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KNOWLEDGE AND USAGE OF CONTRACEPTIVES, INFLUENCING MALE REPRODUCTIVE HEALTH BEHAVIOR

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ABSTRACT

Introduction: *In Pakistan, male involvement in reproductive health started long before the concept of a holistic approach emerged from ICPD in 1994. Men are far behind the knowledge about contraceptives, authority of decisions making, religiosity, and exposure of media, health attitude, physical cost, Knowledge of HIV/STDs, drugs and family planning services. These circumstances have damaging-effect on men's reproductive health as well. The poor reproductive health of men in the entire Pakistan has been reported in many studies. The different national and international agencies have shown a great concern on this alarming situation of men's deteriorating reproductive health status. They have recommended investigating the men reproductive health status in relation to different aspects. In this context the main objectives of this study is to identify and analyze different types of socio-cultural characteristics, affect the attitudes, lack of awareness of respondents toward reproductive health behavior were examined in Punjab-Pakistan.*

Methodology: *A cross sectional study was conducted in 3-districts of Punjab province. In this way the total sample size will be 600, 300 from rural and 300 from urban areas. A well-structured questionnaire consisting of open ended and close ended questions has been prepared in the light of research objectives. Pre-testing was also in the study plan to examine the work-ability of questionnaire and to know the sensitive issues which can be tackled intelligently.*

Results: *Bi-variate and multivariate analyses were used to explore the relationship between different terms MRHB. The results regarding age, discussion about reproductive health problems, general health status, Knowledge about Contraceptive, Contraceptive use behavior of the respondents and their reproductive health behavior were having their strong relationship and*

communication of affairs with wife having no relation and in multivariate analysis were used to build model and respondents age at marriage were highly significant and age of the respondent, communication of affairs, ideal number of children in a family were non-significant with MRHB.. The value of adjusting R^2 is 0.660 and it indicates that about 66% variation in the dependent variable is explained by knowledge about contraceptive and use of contraceptive.

Keywords: Reproductive health behaviour

INTRODUCTION

The broadened agenda for reproductive health care has emphasized the interest in STIs, and not limited to HIV. Three main historical features which have leads to this change are as followed: Among the historically discernible influences resulting in this change three stand out. First, women's health advocates and other interest groups opposed the vertical contraceptive delivery systems designed to achieve demographic goals and which overlooked other issues in reproductive health (Sen et al., 1994). Second the HIV pandemic raised awareness of other sexually transmitted infections, given the acknowledged interrelationship of the two epidemics (Jones. and Wasserheit., 1991). Finally, the influential 1993 world Development Report disclosed the burden of health problems caused by STIs (World Bank., 1993).

Knowledge

Survey on men as active participants present the key role of men in family planning and particularly in fertility choice of their wives. Survey conducted on the basis of demographic and health factors have shown that most of the men know and use a variety of family planning methods. A vast majority in most of the surveys, men can name at least one method of contraceptive method, for example, in 21 countries included in one analysis; more than 90 percent of men have known and reported a contraceptive method (Drennan., 1998). However, beyond the knowledge of, and attitude towards, contraceptive methods, men are often found to misunderstand and misinterpret possible infection's signs for having very less knowledge and understanding of primary reproductive health (Singh and Darroch, 1998).

Objectives

I. To probe into the socio-cultural characteristics of the respondents living in rural and urban areas.
II. To find out the factors which affect the attitudes of respondents toward reproductive health.
III. To find out the affect of knowledge about contraceptive use on reproductive health behavior.
IV. To suggest the possible measures to the Government for framing an adequate policy to enhance the reproductive health status for males**.**

Conceptual Framework

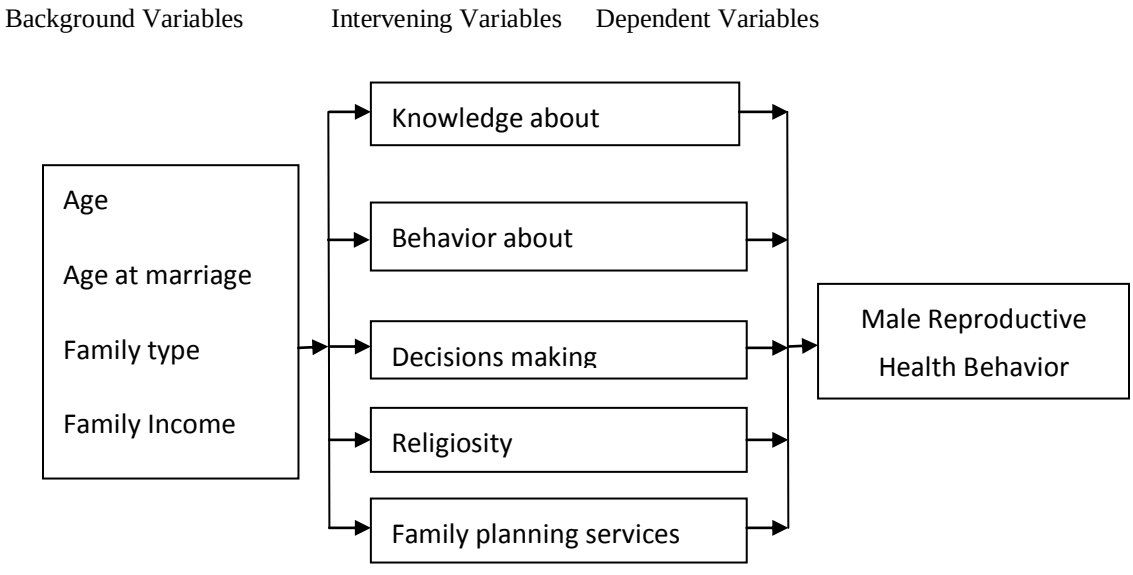


Figure-1.1. Theoretical Frame Work

Reasoned Action Theory

In 1980 Ajzen and Fishbein presented human behavioral named as theory of reasoned action (TRA) encompassing the human behavior has put forward by (Ajzen and Fishbein, 1980), that was resulted from attitude research from the expectancy value models. Theory of Reasoned Action was presented after measuring the compatibility between attitude and behavior. Theory of Reasoned Action was related to voluntary behavior. Later on behavior appeared not to be 100% voluntary and under control, this resulted in the addition of perceived behavioral control. The theory of reasoned action was renamed as the theory of planned behavior after the addition of perceived behavior control. Theory of Reasoned Action described: the intention to perform a behavior provides a base for any human behavior and intention is resultant of a person's attitudes towards behavior and its related norms. Intention can be defined as the basic enforcement behind behavior which can also be described as the psychological representation of a person's readiness or acceptability to perform a certain given action and it is considered to be the occurring antecedent of behavior. There are three things which determine the intention of some action.

- Attitude toward the specific behavior
- Subjective norms
- Pre-defined rules for behavior control.

The Provision of useful information for the development of communication strategy is another theory which helps the researchers a lot in evaluation studies. Other usages of the theory include: voting behavior, disease prevention behavior, birth control behavior, Reproductive Behavior, consumption prediction.

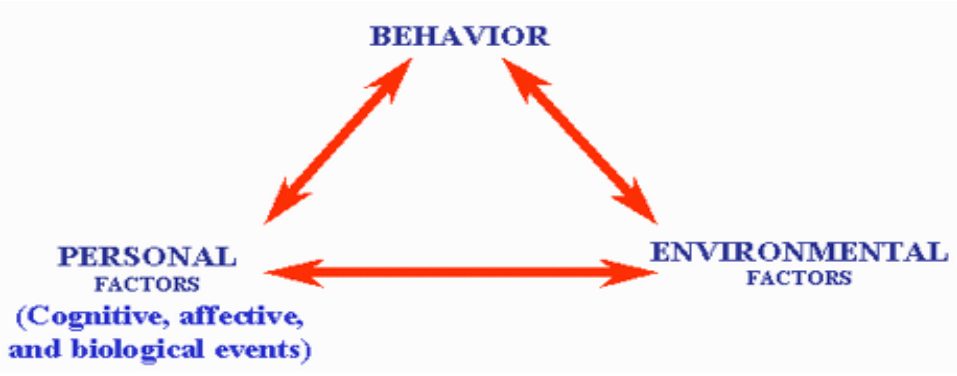
Social Cognitive Theory (SCT)

Social Cognitive Theory (SCT) is based on the learning thoughts of interrelated behavior, environmental factors, and personal factors. It is a process of learning through terms including thoughts, experiences and senses that leads to develop both constructivism and Cooperative Learning. According to Social Cognitive Theory, the researchers have deduced that a person learns from his personal experiences as well as from the environment in which he is living. The past experiences and result are observed closely to determine and understand the new actions and behaviors and the strategies to analyze the new behavior. Because Social Cognitive Theory is based on understanding an individual's reality construct, it is especially useful when applied to interventions aimed at personality development, behavior pathology, and health promotion. Using the Social Cognitive Theory, we could prevent smoking by a person by exemplifying other, so that the smokers, himself may learn from the ex-smokers that bad result of his behavior with a patient's unique personal learning. Ideally, the patient's affinity with the ex-smoker, when combined with a supportive environment, would help him or her butt out for good. The Social cognitive theory was proposed in 1941 by Miller and Dollard but in 1963 Bandura and Walters broadened the social learning theory by adding the principles of observational learning and vicarious reinforcement that would help the person to learn from others' experiences and thoughts.

Assumptions & Statements

The social cognitive theory discussed the causes which affect the people to attain and maintain any particular behavioral pattern in relation with other co-related strategies (Bandura, 1997). Behavioral change depends on the factors environment, people and behavior. The most important factor to affect a person's behavior is Environment viz milieu that is further divided into two types, 1. Social environment , 2. Physical environment. Family members, friends and colleagues are the factors which form social environment while physical environment consists of the size of the room, the ambient temperature or the availability of certain foods. Environment and *situation* are the key factors to provide the framework for understanding behavior (Parraga, 1990). The cognitive or mental representations of the environment that may affect a person's behavior. The situation is a person's perception of the lace, time, physical features and activity, Environment, people and behavior are the three factors which are constantly interdependent. Behavior cannot be said as the result of environment or the person only just as the environment is not an outcome of the person or behavior. Behavior can be thought by presenting models from the environment. (Glanz *et al.*, 2002). The environment provides models for behavior. *Observational learning* occurs when a person watches the actions of another person and the reinforcements that the person receives (Bandura, 1997).

Figure-1.2. Conceptual Model of SCT.



Source: (Bandura, 1997) Self-efficacy in changing societies. New York: Cambridge University, Press. Baronson (Eds.), Hand book of Social Psychology: 379-440.

Application of the Theory

The Social Cognitive Theory is also related health education and health behavior programs. This theory explains how people acquire and maintain certain behavioral patterns to promote health education and health behavior. This theory also used for providing the basis for intervention strategies.

Sexuality Connection in Reproductive Health

The reproductive health concept was brought into light in the 1980s with a new approach to women's rights with reproductive health and family planning. The main foundation of this approach was , that woman should have their rights to reproductive health, that regulate her fertility to avoid any type of disease infertility or fatal death caused by her reproduction and to bring up healthy children (Germain. and Ordway., 1989). The research on sexual behavior is enlightened due to international AIDs crisis. In casual relationship where long term relationship are not supposed to be developed, condom usage is more common to minimize the effect of any possible rejection (Soskolne et al., 1991). The fullest treatment of this topic of reproductive health behavior of specially men is a study of women in New York City who were exposed to the risk of AIDS because of their intravenous drug use of sexual contacts with male drug users. Women who are sexual decision makers are engaged in prostitution or hustling had more power to determine what type of sex to have and whether to use condoms (unless they were drug dependent themselves than did women sometimes the same women. Women has control over sexual decision making have the only choice to use a condom with their sexual male partner every time they asked their male partner to use a condom. Many researches on contraceptives use also pointed out different misinformation sources about the causes of AIDS/STDs. At this level , the survey emphasis on the more elaborate discussions of all STDs and in sex education classes, on regular basis (Worth., 1989).

Socio-Cultural & Demographic Factors

Looking at the drop in fertility or the increased age at first birth, the decline in the marriage rate or the increased age at marriage, the rise in extra marital births or the increase in divorcee, all the demographic indicators have changed appreciably over the past few decades. It is the rate of change and the timing of the establishment of these new patterns of behavior that differs between European countries rather than the nature of the changes observed (Leridon, 1999). These changes, which are taking place against a background of a general decline in religious influences. All these transformation reflects young people's changing attitude to the family and sexuality, higher educational achievement among young men and women, a rise in the latter's labor force participation rate and the striking spread of modern contraceptive methods (Bozon Michel. and Kontula Osmo., 1998).

The literature on demographic factors had always emphasized that the changes in attitude and behavior of reproductive and population, which influence demographic outcomes, depends on the socio-economic and cultural setup of a population and the changes in the circumstances. It was true that the socio-economic change was conceivably related to one's nation of residence, especially because so much of socio-economic change was driven by policy or at least by the changes in one's more immediate environment. But the "culture" that fertility and population inhabits might not respect political boundaries as easily as do actors such as family planning programmes or economic development (Amin. *et al.*, 2002).

Sexual Behavior

The startling growth of HIV/STIs infections is the main reason to emphasize male responsibility for the safer sexual practices and use of condom. Sexuality and Reproductive behavior means total sexual make-up of an individual, covering, the attitude, values, experience, physical aspect, and preference. In the social context reproductive and Sexual behavior varies individual to individual and within the societies (Bhende, 1993). Many surveys and research on STD/HIV/AIDS have proved that male are more actively involved in earlier sexual activity than females and the propensity for multiple partners is also more among them. Moreover, the risk factor is more in males as they visit CSW (commercial sex workers) and aspect of migration of men away from home makes it more pertinent to involve men in reproductive health (Orobaton., 1993).

Lack of Knowledge in Males/ Men are Uninformed about Fertility Control

keeping in view the child bearing and rearing as a primary concern of women , we expect that men did not know much about contraceptive methods in general and females control methods in particular. The men, in most cases, seem ignorant of contraceptive methods particularly of females control methods. The need is to make men aware of female reproductive cycle while men are having knowledge of contraceptive methods same as women (Ezeh. *et al.*, 1996). On the other hand, men rarely perceive the many and varied dimensions of the use of contraceptive including side effects , effectiveness, ease of use or privacy. According to a survey in Philippine, it is brought

into light that men are as knowledge full of contraceptive methods ad their attribute as women. In general, but among matched spouse, there was a certain level of disagreement (Biddlecom. *et al.*, 1997).

The availability of family planning services for the whole population is a major cause of the decline of fertility and use of contraception had been the main proximate determinant of the decline. Equally, fertility preferences had fallen across the population. There are fertility transitions given consideration on the basis of supply and demand factor. The ratio of the adoption of contraceptive and reproductive change is somewhat the same in educated and working women and women in commercial framing areas (Muhwava, 1996). Mortality and fertility tend to be positively related, in the sense that other things being equal, mortality was likely to have a positive impact on fertility and vice versa. High fertility rates, for instance, were typically associated with short birth spacing, which was quite often detrimental to child health. Maternal education also helped in achieving the planned number of births. This reduction of unplanned pregnancies was another basis of the negative relationship between female education and fertility. Husband's education also plays an important role in several demographic phenomenon like desired family size, knowledge and maternal health care, consensus regarding decision making etc (Murthi *et al.*, 1995). In Pakistan, the lowering of fertility rate is a result of Stronger Government commitment to reproductive health and family planning. Since last many years a noticeable decline in birth rate is witnessed in even developing countries e.g. Pakistan , where the women are preferring bearing two children only that is the result of the fact that human population cannot grow in the face of a limited base or resource (Cleland and Luslt, 1997).

Reproductive Health Services

The majority of health professionals indicated that non-poor women whether urban or rural would go to a doctor or paramedical staff member in private hospital or maternity clinic for care. Poor women on the other hand, whether urban or rural, more generally availed themselves of these services of higher level staff in public facilities. Urban women with more resources are more likely to be hospitalized if any complication occurs. Rural women with resources are the next most likely to be hospitalized over poor urban women, suggesting that financial resources are more important predictor of hospitalization than residence (Fikree., 2003).

The availability of basic medical services in health facilities, data shows higher level of facilities in public and private sector, have a good range of services, including specialists in gynecology, medical and allied services, surgical capability as well as radiology and anesthesia. However middle health facilities (THQs and RHCs) in the public sector show a troubling lack of basic services, which are of major concern in terms of improving access to reproductive health services in semi-urban and rural areas of Pakistan (Shah, 2003).

It is needed to improve family planning services in Pakistan with an insight to weaken the obstacle that restrict Pakistani couples for the practice of effective contraception. The priority that must be given to improving family planning services especially to men. Most of the Pakistani women are aware of the contraception due to induction of abortions or their past experiences with contraceptives.

Knowledge/Use of Contraceptives

It must be stressed that in certain situations, the question of contraception may not arise as it is suggest a certain social capacity to control the course of one's life (Bertin., 1995). Where the issues of social survival are such that they undermine any use of contraception. Some studies showing that women with the most education and women who are atheists are more open to contraceptive issues (Stembera and Velebil, 2000). It should also be noted that contraception can be considered only if the woman and man feels concerned by contraceptive issues. This implies that she must feel free to have a sexual life, which is far from being the case in all societies. While another study emphasis on young men's involvement in reproductive behaviors, and said that is a very important issue to involve young men as well as women in this typical issue (Bozon., 1998; Narring, 2000). Similarly another study showed that, Young men and young women experience sexuality in a very different way. Men focus much more on physical pleasure, whereas women are more concerned with the affective and emotional aspects. These ways of experiencing, which produce and reproduce social gender relationships, has an impact on how contraception is regarded and managed (Bajos et al., 2002). According to the studies, young men directly and record their attitudes as reported by young women, underline young men's lack of involvement in contraception in central and eastern Europe (Moreau et al., 1996; Durand et al., 2000; Kubba., 2000).

Cultural /Normative Cost

The Cairo, International Conference on Population and Development in 1994 and the Bejing Women's Conference in 1995 dealt extensively with various aspects of reproductive health behavior and reproductive rights and emphasized that individuals must be able to lead risk free sex lives and decide on the number and timing of their children. Over the past two centuries, the age at which childbirth is biologically possible has declined, while the period of adolescents' economic dependence has increased. One result of these changes has been a growing cultural conflict over reproductive choices during the transition to adulthood (Rhode., 1993).

The fertility decline has been that it was the product of a loosening of the normative constraints (individualistic value system) that had previously sustained fertility levels (Simmons., 1995). The social construction of sexuality refers to the process by which sexual thoughts, behaviors and conditions (for instance, virginity) are interpreted and ascribed cultural meaning (Ortner and Whitehead., 1981; Vance., 1984). The Ideologies of sexuality in some cultures stress female resistance, male aggression, and mutual antagonism in the sex act, whereas in others they stress reciprocity and mutual pleasure (Standing and Kisekka, 1989). The social construction of sexuality

is inevitably linked with cultural concepts of masculinity and felinity. They are interlocking domains (Vance., 1984).

Men's Role & Responsibility

An increased interest in the sexual health of men can be said to be an outcome of the control of the sexual transmitted infections. The area of the interest for different strategies and services is primarily focused on strategies to encourage and enable men to take responsibility for their sexual and reproductive behavior and their social and family roles. It is emphasized by the ICPD programmes of action that it should be the end aim of all state policies to organize innovative programmes to provide information counseling and services for easily accessible health services to adult men. Moreover, the ICPD declaration targets men for STI control strategies. Men are given importance to be responsible for advice and encouragement for their sexual and reproductive behavior along with the acceptance of the major share in prevention of sexuality transmitted diseases (United, 1994).

Knowledge of Reproductive Heath

The attention has focused on an interest in the knowledge and use of male methods of contraception methods to increase support for the partner's use of contraception joint decision making and preventing the spread of STIs by more responsible male behavior. However, in both the ICPD document and the published men's own reproductive and sexual health concern. The overwhelming imbalance towards women's rights and men's responsibilities; a near exclusive demand for female reproductive health since gender issues remain (rightly) at the forefront of concern (Basu., 1996).

In the surveys of 15-21 countries, the majority of men have knowledge at least one method of contraception and more than 91 percent of men could name a contraceptive method (Drennan, 1998). The people engaged in stable sexual intercourse in effective relationship are found avoiding the use of condoms in every intercourse. It is unacceptable in our social set up to meet women as respondents in this matter becomes even more difficult in strong relationship to seek methods for the prevention against STDs/AIDs because it will be acknowledged as infidelity on the part of women. In such type of monogamous relationship the women cant taken any initiative to avoid such risk and most of the times, their male sex partners were using drugs (Alves et al., 2002).

Material and methods

A cross-sectional study was conducted with 600 married males having at least one child to look into their reproductive health behavior and its implications for human health and society in three districts; Rawalpindi, Toba-Tek Singh, and Bahawalpur, of Punjab province in Pakistan. From each district respondents were selected through *proportionate random sampling technique* (see table-1).

A cross-sectional survey was carried out from Punjab province. Punjab is the most populated province of Pakistan, with 86084,000 million people in 2005 (Wikipedia., 2009). The survey was done in urban and rural areas of the above mentioned three Districts. The multistage sampling technique at different and varied stage was used to choose the area for study. A representative sample of 600 males was interviewed (Fitzggibbon., 1987; Morgan., 1997). A well-designed interviewing schedule was constructed in the light of research objectives and the conceptual framework of the study to collect data and draw inferences.

Table-1. Selection of sample from selected localities according to their population

District	Population	Union Council	Locality / Village	Respondents per Locality / Village
Toba-Tek-Singh	1,621,593 21.9% (131)	3 – Urban	3 – Colonies	22 – Respondents from each colony
		3 – Rural	3 – Villages	22 – Respondents from each village
Bahawalpur	3,117,000 32.9 % (197)	3 – Urban	3 – Colonies	33 – Respondents from each colony
		3 – Rural	3 – Villages	33 – Respondents from each village
Rawalpindi	3,363,911 45.2 % (272)	3 – Urban	3 – Colonies	45 – Respondents from each colony
		3 – Rural	3 – Villages	45 – Respondents from each village

The date researchers were selected by using "Survey" method that formed a team of male interviewers for the compilation of data from the interviewed male participants. The special course of train the team for data collection and gathering information were arranged. For the data collection, a well-structured interviewing schedule consisting of open-ended and closed ended questions was prepared in the light of research objectives. Pre-testing was done in order to ensure the validity and accuracy of interviewing schedule. The ambiguities encountered during this trial and error stage were carefully rectified on revision and modification of the interviewing schedule (Good and Hatt., 1952). In this regard, twenty interviews were conducted as pre-testing. During the process some ambiguities were identified. So after pre testing some of the changes were made as few questions were modified in the interviewing schedule. The study was conducted to ensure generalizations of research findings to the larger population of Pakistan.

The researcher checked and edited every questionnaire at the end of the interview on the same day. Before conducting the interview, at the time of designing stage, the much of the emphasis was given to sensitive and embarrassing questions which could have been against the cultural ideology of the people. After the pre-test was held, some questions were discarded from the questionnaire because it was sensed that the respondents would not give an air to their thoughts fully. The face and content validity was ensured by the consultation of a panel of three experts in the discipline of Rural Sociology and Agricultural Extension, University of Agriculture, Faisalabad.-Pakistan. A

reliable instrument yields the same results over repeated measures and subject. Cronbach. and Paul. (1955) stated that a valid questionnaire via instrument gives the some results after repeated measures and subject, measurement is reliable, then to the degree that it does not vary over time (stability) and to the degree that the same basic measurement procedure employed in different context at the same time yields the same results (equivalence). Cronbach' alpha coefficient was calculated by using SPSS computer software. Cronbach' alpha coefficient value was 0.66 showing a good level of reliability for the instrument.

Data Analysis

The SPSS/PC+ 15.0 Statistical Package for Social Sciences were used for analyzing the data. Frequency distributions of the variables were first obtained and, where appropriate, cross-tabulated the Chi-square and Gamma was applied to check the significance. Bi-variate & Multivariate (simple linear regression) was also carried out for assessing the relative importance of each of the independent variables in relation to the dependent variable.

Frequency Distribution

The data that have been coded and prepared for automatic processing are now ready for analysis. The first task is to construct frequency distributions to examine the pattern of the responses to each of the independent and dependent variables under investigation. A frequency distribution of a single variable, sometimes referred to as a uni-variate frequency distribution, is the frequency of observations in each category of a variable.

To construct a frequency distribution, the researcher simply lists the categories of the variable and counts the number of observations in each. It gives the standard form of a uni-variate frequency distribution.

Demographic Characteristics

The general objective of this study is to analyze the implication of the socio-cultural milieu of the society on male reproductive health. In this chapter an attempt has been made to discuss, analyze and interpret relevant data for deriving conclusions and formulating appropriate suggestions in the light of the study results. In any social setup the socio-economic and demographic characteristics of an individual play a vital role in shaping attitudes, behavior and practice and their social standing in the social setup. It is therefore imperative to explain socio-economic and demographic characteristics of the respondents under study.

Table-1. Distribution of the respondents according to their demographic characteristics (n=600)

Age (years)	**Respondents**		**Wives**	
	F	**%**	**F**	**%**
Upto 35	273	45.5	456	76.0
35-45	231	38.5	103	17.1
46 and above	96	16.0	41	6.9

Mean = 43.66	S.D. = 10.44			
Mean = 38.05	S.D. = 10.29			
Members	**Adult**		**Children**	
	F	**%**	**F**	**%**
0-1	91	15.2	68	11.3
1-2	87	14.5	88	14.7
3-4	340	56.7	111	18.5
5-8	79	13.2	330	55.0
9 & above	3	0.5	3	0.5
Mean adult = 3.09	S.D = 1.81			
Mean children = 4.24	S.D = 2.38			
Duration of Marriage (years)	**F**		**%**	
1-10	259		43.1	
11-20	195		32.5	
21 and Above	146		24.4	
Mean = 16.41	S.D = 10.27			
Family Structure				
Nuclear	234		39.0	
Joint	326		54.3	
Extended	40		6.7	
Marriage Within family				
Yes	386		64.4	
No	214		35.6	
Respondent's Opinion Taken at the Time of Marriage				
Yes	325		54.2	
No	275		45.8	
Decision about marriage				
Your own choice	71		11.8	
Parent's choice	378		63.0	
Parent's and Own choice	142		23.7	
Relative's and Parent's choice	9		1.5	
No of Marriages				
1 (first)	569		94.8	
2 (second)	31		5.2	

Socio economic characteristics

Monthly Income

The concept of income is that the sum of total monthly earnings received by the respondents by all sources. Monthly income is also an indicator of socio-economic status of the respondents and their family. The employed respondents were asked about their monthly income which is expressed in terms of Pakistani rupee. About 37.2 percent of the respondents and their wives monthly family income from all sources was found to be up to Rs.10,000, while major proportion (43.3 percent) had monthly income from all sources Rs.10,001-20,000 and remaining 19.5 percent of them had Rs.20,001 and above. The mean monthly income of the respondents' and their wives from all sources calculated was 12445 with standard deviation 7503.50.

Occupation of the Respondents' and Their Wives

The analysis presented below is restricted to those respondents' and their wives occupation who have ever worked, including those who are currently working and those who have worked in the

past, and those who have never worked. The reason for choosing this definition is in order to include seasonal and occasional work that only occurs at certain times of the year. Themes explored include the type of work undertaken, the workload, and the distribution and control of earnings. The status of WORK of the respondents' and their wives' work is also explored (i.e., Household, Business, Govt. service, Semi Govt. service, Labor, Private job, Tailoring, Technician, Retired, Agriculture, Dispenser, Livestock).

The data presented in Table 2 shows huge majorities i.e. 90.5 percent of the respondent's wives were households wives, while 5.7 percent of the wives belonged to teaching occupation, 2.8 percent of them were nurses and remaining one percent of the wives were doing government services. Whereas, Table 4.2 shows that a major proportion i.e. 40.4 percent of the respondents was found to be agriculturalist. While 17.5 percent of the respondents were businessmen, 13.5 percent were doing government service and 18.0 percent of them were doing private job. About 10.0 percent of the respondents belonged to teaching profession and only 3 respondents were found male nurse. Almost the same results were found by another researcher Saeed (2002).

Table-2. Distribution of the respondents according to their socio-economic status (n=600)

	All sources*			
Monthly Income	**F**		**%**	
Upto 10,000	223		37.2	
10,001-20,000	260		43.3	
20,001-and above	117		19.5	
Mean* = 12445	S.D. = 75.3.50			
Wife is a Working women				
Yes	57		9.5	
No	543		91.5	
Occupation	**Respondents**		**Wives**	
	F	**%**	**F**	**%**
Household wives	--	--	543	90.5
Business	105	17.5	--	--
Govt. service	81	13.5	6	1.0
Private job	108	18.0	--	--
Agriculture	243	40.4	--	--
Teaching	60	10.0	34	5.7
Nurse	03	0.4	17	2.8

Residence	**Yes**		**No**	
	F	**%**	**F**	**%**
Living in own house	379	63.2	221	36.8
Wife's own house	12	2.0	588	98.0
Rented house	126	21.0	474	79.0
With parents of the respondents	79	13.2	521	86.8
With parents of wife	--	--	600	100.0
Company/Employer's house	32	5.3	568	94.7

Table-3. Distribution of respondents according to their views about discussion of following matters with his wife (n=600)

Matters	Never		Rarely		Frequently	
	F	%	F	%	F	%
Education of children	215	35.8	196	32.7	189	31.5
Career determination of children	173	28.8	279	46.5	148	24.7
Home Budget	155	25.8	265	44.2	180	30.0
Children's marriages	89	14.8	340	56.7	171	28.5
Interference of in-laws	89	14.8	309	51.5	202	33.7
Inclination of husband towards his parents	137	22.8	396	66.0	67	11.2
Permission for household independent working	145	24.2	321	53.5	134	22.3
Feel household work as fatigue	369	61.5	131	21.8	100	16.7
Enjoying position as housewife	77	12.8	308	51.3	215	35.8
Interference in office work	572	95.3	12	2.2	16	2.7

Table-4. Distribution of the respondent according to their behavior that they allow their wife in mobility activities (n=600)

Aspects	No Permission		With Restrictions		Without any Restrictions	
	F	%	F	%	F	%
Access to Television	146	24.3	235	39.2	219	36.5
Access to Telephone	109	18.2	207	34.5	284	47.3
Access to Financial resources	112	18.7	323	53.3	165	27.5
Relations with parents/peoples	90	15.0	227	37.8	283	47.2
Permission to go to market.	107	17.8	222	37.0	271	45.2

Knowledge about Contraception

Knowledge about contraceptive is very major, close and strong relationship with the reproductive health **behavior** of the male respondents. In this section respondents were asked about the level of their knowledge about contraceptive to check the relationship between the knowledge about contraceptive and male reproductive health behavior. A large number of respondents among married women are found having a knowledge of contraception because they are supposed to prove fertility soon after marriage following the strong cultural norms of Pakistan. So , the women were asked about the knowledge of contraception and their attitude towards it is displayed in Table 4.20, which reveals that a majority (63.8 percent) of the respondents were aware of about the contraceptives. Whereas, about 36.2 percent of the respondents were not aware about contraception.

Table-5. Responses of the respondents according to their knowledge about contraception (n=600)

Knowledge about contraceptive	F	%
Yes	383	63.8
No	217	36.2
Total	**600**	**100.0**

Knowledge about the Use of the Contraceptive

Pakistani society is a male dominated society. And the women can't adopt any method of contraception without the standing support and involvement of their husbands. The exclusion of male from family planning is one reason, which has resulted in high fertility rate and reproductive health complications in both male and female. Male involvement reproductive health issues and in family planning and use of male related contraceptive procedures long with motivated rather than choice for methods are associated with the family decline and resulted in long term benefits for women. Young married women and men are not likely to use contraception until later in marriage. As a result, first birth intervals are very short. Although the majority of both males and females plan to use contraception in the future, females tend to answer that they are undecided regarding the method of choice, while males most frequently mention pill or injectables as the method to be used in the household. The respondents' were asked about their knowledge about the purpose of the use of contraceptive and data in this regard are presented in Table 6 which reveals that about 45.8 percent of the respondents used contraceptives to avoid pregnancy, 36.2 percent of the respondents had no knowledge about that, 11.0 percent of the respondents were used for interval in birth, and remaining 7.0 percent for to avoid getting RH diseases. Respondents who have knowledge about any of contraceptive methods, further asked about their use of contraceptives, Use of contraception is reflects the positive behavior of the male partner, and the respondents' were asked about the use of contraceptives and the table 4.21 shows that the majority i.e. 59.8 percent respondents were never used any of contraceptive method in their married or un-married life, where as remaining 40.2 percent of the respondents' contraceptive user in their reproductive life for preventing the pregnancies.

The respondents who using the contraceptive method for prevented pregnancy or any other reasons, further asked about the methods of contraception they used and their responses are presented in Table 6**,** which reveals that 60.8 percent were in none users, 14.2 percent of the respondents used pills methods followed by condoms 11.0 percent, female sterilization 4.7 percent, IUD 4.3 percent, Injection 4.2 percent and 0.8 percent of the respondents were used both pills and condoms. A lesser number of the respondents 4.2 percent and 0.8 percent used injection and both pills and condoms, respectively, as contraceptive methods to prevent the pregnancy. The respondents who ever used contraceptives for prevented pregnancy or any other reasons further asked about the advised by whom for using the current methods of contraception and their responses are presented in Table 6, which reveals that 13.3 percent of the respondents were advised by their spouses about their current family planning method, 11.7 percent of the respondents advised by their friends, followed by family planning personals 7.7 percent, LHV 4.0 percent, and from any other sources 2.5 percent.

Table-6. Distribution of the respondents according to their knowledge about the use of the contraceptive (n=600)

Knowledge about the use of the contraceptive	F	%
To avoid getting RH disease	42	7.0
To avoid pregnancy	275	45.8

To interval in birth	66	11.0
No knowledge	217	36.2
Use of Contraceptive method		
Yes	241	40.2
No	359	59.8
Contraceptive method		
Pills	85	14.2
Injection	25	4.2
Condom	66	11.0
IUD	26	4.3
Female sterilization	28	4.7
Both (Pills &Condom)	5	0.8
No	365	60.8
Advised to use contraceptive		
Friends	70	11.7
Spouse	80	13.3
Family Planning Personal	46	7.7
LHV	24	4.0
Any other source	15	2.5
No	365	60.8

Respondent According To Currently Using Any Method of Contraceptive for Delay or Avoiding Pregnancy

Table 7, reflects that a significant number of the respondents i.e. 69.0 percent were not using currently any methods of contraceptives, while 31.0 percent of the respondents were currently using contraceptive method for delay or avoiding pregnancy.

Table-7. Distribution of the respondent according to currently using any method of contraceptive for delay or avoiding pregnancy (n=600)

Response	**F**	**%**
Yes	186	31.0
No	414	69.0

Respondents According To the Name of the Places from Where Contraceptives Were Available

The respondents who using or having knowledge about contraceptive further asked about the availability of the contraceptive from which places in Table 8, Data reveal that a huge majority i.e. 84.0 percent were reported that the contraceptives were available at general stores, while another majority i.e. 64.5 percent told that the contraceptive are available at medical pharmacies and 26.0 percent told that contraceptive are available from NGOs. More than half i.e. 56.7 percent of the respondents reported that the contraceptives are available at Family Planning Centers, 20.8 percent, 20.8 percent LHW, 15.2 percent were stated the availability of contraceptives from any other sources.

Table-8. Distribution of the respondents according to the name of the places from where contraceptives were available (n=600)

Name of the Places	Yes		No	
	F	%	F	%
General Stores	504	84.0	96	16.0
Medical Pharmacies	387	64.5	213	35.5
NGOs	156	26.0	444	74.0
Family Planning Centers	340	56.7	260	43.3
LHW	125	20.8	475	79.2

Respondents' Behavior According To the Role and Status of Women

The percentage distribution of the respondents showed their view point on the role and status of women in social life extent of change in the attitude occurred on their reproductive health behavior. Table 9 presented that the majority of the respondents i.e. 69.3 percent reported that to agree, women should take initiative to resolve conflict with her husband, positive change was observed in the behavior of the respondent in this regard. Whereas 58.5, 41.2, 34.7, 27.5 percent were agreed women should always pay due respect to her husband, women should equally express herself about any affair, women should encourage to get higher education and women should take part in the decision of selecting her mate respectively.

About 48.8, 40.8, 37.3, 28.0 and 27.5 percent of the respondent were reported that their responses neutral, women should equally express their herself about any affairs, women should always pay due respect to her husband, women should be encourage to get higher education, women should take initiative in resolving conflict with her husband and women should take part in decision making to selecting her mate respectively.

But the respondents were strongly disagreed on the statements that, women should take part in decision making to selecting her mate, women should be encourage to get higher education, women should equally express their herself about any affairs, women should take initiative in resolving conflict with her husband, and women should always pay due respect to her husband as 45.0, 28.0, 9.0, 2.7 and 0.7 percent, respectively.

Table-9. Distribution of the respondent's behavior according to the role and Status of women (n=600)

	Disagree		Neutral		Agree	
Matters	**F**	**%**	**F**	**%**	**F**	**%**
A women Should take part in selecting her mate	270	45.0	165	27.5	165	27.5
A women should equally express herself about affairs of home life	54	9.0	299	48.8	247	41.2
A women should take initiatives in resolving conflict with her husband (if any arise)	16	2.7	168	28.0	416	69.3
A women should be encourage to get	168	28.0	224	37.3	208	34.7

higher education						
A women should always pay due respect to her husband	4	0.7	245	40.8	451	58.5

Respondent According To Their Behavior That They Allow Their Wife in Mobility Activities

Mobility is restricted for females in our society. They are important part of gender dimension in the execution of mobility. In the cultural setting of our survey , women are mostly mobile when their husbands allow them to move outside the house, otherwise they are restricted to go anywhere in the company of someone even if they are going to their neighbours. The cultural restrictions on mobility are not limited to married women alone but also young females face the hardship in the country. In this connection the respondents' were asked about the mobility violence faced during the last 12 months and their responses are displayed in Table 10, which reveals that access to telephone, relation with parents/peoples, permission to go to market, access to television and access to financial resources were the types of mobility activities which allowed without any restrictions by the respondent to their wives as reported by 47.3, 47.2, 45.2, 36.5, and 27.5 percent of the respondents. Moreover, respondents had given permission with restrictions to their wives to access to financial resources, access to television, relation with parents/peoples, permission to go to market, and access to telephone, and as reported by 53.3, 39.2, 37.8, 37.0, and 34.5 percent of the respondents, respectively. However, respondents had never gave permission to their wives about access to television 24.3 percent followed by access to financial resources 18.7 percent, access to telephone 18.2 percent permission to go to market 17.8 percent and relations with parents/peoples 15.0 percent.

Table-10. Distribution of the respondent according to their behavior that they allow their wife in mobility activities (n=600)

Aspects	**No Permission**		**With Restrictions**		**Without any Restrictions**	
	F	**%**	**F**	**%**	**F**	**%**
Access to Television	146	24.3	235	39.2	219	36.5
Access to Telephone	109	18.2	207	34.5	284	47.3
Access to Financial resources	112	18.7	323	53.3	165	27.5
Relations with parents/peoples	90	15.0	227	37.8	283	47.2
Permission to go to market.	107	17.8	222	37.0	271	45.2

Media Exposure

Media is the major source of motivation and influence the behavior of the individual as well as the whole. Different medium effects on different intensity on the behavioral change especially on sexual behavior. Respondents were asked about the more influential medium of the media, which influence the behavior on sexual grounds in Table 11, To great extent, reported by the respondents as per their percentages as 49.8 percent of the respondents were influenced with different type of magazines, because majority have easily approach on local level stalls etc. and can easily get the different magazines, 48.0, 44.7, 40.8, 39.7, 37.8, 35.2, 32.3, and 27.0 percent, influenced with

Cinema / Theaters, any other type of sources, Social company/relations, T.V, Cable, CD/DVDs, Cellular technology, and net café respectively. Where as respondents influence level to some extent for above medium of the media on sexual behavior, 48.3, 45.8, 45.0, 44.2, 42.5, 42.5,35.8, 35.3,and 32.5 percent for net café, social company/relations, cellular technology, cable, TV, cinema/theater, any other medium, magazines, and CD/DVDs respectively. Whereas very little number of the respondent said that these medium effect not at all on their sexual behavior as 32.3, 24.7, 22.7, 19.5, 18.0, 17.8, 14.8, 13.3, and 9.5 percent for CD/DVDs, Net café, cellular technology, any other medium of the media, cable, TV, magazines, social company/relations, and cinema/theater respectively.

Table-11. Distribution of the respondents according to which medium or media/Communication has in the most influence on their sexual behavior (n=600)

Media / Communication	To great Extent		To Some Extent		Not at all	
	F	%	F	%	F	%
TV	238	39.7	255	42.5	107	17.8
Cable/Dish/Decoder	227	37.8	265	44.2	108	18.0
Video Cd /DVDs	211	35.2	195	32.5	194	32.3
Net Café	162	27.0	290	48.3	148	24.7
Cinema / Theater	288	48.0	255	42.5	57	9.5
Cellular technology	194	32.3	270	45.0	136	22.7
Magazines	299	49.8	212	35.3	89	14.8
Social company/relations	245	40.8	275	45.8	80	13.3
Any other	268	44.7	215	35.8	117	19.5

Respondents According To the Name of the Places from Where Contraceptives Were Available

The respondents who using or having knowledge about contraceptive further asked about the availability of the contraceptive from which places in Table 12, Data reveal that a huge majority i.e. 84.0 percent were reported that the contraceptives were available at general stores, while another majority i.e. 64.5 percent told that the contraceptive are available at medical pharmacies and 26.0 percent told that contraceptive are available from NGOs. More than half i.e. 56.7 percent of the respondents reported that the contraceptives are available at Family Planning Centers, 20.8 percent, 20.8 percent LHW, 15.2 percent were stated the availability of contraceptives from any other sources.

Table-12. Distribution of the respondents according to the name of the places from where contraceptives were available (n=600)

Name of the Places	*Yes*		No	
	F	%	F	%
General Stores	504	84.0	96	16.0
Medical Pharmacies	387	64.5	213	35.5
NGOs	156	26.0	444	74.0

Family Planning Centers	340	56.7	260	43.3
LHW	125	20.8	475	79.2

Bi-variate Analysis

The investigation of a bi-variate relation is a vital step in explaining and testing the research hypothesis. A relationship of the two variables means that the distributions of values of the two variables are associated. The validity of a bi-variate relationship is confirmed through the chi-square test. This is a statistical test which is widely used to know the probability (or the level of significance) that the observed relationship between two variables may have risen by chance. This measure is calculated by comparing the observed frequencies in each cell in a contingency table with those that would occur if there was no relationship between two variables. Generally, significance of the relationship is examined by establishing a null hypothesis. A confirmation or rejection is made concerning the chi-square value and the level of significance. The level of significance is basically, an acceptable risk that the null hypothesis may be incorrectly rejected. In other words, the level of significance relates to the probability that we might be making such a false inference. Usually the level of significance is taken as 0.05 or 5 percent. The chi-square test helps to explain a relationship but not the strength of a relationship. The strength is related to the degree or extent of a relationship between the variables.

Association between the General Health Status of the Respondent and Their Reproductive Health Behavior

The study indicates the relationship between general health status of the respondents with their reproductive health behavior. The respondents were asked to answer about the general health status from the levels i.e. very god, just normal, poor, and very poor on index variable. In order to assess the reproductive health behavior of the respondents were asked the statements i.e. General health, Mental health, Reproductive health, Drugs use, Contraceptive knowledge and use, HIV/STDs knowledge and behavior were computed to construct the index variable. The detailed study of said table showed that 22.8 percent respondents who reported their very good health status attained low score on the reproductive health behavior index variable. The respondents who had very poor health status had low score on the reproductive health behavior index variable (67.7 percent). The table also reflects that 49.8 percent of the respondents, their health status was very good had high score on the reproductive health behavior index variable were negative than the respondents who had very poor health status and the same score (positive) on the reproductive health behavior index variable (15.1 percent). It can be said that there is association between the general health status of the respondents and the reproductive health behavior. It indicates that lower the general health status of the respondents, lower is the reproductive health behavior and higher the general health status of the respondents, higher is the reproductive health behavior. In order to examine the significance relationship between the general health status of the respondents and the reproductive health behavior. The chi-square and the gamma test are applied. The chi-square value was 97.17, which was highly significant ($P>0.01$). The said table also reflects that there is strong relationship between general health status of the respondents and their reproductive health behavior. As general

health status of the respondents increases the reproductive health behavior also increases. Gamma was significant with value of 0.199 (P>0.01). Therefore, the hypothesis the general health status of the respondent is associated with the reproductive health behavior: Higher the general health status of the respondent, higher will be the reproductive health behavior as compared to lower general health status of the respondent, lower the reproductive health behavior was accepted.

Hypothesis 1 General health status of the respondent is associated with the reproductive health behavior: Higher the health status of the respondent, higher will be the reproductive health behavior as compared to low health status of the respondent.

Table-13. Association between the general health status of the respondent and their reproductive health behavior (n=600)

General Health	Male reproductive health behavior			
	Low	**Medium**	**High**	**Total**
Very good	50 (22.8)	60 (27.4)	109 (49.8)	219 (36.5)
Just normal	59 (38.1)	40 (25.8)	56 (36.1)	155 (25.9)
Poor	85 (66.9)	22 (17.4)	20 (15.7)	127 (21.1)
Very poor	67 (67.7)	17 (17.2)	15 (15.1)	99 (16.5)
Total	**261 (43.4)**	**139 (23.3)**	**200 (33.3)**	**600 (100.0)**

Chi Square value. 97.17** **.Highly significant

Gamma Value 0.199* *.Significant

Association between Knowledge about Contraceptive of the Respondent and Their Reproductive Health Behavior

The study indicates the relationship between Knowledge about Contraceptive of the respondents with their reproductive health behavior. The respondents were asked to answer about the Knowledge about Contraceptive from the levels i.e. yes or no, on index variable. In order to assess the reproductive health behavior of the respondents were asked the statements i.e. General health, Mental health, Reproductive health, Drugs use, Contraceptive knowledge and use, HIV/STDs knowledge and behavior were computed to construct the index variable. It is shown in table 14 reveals the relationship of the Knowledge about Contraceptive of the respondents with the reproductive health behavior. The detailed study of said table showed that 27.2 percent respondents who reported their Knowledge about Contraceptive attained low score on the reproductive health behavior index variable. The respondents who reported their no Knowledge about Contraceptive had low score on the reproductive health behavior index variable (76.3 percent). The table also reflects that 47.9 percent of the respondents , who had the Knowledge about Contraceptive had high score on the reproductive health behavior index variable were negative than the respondents who had no Knowledge about Contraceptive and the same score (positive) on the reproductive

health behavior index variable (4.1 percent). It can be said that there is association between the Knowledge about Contraceptive of the respondents and the reproductive health behavior. It indicates that lower the Knowledge about Contraceptive of the respondents, lower is the reproductive health behavior and higher the Knowledge about Contraceptive of the respondents, higher is the reproductive health behavior. In order to examine the significance relationship between the Knowledge about Contraceptive of the respondents and the reproductive health behavior. The chi-square and the gamma test are applied. The chi-square value was 152.40, which was highly significant (P>0.01). The said table also reflects that there is strong relationship between Knowledge about Contraceptive of the respondents and their reproductive health behavior. As Knowledge about Contraceptive of the respondents increases the reproductive health behavior also increases. Gamma was also highly significant with value of 0.079 (P>0.01). Therefore, the hypothesis the Knowledge about Contraceptive of the respondent is associated with the reproductive health behavior: Higher the Knowledge about Contraceptive of the respondent, higher will be the reproductive health behavior as compared to Knowledge about Contraceptive of the respondent, lower the reproductive health behavior was accepted.

Hypothesis 2: Knowledge about Contraceptive of the respondent is associated with the reproductive health behavior: Higher the knowledge about contraceptive of the respondent, higher will be the reproductive health behavior as compared to lower Contraceptive knowledge of the respondent.

Table-14. Association between Knowledge about Contraceptive of the respondent and their reproductive health behavior (n=600)

Knowledge about contraceptive	**Male reproductive health behavior**			
	Low	**Medium**	**High**	**Total**
Yes	109 (27.2)	100 (24.9)	192 (47.9)	401 (66.8)
No	152 (76.3)	39 (19.6)	8 (4.1)	199 (33.2)
Total	**261 (43.4)**	**139 (23.3)**	**200 (33.3)**	**600 (100.0)**

Chi Square value. 152.40** **.Highly significant

Gamma value. 0.79** **.Highly significant

Association between Contraceptive Use Behavior of the Respondent and Their Reproductive Health Behavior

The study indicates the relationship between Contraceptive use behavior of the respondents with their reproductive health behavior. The respondents were asked to answer about the Contraceptive use behavior from the levels i.e. yes or no, on index variable. In order to assess the reproductive health behavior of the respondents were asked the statements i.e. General health, Mental health, Reproductive health, Drugs use, Contraceptive knowledge and use, HIV/STDs knowledge and behavior were computed to construct the index variable. It is shown in table 15 reveals the

relationship of the Contraceptive use behavior of the respondents with the reproductive health behavior. The detailed study of said table showed that 29.9 percent respondents who reported their Contraceptive use behavior attained low score on the reproductive health behavior index variable. The respondents who didn't use contraceptives had low score on the reproductive health behavior index variable (55.9 percent). The table also reflects that 44.9 percent of the respondents , who had the Contraceptive use behavior had high score on the reproductive health behavior index variable were negative than the respondents who had no Contraceptive use behavior and the same score (positive) on the reproductive health behavior index variable (22.9 percent). It can be said that there is association between the Contraceptive use behavior of the respondents and the reproductive health behavior. It indicates that lower the Contraceptive use behavior of the respondents, lower is the reproductive health behavior and higher the Contraceptive use behavior of the respondents, higher is the reproductive health behavior. In order to examine the significance relationship between the Contraceptive use behavior of the respondents and the reproductive health behavior. The chi-square and the gamma test are applied. The chi-square value was 46.20, which was highly significant (P>0.01). The said table also reflects that there is strong relationship between Contraceptive use behavior of the respondents and their reproductive health behavior. As Contraceptive use behavior of the respondents increases the reproductive health behavior also increases. Gamma was highly significant with value of 0.503 (P>0.01). Therefore, the hypothesis the Contraceptive use behavior of the respondent is associated with the reproductive health behavior: Higher the Contraceptive use behavior of the respondent, higher will be the reproductive health behavior as compared to Contraceptive use behavior of the respondent, lower the reproductive health behavior was accepted.

Hypothesis 3: Contraceptive use behavior of the respondent is associated with the reproductive health behavior: Higher the contraceptive use of the respondent, higher will be the reproductive health behavior as compared to lower Contraceptive use behavior of the respondent.

Table-15. Association between Contraceptive use behavior of the respondent and their reproductive health behavior (n=600)

Contraceptive	**Male reproductive health behavior**			
Use	**Low**	**Medium**	**High**	**Total**
Yes	85 (29.9)	72 (25.2)	128 (44.9)	285 (47.5)
No	176 (55.9)	67 (21.2)	72 (22.9)	315 (52.5)
Total	**261 (43.4)**	**139 (23.3)**	**200 (33.3)**	**600 (100.0)**

Chi Square value. 46.20** **.Highly significant

Gamma Value. 0.503** **.Highly Significant

Association between Media and the Reproductive Health Behavior

The study indicates the relationship between Media exposure of the respondents with their reproductive health behavior. The respondents were asked to answer about their exposure to media from the levels i.e. 1, 2, and 3 on index variable. In order to assess the reproductive health behavior of the respondents were asked the statements i.e. General health and Mental health, Reproductive health, Drugs use, Contraceptive knowledge and use, HIV/STDs knowledge and behavior were computed to construct the index variable. It is shown in table 16 reveals the relationship of the media exposure of the respondents with the reproductive health behavior. The detailed study of said table showed that 87.5 percent respondents who reported their media exposure in level 1, attained low score on the reproductive health behavior index variable. The respondents who reported their media exposure in level 3 had low score on the reproductive health behavior index variable (23.6 percent). The table also reflects that 6.25 percent of the respondents , who had their 1 level of media exposure had high score on the reproductive health behavior index variable were negative than the respondents who had level 3 media exposure and the same score (positive) on the reproductive health behavior index variable (54.26 percent). It can be said that there is association between the Contraceptive use behavior of the respondents and the reproductive health behavior. It indicates that lower the Contraceptive use behavior of the respondents, lower is the reproductive health behavior and higher the Contraceptive use behavior of the respondents, higher is the reproductive health behavior. In order to examine the significance relationship between the Contraceptive use behavior of the respondents and the reproductive health behavior. The chi-square and the gamma test are applied. The chi-square value was 211.13, which was highly significant (P>0.01). The said table also reflects that there is strong relationship between Contraceptive use behavior of the respondents and their reproductive health behavior. As Contraceptive use behavior of the respondents increases the reproductive health behavior also increases. Gamma was highly significant with value of 0.290 (P>0.01). Therefore, the hypothesis the Contraceptive use behavior of the respondent is associated with the reproductive health behavior: Higher the Contraceptive use behavior of the respondent, higher will be the reproductive health behavior as compared to Contraceptive use behavior of the respondent, lower the reproductive health behavior was accepted.

Hypothesis 4: Exposure to media of the respondent is associated with the reproductive health behavior: Higher the Media excess of the respondent, higher will be the reproductive health behavior as compared to lower media excess of the respondent.

Table-16. Association between Media and their reproductive health behavior (n=600)

Media	Male reproductive health behavior			
	Low	Medium	High	Total
1	140 (87.5)	10 (6.25)	10 (6.25)	160 (26.7)
2	60 (32.96)	72 (39.5)	50 (27.5)	182 (30.3)
3	61 (23.64)	57 (22.09)	140 (54.26)	258 (43.0)

Total	**261 (43.4)**	**139 (23.3)**	**200 (33.3)**	**600 (100.0)**

Chi Square value: 211.23** **.Highly significant

Gamma Value: 0.290** **.Highly Significant

Multivariate Regression Analysis

As mentioned multivariate regression analysis is used to establish the relative importance of each of the background variables of the socio-cultural milieu of the society on male reproductive health related variables in terms of explained variation in the dependent variables. The standardized partial regressions co-efficient (beta's) are used to estimate the relative significance of each of the predictor variables, and the multiple co-efficient of determination (R^2) is used to measure how well the independent variables explained the dependent variable. The linear regression is used. The suitability of regression is examined through verifying its assumptions.

The data of the study met the assumption reflecting that the data follow the normal curve indicating the suitability of the linear regression. The linear regression is representing as:-

$$Y = a + b_1 X_1 + b_2 X_2 + b_3 X_3 + \ldots\ldots\ldots\ldots\ldots$$

Y indicates the response variable, while $X_1, X_2, X_3 \ldots\ldots\ldots\ldots$ indicates the independent variable such as Age of the respondent, Respondent age at marriage, Family type, Family Income, Type of residence, Occupation, Number of children, Knowledge about contraceptives, Decisions making, Religiosity, Exposure of media, Health attitude, Family planning services.

A is intercept and beta (β) is regression coefficient beta (β) indicates the rate of change in independent variable when independent variable is changed by one unit. Higher the value of beta (β) is the reflection of higher the contribution of that independent variable in exploring dependent variable. The magnitude of the beta (β) indicates the relative significance of the independent variable. Another measures coefficient of variation (R^2) is used to see the fitness of the model. If the value of R^2 is more than 0.4 in social sciences then the model is regarded as best fit model (Asif F, 2010) in other words it can be said that independent variables in the model are relevant and appropriate to explain dependent variables.

Association between Different Independent Variables of the Respondents with the Male Reproductive Health Behavior

The result of multiple linear regression analysis presented in Table 17 shows that reproductive health behavior of the respondents was positively related to Age of the respondents, the age of the respondent is the major indicator to determine the reproductive health behavior, lower age men have very low reproductive health behavior on the other side the respondents with mature aged have mature behavior about reproductive health, statistically it presented as beta coefficient -0.0151 non-significant at 0.232. Another important indicator is the "age at marriage" which is more closed link with the reproductive health behavior of the men with their wives, early marriages have shown the irresponsible behavior of men's with their wives whereas late marriages also effects to the pattern of reproductive health behavior of men, statistically beta coefficient 0.265 significant at

0.00, Different studies also indicate the marriage pattern for males and females in Pakistan are young and universal (Zafar., 1996). The different surveys also indicate the increase in age at marriage still as compared to many developing societies the age at marriage particularly for females is very young. A large number of women in Pakistan get married in their teen ages. The society's attitude toward the female marriage also effect to reproductive health of both male and female.

Duration of marriage also closely associated with the dependent variable of male reproductive health behavior, it presented that the duration of marriages of the respondent's beta coefficient 0.491 highly significant at 0.00, As Education is a very essential for all in developing society as well as developed. With our education no society can be flourished and achieved its goal, that's why every projects, programmes and researched mainly based and emphasizes on education and education pattern. In this present study the education is a very key indicator for accessing the respondent's behavior about reproductive health in Punjab especially where education level as far better as compared to the other Provinces of Pakistan. If the education level increases any of the response can be better that those where education level is not maintained. The present study showed that the educated men are more likely to be aware and conscious especially about their reproductive health and their reproductive health behavior also better that those who are unaware and less educated. Statistically Education of the respondents beta coefficient 0.091 significant at 0.044, in the present study, It appears that the monthly income of the respondents is one of the most important factor effecting their reproductive health behavior, positively signs of income of the respondent and statistically beta coefficient -0.361 highly significant at 0.00, with better income level likely to better reproductive health behavior in their married life as those who had lower income level. The result of the present study as in line with the result presented by Longdeild *et al.* (2004). This study explored that men's economic power allow them to develop better sexual relationship with their women. The analysis further indicates that one indicator i.e. Communication with wives under the inter-spousal communication has important determinant and create a major effect on men's reproductive health behavior with their wives. Statistically shoed the beta coefficient 0.703 highly significant at 0.00, the result presented here is supported by worldwide studies. The analysis further indicates that the respondent's communication of affairs with their wives is another important contributing factor to delineate the men's reproductive health behavior in positive sides, statistically it proves that the beta coefficient -0.065 non-significant at 0.309. Found by applying logistic regression analysis that couples who made joint discussions about different affairs were found to be 1.8 times more likely to be current users of any contraceptives method than those couples for which the husband alone makes such decisions. Ideal number of children in a family beta coefficient -0.130 significant at 0.019, Drugs Using beta coefficient -0.246 highly significant at 0.00, Discussion about Reproductive Health Problems beta coefficient 0.008 non-significant at 0.882 , General Health beta coefficient -0.562 highly significant at 0.00, knowledge about contraceptive beta coefficient 0.331 highly significant at 0.000, Use of Contraceptives beta coefficient -0.128 significant at 0.010, The respondent's exposure to mass

media is appeared as another important variable. It contributes positively in shaping the married men's attitude towards reproductive health behavior. Statistically significant value of Media Exposure beta coefficient -0.0164 non-significant at 0.136, indicating higher prevalence practice of healthy reproductive health behavior of men's with their partners who have exposure to mass media (T.V, Radio, news papers, books, internet etc) compared to those who has no exposure to electronic media . It is suggesting that different means of mass communication as mentioned above may be useful way for reaching such people with motivational campaigns and publicizing the reproductive health measures among men and women which may enhance the practice of healthy reproductive health behavior for both men and women. The findings of the present study are supported by the findings of Schoemaker (2005). According to him, a dramatic increase in contraceptive use and an equally dramatic fertility decline was observed due to the exposure of family planning messages through broadcast media. Awareness about HIV/STDs also has a vital role in determining the men's attitude towards the practice of better reproductive health behavior with their wives and partners. The data clearly shows that those married men who have no knowledge about HIV/STDs and its preventive measures were less incline towards their reproductive health behavior it reflected that the better the knowledge about HIV/STDs and better the reproductive health behavior of men. The result statistically presented that the knowledge about HIV/STDs beta coefficient 0.159 highly significant at 0.00, the value of adjusting R^2 is 0.660. The result of present study are in accordance with the results of the other international studies Prata *et al.* (2005), found that the men were more knowledge that women about preventing pregnancy and HIV/STDs infections. The value of R^2 is 0.660 indicates that about 66% variation in the dependent variable is explained by knowledge about contraceptive and use of contraceptive, communication with wives, drug use, reproductive health problems, general health, knowledge about HIV, Media exposure, it can be said that the model is well fitted and variables are appropriate. Keeping in view the standardized regression coefficient and its significant level the following model is developed. Y (Male Reproductive Health Behavior) = $\alpha - 0.562x_{11} - 0.246x_9 + 0.703x_6 + 0.331x_{12} + 0.265x_2 + 0.159x_{15}$.

Table-17. Association between different independent variables of the respondents with the Male Reproductive Health Behavior (n=600)

Independent variables of the respondents	Unstandardized Coefficients	Standardized Coefficients	Level	
	Std. Error	Beta	T	Sig.
Age at marriage	0.284	0.265	7.929	0.000**
General health	-0.389	-0.562	-8.742	0.000**
Knowledge about contraceptive	0.535	0.331	6.252	0.000**
Contraceptive use	-0.201	-0.128	-2.584	0.010*

Adjusted R square value = 0.660

The next chapter deals with summary findings, conclusions, recommendations or suggestions in the light of descriptive, inferential and multivariate analyses.

CONCLUSION

It is concluded that in developing countries like Pakistan, the socio-cultural contexts are the male dominant society, especially on reproductive health and fertility matters, there is no freedom for female they all decision making power in the control of the men, Men's attitude towards women right and contraceptive use was expected to affect birth, and reproductive health issues. On overall basis, men's attitude towards contraceptive use and women role was positive in the study. Majority of the respondents in general, were in favor in use of contraception in order to promote healthy activities and get better living through limited family size. Following conclusions in particulars were deducted from the present study:-

i) The chi-square value was 137.46, which was highly significant (P>0.01). It that there is strong relationship between age of the respondents and their reproductive health behavior. As age of the respondents increases the reproductive health behavior also increases. Gamma was significant with value of 0.246 (P>0.01).

ii) The chi-square value was 213.659, which was highly significant (P>0.01). That there is strong relationship between age at marriage of the respondents and their reproductive health behavior. As age at the marriage of the respondents increases the reproductive health behavior also increases. Gamma was also significant with value of 0.707 (P>0.01). The chi-square value was 97.17, which was highly significant (P>0.01). That there is strong relationship between general health status of the respondents and their reproductive health behavior. As general health status of the respondents increases the reproductive health behavior also increases. Gamma was significant with value of 0.199 (P>0.01). The chi-square value was 152.40, which was highly significant (P>0.01). That there is strong relationship between Knowledge about Contraceptive of the respondents and their reproductive health behavior. As Knowledge about Contraceptive of the respondents increases the reproductive health behavior also increases. Gamma was also highly significant with value of 0.079 (P>0.01). The chi-square value was 46.20, which was highly significant (P>0.01). That there is strong relationship between Contraceptive use behavior of the respondents and their reproductive health behavior. As Contraceptive use behavior of the respondents increases the reproductive health behavior also increases. Gamma was highly significant with value of 0.503 (P>0.01). The chi-square and the gamma test are applied. The chi-square value was 211.13, which was highly significant (P>0.01). That there is strong relationship between Contraceptive use behavior of the respondents and their reproductive health behavior. As Contraceptive use behavior of the respondents increases the reproductive health behavior also increases. Gamma was highly significant with value of 0.290 (P>0.01).

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