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Understanding gendered influences on women's reproductive health in Pakistan: moving beyond the 'autonomy paradigm'

ZUBIA MUMTAZ and SARAH SALWAY

Abstract: Recent research and policy discourse commonly views the limited 'autonomy' of women in developing countries as a key barrier to improvements in their reproductive health. Rarely, however, is the notion of women's autonomy interrogated for its conceptual adequacy or usefulness for understanding the determinants of women's reproductive health, formulation of effective policy or design of programs. Using empirical ethnographic data, this paper draws attention to the incongruities between the concept of 'women's autonomy' and the gendered social, cultural, economic and political realities of women's lives in rural Punjab, Pakistan. These inadequacies include: the paradigm's undue emphasis on women's independent, autonomous action; a lack of attention to men and masculinities; a disregard of the multi-sited constitution of gender relations and gender inequality; an erroneous assumption that uptake of reproductive health services is an indicator of autonomy; and a failure to explore the interplay of other axes of disadvantage such as caste, class or socio-economic position. This paper calls for alternative, more nuanced, theoretical approaches to conceptualizing gender inequalities to enhance our understanding of women's reproductive wellbeing in Pakistan. The extent to which our arguments may be relevant to the wider South Asian context, and women's lives in other parts of the world, is also discussed.

Introduction

Contemporary scholarship and policy responses in diverse developing country settings emphasize women's limited 'autonomy' as a key barrier to improvements in their reproductive health (Bloom, Wypij & Das Gupta, 2001; Mason & Smith, 2000; Sathar & Kazi, 1997). Broadly described as 'control over their lives', women's autonomy is viewed as a set of multiple, but inter-linked domains including, but not limited to decision-making authority, economic and social autonomy, emotional and physical autonomy (Jejeebhoy, 2000). A large body of research has focused on developing and refining measures of women's autonomy (Agarwal & Lynch, 2006; Kishore, 2000) and exploring the links between these measures and women's reproductive health (Ghuman, Lee & Smith, 2006; Fikree, Khan, Kadir, Sajan & Rahber, 2001; Morgan & Niraula, 1995; Sathar & Kazi, 1997). This 'women's autonomy paradigm' received a powerful policy impetus from the Cairo declaration (UN, 1994) and it has been particularly prominent in research focused on South Asian settings (Fikree et al., 2001; Ghuman et al., 2006; Mullany, Hindin and Becker, 2005; Sathar et al., 1997).

However, recent theoretical work and a critical re-examination of empirical evidence from various South Asian contexts, leads us to question the adequacy and appropriateness of 'women's autonomy' as the conceptual framework for understanding gendered influences on women's reproductive health. Anthropological research has highlighted the cultural incongruity of 'autonomy' as a concept in various South Asian settings. Jeffery, Jeffery & Lyon (1989) found no local translations of the term 'autonomy' during their fieldwork in northern India and noted that those words that came closest to it, such as '*azadi*' or '*khudmukhtari*', have pejorative connotations at the individual level. Research from Bangladesh highlights the mix of cooperation and conflict that exists between tightly interconnected family members and the primacy of women's kinship-based entitlements (Kabeer, 1997; White, 1992). Notwithstanding variation and complexity, evidence from across South Asia suggests that households are commonly organized along corporate lines where a powerful ideology of 'togetherness' and inter-dependence binds the activities and resources of family members (White, 1992; Mumtaz, 2002). Furthermore, dependency has been highlighted as a key element of the cultural constitution of female identity in research across Pakistan, Bangladesh and India (Shah, 1986; White, 1992; Jeffery et al., 1989).

Survey research also tends to undermine our confidence in the adequacy of the 'autonomy paradigm'. For instance, survey data from Pakistan repeatedly show a weak or no relationship between women's reproductive health and measures of their 'autonomy', such as independent final decision-making, unaccompanied travel and control over personal income (Fikree et al., 2001, Mumtaz and Salway, 2005, 2007; Sathar et al., 1997). A 10-district survey of rural Punjab found no relationship between contraceptive use and women's mobility, economic autonomy and making 'outside' decisions (Sathar et al., 1997). Fikree et al. (2001) found contraceptive use unrelated to women's ability to travel to six different locations and their involvement in routine household decisions in urban Sind. Similar findings are seen at the national level for Pakistan, with weak or no associations demonstrated between women's self-reported travel alone, final decision-making, paid work or control over income and contraceptive use or uptake of antenatal care (Mumtaz, 2002). Only one survey from Punjab found that contraceptive users were more mobile and had greater authority in household expenditures (Population Council, 1997).

A further problem with work that has been set within the 'autonomy paradigm' is the lack of consensus on the definition and operationalisation of the central concept. Dixon-Mueller (1978, p.

6) described autonomy as the 'degree of access to and control over material resources'. Dyson and Moore (1983, p. 45) expressed autonomy as 'the ability - technical, social and psychological - to obtain information and to use to as the basis for making decisions about one's private concerns and those of one's intimates'. Jejeebhoy (2000) understands women's autonomy as 'control over their lives' (p. 205). There is also confusion about use of the term itself, for 'autonomy' is used interchangeably with 'empowerment' by some authors (Presser and Sen, 1997), while others view empowerment as a dynamic concept that includes both processes and outcome (Kabeer, 2000), and autonomy as more static (Jejeebhoy, 2000). Further imprecision is added the by use of multiple terms to describe the gendered positioning of women relative to men. These include 'women's status', 'women's position' (Mason 1987), 'gender inequality' (Morgan and Niraula, 1995) and 'women's empowerment' (Kishore, 2000).

Theorists have also challenged the usefulness of the notion of women's autonomy for understanding gendered structures, processes and inequalities in South Asia, as well as elsewhere. Triandis (1995) and Ogden (1996) argue that the notion of individuals as unique, bounded entities and the inherent value of individualism and autonomy are not unquestioned universals (a theme that we take up more below in our discussion). Reproductive health research (and related policy discourse) that is embedded within the autonomy paradigm frequently fails to acknowledge the assumptions, values and points of reference upon which it is founded or to consider whether these have pertinence for the women whose lives are the subject of scrutiny.

Nonetheless, and despite an increasing awareness of the theoretical and operational difficulties associated with reproductive health research that is framed by the 'autonomy paradigm', this framework remains well-entrenched and uncritically mobilized in research, policy and programme design in developing countries the world over (Fikree et al., 2001; Ghuman et al., 2006; Government of Pakistan, 2002; PAVHNA, 2008). Whilst women's rights to a broad range of social, human and material resources are inalienable, and nowhere more relevant than in the realm of reproductive health, there is a need to critically rethink the concept of 'women's autonomy' as *the* framework for understanding gender and reproductive health in South Asia and elsewhere. The present paper contributes to this critique by presenting a detailed and systematic assessment of the adequacy of the 'autonomy' paradigm for understanding the gendered influences on women's reproductive health within a particular South Asian context - rural Punjab, Pakistan. In so doing, we draw particularly on recent developments in the conceptualization of gender (see Connell, 2002), that have to date had relatively little impact on reproductive health research on South Asia. Having

presented our case for rural Punjab, we turn to consider the wider applicability of our concerns for other South Asian settings and women's reproductive health more generally in other parts of the world. The term 'women's gendered position' is used as generic phrase to refer to the social construct of a female person.

Empirical setting, methods and data

This paper draws on detailed ethnographic work carried out in village Jatti¹, Punjab, Pakistan. Agriculture and livestock rearing are the primary economic activities. There are three primary schools in the village, two for boys and one for girls. A medical technician residing in the village is the only healthcare provider.

Four sequential phases of fieldwork were conducted from January to May 2001 during which the principal researcher (ZM) and a team of one male and one female anthropologist lived in the village. In the first phase, two social mapping exercises and an informal house-to-house survey were conducted. This enabled collection of general information about kinship, class, economic and political structures as well as familiarisation with village members.

In phase two, observation of daily life (to an extent participative) and informal interviews were the primary methods used. A total of 171 observation and informal interview episodes were recorded, but this was just a fraction of the information absorbed.

Phase three became more focused as we explored in greater depth the emic perspectives and contextual meanings of the various dimensions of socio-cultural construction of gender and their implications for use of contraceptive methods and antenatal care services. A total of 35 informal, semi-structured interviews were conducted, including 15 women, 15 husbands and five mothers-in-law. Women were purposively selected based on experience that we believed might illuminate gendered influences on reproductive health. Six focus group discussions with 6-10 respondents each were also conducted, four with women and two with men.

The final phase was a very focused and in-depth exploration of gender-related power structures and contestation of normatively prescribed gender roles. Five very detailed case studies were conducted by repeated interviews and observation of the women, their husbands and other family members.

The interviews and focus groups were conducted in *potohari*, tape-recorded and later translated and transcribed by native *potohari* speakers under close supervision of the principal investigator.

Observation notes were recorded as field-notes either in journals or directly in Microsoft Word. Data were analyzed using thematic content analysis and constant comparative techniques. The transcripts were open-coded manually and re-categorised. The categories were then searched for patterns and insights regarding dimensions of the socio-cultural construction of gender and the experience and management of reproductive health with a particular focus on contraceptive use and pregnancy (Ritchie, Spencer and O'Connor, 2003).

The ‘autonomy paradigm’: exploring its inadequacies for rural Punjab

In the sections that follow we identify seven ways in which the ‘autonomy’ paradigm as commonly operationalised within the reproductive health literature was inadequate for explaining the gendered influences on women’s reproductive health in our rural Punjabi Pakistani study site. These are (1) an undue emphasis on women’s independent, autonomous action, ignoring the strong emotional and structural bonds that tie women and men (2) a singular focus on the husband-wife relationship to the exclusion of other key actors (3) insufficient attention to men and masculinities (4) a lack of cultural specificity in the development of indicators to measure women’s gendered position (5) a disregard of the multi-sited constitution of gender relations (6) the erroneous assumption that change in women’s gendered position is a unidirectional linear process and finally (7) that greater autonomy will lead to increased uptake of reproductive health services, specifically family planning and antenatal care services and that an increased use of RH services is necessarily explained by greater autonomy. In the discussion that follows below we consider whether these limitations are more widely applicable.

An interconnected society: an undue emphasis on women’s independent, autonomous action

The ‘autonomy paradigm’ places undue emphasis on women’s independent, autonomous action, ignoring the fact that household members, both men and women, are tied together by strong emotional and structural bonds. For women in particular, gendered inequalities in access to resources beyond the home often mean that their interests are strongly vested in their families.

Akhathe (togetherness)

A primary theme emerging from our empirical data is the pre-eminence of communality rather than individuality as the social ethic. The concept of ‘*akhathe*’, roughly translated as ‘togetherness’ or ‘jointness’, was the bedrock of Jatti society. The joint family system is just one of its more obvious manifestations for *akhathe* is the principle that forms the basis of the villagers’ sense of self and their socially-recognized identity. The interconnectedness operates at two levels: binding the individual to the family, and families to the *biradari* (a group of households related by blood).

These social relationships constitute an individual's social identity, for an individual is not a construct separate from others. Both men and women are identified first by their *zaat* (caste), then their father's name (husband and later sons for women) and finally their own name, in that order.

The *biradari* is a social unit in which a person participates in a network of relationships that has bearing on his/her economic and social wellbeing. The central elements of *biradari* membership are blood relationships, affective ties, trust and reciprocity. These in turn generate a system of claims and obligations, rights and responsibilities. Membership of a *biradari* enables individuals to draw upon favors, privileged information, material resources and access to opportunities. The society is thus based on institutionalized relationships of mutual dependency that, in the absence of formal welfare institutions, is a form of social insurance.

Mazboot aurat

These social relationships have an important gendered dimension. For men, the key social ties, in accordance with patriarchal norms, are based primarily on blood relationships. These include the parents, siblings, *tayas* and *chachas* (father's elder and younger brothers respectively). The relationships based on marriage ties, besides with the wife herself, are not so critical. On the other hand, a woman's key social ties are her marriage ties. Blood ties, by their nature, are usually secure and certain. Thus, for men, the degree of strength in their social ties was not a major concern. In contrast, the strength of social relationships held greater importance for women since their key marriage-based ties were subject to greater variability and vagaries of *kismet* (luck). Women intuitively understood the significance of their marital relationships and used two terms to describe it; '*mazboot aurat*' (*strong woman*) and '*kamzor aurat*' (*weak woman*). The emic understanding of these terms referred to the strength of a woman's relationships and linkages with her marital family - the degree to which a woman is embedded in her marital family. A '*mazboot aurat*' is deeply and securely embedded; a '*kamzor aurat*'s ties are weak and uncertain.

Endogamy is the dominant marriage pattern in Jatti (95% of all marriages in Jatti and 67% in Pakistan (PDHS 2008). Endogamous marriages not only ensure a woman's linkages with her natal family are retained after marriage, they also increase a man's stake in his marital ties. When a man marries a first cousin, she is not just his wife, but the daughter of his mother or father's sister. In a context, where family connections are practically sacrosanct, he is bound to the woman by more than a marriage contract. Endogamy thus supports marriage ties within a framework of blood ties, and increases a woman's chances of becoming *mazboot*. Nonetheless, it is still relevant to draw a distinction between marriage ties and blood ties, because patriarchal kinship systems and virilocal

residence means that marriage ties have an effect on women's day to day life in a manner they do not for men.

This connectedness is more than academic, as it determines behaviours that range from patterns of household resource sharing to reproductive health information networks and women's access to reproductive health services. Clearly, these kinship structures and a concept of personhood as a composite site of social relationships, do not align well with notions of 'women's autonomy', with its emphasis on individualism and independence.

An over-emphasis on the husband-wife relationship

The second important way in which the 'autonomy paradigm' as commonly operationalized within the reproductive health literature misrepresents the lives of the Pakistani women in our fieldwork site is its tendency to over-emphasise the husband-wife relationship to the exclusion of other key actors. For instance, surveys have often sought to measure husbands' and wives' control over decisions, husband-wife communication, a woman's need for her husband's permission and so on (Allendorf, 2007; Ghuman et al., 2006). While not denying the significance of the husband-wife bond, our empirical work illustrated ways in which women's relationships with other individuals, particularly older women, were important.²

Women-to-women bonds

Women-to-women bonds in Jatti constituted a woman's key social resource. In a context of sexual segregation, *biradari* women were easy to access without arousing suspicion. It was, however, within the realm of reproductive health that women's social relationships with other women were particularly crucial. In a setting of limited education and female seclusion, *biradari* women were a primary source of reproductive health knowledge. Experiences of use of modern contraceptive methods or antenatal care were shared, assessed and evaluated with *biradari* women. This sharing of information also created a *mahol* (social climate) that promoted or inhibited use of health services. Moreover, pregnancy and its associated decision-making (for instance, whether or not antenatal care should be sought, the preferred attendant at delivery and so on) was normatively within the older women's domain. Older women were considered *siyarni* (wise and experienced) and vested with the authority to make these decisions. The quality of a younger woman's inter-personal relationship with older women was therefore an important determinant of whether the younger woman received any healthcare during pregnancy. *Mazboot* women with a strong network of inter-personal relationships with the natal family and other *biradari* women were in a stronger position to negotiate care during pregnancy when not forthcoming. At a societal level, women to

women bonds constitute a conduit for transfer of resources from rich landlords to poor tenants, usually in the form of transport or financial help in accessing health care for a complicated childbirth.

The women's autonomy framework, with its focus on independence, fails to take into these bonds and the crucial support women provide each other in a context dominated by patriarchal norms that have traditionally been hostile to women's interests.

A lack of attention to men and masculinities

A further shortcoming of the autonomy paradigm as applied in the reproductive health context is its focus on women and women's gendered position to the neglect of the socio-cultural construction of men and masculinities. Though there has been increasing attention to treating men as 'partners' who should shoulder equal responsibility for reproduction (UNFPA, 2004), the autonomy paradigm with its focus on women's independence still commonly fails to appreciate the complex ways in which men and masculinities shape women's reproductive health experiences.

Men's crucial role in attitudinal change around family size and fertility control

Our empirical work revealed that, somewhat unexpectedly, Jatti was a context in which a small family was the new norm and contraceptive use the means to achieve it. Over 50% of the 49 eligible couples in the village reported contraceptive use, and only 10% were non-users who did not want any more children. These findings are unusual in Pakistan, a context characterised by stubborn resistance to fertility change (PDHS, 2007).

Further analysis showed that younger men and older women are the key force behind this ideational change. The younger men, largely under 40 years of age and who started their families in the nineties had internalized the concept of small families and fertility control. More interestingly, these reductions in family size were not in any way construed as indicating that the man was any less a '*marud*' (conforming to ideals of masculinity). Instead, practical reasons, such as *mehngai* (rising cost of living) were articulated by way of explanation. Young women, particularly in the early years of marriage, were not expected to have independent opinions, much less desires or goals regarding family size, and nor was there any evidence to the contrary. Their articulated desires regarding small family size and acceptability of contraceptive use simply aligned with the new societal norms.

Men's involvement in women's reproductive health issues

Whilst men in Jatti played a crucial role in the creation of a *mahol* conducive to fertility control, they were not directly involved in seeking family planning services. This was largely in deference to the gendered norms that exclude men from their wives' reproductive health issues. This exclusion is part of the socio-cultural construction of masculinity, which dictates that an ideal *marud* should not be emotionally involved with his wife nor spend too much time in her company. Pregnancy, by its very nature, is associated with sex and the whole issue is shrouded with the concept of *sharam* (shame). In joint families, where members of the older generation are present, a man is considered *besharam* (shameless) if he exhibits an 'excessive' interest in his pregnant wife. A belief system that views the whole physiological process of reproduction is somehow '*napaak*' (impure) and 'polluting' in concert with the notion of pregnancy as a uniquely feminine attribute, further excludes men.

This exclusion has important implications for women's reproductive health for it results in men having minimal knowledge of symptoms of danger in pregnancy. Husbands, particularly young husbands, who would otherwise be powerful decision-makers, were effectively marginalised from this arena despite their instrumental and emotional interest in their wives' well-being. However, the exclusion was not complete because, as providers, men shoulder the financial burden of any health care sought. Other family men, commonly the husband's older brothers, were frequently consulted in decision-making around seeking -medical care.

Men and the socio-cultural construction of masculinities are now recognised to have important implications for women's reproductive health outcomes (Mullany, Becker and Hindin, 2007), however, research based within the autonomy paradigm seems unlikely to produce a full understanding of these complex influences.

A lack of cultural specificity in measures of women's gendered position

Informed by the 'autonomy' paradigm, a set of standard indicators have been developed and used to measure women's gendered position across multiple settings (for instance the ubiquitous Demographic and Health Surveys). In the South Asian literature, particular attention has been given to three dimensions: independent mobility, final decision-making, and control over financial resources. Our data from Jatti illustrate that a failure to recognise the nuanced and contingent nature of these dimensions of women's lives may mean that such indicators fail to capture what is intended.

Slaa-mashwara

In relation to decision-making, measures that are not culturally-informed fail to effectively assess the degree to which women are involved in and able to influence decisions within their families.

Common wisdom in *Jatti* states the need for *slaa-mashwara* before making any *faisla* (decision). *Slaa mashwara* roughly translates as ‘discussion and opinion’, and the term captures the co-operative and consensus-based nature of the decision-making process in this society. Negotiation is particularly emphasized in this context for it indicates that the individual is acting within the ideology of *akhathe* (togetherness). Not only should *slaa-mashwara* involve close family members, including wives and mothers, but for some decisions, particularly marriage negotiations, it is essential to consult with members of the wider *biradari*.

Despite the emphasis on joint-decision-making, and acknowledgement of women’s role in decision making, it was clear that *Jatti* women’s involvement should not be too obvious. Men were normatively expected to make final decisions, or be seen to be doing so, albeit after *slaa-mashwara*. Whilst older women may overtly have a considerable say in the *slaa-mashwara* process, young women were not expected to voice their opinion forcefully, nor be seen as making the *akhri faisla* (final decision), for doing so was considered an erosion of their husband’s masculinity. While there was space for the young women to participate in and greatly influence decisions in private, in public women went to great lengths to credit men for any decision. Moreover, decision-making in domestic domains, that have tended to be the foci of survey measures aimed at assessing women’s decision-making involvement, did not necessarily translate into an ability to make *reproductive health* decisions. Decisions relating to young women’s reproductive health issues remained older women’s culturally ordained responsibility. Decision-making domains were found to be quite distinct so that heavy involvement by certain actors in one domain did not straightforwardly predict involvement in other spheres of family life.

Women’s access to and control over economic resources

A key argument in prior research literature for exploring women’s control of income is that access to healthcare commonly involves financial outlays and that earning an income produces shifts in gender relations that will result in women having greater power within the household (Kabeer, 1997). Here again we find complexity in the meanings associated with observed behaviours, and the need to look beneath the surface for emic meaning.

Our empirical work in *Jatti* largely confirmed the patterns reported in previous work in South Asia: men were primary providers and woman’s work for wages was a sign of economic poverty and

men's inability to provide (Kabeer, 1997). There were a few households in which women were either the primary providers or made relatively large contributions to household income. However, where women did play such income-earning roles there was no automatic shift in household gender relations. These women, without exception, handed over their wages for household use. Such behaviour can be understood within the kinship ideology of *akhathe*, the fact that women view their interests as closely tied to their family's wellbeing and the limited options women have outside the family unit. Women's maternal desires to protect the welfare of their children were also operative. In fact, the earning women often made a concerted effort to uphold the image of their husbands as primary providers, mainly in deference to the ideology of male provision, but also to avoid threatening their marital ties.

Equally, however, the handing over of income by these working women could not be interpreted simplistically as a reflection of their lack of power over household resource distribution. Rather than keeping their money and independently deciding its use for reproductive health care, the overall strengthening of the financial status of the household was the strategy women pursued towards securing the care that they wanted. Survey findings reveal that the socioeconomic status of the household is a far stronger predictor of uptake of reproductive health services than whether a woman herself is working (Mumtaz and Salway 2007); further suggesting that measures of 'control over income' fail to adequately capture the complexities of household resource management and allocation.

'I never go anywhere'

In relation to mobility there has been a tendency to reify the norm of female seclusion and the 'public-private' divide within the South Asian reproductive health literature. The diversity of behaviour in practice has been overlooked as well as its dependence on local context and economic imperatives. While women's mobility is clearly an important aspect of their gendered identity, our work in Jatti clearly illustrates that travel beyond the home cannot simply be equated with some notion of 'freedom of movement'.

Despite the frequent assertions from women that 'I never go anywhere', women were seen to travel alone in remote fields herding cattle and visiting relatives. One explanation for the variance between observed and reported mobility was the emic construction of space and movement. A space was classified as '*ander*' (inside) when populated by *biradari* members. Presence of a non-*biradari* member transformed it into *baar* (outside space) irrespective of its geographical location.

Nonetheless, unaccompanied mobility within the village was higher among poorer women than the better off, largely because of the necessity of their work-related movement. This mobility, however, came with a cost of physical insecurity and loss of social prestige (see below for more on this). In contrast, where high socio-economic status, strong social linkages and employment converge, as in the case of educated professional women, such movement was more legitimate.

Importantly, we found no direct relationship between a woman's usual patterns of mobility and uptake of reproductive health services. The decision to use a service was the key issue. Once a decision was made, women invariably travelled *with company*. Women sought company for it protected them from potential accusations of sexual misdemeanour and ensured someone would look after their interests the case of incapacitation in a usually hostile health care system. Thus the survey measure 'unaccompanied mobility' was not an indicator of an autonomous independent women that it is commonly assumed to be.

These three sets of findings illustrate the complexities and subtleties of measuring a multidimensional construct such as women's gendered position and the importance of context. The women's autonomy framework, with its focus on individualism and independence and its assumption of universal applicability, tends towards over-simplification of complex and context-dependent dimensions of women's lives.

A lack of attention to the multi-sited constitution of gender relations and gender inequality

While it cannot be denied that the household is a central location for understanding gendered influences on women's reproductive health, much work located within the autonomy paradigm has tended to divorce the household from the wider socio-cultural and economic context within which it is situated. According to Connell (2002), it is impossible to understand personal level gender relations without taking into account gendered inequalities in society's institutions, labour markets, governments, judiciary and the media. Pre-existing societal level gender inequalities and rigidity of prescribed forms of behaviour may constitute as powerful an influence on women's reproductive health as an individual woman's or household-level characteristics.

Women's caste and class related vulnerabilities

Our work in Jatti showed that while all women were disadvantaged by their gender, higher caste and closely associated socio-economic class attenuated the impact of gender hierarchies on women's reproductive health. Subordination by caste, class and gender converged to disproportionately disadvantage poor women. In Jatti, *zaat* is a concept similar to the Hindu caste

system. An individual is born into a certain *zaat*, which determines occupation and from there socio-economic class, upon which hinges prestige and power. There were three major *zaats* in Jatti: the Rajas, Maliks and Kammis. The 21 Raja families owned about 90% of the land. Land ownership conferred power and prestige. The Maliks could be considered middle-class. Some worked as tenant farmers on Raja lands whilst the educated ones worked as school teachers. The poorest and socially weakest were the Kammis. They did low prestige work, were politically marginalized and most helpless in the face of blatant violation of their rights.

Analyses of the social stratification of Muslim communities in the sub-continent repeatedly discuss whether the concept of the 'caste system' is a relevant paradigm for understanding class differences (Madan, 2001). Our analyses of the *zaat* system in Jatti suggest that whilst it lacks the basic criteria of the Hindu caste system, which is based on notions of purity and pollution, it is very hierarchical. The Rajas have the highest social status, while the Kammis are considered *katia* (low class) and *kameenee* (low forms of life).

Poor Malik and Kammi women's lower caste converged with their poverty-pushed work outside the home and subsequent greater mobility to render them vulnerable to sexual abuse by rich land-owning Raja men. If the Raja men's accounts are to be believed, sexual activity with Kammi women was commonplace and amounted to rape. Presented as the result of highly sexed Kammi women chasing rich Raja men, this sexual activity was clearly embedded in power differentials based on class and gender.

Girls' schooling

The state of girls' educational opportunities in Jatti also revealed the gender hierarchies embedded in broader societal institutions. There was only one school for girls in the village, compared to two for boys. Much more revealing was the location of the girls' school – in the village graveyard. The graveyard was the only common land the villagers were willing to donate, indicating the value they gave to girls' education. The quality of education provided was also very poor, which contributed to a high drop-out rate. Another societal barrier to girls' education was the insecurity of the larger environment. As discussed above, the landowners viewed lower *zaat* women as legitimate objects for sexual gratification, even if it meant using force. The general climate of insecurity thus created was frequently cited as a reason for limiting women's mobility and not sending girls to far-away schools, with resultant low levels of female literacy. Low levels of women's education are positively associated with low contraceptive and antenatal care use rates (Mumtaz, 2002).

The autonomy paradigm, with its focus on the individual woman and the form of gender relations at the household level, is silent about the role of gender hierarchies embedded in societal institutions and how they serve to create vulnerabilities that undermine women's health. It leaves unquestioned the social hierarchies of gender, class and *zaat* (caste) in collectivities and communities and ignores how these structures ultimately affect women's reproductive health and wellbeing.

Change in women's position is erroneously presented as unidirectional

Much of the reproductive health research within the 'autonomy paradigm' has tended to present change in women's position as a unidirectional, linear process, from 'traditional' women who lack 'freedom and control' to 'modern, autonomous women'. Such an analysis leaves no room for the multidimensionality of women's gendered position or the multiplicities of forms of femininity found in practice. It also downplays the agency that individual actors display in perpetuating and renegotiating the gender order (Connell, 2002).

Such complexities were readily apparent in *Jatti* and emerged most clearly in the economic realm. Larger forces, beyond the control of individuals, made some women the primary providers in the presence of healthy working male members. Other women managed household and farming finances because their otherwise hardworking husbands were not good negotiators. These reversals show that gender norms are amenable to manipulation and individual behaviours adjusted in response to particular circumstances, opportunities or constraints.

More interestingly, these situations were not taken as 'masculinization' or 'modernization' of the women in any way. Rather the women constructed their new role of a provider as another form of femininity that seamlessly merged with an existing notion of femininity, that of the 'mother as nurturer'. In fact, the women made extra effort to downplay their economic contribution and actively embrace other aspects of femininity to demonstrate their acquiescence with the dominant gender role expectations. The gender hierarchies, despite small shifts in the 'doing' of gender roles by men and women, remained intact.

Transformation of a woman's gendered position is a conceptually complex terrain. Women adapt their gender identities and behaviours over the course of their lives in response to changing circumstances. Ideals of gendered roles, behaviours and practices are not fixed, nor are notions of ideal womanhood. The women's autonomy discourse, with its polarized view of the oppressed woman, fails to acknowledge the many ways in which women negotiate gender rules and norms, and how they stretch the boundaries of 'acceptable' behaviours and practices.

Uptake of reproductive health services is erroneously assumed to be an indicator of greater ‘autonomy’

There has been a tendency to assume that the uptake of reproductive health services is itself an indicator of women’s greater ‘autonomy’; that ‘autonomous’ women will necessarily be more likely to use services. Most analyses have tended to compare users and non-users of services at particular points in time and looked for indications that users are more ‘autonomous’ (see Bhatia & Cleland, 1995). The general lack of strong empirical associations, however, suggests that the assumption that more ‘autonomous’ women will be more likely to use services is flawed

As discussed above, Jatti was a context unexpectedly characterized by a positive attitude to volitional fertility control, primarily through contraceptive use. There was, however, little evidence of corresponding change in gender ideologies. There was no evidence of increases/changes in women’s access to or control over economic resources, decision-making authority, unaccompanied mobility or social identity to explain the profound changes taking place. Son preference, another gendered value, was also unchanged although reduced to one to two sons.

We postulate that women’s lower fertility today was the result of the following sequence of events. The concept of fertility control was not new for older women - most had wanted to control their fertility when young, but did not have the technology to do so. Electrification of the village exposed the villagers to health education messages, which had a two-fold impact; they highlighted and gave legitimacy to what was essentially a woman’s, possibly unspoken need and they recruited and converted the younger men, a powerful decision-making group of the future. The economic deterioration of the 1990’s in Pakistan acted as a catalyst to reduce family size in an environment primed for change. The newly paved all weather metalled road provided the infrastructural support that enabled women to commute to the nearest urban area, located about four hours drive away, to access the contraceptive services.

Similarly, uptake of ANC services had occurred in certain families without any significant shifts in gender norms. Antenatal care use was primarily determined by the acceptance of its utility by a woman’s marital family, whether it was an acceptable behavior in the eyes of the larger *biradari* and a financial ability to pay. There was, however, no change in gendered behaviors such as in younger women’s acquiescence to older women’s decision-making authority in matters related to pregnancy or the husband’s exclusion from their wives reproductive health domain.

Clearly, either changes in the gender order are not *necessary* for large rises in the use of reproductive health services to take place or the autonomy framework is an inadequate framework to capture the changes in reproductive health seeking behaviour and associated gendered structures that may have occurred.

Discussion

This article highlights the inadequacy of the autonomy perspective for understanding gendered influences on women's reproductive health, and for grounding reproductive health policy and programs in Pakistan and South Asia generally. Women's rights to a broad range of social, human and material resources are inalienable. However, as our empirical data suggest, a vision of exercising these rights via autonomous independent action is problematic. Policies based on such a conceptualization are unlikely to lead to effective action because of the incongruity between notions of individualism inherent in the concept of autonomy with the socially-embedded reality of people's lives.

Prior research from Pakistan and South Asia has drawn attention to the inadequacies of the autonomy paradigm for conceptualizing the influence of gender on women's reproductive health without clearly articulating it as such. For example, research from Pakistan highlights the important role mothers-in-law play in fertility decision-making (Kadir, Fikree, Khan and Sajan, 2003). Women who report discussing family planning with their mother's-in-law were more likely to report use of a modern contraceptive method (Fikree et al., 2001). These findings support our assertion that women to women bonds are a young woman's key social resource. Similarly, survey findings from Nepal show that higher women's autonomy, as measured by a woman's final decision-making, was associated with significantly lower male involvement in her pregnancy health (Mullany et al. (2005). The authors proceed to question whether the notion of women's autonomy, with its focus on women's independent decision-making power impedes male involvement in women's health.

The autonomy paradigm has provided some important, if imperfect insights in understanding how gender inequities have impacted upon women's reproductive health. The need now is to complement this discourse with a coherent set of theories and assumptions that (1) are explicitly informed by concepts of a person, not as a isolated atomic individual, but one embedded in a web of social relationships (2) take into account the broader social, political, economic, racial, and gender hierarchies and how the resultant inequities operate, at the level of individual women, family, society, nation-states and globally, to shape women's experiences of reproductive health and illness (3) engages men not as the 'oppressors' that women have to break away from, but as partners

connected by strong emotional and affective ties, remaining cognizant of the gender imbalances that exist (4) will incorporate the knowledge and lived experiences of women traditionally excluded from the production of knowledge.

The concept of centrality, first put forward by McCarthy (1967) and elaborated upon by White (1992) offers important insights and a way forward for re-thinking gender as a social construct. Its focus on relationships rather than essential individualism, its sensitivity to the connectedness of women and men as people who live under the same roof and share a life aligns closely with our empirical finding that women want to be *mazboot* members of their families. This approach, subject to further theoretical development, may enable us to identify ways to strengthen women's rights within the household and make them secure and valued members of their families, with strong formal legal, political and economic rights in the broader society.

The generalizability of our arguments must be considered. To what extent do findings from one village setting in Pakistan apply to the rest of Pakistan, South Asia and beyond? Pakistan is a large, heterogeneous country in which gender rules, regulations and behaviours vary by ethnicity, rural-urban areas, and class (Mumtaz, 2002; Donnan, 1997). While we do not claim that the specifics of the Jatti socio-cultural setting will necessarily apply to other parts of Pakistan, we do argue that the generic inadequacies of the 'autonomy paradigm' discussed above are likely to be widely felt for the following reasons. One, the foundational principles underlying gender ideologies and values, kinship systems and concepts of personhood tend to be common over large regions (Jejeebhoy and Sathar, 2001; Dyson and Moore, 1983). Second, gender systems are not isolated structures; they are embedded in political, social and economic contexts (Morgan & Niralua, 1995). Previous research has shown that Northern Punjab, the site of our fieldwork, is characterized by a political economy in which arid agricultural practices and small landholdings force men to seek off-farm work in nearby urban areas. The resultant exposure to alternate lifestyles combined with women's greater involvement in farming activities has resulted in relatively relaxed gender norms compared to other parts of Pakistan. Skewed land distribution patterns and correspondingly powerful landlords mean class and gender hierarchies are more acute in Southern Punjab, Sind and Baluchistan. We content that our empirical data from Northern Punjab are conservative and the generic inadequacies of the autonomy paradigm are likely to be felt more acutely in the rest of Pakistan (Sathar and Kazi, 1997). Third, if we assume that the kinship systems and associated gender structures are somewhat similar in the belt of classical patriarchy that extends from the Middle East, across northern parts of South Asia to South East Asia and China, then our arguments may even be applicable to these regions.

This leads to the next question: Do the generic inadequacies of the women's autonomy paradigm have a global relevance? Is it even appropriate to dichotomize South Asian-Western notions of personhood? The concept of individual autonomy, despite its centrality in western moral and political philosophy, and the fact that it remains a key foundational assumption of personhood in contemporary western cultures, is a contested concept. Code (1991), for example, contends that the notion of self-sufficient independence implicit in the concept of autonomy is a western cultural character ideal that is inherently masculine, and it devalues relationships of interdependence such as friendships, loyalty, caring and responsibility. Nedelsky (1989) argues that the presupposition of separateness embedded in the concept of autonomy is counter to the recognition that people are socially embedded and seem to be at least partially constituted by their social relations. Anthropological work also suggests that the contrast between Western and South Asian personhood has been too starkly drawn (Carsten, 2001; Jeffery et al. 1989) for a central tenant of the sociological perspective is that people are socially embedded. All over the world, people experience their lives bound up with concerns of other people, with obligations and demands, joys and benefits of a social life. It may, therefore, be safe to assume that the first limitation of the autonomy paradigm, its focus on individualism to the neglect of social relationships, may have universal applicability.

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¹ Names have been changed to ensure confidentiality.

² In contexts outside South Asia where marriage practices and household living arrangements mean that sexual partner may not necessarily be formally married, and husbands and wives do not necessarily reside together there seems to have been greater attention to other relationships (Peltzer et al., 2006).