynamics of marriages were established as very influential on the side of women in the exercise of reproductive autonomies. Whereas the partners who were associated with controlling partnerships were emotionally distressed and helpless, the ones in supportive marriage felt better able to manage their reproductive health.

The same holds true in the case of one woman in a domineering marriage who recounted how she had to be unable to make her own reproduction decisions:

> *My husband and his mother decide everything about our children even when they are supposed to be born. I am not the person who can decide the number of children to be born to us and whether we should employ birth control methods. Personally, I am invisible in my own marriage. I am just expected to trail behind as they give all the major decisions of my life. I become depressed as I feel that my wants and my thoughts are not significant.*

A woman in a more supportive relationship however said:

> *Decision making in my case is done together with my spouse. We are both in concurrence on such important matters as family planning and my partner does not ignore my opinion. I feel secure because I know that I am not alone as we are also in it together and we both have a responsibility to bring up our kids. I feel stronger since I never get the feeling that I have been the sole maker of these decisions. We discuss the choices regarding birth control, and I am heard. I strongly believe that a respectful marriage could lead to a more acceptable reproductive environment in which both spouses will find themselves in.*

The psychological ties that overbearing relationships may have on women have been portrayed through these contrasting stories. Women in positive relationships will give high scores in emotional well-being and empowerment whereas women in controlling relationships are prone to give scores in loneliness, dissatisfaction and sadness.

Emotional and Psychological Impact

Lacked reproductive choice has major emotional and psychological consequences. Most women expressed feelings of loss, powerlessness and desolation when their views were not considered during decisions on the reproductive aspect.

One of the members shared about her emotional problems:

> *I can say that I cannot control my life, and this is why I often cry. All I must do is take a day off or visit a doctor only after my husband gives me the permission to do it. I am in the world of somebody, but it is not my world. An inability to balance my daily decisions and reproductive health has changed my mental health negatively.*

This quote underlines the adverse consequences that the absence of control over the reproductive decisions may have on the mental well-being. Being unable to control their own bodies, women often experience mental exhaustion and the decreased self-esteem.

The other participant indicated the psychological burden:

> *Due to the fact that other people control my life, sometimes I feel that I do not form a complete person. I cannot take decisions about the future or health. It is challenging to live like this knowing the fact that my wishes do not matter. It is also exhausting to be in a situation where I always must live according to rules set by someone else, as claimed by this criterion to be able to do that.*

This emotional suffering has a wider implication on the psychological impact of limited choices in terms of reproductive autonomy. When women have no control over their reproductive choices, then they can also feel helpless, irritated, and even depressed. It is also important to discuss the psychological impact of lack of autonomy besides considering the physical aspects of reproductive health.

Discussion

Reproductive autonomy entails when an individual especially women being able to make her decisions on reproductive health. This incorporates decisions regarding sexual acts, bearing children, birth space, planning pregnancy, the use of contraceptives, birth control as well as the liberty to refuse or have sex. Even though reproduction autonomy is critical to the empowerment and overall well-being of women, the same remains a debatable issue in most parts of the world due to family structure, cultural beliefs, religion, and socioeconomic environment among others. The matter is vital in terms of understanding how women address this challenge and complexities of making reproductive choices as well as the challenges facing them in the process of trying to take control over their bodies.

Research has underscored the interconnected nature of reproductive violence with other forms of violence, including domestic violence and sexual violence (World Health Organization, 2013). In Pakistan, studies have revealed a significant overlap between reproductive violence and physical violence, with 75% of women experiencing both forms of violence (Fikree et al., 2005). Furthermore, reproductive violence has been linked to adverse pregnancy outcomes, such as miscarriage, stillbirth, and maternal mortality (Heise, 1998).

Cultural and social norms that justify male control over women's bodies contribute to reproductive violence. Economic factors, such as poverty and economic dependence, also increase women's vulnerability (Khan et al., 2019). Healthcare providers play a critical role in identifying and addressing reproductive violence.

Moreover, by utilizing family planning services, couples can make informed decisions about their reproductive health, including the number and spacing of children individuals plan to have. This autonomy is essential for ensuring safe motherhood and fostering healthy families. In male-dominated societies, women often lack the autonomy to make independent decisions, leaving them vulnerable to various problems, including sexual violence (Acharya et al., 2023). Advancing women's rights and autonomy is a transformative process that enables individuals to make strategic choices, previously denied to them (Kabeer, 1999).

In Pakistan, the scarcity of comprehensive reproductive health services and supportive policies exacerbates reproductive violence (Khan et al., 2019). The country's patriarchal culture and social norms perpetuate gender-based violence, including reproductive violence (Pakistan Demographic and Health Survey, 2017-18). International human rights law and national policies emphasize the need to address reproductive violence as a human rights violation (United Nations, 1993).

Despite growing recognition, research on reproductive violence in Pakistan remains limited (Khan et al., 2019). This literature review highlights the complexity of reproductive violence, emphasizing the need for comprehensive understanding and effective interventions. Numerous issues that the international community has determined require immediate attention are caused by the disregard for sexual and reproductive health and rights. These include rapid population growth, adolescent pregnancy, HIV/AIDS, maternal mortality, gender-based violence, and abandoned children. Millions of people die each year because of this widespread violation of human rights,

and many more are left permanently harmed or infected. The majority are women and reside in developing nations. Health and sexual rights are not personal issues. Instead, they can directly affect a nation's economy, as is evident in the African nations most affected by the AIDS pandemic. The location and timing of women's access to reproductive options and healthcare were decided by their husbands. Women are now forced into subordinate positions and have less decision-making authority due to power dynamics and the gender distribution of roles, or division of labor, which is crucial to the reproduction of the social order. Mothers who had girls were more likely to prefer boys, and this preference was frequently shown by the husband and mother-in-law's lack of support and animosity ("International Technical Guidance on Sexuality Education: An Evidence-informed Approach," 2018).

Regarding reproductive health choices, such as avoiding conception, spacing, the number of children, using contraceptives, and permanent family planning, one-third of spouses made their own decisions. Girls who marry young may feel helpless and find it difficult to express their reproductive choices, such as negotiating the use of contraception. Marriage and family laws frequently dictate that women should marry before men do, limit them to roles involving childrearing and service, and deny them the same opportunities as men. A lower marriage age has been linked to less autonomy because it is positively correlated with premarital employment, media exposure, and education. Defining Ideas and Rights The following fundamental ideas and definitions were agreed upon at the United Nations conferences in the 1990s: A state of total physical, mental, and social well-being in all areas pertaining to the reproductive system and its operations and processes is known as reproductive health; it goes beyond simply being free from illness or infirmity. People should be able to have fulfilling and safe sexual lives to maintain their sexual health. Gender relations ought to be reciprocal, responsible, and equal. The behaviors necessary to combat sexually transmitted diseases (STDs), such as HIV/AIDS, are included in sexual health ("International Technical Guidance on Sexuality Education: An Evidence-informed Approach," 2018).

Conclusion

This study concludes that one of the factors which limit reproductive autonomy of women in Hazara Division are gender inequity, socio cultural norms and religious practices. Even with the increase in access to reproductive education and reproductive health services, the existing control mechanisms within the families especially in the rural setting is the major impediment to reproductive control and decision-making by the women. Decision-making concerning family planning, birth control, birth spacing, contraception, and pregnancy within a patriarchal family structure often disregards women's choices and views thus giving unprecedented power to male members. There's still more to be done to combat gender-based savagery and patriarchal hones, indeed with headways in get to reproductive wellbeing medications. Further, efforts are needed to mainstream mental health factors in the reproductive autonomy and empowerment of women as this is one of the crucial factors that may inflict more harms and risk to women health. In order to make informed decisions surrounding reproductive empowerment, the policy influencers may include views, experiences, first-hand knowledge and decisions of women folk.

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