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Exploring the Influence of Socio-Cultural Barriers on Reproductive Health Decision-Making Among Working Women

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ABSTRACT: The Socio-cultural influences are important in the reproductive health choice of working women that influence their autonomy, medical care access, and competency to take effective decisions. This qualitative research set out to examine the influence of socio-cultural barriers on reproductive health decision-making among working women and specifically the family expectations, cultural norms, work-related demands, and access to healthcare services. It was a qualitative research design, and the study gathered data using semi-structured and in-depth interviews with married working women with various educational, job, and socio-economic backgrounds. Researchers used convenience sampling of eligible women and thematic analysis to identify common patterns and themes in their reproductive health decision-making experiences. The results established that family norms especially, husband and in-law pressure had great impact on reproductive health choices. Although women were involved in the economy, their influence in decisions in the household was still not strong, and thus there was a lack of reproductive control. Social norms and cultural stigma around reproductive health enhanced silence and fear of being judged and waiting longer to seek healthcare services. Workplace inflexibility, fear of income loss, and limited reproductive health information restrict working women's decision-making. Socio-cultural, familial, and structural factors are interconnected, making reproductive health choices a collective, not solely individual, matter. The results indicate that the intervention should be context-specific, such as family and community awareness interventions, supportive work policies, and greater access to reproductive healthcare services, to promote the reproductive autonomy and well-being of women.

KEYWORDS: Reproductive Health, Socio-Cultural Barriers, Working Women, Decision Making, Qualitative Research, Women Autonomy

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Introduction

Reproductive health is an essential part of overall women well being and it is unanimously agreed in the world as a basic human right. According to the World Health Organization, reproductive health is a state of full physical, mental, and social health with all the issues connected to the reproductive system, and not the lack of a disease (WHO, 2018). The informed choice of women concerning contraceptives, pregnancy, birth control, and the use of reproductive medical services is a decisive factor that affects the physical, psychological, and

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socio-emotional health of females (UNFPA, 2019). Even though the world has made commitment to reproductive rights, despite this, women in most developing countries still face limitations when it comes to exercising their autonomy when deciding on reproduction matters. The issue of reproductive health choice is not only personal but a very entrenched issue in the socio-cultural framework, family units and the gendered power dynamics. The reproductive decision of women is frequently affected or manipulated by husbands, in-laws and other family members in patriarchal societies that restrict the autonomy of women even on the health issues that are directly related to them (Bloom et al., 2001; Jejeebhoy et al., 2014). More silence about reproductive health and stigma around contraception as well as inflexible gender roles act as an additional limitation to the free discussion and access to timely reproductive health services (Shaikh & Hatcher, 2005). Employment is often linked to being empowered, getting financial autonomy, and gaining access to information. Nevertheless, the presence in the labor force does not always imply the independence in making a reproductive health choice, especially in patriarchal societies where the traditional gender roles are still highly ingrained (Kabeer, 2016).

Working women tend to be burdened by the dual roles of taking up a career and socially assigned family and reproductive roles. Restrictions in the workplace, including constraints on working hours, fear of loss of income, and the lack of institutional support also prove to be obstacles on the way of women in their quest to address their reproductive health requirements (ILO, 2017). Deviant socio-cultural expectations, joint families and deeply rooted gender hierarchies that define the reproductive lives of Pakistani women contribute to these challenges. The household level of decision-making is also one of the determinants of reproductive health since women who have less control have low chances of using reproductive health services despite their accessibility (Bloom et al., 2001; UNFPA, 2019). Although previous studies in Pakistan have mostly been quantitative in nature by capturing that which is measurable on the issue of utilization of reproductive health services, there has been little or no qualitative data that describes how working women perceive, experience, and negotiate socio-cultural barriers in their daily lives. Thus, the research problem of the study is to examine the impact of socio-cultural barriers on reproductive health choices of working women through a qualitative research method. This study aims to produce context-specific knowledge that could be used to shape culturally responsive policies, supportive workplace practices, and gender-sensitive reproductive health policies by foreshadowing the lived experience of women to influence the development of culturally responsive policies (Creswell & Poth, 2018).

This paper sets out to discuss the effects of socio-cultural barriers on the reproductive health decision making among working women. Through qualitative research method, the study is dedicated to the views of women in order to comprehend how family demands, cultural values, social forces and work role requirements influence reproductive health decisions. Through the foregrounding of women lived conditions, this study aims to produce contextualized knowledge that could be used to influence the culturally aware health policies, enabling workplace conditions, and gender-sensitive health care services.

Literature Review

Reproductive health has been conceptualized as the multidimensional concept of physical, mental, and social well-being, as opposed to being simply the lack of disease (WHO, 2018) and as a primary human right that is closely connected with autonomy and freedom of choice of women their quality of life (UNFPA, 2019). The

literature that is available is in consistent agreement that the choice of reproductive health of women is never done in isolation but rather influenced by the broader socio-cultural order, familial hierarchies, and unequal gendered power relations, especially in patriarchal societies (Bloom et al., 2001; Jejeebhoy et al., 2014). According to the research, the power regarding reproductive health in households is a decisive factor influencing the outcomes of reproductive health since women with a low level of autonomy usually need approval to access healthcare services, which leads to late access to care, unmet health needs, and limitations to control over contraception, pregnancy, and the timing of decisions in childbearing and delivery (Jejeebhoy & Sathar, 2001; UNFPA, 2019).

The women can also be further inhibited by socio-cultural barriers and restrictions that include the strict gender norms, cultural silence around reproductive health, religious interpretations, and traditional family expectations (Malhotra & Schuler, 2005, Shaikh & Hatcher, 2005). Even though employment is often linked to the notion of empowerment and financial autonomy, it is claimed that working does not always lead to increased reproductive autonomy as employed women still have to cope with a double burden of work and social and gender roles, as well as with occupational limitations, including a rigid working schedule, employment insecurity, and the absence of work-supportive policies (Kabeer, 2016; WHO, 2018; UNFPA, 2019). Working women still face the family pressure on fertility and healthcare choices, which is manifested in the fact that despite their contribution to the economy, they still remain a subject to the gendered hierarchical power in their families (Jejeebhoy & Sathar, 2001).

Although this literature offers rich evidence of the relationship between socio-cultural factors and reproductive health outcomes, it is mainly based on quantitative methodology and services utilisation measures that do not offer much information about how working women perceive, experience, and negotiate these constraints in their daily lives, especially in the Pakistani socio-cultural setting. This gap shows that further qualitative studies tailored to predict the lived experiences of women in order to inform culturally sensitive, women-focused reproductive health policies and interventions are needed.

Theoretical Framework and Research Gap

Multiple theoretical perspectives are used in conducting the current study as they offer a clear explanation of the development of socio-cultural barriers that influence the reproductive health decision-making of women, with the ones being Gender and Power Theory, Feminist Theory, Social Ecological Theory, and Social Norms Theory. Gender and Power Theory focuses on gender inequalities and structural power that restrict the autonomy of women in the household and society (Connell, 1987) and Feminist Theory on the lived realities and experiences of women and how the feminist understanding of gender has influenced the sanction of control over women bodies and health decisions (Social Norms Theory) (Cialdini & Trost, 1998).Despite their economic contribution, working women often remain subject to family pressure regarding fertility and healthcare decisions, reflecting the persistence of gendered power relations within households (Jejeebhoy & Sathar, 2001). While this body of literature provides substantial evidence on the association between socio-cultural factors and reproductive health outcomes, it largely relies on quantitative approaches and service utilization indicators, offering limited insight into how working women perceive, experience, and negotiate these constraints in their everyday lives, particularly within the Pakistani socio-cultural context. This gap highlights the need for qualitative research that foregrounds women's lived experiences to inform culturally

responsive, women-centered reproductive health policies and interventions. Although a lot of literature has been researched with these frameworks, a gap still exists in the literature.

The majority of the current research is based on the quantitative approach and does not represent the experiences of women in a sufficient manner, especially the ways in which working women perceive and maneuver socio-cultural obstacles in their daily lives (Creswell, 2014). This is also where this research study fits in as it uses a qualitative method to examine the influence of the socio-cultural variables on reproductive health choices among working women and thus provides context-specific and female-focused information to the literature.

Research Methodology

The research methodology that was used in this study was qualitative research which sought to examine the impact of socio-cultural obstacles on reproductive health decision-making among working women. The process of making decisions regarding reproductive health is very individual but at the same time there is a cultural and societal influence and embeddedness of the process based on family expectations, cultural norms, gender roles, and work requirements. Qualitative approach was deemed fitting because it can be used to gain a deeper insight into women lived experiences, perceptions and interpretations of their reproductive health choices in certain socio-cultural contexts that could not be sufficiently described using quantitative measures. The research was based on the married working reproductive age urban women who were attracted to occupational diversities in both formal and informal employment sectors. The focus on working women enabled the study to explore the interplay between employment and traditional gender roles and cultural expectations to influence the decision making process of reproductive health. Convenience sampling criterion was applied meaning that those considered were accessible and willing to take part, whereas explicit inclusion criteria (e.g., marital status, employment, and reproductive age) were applied so that the people considered would be relevant to the research problem in question. Sampling did not intend to have any statistical generalization but rather to acquire some in-depth understanding of the experiences of working women.

Twenty working women were involved in the study. The principle of data saturation was the one applied in determining the sample size. The data were gathered with the help of semi-structured in-depth interviews; this approach was selected due to its flexibility and the fact that it could be used to be in line with the research goals. Issues on reproductive health choices, family expectation, communication between the spouse, restraint in the workplace and cultural norms were explored using an interview guide. The interviews were undertaken in a personal supportive atmosphere to allow the interviewees to speak openly and frankly, as the subject of reproductive health is sensitive.Thematic analysis was used to analyze the data collected based on the method put forward by Braun and Clarke. The reading of interview transcripts was done repeatedly in an effort to have familiarization, and first codes were produced. The codes were related and clustered into general themes that were evaluated and narrowed down according to the research purposes and study theory. The analysis process helped to identify the common patterns and also the differences in the experiences of women in reproductive health decision-making. Prior to the collection of data, ethical approval was gained and informed consent was obtained with all the participants. The participation was voluntary, and the anonymity and confidentiality were provided by using the pseudonyms and all the data were stored safely.

The credibility of the research was ensured by the long-term work with the data, deep interviews, and open reporting of the research procedure. The credibility of the data was increased because it was recorded in their own words and the confirmability was achieved because the interpretations were based on the data. Considerable contextual descriptions were given to aid in transferability. The final step was the selective coding process to merge sub-themes into more general themes that represented the main patterns of the socio-cultural barriers and reproductive health decision-making among the working women. This method of coding in a systematic way facilitated the analytical rigor and clarity in the interpretation of the findings.

Participant Profile

Contextual Snapshot As opposed to displaying such demographic details as separate figures, profile of the participants is summarized to bring their social location and realities into perspective.

Table 1

Socio-Demographic Overview of the Participants (N = 20).

Dimension	Category	Frequency
Residence	Urban	20
Age	26–35 years	9
	36–45 years	11
Education	Primary	4
	Secondary	6
	Bachelor	7
	Master	3
Employment	Formal	11
	Informal	9
Family Structure	Joint	13
	Nuclear	7
Decision-Making Power	Low	11
	Medium	6

Table 2

Themes, Sub-Themes and Coding Keys

Theme	Sub-Themes	Key Codes
Family Expectations & Patriarchal Regulation	Early childbearing pressure, in-law control, healthcare permission	Elder authority, fertility control, restricted mobility
Gendered Power & Limited Autonomy	Limited decision-making, layered authority	Gender hierarchy, dependence
Cultural Silence & Social Stigma	Taboo, fear of judgment, stigma of delay	Social shame, silence
Workplace Constraints & Double Burden	Work–family pressure, job insecurity	Time poverty, economic stress
Access to Healthcare & Information	Limited knowledge, dependency	Restricted access, misinformation

Theme 1: Family Expectations and Patriarchal

This theme is used to describe how family expectations and expectations, especially the expectations of husbands and the elder family members, impact the decision-making process of reproductive health by the women and restrict their own autonomy.

One of the respondents said that,

"Everyone was worried when I would bear a child after getting married, not about my health".

One more respondent told me that,

"I cannot visit a doctor without consulting the senior members of my family."

In general, most of the respondents testified that family members dominated the decision-making process when it comes to fertility-related and reproductive healthcare and these decisions were not made by women themselves.

Theme 2: Gendered Power and Limited Autonomy

This theme brings up the role of gendered relations of power constraining the autonomy of women in making reproductive health choices despite their engagement in paid labor.

According to one of the respondents, it is because,

"I make money, yet I do not make decisions related to my health."

Another respondent said that,

"My mother-in-law makes decisions at times more than my husband."

In general, the majority of the respondents stated that the role of economic contribution did not result in the equal right to make decisions in the household as the traditional gender patterns prevailed.

Theme 3: Cultural Silence and Social Stigma

This topic captures the role of cultural silence and fear of social stigma on the reproductive health decision making of women.

One of the respondents indicated that,

"Discussion on reproductive health is a shameful thing."

Another respondent said that,

"It is the word of people that a woman does not bear a baby early."

In general, most of the respondents indicated that stigma and fear of negative labeling prevented open dialogue and procrastinated healthcare-seeking behaviour.

Theme 4: Workplace Constraints and the Double Burden

This theme describes how women are constrained by their work in places like work places, and have their household duties which hinder them to focus on their reproductive health.

One of the respondents told that,

"I lack time to take care of my health due to jobs and other domestic chores."

On the whole, the majority of the respondents told that reproductive health became an extra priority due to time, workload, and fear of a loss of income.

Theme 5: Access to Healthcare and Information

The theme emphasizes the importance of access to healthcare services and proper information in the formation of reproductive health decision-making.

One of the respondents stated that,

"I rely on other people since I am not very good at visiting doctors."

On the whole, most of the interviewees expressed that their ability to make informed decisions regarding reproductive health could be minimized by lack of access to appropriate information and healthcare services.

Discussion

The present study will understand how socio-cultural contexts influence decision-making in reproductive health among working women by placing the results in the theoretical lenses. Instead of being interpreted as individual decisions, reproductive health decisions are situated in the context of the discussion of being entrenched in general systems of power, gender relations, and structural constraints. According to the findings, reproductive autonomy of women is a negotiation process in the family, cultural and institutional setting, the presence of which affects the degree to which women take control of their choices. Patriarchal Theory is applicable to the issue of the continued domination of women reproduction choices by family authority due to the dominant role of males in family structures and elders in their reproductive choices (Connell, 1987). In this view, it is clear that reproductive decision making is an entrenched power but not a preference which argues in feminist terms that patriarchy exists in the normal operation of the family to support the normalization of women limited autonomy in health-related issues.

The rest of the autonomy of economically active women further supports the Gender Role Theory that highlights the fact that gender roles, which are still socially constructed, persist in defining women as secondary decision-makers although they are involved in the paid work (Eagly, 1987). Based on the Feminist Theory,the results contradict the belief that only employment results in empowerment. Empowerment demands the ability and access to income as well as the capacity to make meaningful choice as suggested by Kabeer (1999), where household power relations are left intact. The Social Norms Theory is the most effective theory in explaining the cultural silence and stigma of reproductive health as common expectations and fear of social exclusion influence behavior (Cialdini & Trost, 1998). These rules are informal modes of control that do not enforce them and prevent open discussion and influence the reproductive behavior of women. The results therefore depict that reproductive agency of women is still curtailed by internalized social norms. Feminist Political Economy can be used to explain workplace related limitations taking into consideration the fact that women have to deal with both paid and unpaid work (Elson, 1999).

Instead of being neutral, the workplace recreates gender inequalities due to inability to support the reproductive health of women, especially the low-paid and informal jobs. This meaning places reproductive health choice-making within the wider context of structural inequalities as opposed to choice or time management. Lastly, the explanation of the constrained access to healthcare and information about the reproductive health is parallel to Women Empowerment Frameworks which associate the autonomy with access to resources, information, and supportive institutions (Malhotra & Schuler, 2005). The discussion highlights that reproductive autonomy is conditional being based on enabling environments and in this case without the accessibility to reliable information and health care services, the ability of women to make

informed decisions is limited, irrespective of their employment status. In general, this discussion has shown that decision-making of working women regarding reproductive health is grounded between cross-cutting systems of patriarchy, gender rules, social regulation, and structural constraints. By framing the study results within the existing theoretical insight, the study goes beyond description to provide a rationale as to why socio-cultural obstacles still exist, and emphasizes the need to intervene on a multi-tiered and theory-driven approach in order to increase reproductive autonomy among women.

Recommendations

The research offers a multi-level intervention that includes all the levels to enhance reproductive health decision-making in working women. At the personal level, the concept of shared decision-making needs to be supported at the couple level through counseling programs with lady health workers and the community organization that would involve the elders in the activity to refute the oppressive traditional ideology. On the community level culturally sensitive education programs are supposed to be used to normalize the talk about reproductive health and eliminate stigmatization. Flexible working hours and provision of medical leave should be introduced as some of the workplace reforms especially in the informal sector in order to facilitate the timely use of healthcare. Financial and mobility barriers can be minimized through strengthening community-based healthcare provision, i.e. mobile clinics and increased lady health worker initiatives.

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