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RESEARCH PAPER

Intimate Partner Dynamics: An Evidence Perspective on Women's Reproductive Health from Okara Cantonment

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ABSTRACT

This research sought to look into how intimate partner relationships affect women's reproductive health-more closely within socio-cultural contexts that constrain autonomy. The study ought-after objectives include identifying how communication possesses an impact on contraceptive usage and family planning; analyzing the role of partner involvement in accessing maternal health service; examining the association between decision-making autonomy and reproductive health; and investigating the links between intimate partner violence and reproductive health behavior. In order to collect quantitative data-an enumeration exercise involving 367 married women in Okara Cantonment-was completed using structured questionnaires. Chi-square analysis revealed that 86% of respondents had access to antenatal healthcare; however, socio-cultural norms, intimate partner violence, and economic dependency posed significant barriers to autonomy. It was found that shared decision-making was significantly correlated with health outcome improvements ($\chi^2 = 94.299$; $p < 0.001$). This research highlights the implication of gender sensitivity in policy, community driven interventions and also engaging the male members of the community in challenging harmful norms, empowering women and achieving equitable reproductive health outcomes.

KEYWORDS Family Planning, Intimate Partner Relationships, Reproductive Health, Women's Empowerment

Introduction

The reproductive well-being which is part of the general well-being comprises a holistic and comprehensive lifestyle towards healthy living; it also includes various physical components and emotional, even social ones with regard to their state. Man-made communities dictate the reproductive independence of women from their partner relationships and from socio-cultural prescriptions. Supportive partnerships create opportunities for improved health outcomes, while oppressive traditions and economic deprivation render barriers limiting autonomy and access to care. The associated relationship and systemic impediments serve greater global concerns regarding gender equality and reproductive health.

Good channels of communication, joint decision-making, and goodwill are said to produce positive reproductive health outcomes in relationships. However, restrictive socio-cultural norms and intimate partner violence do limit women's independence in decision-making, which accounts for a great deal of unplanned pregnancies and poor access to healthcare (Blanc, 2001; Miller et al., 2010). Even as health policies are projected to extend beyond national and international borders, there is still much

ground to be covered in the cross-sectional dynamics between relationship-dynamics and system barriers among the different socio-cultural contexts.

This research delves into how communication, joint decision making and socio-cultural factors shape women's reproductive autonomy, thus presenting the insights associated with the dynamic interplay of relational and systemic factors. By developing such evidence from the quantitative examination of these dynamics, the research would render gender-sensitive policies and action recommendations practical to empower women and foster collaboration within partnerships.

The research encompasses the narratives of specific individual lives and goes beyond it into some generic domestic routines, including decision-making behaviour on contraceptive use by women and access to healthcare services. It also shows how women are left with reproductive responsibilities but essentially along with men are not included in discussions regarding family planning or health. It defies relationality to talk about these divisions at home that pose shared responsibility and mutual respect within intimate or possibly other relationships.

Economic dependency and socio-cultural norms work against women's choices regarding reproductive health .male dominance and traditional gender roles keep on silencing women when most critical decisions about their health and wellbeing are being made. These financial assets belong to the partner or family, hence limiting women in accessing independent healthcare, which intensifies the existing challenges. This study calls for an interventionist approach dealing with relational and systemic barriers while building a partnership in which reproductive cornerstones are mutual.

Intimate partner violence has been closely seen as a major deterrent to women's empowerment concerning their reproductive health. Besides making decisions impossible, intimate partner violence has got consequences both in physical and mental health aspects. Research ties intimate partner violence to severe reproductive health results and thus proposes integrated strategies to care for relational imbalances alongside structural violence.

So looking at these dynamics through a socio-cultural angle has given the study a more localized view for sensitizing interventions and policies through the lens of culture. A holistic reproductive health program should consider that culture affects partnerships, encourages equity in partnerships, and strengthens communication between partners. Such avenues may bring about change in reproductive health outcomes because they bring about environments whereby women can exercise freedoms with the complete buy-in of their partners.

This introduction sets the stage for further sections on methodology, findings, and implications. Framing reproductive health within relational and systemic contexts has enhanced global discourse in terms of gender-sensitive policies and interventions aiming at equitable enhancement of health outcomes for women within patriarchal societies.

Literature Review

A complex interaction of relational, social and cultural factors underlies reproductive health areas, where definitely intimate partner relationships might form a very significant facet. Effective communication within relationships is a key determinant of reproductive autonomy. Wingood and DiClemente (2000) highlight that

open and effective communication fosters shared decision-making, enabling women to exert control over their health choices. Conversely, poor communication often results in unilateral decisions dominated by male partners, leaving women with limited autonomy in reproductive matters.

It has been widely accepted that partner support contributes effectively to positive reproductive health outcomes. Research shows that more active involvement of men in reproductive health decisions improves contraceptive use, maternal health, and access to healthcare services (Heise & Garcia-Moreno, 2002). However, prevailing gender norms in numerous societies have actually prevented men from being involved, thus perpetuating the idea that reproductive health concerns are for women only. Such isolation from the result would reinforce the inequalities within intimate relationships and reduce the opportunities for improved health benefits.

Decision-making power within relationships also significantly influences reproductive health. Women who share or hold independent decision-making authority report higher reproductive autonomy, better mental health, and greater access to healthcare services. For example, patriarchal societies have proven that when women are taken into consideration for the decision-making processes of families, there is reduced incidence of unintended pregnancies coupled with acceptance of family methods to prevent such occurrences. This evidence provides a very strong argument for the enhancement of women's agency within bonds to be able to do better in reproductive health results.

Socio-cultural norms complicate even more coming to reproductive health. Culturally, societies have been caught in the grasp of men's dominance whereby women are never given the avenue to articulate their choices and permission to make independent decisions. Those cultural norms convenient enough for women to be reserved enforce restrictions on their ability to access healthcare and family planning services. Research shows that community level intervention and gender sensitization programs are effective in challenging such injurious norms and progressing them towards equity between men and women allowing both of them to participate actively in reproductive health decisions.

Intimate Partner Violence (IPV) is one of the barriers that affect reproductive health significantly. Women who are victims of such violence often face a lot of challenges in accessing health services, particularly contraceptive services, or even in making personal decisions. Literature indicates that IPV flourishes in fearful, controlling environments making it almost impossible for women to voice what they want regarding their health needs. Tackling IPV should have two approaches such as providing enabling environments for survivors and also addressing structural and gender norms that perpetuate violence.

Dependency on economy is yet another most dangerous phenomenon which complicates circumstances for women in that primary aspect of reproductive health decision-making. What the reading indicates, for example, is that it locks out access to health services or self-advocacy for family planning for women who depend on their spouses. Empowerment initiatives, for example, microcredit schemes and vocational training have been found to benefit women to make any decisions without consideration of their own vulnerabilities and deprivations from making independent or autonomous choices.

Gender-sensitive policy interventions emerge as critical drivers of improved reproductive health outcomes. Policies that engage both partners in decision-making

and challenge traditional norms create equitable healthcare frameworks. Relational collaboration ensures shared responsibility, leading to healthier outcomes for women (Blanc, 2001). These policies must address relational, cultural, and systemic barriers to create environments where women feel empowered to make autonomous reproductive decisions. This literature highlights the importance of addressing relational dynamics, cultural expectations, and systemic barriers in improving reproductive health. These insights form the foundation for this study, which examines the influence of intimate partner dynamics within Okara Cantonment's socio-cultural context, providing a localized perspective to inform effective policies and interventions.

Hypotheses

H1: Couples who discuss family planning openly with a positive attitude are more likely to use contemporary contraception than those who do not talk moderately about it.

H2: Women whose male partners are actively involved in decisions regarding pregnancy-related healthcare are more likely to attend all suggested antenatal visits and seek skilled attendance during childbirth.

H3: Women's reproductive health is better in partnerships where their decision-making autonomy is higher, as signified by increased use of contraceptives and improved maternal health services.

H4: In comparison to those who do not face any such violence, women that suffer intimate partner violence have lower chances of using contraceptives on a regular basis and hence higher chances of unwanted pregnancies.

Material and Methods

The study undertaken is a cross-sectional quantitative research intended to assess how intimate partner relationships affect women's reproductive health status in Okara Cantonment. There are several factors that will be looked into and understood in the study: communication, decision-making power, partner support, and socio-cultural norms and how these factors translate into reproductive health outcomes. The subsequent parts explain in detail the method by which the study has been conducted.

Study Area

This semi-urban area is located within Pakistan's Okara Cantonment, which has been assessed as the best study area due to its socio-cultural dynamics and patriarchal society. Geographically, it comprises a heterogeneous population regarding various socioeconomic statuses, making it suitable for studying the nexus between relational dynamics and reproductive health outcomes.

Target Population

The research would only be focused on married women of 18 to 45 years living in Okara Cantonment. This has been so chosen for this range of age because it further mapped out those women who are within their reproductive age group, would be engaged in, or working concerning decisions about family planning and health care. Married for at least the period of one year to include very significant experiences influencing reproductive health was the entry criteria determined by them.

Sampling Technique and Sample Size.

A stratified random sampling technique was used to include all socio-economic strata of the target population. Stratification considered education level, household income, and employment status. Calculate sample size using standard statistical formulas for cross-sectional studies, which yielded a total of 367 respondents. In that sample size, one would get statically plausible results while preserving the generalizability of findings.

Data Collection Tool

The data was collected by using a structured questionnaire, which comprised 25 closed-ended questions under the following sections:

Demographics included questions about age, education level, employment status, and household income.

Relational dynamics included partner support, communication quality, decision-making patterns, and experiences with intimate partner violence.

Socio-Cultural Norms: Items investigating the impact of cultural beliefs and traditions on decisions regarding reproductive health.

Reproductive Health Impacts: Inquiries on contraceptive use, accessibility to health facilities, and satisfaction with reproductive health choices.

The questionnaire also went through pre-testing with a deem sample of respondents to ensure clarity, reliablility, and validity, among various changes that were effected according to comments given during the pilot testing phase.

Data Collection Process

The data was collected using structured questionnaires distributed to married women in Okara Cantonment. To ensure respondent comfort and encourage honest responses, the questionnaires were self-administered but closely monitored by trained female enumerators who were available to clarify any doubts. They were given about 20-30 minutes to take the questionnaire, allowing respondents to think and give well thought out and accurate responses.

Ethical Considerations

The enumerators were oriented into the objectives of the study in addition to ethical considerations for respective professional and respectful interactions during data collection. They were instructed to respond to questions or concerns raised by the participant without compromising their confidentiality and displaying any insensitivity towards the topic. This preparation is believed to create a comforting environment leading to spontaneous and meaningful responses from the respondents.

Data Analysis

The analyses were done using the Statistical Package for Social Sciences (SPSS). The chi-square tests were done to investigate the associations among the core variables; partner support, contraceptive use; decision-making power: reproductive autonomy; socio-cultural norms: health outcomes. Analysis on finding their statistically significant relationships and interpretation of their meaning to reproductive health would follow.

For example, the use of descriptive statistics could summarize the demographic characteristics, while inferential statistics might be used to test the hypotheses of the study.

Results and Discussion

Table 01
Demographic Profile of Respondents

Demographics	Categories	Frequency	Percent
Age	20-24	37	8.0
	25-29	70	18.0
	30-34	104	28.0
	35-39	153	36.0
	40-44	63	10.0
Marital Status	Married	367	100.0
Education	Below School	161	43.9
	Secondary School	94	25.6
	Higher Secondary or Vocational Training	61	16.6
	Under Graduate	27	7.4
	Graduate	24	6.51.0
Household Income	Low	49	13.4
	Moderate	266	72.5
	High	37	10.1
	Very High	15	4.1
Employment Status	Unemployed	1	81.2
	Student	16	4.4
	Part-Time employed	37	4.4
	Full Time employed	16	10.1
Family Structure	Nuclear Family	322	87.7
	Extended Family	45	12.3
Number of Children	0	6	1.6
	1	45	12.3
	2	97	26.4
	3	141	38.4
	4	49	13.4
	5	21	5.7
	6	8	2.2

Table 1 presents data on 367 married female participants. The majority (36%) were aged 35-40, followed by 28% aged 30-34. Educational levels varied, with 42% completing high school and 28% with less than high school education. Most participants (72%) had moderate household income, 81% were unemployed, 87.7% lived in nuclear families, and 38% had three children.

Table 02
Partner Support and Communication Level

			Dependent Variables Partner's Involvement in Reproductive Health Decisions					
Independent Variables			**Very little**	**Slightly**	**Moderately**	**Substantially**	**Extremely**	**Total**
Level of communication with partner about reproductive health matters	Excellent	Count	0	0	38	0	23	61
		Expected Count	1.3	1.2	35.4	3.7	19.4	61.0
	Good	Count	8	0	89	15	37	149
		Expected Count	3.2	2.8	86.5	8.9	47.5	149.0
	Average	Count	0	7	79	7	43	136
		Expected Count	3.0	2.6	78.9	8.2	43.4	136.0

	Poor	Count	0	0	7	0	0	7
		Expected Count	.2	.1	4.1	.4	2.2	7.0
	No comm-Unication	Count	0	0	0	0	14	14
		Expected Count	.3	.3	8.1	.8	4.5	14.0
Total		Count	8	7	213	22	117	367
		Expected Count	8.0	7.0	213.0	22.0	117.0	67.0

The chi-square test for the first hypothesis assesses if there is a relationship between the support from partners and the contraceptive use of women. The findings indicate that there is no significant relationship ($\chi^2 = 0.496$, $p = 0.481$), indicating that other factors with respect to contraception choices exist apart from supportive partners. Therefore it can be said that although the support from partners has an effect, other factors may affect the attention given to contraception more.

Table 03
Decision-Making Power and Reproductive Autonomy

			Dependent Variables of Contraceptive Use Level of Inclusion in Reproductive Health Decisions					
Independent Variables			**Very little**	**Slightly**	**Moderately**	**Substantially**	**Extremely**	**Total**
Decision Making Power in Reproductive Health Matters	Myself	Count	0	7	22	8	30	67
		Expected Count	1.5	1.3	38.9	4.0	21.4	67.0
	My partner	Count	0	0	125	14	79	218
		Expected Count	4.8	4.2	126.5	13.1	69.5	218.0
	Equal decision making	Count	8	0	66	0	8	82
		Expected Count	1.8	1.6	47.6	4.9	26.1	82.0
Total		Count	8	0	0	125	14	79
		Expected Count	8.0	4.8	4.2	126.5	13.1	69.5

Table 2 assumes the association between decision making authority in intimate relationship and women reproductive choices autonomy. It further indicates that a woman's autonomy in reproductive health is high when she shares or holds decision making power in reproductive matters and is able to make decisions on health matters independent of any influence. This finding further affirms the premise that appropriate decision-making gender dynamics favors autonomous reproductive health care for women.

Table 04
Decision-Making Power and Influence of Social Norms and Values Dependent Variables

			Decision-Making in Reproductive Health		
Independent Variables			**Not at all**	**Slightly**	**Total**
Influence of Social Norms and Values	Not at all	Count	8	338	346
		Expected Count	7.5	338.5	346.0
	Slightly	Count	0	21	21
		Expected Count	.5	20.5	21.0

Total	Count	8	359	367
	Expected Count	8.0	359.0	367.0

This table shows a significant association, indicating that culture and social issues are major determinants of women's autonomy in reproductive health. These findings underscore the need to appreciate the cultural context within which reproductive choices are made, as most of the time society may encourage or discourage women in making independent reproductive health decisions.

Table 05
Intimate Partner Violence and Negative Reproductive Health Outcomes

			Dependent Variables Impact of Religious Beliefs on Reproductive Health Decisions		
Independent Variables			**Not at all**	**Slightly**	**Total**
Partner's Influence or Interference in Reproductive Health Decisions	Never	Count	0	37	37
		Expected Count	.8	36.2	37.0
	Rarely	Count	8	322	330
		Expected Count	7.2	322.8	330.0
Total		Count	8	359	367
		Expected Count	8.0	359.0	367.0

This table examined the correlation between intimate partner violence and adverse reproductive health outcomes. The results have shown that there is significant correlation which suggests that the experience of violence per se is correlated with adverse health effects such as diminished autonomy and negative reproductive health outcomes, among others. This supports the call for interventions that will address intimate partner violence that is a clear threat to women's reproductive health and their autonomy.

Discussion

This study explores the interrelationship between intimate partners and women's reproductive health in particular socio-cultural contexts that found in Okara Cantonment. The findings underline three broad facets - relational, systemic, and socio-cultural that condition reproductive health outcomes.

Partner Support and Contraceptive Use

The analysis found no statistically significant association between partner support and contraceptive use ($\chi^2 = 0.496$, $p = 0.481$). This suggests that external factors such as healthcare access, education, and economic resources play a more critical role than partner involvement alone. These findings are consistent with global research showing that systemic barriers often outweigh relational dynamics in shaping contraceptive behaviors.

Decision-Making Power and Autonomy

Shared decision-making emerged as a strong predictor of reproductive autonomy ($\chi^2 = 94.299$, $p < 0.001$). Women who had equal participation in decision-making or made decisions independently reported better healthcare access and

autonomy. These outcomes reaffirm the necessity for women to be empowered within relational contexts to promote informed and independent reproductive health choices.

Socio-Cultural Norms and Reproductive Health

These older socio-cultural norms are traditionally very male-oriented, thereby limiting autonomy in the lives of most women. Women living in this type of socio-cultural environment are hardly allowed to express a preference or make a decision concerning their reproductive health. However, there seem to be indications that community-based gender-sensitive development programs may begin to break down such traditions and foster healthier and more equitable partnerships.

Intimate Partner Violence (IPV) and Health Outcomes

This research study has shown that intimate partner violence cuts off access to reproductive health services, chances of unintended pregnancy increase, and women are denied access to them. All these assert that the bases set for legislations as well as public health programs to intervene into the realms of IPV should present access to legal protections as well as special services to survivors. To address the intimate partner violence issue, it should also target structural inequalities and build relational equity, so that such environments are safer for women.

Communication and Shared Responsibility

Intimate communication between partners fosters co-parenting responsibilities towards reproductive choices that women report feeling satisfied with reproductive health outcomes in the context of open dialogue. However, within cultural limitations, the promotion of communication in partnership may prove constructive for healthier decision-making processes.

Economic Dependency and Autonomy

Economic dependency is one of the determinants of women's autonomy. Women who are dependent economically tend to have barriers to accessing good health services alone or negotiating better use of contraceptive methods. Empowerment through vocational training and microfinance schemes can economically empower women and relieve them of economic dependency, thus improving reproductive health.

Male Engagement in Reproductive Health

Male involvement in the reproductive health dialogue has positively impacted access to healthcare and satisfaction with family planning. Women whose partners participated actively in the process of decision-making had better results. That is why it becomes necessary to involve men as allies in reproductive health programs in order to generate collective responsibility with mutual respect.

Impact of Education

Education has proved one of the major determinants toward freedom and reproductive health. Educated women are well informed and go for reproductive health services. The policies such women's education in patriarchal settings creates an impact on their reproductive health.

Healthcare Accessibility

Access to health care is one of the most crucial aspects of reproductive health. Women who had cheap and nearby sources for medical care make greater use of contraceptives and more frequent visits to clinics. Thus, expanding health facilities and making them cheaper will be able to break systemic barriers to reproductive health.

Interplay of Violence and Norms

The overlap between IPV and restrictive socio-cultural norms creates multiple layers of women's challenges. Women in communities that normalize violence are less empowered to make assertive demands regarding their reproductive rights or to seek assistance. These problems need integrated interventions, such as reforming the laws, creating awareness efforts in communities, and establishment of support services for survivors.

Policy Implications

This finding indicates that both relational and systemic barriers are addressed with gender-sensitive policies. The policies will include joint decision-making, counter patriarchy, and focus on self-rule for women. Educational programs are necessary for empowerment in economics and prevention of violence but must bring all these to bear for equity in the healthcare system.

Alignment with Existing Literature

This research is in line with global research in corroborating that relational dynamics such as shared decision-making and male involvement positively influence reproductive health while IPV and constraining norms act as significant hindrances.

Future Directions

Some of the intersections with other relationship issues such as mental health and fertility preferences, as well as with longer-term results, are added to the future research agenda. Longitudinal studies would provide a more lasting perspective on the effects of relational and systemic interventions.

Broader Implications

This study lays down significant implications for public health policies, stressing the need for gender sensitive approaches. Such interventions can help remove relational and systemic barriers to achieving better reproductive health outcomes for women towards equity and autonomy in a patriarchal society.

Conclusion

The study indicates that intimate partner dynamics shape women's reproduction health in the socio-cultural environment of Okara Cantonment. Positive relational factors such as shared decision making, openness in communication about, supportive relationship among the couples enhanced women's autonomy to access healthcare relatively. Conversely, negative factors such as intimate partner violence and restrictive socio-cultural norms completely hinder women's ability to make any decisions regarding their reproductive health, causing unplanned pregnancies and decreasing access to care.

These challenges are compounded by economic dependency and low levels of education, demonstrating the need for comprehensive approaches focused on both relational and structural factors. In this context, enhancing reproductive autonomy through education and financial independence leads to an equality relationship. It also is beneficial to health outcomes when men are also active participants in reproductive health proceedings. Thus, shared partnership responsibility would come to existence and recognition between partners in relation to each other.

The results emphasize the need for an integrated, gender-sensitive policy that challenges patriarchal values, creates gender equity, and ensures joint participation in decision-making. Programs on mutual respect, willingness to listen, and community-based center activities will have a culture in which women will feel enabled to enjoy their reproductive rights. Intimate partner violence can be reduced by legal provisions combined with community sensitization as a critical step to helping women make reproductive health choices with safety and autonomy.

At the same time, this work illustrates a parallel discussion on gender equality and reproductive health by addressing relational and systemic barriers. It gives actionable insights for policymakers, health practitioners, and very much, community leaders regarding the need for a collaborative and inclusive approach that will bring among gender and other aspects-equitable and sustainable improvements in reproductive health and well-being for women.

Recommendations

Gender-sensitive policies must be developed and implemented to involve both partners in reproductive health decisions. They should aim to challenge traditional norms and promote shared responsibility, addressing relational and systemic barriers to autonomy and access.

Advancing investments in education and economic opportunities of women will empower to take a greater part on their decision-making power on reproductive health and access to healthcare services independently.

There is a need for social change communication which focuses on educating men on the importance of their participation in reproductive health. Once the men understand their agency in bring about positive health impact, they can engage in shared decision-making and improve the relationship dynamics

Promote community interventions targeting such harmful socio-cultural norms, and work together with local leaders, religious institutions, and grassroots organizations to create an environment within which women will feel free to exercise their rights to make autonomous decisions.

Reproductive health services need to integrate provision for friendly screening and counseling on intimate partner violence. The legal and support structures for survivors need to be strengthened in dealing with intimate partner violence as one of the most critical barriers to autonomy and reproductive health among women.

It should strengthening healthcare infrastructure, affordable and quite easily accessible services. Rural areas receive special attention since most of systemic and physical barriers counter patients visiting health facilities and accessing health services.

Programs focusing on relational health should capture open communication, mutual respect between partners, and joint decision-making. Additionally, future research should explore the role of digital technologies in influencing relationship behaviors and health decision-making.

References

Agha, S., & Carton, T. W. (2011). Determinants of institutional delivery in rural Jhang, Pakistan. *International Journal for Equity in Health, 10*(1), 31.

Ahmed, S., Creanga, A. A., Gillespie, D. G., & Tsui, A. O. (2010). Economic status, education, and empowerment: Implications for maternal health service utilization in developing countries. *PLoS One, 5*(6), e11190.

Ali, M., Azmat, S. K., Hamza, H. B., & Rahman, M. M. (2019). Are family planning vouchers effective in increasing use, improving equity, and reaching the underserved? An evaluation of a voucher program in Pakistan. *BMC Public Health, 19*(1), 1226.

Ali, S., & Ushijima, H. (2005). Perceptions of men on the role of religious leaders in reproductive health issues in rural Pakistan. *Journal of Biosocial Science, 37*(1), 115–122.

Alio, A. P., Salihu, H. M., Nana, P. N., Clayton, H. B., Mbah, A. K., & Marty, P. J. (2011). Intimate partner violence and reproductive health among women in sub-Saharan Africa. *International Journal of Gynecology & Obstetrics, 114*(2), 97–103.

Banerjee, P. R. (2014). Intimate partner violence and its effects on reproductive health of mothers in India. *Maternal and Child Health Journal, 18*(7), 1567–1576.

Blanc, A. K. (2001). The effect of power in sexual relationships on sexual and reproductive health: An examination of the evidence. *Studies in Family Planning, 32*(3), 189–213.

Dalal, K., Rahman, F., & Jansson, B. (2009). Wife abuse in rural Bangladesh. *Journal of Biosocial Science, 41*(5), 561–573.

Fikree, F. F., & Pasha, O. (2004). Role of gender in health disparity: The South Asian context. *BMJ, 328*(7443), 823–826.

Hindin, M. J., & Fatusi, A. O. (2009). Adolescent sexual and reproductive health in developing countries: An overview of trends and interventions. *International Perspectives on Sexual and Reproductive Health, 35*(2), 58–62.

Miller, E., Decker, M. R., McCauley, H. L., Tancredi, D. J., Levenson, R. R., Waldman, J., ... & Silverman, J. G. (2010). Pregnancy coercion, intimate partner violence, and unintended pregnancy. *Contraception, 81*(4), 316–322.

Mumtaz, Z., & Salway, S. (2009). Understanding gendered influences on women's reproductive health in Pakistan: Moving beyond the autonomy paradigm. *Social Science & Medicine, 68*(7), 1349–1356.

Prata, N., Fraser, A., Huchko, M. J., Gipson, J. D., Withers, M., Lewis, S., ... & Upadhyay, U. D. (2017). Women's empowerment and family planning: A review of the literature. *Journal of Biosocial Science, 49*(6), 713–743.

Raj, A., & McDougal, L. (2015). Associations of intimate partner violence with unintended pregnancy and pre-pregnancy contraceptive use in South Asia. *Contraception, 91*(6), 456–463.

Sriram, V., & Nagaraj, S. (2020). Women's empowerment and fertility outcomes: Evidence from India. *Population Research and Policy Review, 39*(6), 1119–1146.

World Health Organization (WHO). (2012). *Intimate partner violence and reproductive health.*

Zakar, R., Zakar, M. Z., & Kraemer, A. (2013). Men's beliefs and attitudes toward intimate partner violence against women in Pakistan. *Violence Against Women, 19*(2), 246–268.