International Journal of Environment, Ecology, Family and Urban Studies (IJEEFUS)
ISSN 2250-0065
Vol.2, Issue 3 Sep 2012 1-25

DEMOGRAPHIC TRAITS AND MEDIA EXPOSURE INFLUENCING MALE REPRODUCTIVE HEALTH BEHAVIOR

[1]YASIR NAWAZ, [2]BABAK MAHMOOD & [3]ASHFAQ AHMAD MAAN

[1,2]Assistant Professors, Department of Sociology University of Sargodha, Sargodha, Pakistan

[3] Professor and Chairman, Department of Rural Sociology, University of Agriculture, Faisalabad, Pakistan

ABSTRACT

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 authority of decisions making, religiosity and exposure of media. 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. 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.

KEYWORDS: Media Exposure, Pakistan , Male Reproductive Health**.**

INTRODUCTION

World health organization defines reproductive health as, basic human right which refers that a state of complete physical, social, and mental well being and not merely the absence of disease and infirmity in all matters relating to the reproductive system and to its functions and processes (WHO, 2004)**.** The ICPD Programme of Action investigates all countries including Pakistan to insure the reproductive health for men and women both on the maxim, “Affordable, Accessible, Acceptable, and Convenient”. The ICPD encouraged the programmes of Reproductive Health, condemn to consider men and women separately rather they favor a more holistic approach that includes Men and focuses on couples (ICPD, 1994). Millennium Development Goals as a set by millennium summit, 2000 at top most level are: Gender equality, HIV/STDs, and Reproductive Health. Subsequently, the additional target was set including universal access to reproductive health by 2015, with their related indicators of Male Reproductive health behavior (Millennium Summit, 2000). Pakistan is the signatory of the ICPD and MDGs, Government of Pakistan is geared to achieve the targets till 2015, especially on Reproductive Health with inclusion of male participation (Babar T. Sheikh, 2008). In 1994, United Nations reported that, 1990s have been emphasizing on reproductive health programs. But the need of men's involvement is less focused or directed. The prior concern is still to vitalize the men's responsibilities and their roles

with regards to their partner's health. The family planning programs such as traditional levels and individual's determination for both male and female contraceptive methods have been replaced by a holistic approach encompassing with a broader spectrum of reproductive health behavior concerns**.** 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 changes 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).

METHODOLOGY

A cross sectional study was conducted in 3-districts of Punjab province. One tehsils from each district selected randomly and sample of 272 men from Tehsil-1 i.e. Rawalpindi, 197 from Tehsil-2 i.e. Bahawalpur and 131 from Tehsil-3 i.e. Toba Tek Singh. From each Tehsil equal no. of respondents was selected from rural and urban areas by random sampling technique to explore the research objectives. 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, age at marriage, duration of marriage, discussion about reproductive health problems, general health status, 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, duration of marriage, education, income, communication with wives, drugs using were highly significant and age of the respondent, communication of affairs, ideal number of children in a family were non-significant with MRHB.

RECOMMENDATIONS

Based on the research findings it is suggested that a general acceptance of contraceptive use, men along with women should be include in the target group as most of the decisions regarding family planning and contraception necessitate prior approval of male partners. Men shall be educating to give women all due rights especially their reproductive rights and involve them in reproductive and contraceptive decision making.

SOCIO-CULTURAL & DEMOGRAPHIC FACTORS

To bear a child soon after the marriage is cultural taboo of South Asian society in which the majority of adolescent bear children within marriage. As relatively new family members, young mothers are isolated and vulnerable. They have limited control over their lives and lack social support. However, the first birth may offer a unique opportunity to improve the prospects of young mothers. Because the juvenile women are about to give birth to the next generation, husbands and husbands' families may be open to new information and behavior change (Naheed, 1997). It was noticed that there was reluctance in men for reproductive health programmes participation but the participation of males in counseling programmes has shown a great rise in the use of contraceptives among their wives, hinting that men are susceptible to change initial bias against family planning (Mbizvo, 1996).

OBJECTIVES

1. To probe into the socio-cultural characteristics of the respondents living in rural and urban areas.
2. To find out the affect of age on the attitudes of respondents toward reproductive health.
3. To note the affect of family type on the attitudes of respondents toward reproductive health.
4. To find out the affect of media on the attitudes of respondents toward reproductive health.

CONCEPTUAL FRAMEWORK

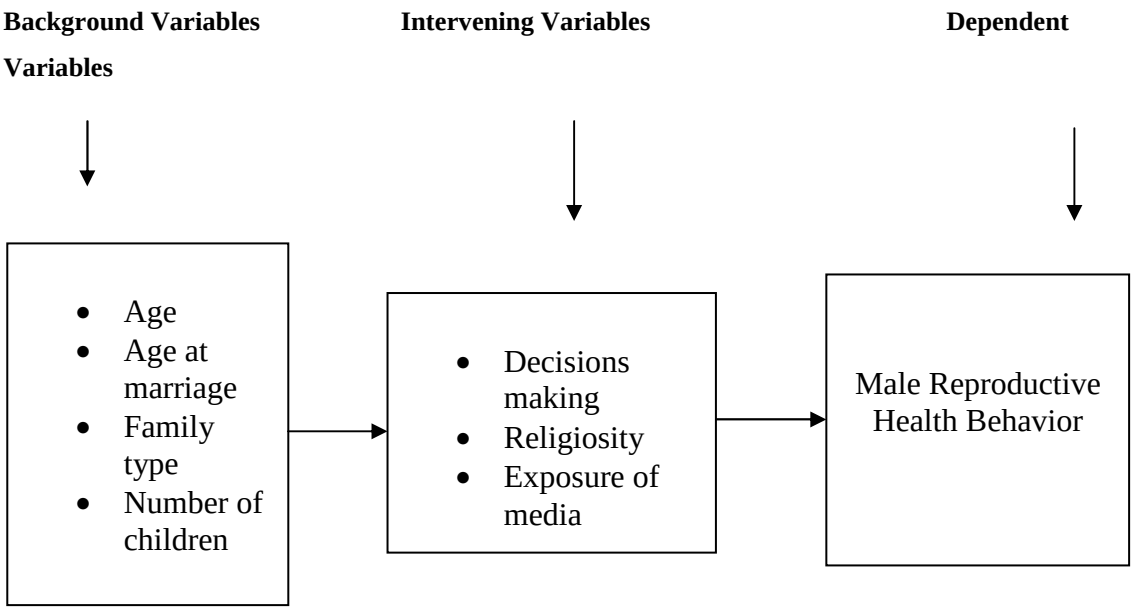


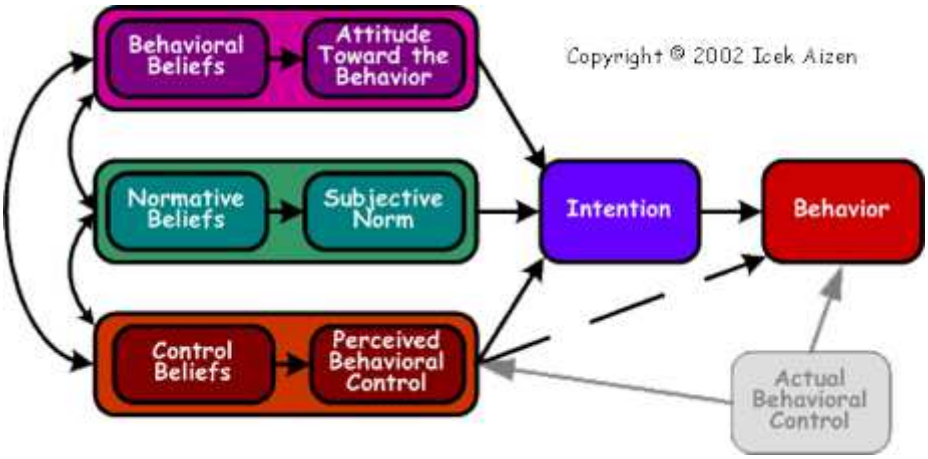
Figure 1.1

THEORETICAL FRAME WORK

Reasoned Action Theory

In 1980 Ajzen and Fishbein presented human behavioral theory named as theory of reasoned action (TRA) encompassing the human behavior, 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 planned behavior presented that the specific attitudes towards a behavior can give an insight to the behavior beforehand. This attitude towards the behavior can measured after having a prospect of the subject norms of the people involved. The reaction of the peoples to a certain behavior also set the boundaries of some action. To predict one's intentions, knowing these beliefs can be as important as knowing the person's attitudes. Planned behavioral control refers to the people's own bent of mind about their ability to perform a given behavior. The acceptability of an attitude, the influencing factors to a certain behavior and the mental framework of the behavior control are the key factors to force a person to perform the behavior intently (Ajzen, I., 2002).

Figure 1.2 Model of the Reasoned Action Theory



Source: (Ajzen, I. (2002). Perceived Behavioral Control, Self-Efficacy, Locus of Control, and the Theory of Planned Behavior.

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. 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.

CONCEPTS OF THE SOCIAL COGNITIVE THEORY

The concept of behavior can be viewed in many ways. *Behavioral capability* means to have an insight, of certain behavior and to possess the skills to perform it, by a person.

Environment

Environment is the amalgamation of such factors which are external to a person but still they provide opportunities and support by the society.

Situation

Situation means how a person perceives the environment clearing all the cliché of wrong perceptions to healthful forms promotions.

Capabilities of Behavior

Skills and knowledge to perform a given behavior; it’s a training of skills to attain mastery learning.

Expectations

The outcome of behavior is taken into account in advance; Positive outcomes of behavior of healthful.

Expectancies

The expectations of a person in response to the value that is given to the result, incentives, and resultant variables are seen in the light of their functional meaning .

Self-Control

means to keep a check to attain some specific goals to attain any special behavior, which provides opportunities to have a self monitoring goal, setting-, problem solving and self-reward.

Observational Learning

It depends on the observation of other people's behavior to acquire a certain pattern of behavior including the role models to attain some desired behavior.

Reinforcements

The person’s aptitudes to accept or deny any behavioral pattern give a base to the reoccurrence of behavior.

Self-Efficacy

The self-effective perception of some action leads to perform a particular behavior confidently; being self-effective leads to behavioral change in small steps victoriously.

Emotional Coping Responses

This factor comprises of the strategies, policies and tactics employed by a person to deal with emotionally charged actions or reflections; provide training in the solving of problem and management of stress.

Reciprocal Determinism

Every point in behavior change is directly related to the other one as it is an unbreakable chain involving environmental. His expertise and personal change (Pajares, 2002).

REPRODUCTIVE HEALTH PROBLEM

Reproductive health problems have been recognized with the development and change in social, economic and socio-cultural milieu at global level. References elaborate different approaches relating to reproductive health problems and reproductive health behavior; discussed within socio-economic and socio-cultural context. A massive increase in population is the root cause of male reproductive health behavior of men and women. It was found in the report of Population Council of Pakistan that the prestigious status of motherhood is a cause of males less participation in reproductive and family planning programs. The difference in male and female child rearing responsibilities also leads to differences in the use of contraception. Very few studies have actually looked into men's attitudes about contraception, pregnancy and child rearing and also in the possible ways of changing their resistance (Population Council,1994). Whereas the contraceptive programs have very little to offer men in term of modern contraceptives, other than condom and vasectomy. Another point consider is to ponder that whether men would have elected to use contraceptives, or the other medical methods which involve no or less risks to their health (Kumar. S, 1996). Satisfactorily, it can be said that after long focused attention paid on male reproductive health emphasis is going to be laid on the management of reproductive behavior of men. Family planning Programs and policies increasingly focus on the male partner's role and responsibilities in contraceptive decision-making and use (Brindis, 1998). The prevalence of contraceptive use among married males in Pakistan was found 2 percent, low as compared to many other south Asian countries. Knowledge about sexual issues and STDs has been found to be of satisfactory level among females. But relatively little is known about sexual health knowledge and information-seeking behaviors of males (Pachauri & Santhya, 2002).

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). 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 and Kontula, 1998).

AGE AND MARRIAGE

Young men have less knowledge about fertility and reproductive health or the female menstrual cycle and other issues related to reproductive than older men (Drennan, 1998).

EARLY & LATE MARRIAGE

Reproductive health behavior of men specially affected with the marriage pattern, early and late marriages in Pakistan affects the sexual behavior of the male. In a research reported that late average age at marriage is another factor contributing to the spread of HIV because of late marriages which leads to premarital sexual activity and a long period of irresponsible sexual and reproductive health behavior of men. Sexual behavior before and after marriage and Age at marriage could play vital role in the spread of HIV (Orubuloye 1994). Fathers, being the head of the family, are instigated to motivate through information on sexuality and contraception requirement to their sons in their transition from adolescence to adulthood for guide them before and after marriage (Mundigo, 1995).

REPRODUCTIVE BEHAVIOR IN GENDER CONTEXT

Reproductive behavior and sexuality has different meaning for different people in different contexts. We cannot ignore the issue of sexuality and gender relations, which is the underlying cause of virtually all of the behaviors and conditions addressed by reproductive health either of male or female (Narayana, 1996). One of the critical categories of differentiation is gender. Girls, Boys, Women, and Men not only have different bodies, but they are also socialized into different gender roles that significantly influence their sexual behavior. It is this society, which provides the context in which behavior shaped. It is infecting the tremendous pressure of traditional gender role ideologies, which create individual's assumptions about his or her own sexuality (Amuchastegni, 1996).

MATERIALS AND METHODS

The materials and methods provide a path to researcher how to complete the process of collection, analyzing and interpretation of data. The research design is the "blueprint" that enables the researcher to come up with the solutions to the problems encountered during the research (Nachmias and Nachmias, 1992). It gives the study design, selection criteria for respondents, sampling procedures, sample size, selection and training of interviewers and different statistical techniques used for data analysis, such as Cronbach's Alpha Reliability Test, Uni-variate analysis, Bi-variate analysis, and Multi-variate analysis, such as Ordinal Regression Model. Therefore, the main objective of this chapter is to explain various tools and techniques employed for the data collection, analysis and interpretation of the

data. 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.* 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). A representative sample of 600 males was interviewed (Morgan, 1997; Fitzggibbon and Morris, 1987). 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

Social scientists deal with human beings, which are most sensitive in nature. In such studies it is quite essential that during development of measurement instrument, all aspects of data quality and human nature should be taken into account. 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 pre-testing (20 interviews) was carried out to examine the sensitivity of the questions and to ensure that the respondents could understand the questions and answer them fully. Pre-testing helped to check the workability of the research tools. The ambiguities

encountered during this trial and error stage were carefully rectified on revision and modification of the interviewing schedule (Goode and Hatt, 1952). 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. It was end so to have a glance at the completeness, accuracy and uniformity because of inaccessibility to the respondent at later stages. The researcher carried out the cleaning process for the data by checking against the coding sheet or the original questionnaire in order to clean the data from illegal codes, inconsistencies and improbabilities through computer editing. When it was definite that the data was cleaned and free of errors. Validity can be described as the confirmation of the measure in reflecting the concept that is targeted to evaluate or the limit to which and how well the concept can be measured. In the present case, validity has been measured by face and content validity (Cronbach & Paul, 1955). Content validity is the measurement to which the items questioned about represent the content that the instrument is designed to measure (Phillips, 1976 and Rusin, 1983). 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. The provision of accurate information is the most significant consideration for any researchers. A reliable instrument yields the same results over repeated measures and subject. Cronbach (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

In this section 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 2: Distribution of the respondents according to their demographic characteristics (n=600)

Age (years)	**Respondents**		**Wives**	
	F	**%**	**F**	**%**
Upto 35	273	45.5	456	76
35-45	231	38.5	103	17.1
46 and above	96	16	41	6.9
Mean = 43.66 S.D. = 10.44				
Mean = 38.05 S.D. = 10.29				
Age at Marriage				
Up to 25	209	34.8	294	49
26-30	256	42.7	210	35
31 and above	135	22.5	96	16
Mean = 27.52 S.D. = 3.92 Mean = 22.25 S.D. = 3.99				
Members	**Adult**		**Children**	
	F	**%**	**F**	**%**
0-1	91	15.2	68	11.3
2-Jan	87	14.5	88	14.7
4-Mar	340	56.7	111	18.5
8-May	79	13.2	330	55
9 & above	3	0.5	3	0.5
Mean adult = 3.09 S.D = 1.81 Mean children = 4.24 S.D = 2.38				

Family Structure		
Nuclear	234	39
Joint	326	54.3
Extended	40	6.7

Attitude of the Respondents to give the Specific Amount to Their Wives

The analysis presented below is restricted to those respondents who give the specific amount to their wives monthly basis including those who didn't ever. The data presented in Table 3 shows that a slightly more than half (53.7 percent) of the respondents gave the specific amount to their wives monthly, while the remaining 46.3 percent of the respondents were not gave any of the amount to their wives.

Table 3: Distribution of respondents according their attitude to give specific amount to their wives monthly (n=600)

Give Specific amount to their wives	Attitude	
	F	**%**
Yes	322	53.7
No	278	46.3

Table 4: 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	165	27.5	165	27.5
A women should equally express herself about affairs of home life	54	9	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	416	69.3
A women should be encourage to get higher education	168	28	224	37.3	208	34.7
A women should always pay due respect to her husband	4	0.7	245	40.8	451	58.5

INFORMATION SOURCES (MEDIA)

Media play a key role in any social economical and mental change in behavior. Table presented that access of the media information were frequent to the respondent like News paper, Radio, Television and internet reported as 26.7, 19.0, 13.8 and 2.8 percent respectively. Whereas Rarely access of the respondent i.e. 74.8, 55.5, 46.8, 43.2, 30.0 and 8.7 percent of the respondent to Television, Radio, Newspaper, Magazines, Internet and any other media sources respectively. And the respondents never used to any source of information (media), Internet, Magazines, newspaper, Radio, and Television respectively. Respondents' exposure to media reflects the behavior of the respondents' on the matters of reproductive health and reproductive health issues. Because the knowledge and information regarding the contraceptives, and other reproductive health problems can be easily float to the lay man with the help of mass media, and other print media as well. So that media also should play vital role on the health related matters especially on reproductive health for changing the behavior of the male community.

Table 5: Distribution of the respondent according to their information sources (MEDIA) (n=600)

Information sources	Never		Rarely		Frequently	
	Freq.	%	Freq.	%	Freq.	%
Newspaper	159	26.5	281	46.8	160	26.7
Radio	153	25.5	333	55.5	114	19
Internet	403	67.2	180	30	17	2.8
Television	68	11.3	449	74.8	83	13.8
Magazines	341	56.8	259	43.2	--	--
Satellite channels	548	91.3	52	8.7	--	--

FERTILITY PREFERENCE

It is well established fact that the fertility preferences are affected positively as well as negatively on the reproductive health behavior of the male globally and specifically in Pakistan. No doubt the families gained socio-economic benefits from the male members at the same time they also reported dimension of adverse effects of the fertility preferences. In Table 6 describes that majority of the respondents 50.3 percent wished 3-4 son in their preferences, 36.8 percent were reported 1-2 son, 8.5 percent for 5 and above male child and very less percentage i.e. 4.3 percent of the respondents had no fertility preferences. Furthermore, the respondents asked about their fertility preferences about girl child (daughter). They reported, 1-2, 3-4, no preferences for daughter or son, and 5 daughters and above as 55.2, 30.0, 11.8 and 3.0 percent, respectively. In table 4.12 the figures speaks that about the respondent's preferences of desire more children, and more than 55.8 percent of the respondents desire no more children at all, whereas 37.3 percent reported to desire more children, but the very low percentage 6.8

percent of the respondents were believed and stated that it's all up to ALLAH. With regards to fertility preferences the respondents asked on the no. of children they want in their family, and data showed the trend was major proportion i.e 62.7 percent of the respondents were strongly believed on ALLAH, with having no desire, whereas 19.3 percent, 12.3 and 5.7 percent of the respondent has desired for 1, 2, 3 children, respectively. The data furthermore expressed that idealism trend of the no of children in a family. Data reveals that, 36.5 percent of the respondents stated that the ideal no. of children should be 2-3, while 34.2 percent of the respondents' opinion that the ideal number of children should be 4-5 and 29.3 percent of them stated 6 and above children are ideal number of children.

Table 6: Distribution of the respondents according to their fertility preference (n=600)

Number of sons	**F**	**%**
No son / Up to Allah	86	14.3
2-Jan	332	55.3
4-Mar	161	26.8
5 and above	21	3.5
Number of daughter		
No daughter	71	11.8
2-Jan	331	55.2
4-Mar	180	30
5 and above	18	3
Wanted more children		
Yes	224	37.3
No	335	55.8
Up to Allah	41	6.8
Wanted /desired number of children		
One	116	19.3
Two	74	12.3
Three	34	5.7
Up to Allah	376	62.7
Ideal number of children (Nos)	**F**	**%**
3-Feb	219	36.5
5-Apr	205	34.2
6 and above	176	29.3

HEALTH

The People of Pakistan have a limited access to health related facilities education and services. The male are the utmost sufferers on their sexual health and reproductive health. They required a clear picture of their body to prevent from guilt, ambiguity, and confusion. This might effect on their positive or negative self-image. The negative image might leads to physical, mental psychological and socio-economic trauma. Table 7 shows that the majority of the respondents i.e. 72.2 percent reported that they faced physical illness and remaining 27.8 percent of them told that they had no physical illness.

Table 7: Distribution of the respondents according to their general health problems in their life (n=600)

Face physical illness in their life	F	%
Yes	433	72.2
No	167	27.8

Respondents According to Their Physical Health Problems

Table 8 reveals that from 65.7 percent of the respondents disclosed that they had the health problems like stomach, and chronic diseases during their life span. Whereas 27.8 percent of the respondents' faced lever related disease. Heart and kidney patient reported 13.8, 10.8 percent respectively. And 5.7 percent of the respondents' reported Ocular damage, tuberculosis and only 2.8 percent of the respondents were with the disability of any organs. Moreover 11.3 percent of those respondents' who have faced any other kind of illness in their life. Sharif in 2002 also reported that the stomach diseases in Pakistan are almost more than fifty percent i.e., 53 percent and liver related diseases are arises dramatically and its percentage in his study was 21 percent.

Table 8: Distribution of the respondents according to their general health problems (n=600)

Problems	Yes		No	
	F	%	F	%
Stomach	394	65.7	206	34.3
Chronic pain/diseases	394	65.7	206	34.3
Disability of any organ	17	2.8	583	97.2
Ocular damage	34	5.7	566	94.3
Tuberculosis	34	5.7	566	94.3
Lever	167	27.8	433	7202
Kidney	65	10.8	535	89.2
Heart	83	13.8	517	86.2
Any other disease	68	11.3	532	88.7

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. In other words, the variation explained by one variable is patterned in such a manner that its variance is not randomly distributed in connection with the other variables. In the context of a bi-variate relationship, the problem arises whether a relationship is real or has arisen by chance. 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. These are known as expected frequencies. The value of Chi-square depends upon the difference between the expected and observed frequencies. A large difference is an indication of the high value of the chi-square.

Generally, significance of the relationship is examined by establishing a null hypothesis, in which it is assumed that there is no difference or no relationship between two variables. 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.

ANALYSIS

Bivariate analysis is carried out to explore the relationship between predictor (Independent) i.e. (age of the respondents, education, wife's education, income, family income, family size, Family structure) and response variable male reproductive health behavior which is based upon the changes in education, economic condition, family and social relations. The index variable of independent variables was constructed by adding the responses on basis of these statements. The score range from 4 to 16. The score ranging from 4-16 has been converted into three equal categories respondents who scored from 4-7 is categorized as "Low", while the score range 8-11 is categorized as "Medium", while 12-16 is categorized as "High" effect. The index variable reproductive health behavior is based upon the four statements education, economic condition, family and social relations. The respondent's views on these statements are measured on 3 points lickered scale "To great extent", "To reasonable extent", "To some extent", "Not at all". The respondents viewed that "To great extent" education occurred given score 4, "To reasonable extent scored as 3", "To some extent scored as 2", "Not at all scored as 1". The index variable is constructed by adding the responses on these statements. The score range from 4 to 16. 4 indicate that there is no reproductive health behavior in terms of education, economic condition, family and social relations. While score 16 indicates that due to migration "To great extent". The score ranging

from 4-16 has been converted into three equal categories respondents who scored from 4-7 is categorized as “Low” impact while the score range 8-11 is categorized as “Medium” impact, while 12-16 is categorized as “High” reproductive health behavior.

ASSOCIATION BETWEEN THE AGE OF THE RESPONDENT AND THEIR REPRODUCTIVE HEALTH BEHAVIOR

The study indicates the relationship between ages of the respondents with their reproductive health behavior. The respondents were asked to answer about the age of the respondents in number of years i.e. up to 35, 36-45, 46 and above 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 contraceptive use, HIV/STDs knowledge and behavior were computed to construct the index variable. It is shown in Table 9 reveals the relationship of age of the respondents with the reproductive health behavior. The detailed study of said table shows that 66.1 percent respondents attained age up to 35 and had low score on the reproductive health behavior index variable. The respondents who had attained age group of 46 and above had low score on the reproductive health behavior index variable (15.2 percent). The table also reflects that 14.4 percent of the respondents who had attained the age of up to 35 had high score on the reproductive health behavior index variable were negative than the respondents who had age of 46 and above and the same score (positive) on the reproductive health behavior index variable (60.9 percent). It can be said that there is association between age of the respondents and the reproductive health behavior. It indicates that lower the age of the respondents, lower is the reproductive health behavior and higher the age of the respondents, higher is the reproductive health behavior. In order to examine the significance relationship between the age of the respondents and the reproductive health behavior. The chi-square and the gamma test are applied. The chi-square value was 137.46, which was highly significant (P>0.01). The said table also reflects 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). Therefore, the hypothesis the age of the respondent is associated with the reproductive health behavior: Higher the age of the respondent, higher will be the reproductive health behavior as compared to lower age of the respondent, lower the reproductive health behavior was accepted.

Hypothesis 1: Age of the respondent is associated with the reproductive health behavior: Higher the age of the respondent, higher will be the reproductive health as compared to lower age of the respondent.

Table 9: Association between the age of the respondent and their reproductive health Behavior (n=600)

Age (years)	Male reproductive health behavior			
	Low	**Medium**	**High**	**Total**
Upto 35	119 -66.1	35 -19.4	26 -14.4	180 -30
36-45	111 -51.6	55 -25.5	49 -22.7	215 -35.8
46 & above	31 -15.2	49 -23.9	125 -60.9	205 -34.2
Total	**261 -43.4**	**139 -23.3**	**200 -33.3**	**600 -100**

Chi Square value. 137.46** ****. Highly significant**

Gamma value. 0.246* *. Significant

ASSOCIATION BETWEEN THE AGE AT MARRIAGE OF THE RESPONDENT AND THEIR REPRODUCTIVE HEALTH BEHAVIOR

The study indicates the relationship between ages at marriage of the respondents with their reproductive health behavior. The respondents were asked to answer about the age at marriage in number of years i.e. up to 25, 26-30, 31 and above 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 10 reveals the relationship of age at marriage of the respondents with the reproductive health behavior. The detailed study of said table showed that 66.6 percent respondents had married at the age up to 25 and also attained low score on the reproductive health behavior index variable. The respondents who had married at the age group of 31 and above had low score on the reproductive health behavior index variable (16.6 percent). The table also reflects that 11.9 percent of the respondents who had attained the age of up to 25 had high score on the reproductive health behavior index variable were negative than the respondents who had married at the age of 31 and above and the same score (positive) on the reproductive health behavior index variable (57.2 percent). It can be said that there is association between age at marriage of the respondents and the reproductive health behavior. It indicates that lower the age at the marriage of the respondents, lower is the reproductive health behavior and higher the age at the marriage of the respondents, higher is the reproductive health behavior. In order to examine the significance relationship between the age at the marriage of the respondents and the reproductive health behavior. The chi-square and the gamma test are applied. The chi-square value was 213.659, which was highly significant (P>0.01). The said table also reflects 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). Therefore, the hypothesis the age at

marriage of the respondent is associated with the reproductive health behavior: Higher the age at marriage of the respondent, higher will be the reproductive health behavior as compared to lower age at marriage of the respondent, lower the reproductive health behavior was accepted.

Hypothesis 2: Age at marriage of the respondent is associated with the reproductive health behavior: Higher the age at the marriage of the respondent, higher will be the reproductive health behavior as compared to lower age at marriage of the respondent.

Table 10: Association between the age at marriage of the respondent and their reproductive health behavior (n=600)

Age at marriage (years)	**Male reproductive health behavior**			
	Low	**Medium**	**High**	**Total**
Upto 25	156 -66.6	50 -21.4	28 -11.9	234 -39
26-30	70 -44.9	34 -21.8	52 -20.3	156 -26
31 and above	35 -16.6	55 -26.2	120 -57.2	210 -35
Total	**261** **-43.4**	**139** **-23.3**	**200** **-33.3**	**600** **-100**

Chi Square value. 213.659 **.Highly significant**

Gamma value. 0.707 **.Highly significant**

ASSOCIATION BETWEEN THE DURATION MARRIAGE OF THE RESPONDENT AND THEIR REPRODUCTIVE HEALTH BEHAVIOR

The study indicates the relationship between duration of marriage of the respondents with their reproductive health behavior. The respondents were asked to answer about the duration of marriage in number of years i.e. up to 1-10, 11-20, 21 and above 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 11 reveals the relationship of the duration of marriage of the respondents with the reproductive health behavior. The detailed study of said table showed that 70.5 percent respondents had the duration of their marriage 1-10years and also attained low score on the reproductive health behavior index variable. The respondents who had their

marriage duration 31 and above year had low score on the reproductive health behavior index variable (20.3 percent). The table also reflects that 14.5 percent of the respondents who had attained their duration of marriage 1-10 years had high score on the reproductive health behavior index variable were negative than the respondents who had their duration of marriage of 21 and above and the same score (positive) on the reproductive health behavior index variable (58.1 percent). It can be said that there is association between the duration of marriage of the respondents and the reproductive health behavior. It indicates that lower the duration of marriage of the respondents, lower is the reproductive health behavior and higher the duration of marriage of the respondents, higher is the reproductive health behavior. In order to examine the significance relationship between the duration of marriage of the respondents and the reproductive health behavior. The chi-square and the gamma test are applied. The chi-square value was 199.992, which was highly significant (P>0.01). The said table also reflects that there is strong relationship between duration of marriage of the respondents and their reproductive health behavior. As duration of marriage of the respondents increases the reproductive health behavior also increases. But Gamma was non-significant with value of -0.321 (P>0.01). Therefore, the hypothesis the duration of marriage of the respondent is associated with the reproductive health behavior: Higher the duration of marriage of the respondent, higher will be the reproductive health behavior as compared to lower duration of marriage of the respondent, lower the reproductive health behavior was accepted.

Hypothesis 3: Duration of the marriage of the respondent is associated with the reproductive health behavior: Higher the duration of the marriage of the respondent, higher will be the reproductive health behavior as compared to less duration of marriage of the respondent.

Table 11:Association between the duration of marriage of the respondent andtheir reproductive health behavior (n=600)

Duration of marriage (years)	**Male reproductive health behavior**			
	Low	**Medium**	**High**	**Total**
10-Jan	165 -70.5	35 -14.9	34 -14.5	234 -39
20-Nov	61 -31.4	67 -34.5	66 -34	194 -34.4
21 and above	35 -20.3	37 -21.5	100 -58.1	172 -28.6
Total	**261** **-43.4**	**139** **-23.3**	**200** **-33.3**	**600** **-100**

Chi Square value. 199.992** **.Highly significant

Gamma value. -0.321 [NS] [NS]. Non-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:-

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

Y indicates the response variable, while X_1, X_2, X_3.....indicates the independent variable such as Age of the respondent, Respondent age at marriage, Family type, Number of children, , Decisions making, Religiosity, Exposure of media, Health attitude.

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 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 12 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.

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 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. 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, general health, , 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 12: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	-5.369	-0.051	-1.196	0.232 ^{NS}
Age at marriage	0.284	0.265	7.929	0.000**
Duration of marriage	0.449	0.491	7.472	0.041*

Adjusted R square value = 0.660

CONCLUSIONS

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:-

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).

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 199.992, which was highly significant (P>0.01). That there is strong relationship between duration of marriage of the respondents and their reproductive health behavior. As duration of marriage of the respondents increases the reproductive health behavior also increases. But Gamma was non-significant with value of -0.321 (P>0.01).

REFERENCES

1. Ajzen, I. (2002). Perceived Behavioral Control, Self-Efficacy, Locus of Control, and the Theory of Planned Behavior. Journal of Applied Social Psychology, 32, 665-683.
2. Ajzen, I., & Fishbein, M. (1980). Understanding attitudes and predicting social behavior. Englewood Cliffs, NJ: Prentice-Hall.
3. Amuchastegni, Ana (1996) " Research Bias in the field of sexuality and reproductive health" in zeidenstein , S. And Kristen moore (eds) Learning about sexuality a practical Begning . The population Council, International Women'sHealth Coalition, New york. Pp. 86-97.
4. Babat T. Sheikh, 2008. ICPD to MDGs- Agha Khan University Karachi.
5. Bozon, 1998. ,Narring, Wydler et al. 2000. Bozon, Michel and Kontula, Osmo 1998. "Sexual initiation and gender: a cross-cultural analysis of trends in the 20th century." Pp. 37-67 in Sexual behavior and HIV/AIDS in Europe: comparisons of national surveys, edited.
6. Brindis . 1998. A profile of the Adolescent male family planning client. Family Planning Perspectives, 30, 63-66.

7. Cronbach & Paul, 1955. Relationship power, condom use and HIV risk among women in the USA
   AIDS Care: Psychological and Socio-medical Aspects of AIDS/HIV, 1360-0451, Volume 14, Issue 6, 2002, Pages 789 – 800.

8. Drennan, 1998, Reproductive health: new perspectives on men's participation . population reports, series J No. 46 Baltimore. Johns Hopkins school of public health population information program. October, 1998.

9. Fitzggibbon, 1987. Fitzggibbon, Taylor, C. and L.L. Morris. 1987. How to Fitzpatrick et al, 1989. Health seeking behavior and the control of sexually transmitted disease. Health Policy and Planning, Vol 12, 19-28, Copyright © 1997 by Oxford University Press.

10. Good and Hatt, 1952. Methods in social research, The University of Chicago Press Govt. of Pakistan. 2001 Census report of Pakistan, Population census organization statistics division, Islamabad.

11. ICPD, 1994. International Conference on Population and Development. Programme of Action of the International Conference on Population and Development. New York: United Nations, 1994.

12. Jones and Wasserheit, 1991. Introduction to the biology and natural history of sexuality transmitted diseases. In JN Wasserheit, et al eds. Research Issues in human behavior and sexuality transmitted diseases in the AIDS era. Washington DC , American Society for Microbiology, 1991. Journal article by Ruth Andrea Levinson; Adolescence, Vol. 30.

13. Kumar. S 1996. Sanjeev kumar involving the male (1996) seminar, 447, November la Loi 200 – B-1049 Brussels, Fax (32-2) 299 25 25.

14. Leridon, H. 1999. Sample obtained: characteristics and adjustment. In Spira, A. Bajos, N. and ASCF Group. Sexual Behavior and AIDS. Avebury, London, UK. pp 69–76. Lessons from United Auto Workers v. Johnson.

15. Longdeild K, Anne G, Margaret W, and jhon B. 2004 " Relationship between older men and younger women" implication for STIs/HIV in Kenya. Studies in family planning. 35(2): 125-134.

16. Mbizvo, M.T., M.T. Bassett. 1996. Reproductive health and AIDS prevention in sub Saharan Africa: the case for increased male participation. Health Policy and Planning. 11(1):4-92.

17. Millennium Summit, 2000. European Commission Report: Millennium Development Goals.

18. Miller, N.E. & Dollard, J. (1941). Social Learning and Imitation. New Haven, CT: Yale University Press.

19. Morgan, 1997: Fitzggibbon, 1987. Morris. 1987. How to design a program evaluation.

20. Mundigo, 1995. " Men's role , sexuality and reproductive health international lecture series on Population issues Chicago."

21. Nachmias,C. 1992 'Research Methods in the social sciences published by Edwards Arnold. A Division of Hodder & Stoughton, London. Martin Press Inc. Kent, UK.

22. Naheed, M. 1997. Pregnancy and postpartum experience among young parents in Bangladesh. Preliminary Observation. Bangladesh. Reproductive Health Alliance, UK.

23. Narayana, 1996. " Family violence, sex and reproductive health behavior among men in utterpardesh India."

24. Orubuloye, 1994. Sexual Networking and AIDS . Behavioral research and social context. Health transition series. No-4, Canberra: Australian National University.

25. Pachauri, S. and Santhya, K.G 2002. " Reproductive choices for Asian Adolescent : A focus on contraceptive behavior. InL. Fam. Plan. Prespec..28, 186-195.

26. Pajares, F., & Schunk, D. H. (2001). Self-beliefs and school success: Self-efficacy, self-concept, and school achievement. In R. Riding & S. Rayner (Eds.), Self-perception (pp. 239-266). London: Ablex Publishing.

27. Phillips,1976 & Rusin, 1984:. Transferring health and family planning service innovations to the public sector: an experiment in organization development in Bangladesh. Studies in Family Planning 1984c; 15(2): 62-73.

28. Population Council , 1994 Men's and women's social responsibilities for child bearing Population study, Islamabad.

29. Prata N, Farnaz V, and Ashley F. 2005. Gender and relationship differences in condom use among 15-24 years old in angloa. International Family Planning Perspectives. 31 (4): 192-199.

30. Sen et al., 1994. The Case for Gender Equity in Health Research. Indian Institute of Managment (IIM) Bangalore, Bannerghatte Road, Bangalore 560 076, India. Journal of Health Management, Vol. 4, No. 2, 99-117.

31. Schoemaker. J 2005. " Contaceptive use among the poor in Indonesia. International family planning perspectives. 31(3): 106-114.

32. United Nation, 1994 Programe of action adopted at the international conference on Population and Development, ciaro. United nation September, 1994.

33. Wikipedia, 2009. free encyclopedia. www.wikipedia.org women and men_, Reproductive Health Matters, 7:56-65.

34. World Bank. 1993. World Development Report 1993: Investing in Health. New York:

35. World Health Organization. 2004. Gender Dimensions of HIV Status Disclosure to Sexual Partners: Rates, Barriers and Outcomes. A Review Paper. Geneva: WHO.

36. Zafar., 1996. Family structure and women's Husband-wife as a correlate of contraceptive and fertility behavior. Pakistan Development Review, 35(2): 145-170.