

Socio-Cultural Constraints affecting Women's Reproductive Health Rights and Decision-Making: Evidence from District Layyah, Punjab Pakistan

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ABSTRACT

Reproductive health rights are crucial towards enhancing gender equality and sustainable development. However, in most developing societies; these rights remain restricted due to strong cultural beliefs and limited access to education. This paper explores the role of socio-cultural constraints and level of education on the reproductive health choices of women in District Layyah, Punjab, Pakistan. A quantitative cross-sectional study design was selected. A total of 390 married women aged between 18 and 45 years old were selected as the sample and data were collected through a structured questionnaire based on Knowledge, Attitude and Practice (KAP) model. Descriptive statistics including percentages, frequencies, inferential statistics, chi-square tests, Pearson correlation, and logistic regression were used in the analysis. The findings indicate that a significant percentage of the respondents (68.7%) were aware of reproductive health problems; less than half (46.7%) respondents reported using family planning methods showed a clear gap between knowledge and practice. Women were found to have limited autonomy when it came to making reproductive health decisions due to socio-cultural factors especially family pressure (72.1%) and religious perceptions (56.1%) ($p < 0.05$). Moreover, education was positively and statistically significantly related to better reproductive health practices ($r = 0.428$, $p < 0.01$). Overall, the results indicate that although the women are aware of reproductive health issues but they are still limited in their capacity to take action on this knowledge due to patriarchal systems, economic dependence and the social norms. The research highlights that education can improve the understanding and attitudes, but it is only effective when socio-cultural barriers are also addressed, therefore, integrated and context-specific interventions are important.

Keywords: Reproductive Health, Socio-Cultural Constraints, Knowledge Attitude Practice (KAP), Family Planning, Women's Education, Decision-Making, Rural Pakistan

INTRODUCTION

Reproductive health has been known to be a holistic condition of physical, mental, and social well-being associated with the reproductive system and its processes (WHO, 2022). It involves the capacity of individuals, especially women, to make informed and voluntary choices on the issues of fertility, family planning, and maternal health.

International mechanisms have been strengthening reproductive health rights in the world, with the International Conference on Population and Development (ICPD, 1994) being one of the mechanisms that have changed the emphasis on population control to individual rights and autonomy, especially by women (UNFPA, 2019).

Although these improvements have been made, in developing nations, particularly in South Asia, the differences are still highly prominent, with women having limited reproductive autonomy due to socio-cultural norms, gender inequality, and lack of education. In Pakistan, policy implementation is inconsistent despite the existence of policies that are consistent with international obligations, like the Sustainable Development Goals (SDGs) and the CEDAW. The Pakistan Demographic and Health Survey (2018) state that access to skilled maternal healthcare services and contraceptives uses are low, especially in rural regions.

In certain districts, such as Layyah, the situation is more serious for women, who lack decision-making authority due to their traditional values and poverty, coupled with low literacy levels. Women are expected to either depend on husbands or family elders when making decisions regarding contraception, maternal healthcare and fertility. The cultural taboos and misconceptions on reproductive health also form barrier to the accessibility of information and services.

Education comes in here as a modifying factor. There is a possibility to better educated women to have knowledge about reproductive health issues, cultural barrier and also to be independent in decision making. However, dependency is reinforced and gender inequality is continued in rural areas where education provision is less. In this study, Knowledge, Attitude, and Practice (KAP) framework are used to find the gap between the socio-cultural constraints and the reproductive health decision making of women's educational empowerment in District Layyah. The study explores the gap between knowledge and reality, providing an understanding of structural and cultural barriers which play a role in the success or failure of implementing reproductive health rights.

Objectives of the Study

1. To determine the level of knowledge of women about reproductive health rights.
2. To investigate how socio-cultural norms affect reproductive health decisions among women.
3. To study the role of education in influencing women's reproductive health practices and autonomy.
4. To explore the relationship between knowledge, attitudes, and practices (KAP) in reproductive health.

Research Questions

1. How much do women know about reproductive health rights in District Layyah?
2. What effect do socio-cultural norms have on the reproductive health choices of women?
3. How does education influence the reproductive health practices of women?
4. What is the relationship between knowledge and attitudes, and actual reproductive health behaviors?

Hypotheses

H1: More knowledgeable women on reproductive health rights are more likely to use family planning methods.

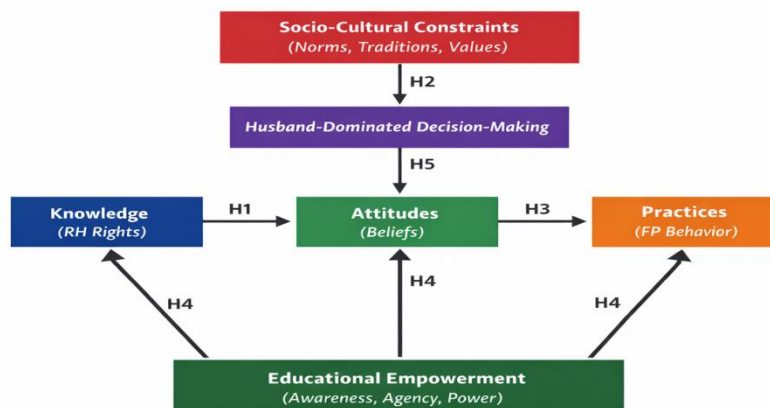
H2: Socio-cultural limitations have a negative implication on the reproductive health decision-making among women.

H3: The reproductive health practices are positively correlated with higher education levels.

H4: Positive beliefs of reproductive health rights improve the chances of contraceptive use.

H5: Cultural factors significantly influence husband-dominated decision-making in women's reproductive health rights in District Layyah.

Conceptual Framework



Conceptual Framework: Socio-Cultural Constraints and Educational Empowerment in Shaping Women's Reproductive Health Decision-Making: Evidence from a KAP Study in District Layyah, Pakistan

Figure 1: Conceptual Framework

LITERATURE REVIEW

Empirical research findings always reveal that there is a disparity between the level of awareness and use of reproductive health services. Studies show that despite being aware of family planning techniques, many women do not use them because of wrong beliefs and socio-cultural constraints (Uprety et al., 2016). On the same note, Ivanovna et al. (2018) reported that there is a high rate of information gaps as young women tend to have no accurate information about contraception and sexually transmitted infections. In third-world countries, knowledge gaps are closely related to education and socioeconomic status.

Tadesse et al. (2020) indicated that women who were educated showed improved knowledge and increased use of reproductive health services. Nevertheless, even with the awareness, cultural stigma and misinformation frequently obstruct the translation of knowledge into practice in women (D'Souza et al., 2022).

Such results are in line with the present study situation, in which women have partial knowledge, yet they do not have the freedom and encouragement to take action on this knowledge. The cultural, religious, and family influences on reproductive health attitudes are profound in nature. Research indicates that despite awareness, negative attitudes and social norms prevent the use of contraceptives, and a lack of control over the number of children (Jil et al., 2024).

Son preference, cultural beliefs like the stigma attached to contraception, are key factors that affect how women view them. According to Zakariya et al. (2020), poor education and open communication are the reasons why misconceptions about menstruation and reproductive health still exist. On the same note, Ayub et al. (2015) observed that although there are high levels of awareness, cultural norms and myths limit the real use of family planning methods.

Positive attitudes have been classified as affected by education and spousal communication. Females who are better educated and economically independent are also more likely to participate in decision-making and have a positive attitude towards reproductive health (Asghar et al., 2014).

The discrepancy between knowledge and practice has been a key concern in the research on reproductive health. Although most women have knowledge of contraceptive methods, they usually do not use them because of availability, cultural constraints, and lack of control (Gautam et al., 2025). The socioeconomic factors have a significant role in determining practices. Women who have higher incomes and are educated tend to seek maternal healthcare services and contraception (Tadesse et al., 2020).

Women in the rural areas, on the other hand, tend to stick to the traditional ways because of poor access to healthcare institutions and social barriers. Research in Pakistan has found that cultural practices, dominance of men, and a lack of mobility of women largely inhibit the reproductive practices of women. These results are similar to those of the current research, where the practices of women are limited regardless of awareness.

One of the important aspects of reproductive health rights is decision-making autonomy. According to research, mutual decision-making between husbands and wives results in increased contraceptive use and improved reproductive outcomes (MacQuarrie and Aziz, 2022).

Nonetheless, in a patriarchal society, decisions are usually made by men or elder members of the family. The independence of women is directly associated with education, social mobility, and economic independence (Osamor & Grady, 2016). Cultural norms and family hierarchy in rural Pakistan restrict the rights of women to make their own choice, which greatly impacts the decision-making process.

Reproductive health behaviors are greatly influenced by socio-cultural factors that encompass patriarchal norms, religious interpretations, and gender roles. Sexuality and contraception cultural taboos impede access to and open discussion (Arousell & Carlbom, 2016). Women in rural areas are also subject to other forms of restriction, like early marriage, preference for sons, and the inability to move.

RESEARCH METHODOLOGY

The research design used in this study was a quantitative cross-sectional research design to investigate the impact of socio-cultural limitation and educational empowerment on the reproductive health decision-making of women in District Layyah, Punjab, Pakistan. Target population of married women of reproductive age (18-45) years were sampled using multistage sampling methods resulting in 390 respondents. A structured questionnaire was used to gather data based on Knowledge, Attitude and Practice (KAP) framework. The questions included were on awareness of reproductive health rights,

attitude towards family planning and gender roles, and actual behavior patterns such as the use of contraceptives and use of maternal health services. The tool has been tailored to consider the social-cultural context of the area of study to ensure that it would capture the informal belief system and knowledge that drives behavior. Data analysis was done by using the SPS and the help of the descriptive statistics, frequencies, and percentages and inferential interpretation to examine the connections between education and socio-cultural influences and reproductive decision-making. The requirements of ethical issues were met in the study with the support of voluntary respondents and confidentiality.

RESULT AND DISCUSSION

Table 1: Socio-Demographic Characteristics of Respondents

Variable	Categories	Frequency	Percent
Family Structure	Nuclear	164	42.2
	Joint	212	54.4
	Extended	14	3.5
Education Level (Respondent)	Illiterate / Uneducated	104	26.4
	Primary School	88	22.6
	Secondary School	72	18.7
	SSC	84	21.4
	HSSC and above	42	10.9
Husband Education	Illiterate / Uneducated	67	17.2
	Primary School	91	23.3
	Secondary School	86	22.1
	SSC	87	22.3
	HSSC and above	59	15.1
Total		390	100

Interpretation

The demographic characteristics of the respondents indicate the important social issues affecting women's reproductive health choices in District Layyah. The percentage of women belonging to joint family is 54.4% and within nuclear family 42.2%. It implies that there are numerous female members living in joint families and decision making are made collectively, mostly by the elders, particularly male. Literacy data shows that 26.4% of women are illiterate while only 10.9% of them have higher secondary education and above. This reflects low educational status of women, which in turn may impact on their knowledge, confidence and decision making ability regarding reproductive health. Similarly, the educational levels of husbands are relatively high, yet low, where only 15.1% of them have higher education. As men play a key role in decision making, their education is also significant in affecting the reproductive health decision making within the family. To conclude, it can be said that demographic profile suggests that low education of women and joint family system are two factors which can reduce their autonomy in decision making in the reproductive health sector.

Table 2: Knowledge, Attitude, Practices and Socio-Cultural Factors

Variable	Categories	Frequency	Percent
Awareness (Knowledge)	Yes	327	83.8
	No	63	16.2
Attitude	Positive	246	63.1
	Negative	144	36.9
Family Planning Use (Practice)	Yes	181	46.4
	No	209	53.6
Family Influence	Yes	281	72.1
	No	109	27.9
Religious Influence	Yes	219	56.1
	No	171	43.9
Total		390	100

Interpretation

The findings indicate that there is a difference between reproductive health knowledge and practices. Most of the respondents (83.8%) said they knew about the reproductive health rights and 63.1% had positive attitudes. Only 46.4% said they were using family planning. This is a clear example that awareness is not enough to enable behavioral change. The socio-cultural factors seem to have significant influence in this gap. Most of the women (72.1%) reported that family influences reproductive health decision making, while 56.1% reported that religious leaders influence reproductive health decision making. These data show that there is not a complete lack of social and cultural constraints on women's decision-making, but rather a reliance on them. The results revealed that the women are knowledgeable and have positive attitudes; however, they do not have much autonomy to put these into practice due to external factors. This means that there is a high level of cultural control and social dependency on reproductive health decision making.

Table 3: Reproductive Health Decision-Making in Household

Decision-Maker	Never n (%)	Rarely n (%)	Sometimes n (%)	Often n (%)	Always n (%)
Respondent (Woman)	78 (20.0)	155 (39.7)	41 (10.5)	79 (20.3)	37 (9.5)
Husband	29 (7.4)	42 (10.8)	70 (17.9)	160 (41.0)	89 (22.8)
In-laws	136 (34.9)	78 (20.0)	116 (29.7)	38 (9.7)	21 (5.4)
Joint (Wife & Husband)	9 (2.3)	35 (9.0)	78 (20.0)	115 (29.5)	153 (39.2)
Joint with Healthcare Provider	159 (40.8)	96 (24.6)	58 (14.9)	38 (9.7)	39 (10.0)

Interpretation

The pattern of decision-making shows a lack of women's autonomy in reproductive health decision-making. Many reported they never (20.0%) or rarely (39.7%) make decisions about their own reproductive health, suggesting limited autonomy. On the other hand, husbands are found to be the main

decision-makers, with 41.0% saying husbands often and 22.8% always make decisions about reproductive health. This illustrates that in most households, men are the prominent decision-makers. While shared decision-making between husbands and wives is relatively frequent (68.7% reporting often or always), this does not necessarily indicate parity between male and female partners as there is still a sense of male dominance. In-laws are not as dominant, with 15.1% reporting their involvement. Moreover, the low frequency of decision-making involving health professionals may reflect a lack of influence of health professionals in the household.

Table 4: Results of Hypotheses Testing and Statistical Analysis

Hypothesis	Test Type	Statistical Values	P-value	Decision
H1	Logistic Regression	B = -1.649, S.E = 0.412, Wald = 16.02, Exp(B) = 0.192	0.000	Supported
H2	Chi-Square Test	$\chi^2 = 18.76$, df = 1	0.000	Supported
H3	Pearson Correlation	r = 0.428	0.000	Supported
H4	Chi-Square Test	$\chi^2 = 14.976$	0.000	Supported
H5	Regression Analysis	B = 1.046, SE = 0.022, $\beta = 0.921$, t = 46.665, R ² = 0.849, F(1,388) = 2177.608	0.000	Supported

Interpretation

The statistical results reveal that all hypotheses are significant (p = 0.000), demonstrating significant relationships between the study variables. H1 shows that there is a significant association between knowledge and family planning. But the negative regression coefficient (B = -1.649) indicates that knowledge is not enough to ensure uptake, revealing the presence of intervening socio-cultural factors. H2 indicates a significant negative influence of socio-cultural constraints on reproductive health choices, suggesting that cultural and family pressures restrain women. H3 demonstrates a positive association (r = 0.428) between education and reproductive health practices, suggesting that education helps women make better decisions. H4 shows a strong effect of attitudes on contraceptive use, which indicates that favorable attitudes lead to greater adoption of family planning practices. H5 shows a strong influence ($\beta = 0.921$) of culture on male dominance in decision-making, which suggests that culture promotes male dominance in reproductive health.

DISCUSSION

The findings of the study indicate that there is a significant difference between the reproductive health awareness and practices among the females of District Layyah. Although most women are aware of their reproductive health rights and hold positive attitude about reproductive health, less than 50% are involved in family planning activities. This discrepancy can be attributed to socio-cultural barriers, including family pressure, religious and patriarchal attitudes. Our findings reveal that women's reproductive health decisions are not made in isolation but are strongly influenced by their husbands, in-laws and community norms. Education is beneficial in terms of knowledge, attitudes and practices; but it is constrained by strong socio-cultural barriers. Women's educational levels may be constrained by traditional gender norms and their reliance on husbands. The decision-making analysis also confirms husbands' dominance in reproductive health decision-making, which is a reflection of gender inequality. While there are growing trends towards joint decision-making, this does not always remove male dominance. Thus, the study confirms that reproductive health practice is not only impacted by knowledge but also by socio-cultural factors, which restrict women's autonomy.

CONCLUSION

These findings show that the socio-cultural restrictions and educational empowerment are the critical factors, which influence the reproductive health decision-making of women in District Layyah. The results indicate that majority of women are belong to lower and middle classes and reside in joint families hence restricting their autonomy in decision making regarding health matters. Most women are already educated about reproductive health; however, their practices are constrained, because they face family pressure and cultural limitations. The results also indicate that education plays an important role in improving women's understanding and decision-making ability, but its effect is reduced by strong traditional norms. The cultural influences, in particular, husband and family dominance is the strongest obstacle in reproductive health choices. Statistical findings support the existence of a strong correlation between socio-cultural restraints and decision-making dominated by husbands. Overall, the study highlights that improving women's education alone is not enough unless socio-cultural barriers are also addressed. Empowerment programs, awareness and cultural change are highly needed to improve the reproductive health rights of women in District Layyah.

RECOMMENDATION

Following the results of the current research, a number of policy level and practical recommendations are offered to enhance the reproductive health decision-making of women in rural settings like District Layyah.

Firstly the community-based awareness activities addressing reproductive health rights and family planning should be extended. Though most women showed basic level of knowledge, the discrepancy between knowledge and practice is that more effective and culturally appropriate methods should be used to bring information to the women. Local health workers and community leaders should be included in the health education campaigns to make them trust and accept them.

Second, women education is to be given first-order priority as a long-term empowerment. The fact that education is positively related to reproductive health practices indicates that the decision making ability of girls can be greatly improved with the increase in their access to formal education. Married women in rural areas should also be provided with adult literacy and informal education programs.

Third, there should be interventions that tackle the socio-cultural and family barriers. Given that family influence was identified to have been very important, husbands, mothers-in-law and other family members who are deemed important should be actively involved in reproductive health programs. The encouragement of male participation can contribute to changing the norms and aid in shared decision-making in households.

Fourth, policy must be designed with a keen consideration of religious and cultural sensitivities. Through the partnership with the religious thinkers and the imparters within the community, the myths can be eliminated and the minds of people can be sensitized towards the positive ways of practicing reproductive health without causing any social barriers. Fifth, there should be increased access, affordability, and friendliness of healthcare services especially in rural regions to women. By reinforcing the primary healthcare systems and making sure that female healthcare providers are available, women can be motivated to consult reproductive healthcare services without fear.

Lastly, policymakers can work on closing the policy-implementation gap. Though national and international frames have proved useful in reproductive health rights, they have minimal impacts at

grassroots. Monitoring, resource mobilization and localized initiatives are required to fulfill policy commitments in order to change.

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