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Describing Determinants of Negotiation and Bargaining to Access and Utilize Resources including Health among Immigrant Pakistani Women in the United States

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Abstract

Objective of this study was to explore the domestic negotiation process around Pakistani homes in Houston. We explored the gendered differences in negotiations and various bargaining strategies employed by Pakistani immigrant women in order to utilize or access various resources including modern healthcare.

Methods: Qualitative research methods were utilized. Nineteen in-depth interviews were conducted with participants, between ages of 25 to 39 years, married, residing in United States for less than 10 years, in addition to five key informant interviews with senior community women, between January to August 2016. Data was analyzed using narrative and thematic content analysis.

Results: Paper presents the determinants of Pakistani immigrant women bargaining power and how women and men manage and negotiate couple, family, and intergenerational dynamics around healthcare as well as other needs. It revealed how Pakistani women mange to fulfill their needs, take care of their health, and what strategies they use to access resources.

Conclusion: We observed that women's education and employment, have significant positive effect on wife's negotiation and decision-making power followed by two other chief determinants that act as a catalyst in wife's bargaining power and autonomy namely, strong natal family and wife sponsored permanent residency.

Keywords: Women's autonomy, decision-making, bargaining power

1. Introduction:

Although gender inequality is a global phenomenon, it is also deeply rooted in many Asian societies, where women routinely face serious restrictions and limitations of autonomy (Nikiema & Potvin, 2008).South Asia as a region, has been well known for the severe problem of discriminations in the independence and supremacy of women and men, respectively. Studies document that women's independence and power to negotiate is influenced by, religion, region and society. They all exert significant effect on the position and level of autonomy of women and can be evident in the context of rural versus urban or developing versus industrialized country (Bloom & Gupta, 2001). Likewise, women's power to negotiate and independence varies between cultures, across regions and socio-economic status, even within the same country (Bloom & Gupta, 2001). The public health importance of women's autonomy in South Asia, lies in the fact that, it is linked with health seeking behavior including, antenatal care, use of contraceptives and health care of children (Bloom & Gupta, 2001; Sharan & Strobino, 2005). However, social norms entail that young married women turn to husbands, mother in-law and family unit elders in all issues, including those related to their own health and well-being. Similarly, in Pakistani society, whether immigrants to United States or otherwise, gender roles are constructed of a combination of traditional roots and social values, where men and older women prefer younger women confined to their homes to do housework for the family.

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Men simply exclude women from main decision-making processes (Ali & Mogren, 2011; Zaman, 2006; Rabbani & Rizvi, 2008).The structure of Pakistani society is widely recognized to be extremely patriarchal, where visibly defined gender roles and large gender disparities in access to resources of all kind prevails (Mumtaz, 2003).In terms of opportunities oftentimes, Pakistani women lack even primary education, nutritious diet and participation in employment/social activities(Mumtaz, 2003; Jejeebhoy & Sathar, 2001; Winkvist & Akhtar, 2000). In general, women are expected to be dependent and homemakers, and men breadwinner.

Such gender disparity in developing countries, like Pakistan, India, Bangladesh, Nepal, is associated with unbalanced bargaining power of women within the household, the consequence of which are disproportionate outcomes in well-being (Ngunjiri, 2013).For example, poor access to and utilization of health services, treatment delays and more health complications. While the literature on gender and migration is mounting, there is comparatively little research and data on what happens to gender relations in the context of migration (Pessar & Mahler, 2006). Moreover, according to Mutema (2010), women remains marginal, even after migration, especially Pakistani women. This situation reveals the utility of using gender as an analytical tool in understanding culture and social change (Mutema, 2010).

The objective of this study is to explore the domestic negotiation process around Pakistani homes in Houston. It centers on bargaining as a strategy, used by Pakistani immigrant women in the U.S. in negotiating power, within and outside the household. I explored the bargaining strategies of Pakistani immigrant women as they attempted to fulfill their needs, or access modern healthcare, or deal with an illness episode. By bargaining power I mean, the ability of husband or wife in a particular situation to exert influence over each other, or the capacity of one to dominate the other due to their influence, power, or status, or through a combination of different persuasion tactics. I wanted to find out how this persuasion or haggling proceeds, and what are the trade materials. By negotiation I mean, the process through which individual with different types of power bargain, until a decision is made. For example, how a wife compromises, discusses her needs and how she plays diplomatically with her husband to get healthcare or other resources. I examined how this negotiation and decision over distribution for resources, including healthcare, advances, or proceeds, who mediates where in the process, and how it is directed by social custom and other grounds. In addition, this study also provides a conceptual understanding of the linkages between gender, religion, norms, immigration and outcomes, within and outside the household.

1.1 Literature Review

South Asian (including Pakistani's) societies are largely gender stratified, and have hierarchical family relations, in which, the patriarch or his (husband)relatives have authority over family members, in particular women (Jejeebhoy & Sathar, 2001). Levels and patterns of female autonomy vary considerably, within cultures, and social structures. According to Aslop & Heinsohn (2005) such gender asymmetries in access to and control over assets, (social, physical, financial, natural and human) access to markets, access to information and organization, dictate power asymmetries and negotiating power, between men and women (Aslop & Heinsohn, 2005). This vulnerable position of women in the bargaining process results in men being able to decide according to their personal wishes at the expense of women. The consequence of women's inability to decide translates to the negligence of women´s health, compared to family´s health, leading to delays in health seeking, and worsening of health conditions (Abou-Shabana & Samir, 2003). Jejeebhoy argued that in a Pakistani society, as in other Islamic settings, women occupy a separate and distinctive position that effectively denies them education and autonomy (Jejeebhoy & Sathar, 2001).Women's lack of control over their own lives, has been cited as the central factor underlying the poorer mortality outcomes experienced by Islamic societies (Mumtaz, 2003).A study by Kamel (2003) conducted in Egypt revealed that, male cases of tuberculosis outnumbered female cases by more than double (2.2:1) indicating that, women's poor access to healthcare services or lower reporting of morbidity, led to under recognition of the condition in women (Kamel et al., 2003).

Research conducted both in India and Pakistan, has shown differential access of males and females to health services, particularly among children, for instance, one study demonstrated that although females outnumbered males, more than half of hospital admittance were boys (Chatterjee & Lambert, 1989). Similarly, another study revealed that even though greater proportions of girls were sick than boys, smaller proportion received remedial treatment (Chatterjee & Lambert, 1989).

In addition, females may be taken to less skilled healthcare provider compared to boys, and money spent on medications, may be destined to treat boys more often than girls. Improved and well-timed therapeutic care for a child, may be the most central feature elucidating high survival among boys in contrast with girls(Chatterjee & Lambert, 1989; Liefooghe et al., 1995).

In brief, the studies mentioned above shed light on how gender asymmetries, in Pakistani society and within a household are structured and modified. A complex range of determinants play different role, that may determine a woman's bargaining power, the consequence of which could be disproportionate outcomes in her well-being. With mounting literature on gender, there is comparatively little research and data on what happens to gender relations in the context of migration (in particular Pakistani household). In this study, gender is utilized as an analytical tool in understanding culture, immigration and social changes.

1.2 Public health significance:

Like other South Asian countries, women in Pakistan, generally have less power and independence compared to men, in all domains of decision making, including, their own health. Furthermore, women often lack equal access to food, education, economic opportunities, productive resources and health care. Research details the ways that Pakistani women's freedom in decision making, and their varying levels of power of negotiation relinked with her ethnicity, level of education, and number and gender of her living children (Kabeer, 1999). Acharya et al.(2010)found that highly educated women were more likely to participate in their own health decision making. However, older women of the house, such as mother in-laws, tend to be the primary decision makers about younger women's health in Asian societies, especially in Pakistan, India, Bangladesh, Nepal (Acharya et al., 2010).

Research exploring women's status in Pakistan, are consistent with other South Asian (India, Bangladesh, Malaysia) countries, demonstrating that, an economically independent or earning wife, family size and the gender of children, has the effect of increase in women's autonomy, and provides her sole bargaining power, and decision making at the household level. Whereas, living in a household, comprising of elder women related to husband, substantially reduce wife's autonomy and decision making in domestic matters (Mumtaz, 2003). Other comparable studies conducted in developing countries, also report that a women's age and family structure are the strongest determinants of her bargaining power and authority in decision making (Sathar & Shahnaz, 2000).Older women and those in a nuclear family set-up are more likely than other women to partake in domestic decisions. The younger the woman, the more vulnerable she is to male dominance, in-law's subordination and holds the least amount of empowerment, influence or authority within or outside the family. This vulnerability most likely decreases over time, as she gains social seniority (Sarikhani, 2012).Similarly, women residing in a nuclear family, have to deal only with subordination to her husband, whereas those living in a joint family, with in-laws and extended members, the most popular type of living arrangement in a Pakistani society, she is placed in a lower rank than all the male members, and senior women in the family. This placement can weaken her bargaining power, leaving her needs unattended (Khatwani, 2017).In such circumstances, a woman who has strong ties with her in-law's, better social network, and/or influential natal family, stands a better chance of negotiating her needs and enjoying some level of decision making. She is considered strong and the husband or in-laws prefer not to interfere with her decisions, that may deprive her of any services, as this may in turn negatively influence husband or in-law's social status and relations (Chatterjee & Lambert, 1989; Sabir, 2015). However, social and cultural norms of society, play a key role, in shaping women's decision-making power within the household (Rabbani & Rizvi, 2008).

Literature from Bangladesh, India, Pakistan, Turkey further highlight how numerous factors, are associated with women's autonomy and bargaining power, at household level, including, education, participation in economic activities, family status and caste, ownership of assets such as land or credit, family size and number of sons, patriarchal structure, and marriage endogamy versus exogamy (Sathar & Shahnaz, 2000; Sarikhani, 2012).Having a professional degree, income or ownership of assets, act as a buffer against women's subordination and ensures women and family well-being (Acharya et al., 2010; Fatima, 2014; Arooj et al., 2013). Women who bring more assets at the time of marriage, improve their social standing in the household. Income controlled by the mother has better effect on the family's health compared to the father. Household allocation decisions are the result of a bargaining process, in which its members seek to allocate resources over which they have control. Crucial to this final allocation is the bargaining strength of each spouse, with income being one of the key factors, that influences this distribution of power however, it is not the only variable (Doss, 2013).

Sometimes the gender of the children can make a difference in the negotiating power of women, for example bearing sons finds her a place in the husband's house, where she can have her needs fulfilled, because sons are expected to bring economic benefit in the future once they start earning. But daughter in South Asian society, is seen as a financial burden, because the money spend to raise her, and then to offer dowry in her marriage, means no economic gain. Preference for sons, holds the strongest place in Pakistani society, and women bearing more sons keep getting their social position upgraded. On the other hand, a woman giving birth to more daughters, will lose her status and benefits in the in-law's house. At other times, simply bearing more children regardless of gender, will help a woman maintain her status at her in-law's household(Mumtaz, 2003; Jejeebhoy & Sathar, 2001).

Another fundamental determinant of women's autonomy is her caste, meaning a type of social classification, which divides people on the basis of inherited social status. Pakistani society comprises of a variety of castes, ranging from the highly prestigious, to moderate, to least influential. For example, the 'Rajput's or the son of king, is a prominent social group, and claim descent from the ancient royal warrior dynasties of India. The 'Jats' or brave, courageous and loyal caste are traditionally agricultural people. The 'Sheikhs' or elder of a tribe, lord, honorable, is attributed to trading families. The 'Mughal', the builders, are descendants of the Mughal dynasty that ruled India and 'Qureshi' ancestry is from the Quraish, the Arab tribe that Prophet Muhammad belonged to, are some of the esteemed caste. The 'Kamin' or 'churas' meaning untouchable or 'neechzaat' (low caste), 'badnasal' (bad lineage) and 'ghulams' (slaves) are the terms for low caste groups (Ghazdar, 2007). A woman belonging to a higher caste is more welcomed in the family. She is taken care of, by in-laws, and participates more in the husband's family. Finally, the type of marriage, arranged or love, endogamous/cousin vs exogamous, holds a key position in a women's married life. Arranged marriages involve both families' consent and participation, with less value given to bride and groom's approval. Women enjoys a reasonable position, though subordinate and less influential, but difficult to terminate. In contrast, a love marriage includes only the couples' approval, with no endorsement from either family side. Such marriages are extremely vulnerable to end poorly, and women in love marriage have the lowest, most subordinate position within the husband's house. Endogamous or cousin marriages, most commonly practiced among Pakistani society, are the least likely to dissolve because the prestige of both families is at stake, and many believe that is what makes the marriage work. Endogamy, in a way, protects women and ensures lifelong shelter and ties within husband's family (Saadat, 2015). Women in an endogamous/cousin marriage stand a better chance to negotiate her needs, given the investments made by the couple's families, than women in exogamous marriage, with either in arranged or love marriage.

Schmidt (2012) article on Bangladesh, provides insights into the relationship between women's bargaining power and the health outcomes of their children. They showed a positive relation between child health outcome and mothers decision making authority (Schmidt, 2012).Similarly, income controlled by the mother, has a greater effect on her family's health, than income in the hands of the father (Thomas, 1990). Using assets at marriage as indicators of intra-household bargaining power, other studies have found that more assets brought to the marriage by women, (in form of dowry) increases education expenditure shares in Bangladesh. In other words, the allocation or spending of money on education of children increases when women bring more assets through dowry because this puts her in a better position to negotiate what she wants (Jejeebhoy & Sathar, 2001).Likewise, Achary et al. (2010) study support, that women who have a significant say in reproductive matters, tend to be more educated, spend more time on household economic activities and marry at later age (Acharya et al., 2010).In brief, past research strongly holds that, improved levels of women's autonomy, in terms of education and income, not only contribute to reduce fertility rates, but also lead to welfare of the children in terms of health and education, as well as reduces the incidence of domestic violence against her (Khan, 2014).In South Asia, as is the case mostly everywhere, women's independence is also positively associated with the socioeconomic development of the country (Khan, 2014; Mukharjee, 2013; Grabowski & Self, 2013).

This study addresses some of the gaps within the existing literature, on the topic of U.S. immigrant Pakistani women's bargaining strategies and determinants, as she attempts to access resources, including health, as an immigrant in Houston, TX. The main objective is to describe married Pakistani immigrant women's autonomy and bargaining power around fulfilling her needs and accessing healthcare.

2. Methodology:

This ethnographic study provides a cultural portrait of immigrant Pakistani women, by means of participant observation in healthcare clinic setting, direct observation in the Pakistani community and family homes, and open-ended semi-structured in-depth interviews (n=24). Observations complemented interviews. Data analysis was guided by narrative analysis and thematic content analysis. First, each transcript was studied thoroughly, and notes were made. In subsequent reading, we coded and grouped codes into themes, ensuring they capture the depth and breadth of the data. Triangulation is done from different data sources to provide a deeper understanding of women's bargaining power, the negotiation process, and their experiences of managing their needs and illness experiences.

2.1 Study Setting

The study site included places of worship or mosque of Islamic Society of Greater Houston (ISGH) including, north and south zone. These mosques are selected based on the fact that, they cater to the largest Muslim population. In addition to mosque, Pakistani families residing in the public housing or apartments, in the Houston Harris County area were also eligible for inclusion. After selection of study participants by the primary researcher, based on a short demographic survey, in-depth interviews were conducted. The study took place between January 2016 to August 2016.

2.2 Study Participants

We interviewed 24 participants. We conducted five key informant interviews of senior community women and used a convenience sample approach to recruit19participants for in-depth interviews about their experiences. The 19 women who spoke about their own experiences identified themselves as Pakistani married immigrants, residing in the U.S. between two to ten years. They were between the ages of 25 to 39 years. All participants were residents of Houston, Texas. At the start of the study, participants were asked to fill a short demographic survey in order to capture their basic background and family ties information, level of acculturation and to some extent, degree of autonomy.

2.3 Data Collection

2.3.1 Participant-observation:

Beyond in-depth interviews, participant-observation approach enabled me to document non-verbal expression of feelings, body language, determine who interacts with whom, grasp how participants communicate within and outside household, how things are organized and prioritized domestically, identified their cultural parameters, observed events that informants maybe unwilling to share, as well as observe situations, participants have described in interviews etc. The main reason for adopting this approach was to develop a holistic understanding of the phenomena under study, and to maintain a high quality of data collection and interpretation.

2.3.2In-Depth Interviews:

This flexible, qualitative tool, allowed us to gaina holistic understanding of women's lived experiences. This was our primary data collection method. The first author, US.a Pakistani immigrant conducted24 in-depth interviews in Urdu and Punjabi using semi-structured questions with probes. These interviews with women about their personal experiences were pilot tested with two women from the community. Human subjects' approval is obtained from the University of Texas Health Science Centre at Houston and Institutional Review Boards (IRB)(HSC-SPH-15-0572).

2.3.3 Recruitment process, consent, explanation of the study to participants:

Flyers were distributed in the Houston, Harris county mosques (places of worship) with introductory information, detailing my study and my contact information. Flyers were also distributed in public housing and apartment complexes that are heavily populated with immigrant Pakistani families. Individuals who agreed to participate were informed of the intent of the study and advised of their rights as study participants. After participants provided verbal informed consent I conducted digitally recorded audio interviews.

3. Results:

Based on our data set, fifteen participant women out of nineteen, had some sort of support system, either alone or in combination. Fourteen of the fifteen, are leading a normal life, while one of the fifteen (#),is experiencing a stressful life, despite the presence of a support factor/s.

On the other hand, out of four women, without any sort of support system, one is leading a standard life(*) without any stress or tension, compared to three women participants(**) who are going through a turbulent life experience. (See Table 1 participant's characteristics below).

Table 1: Participant Characteristics

Participants	Wife Cast	Type of Marriage	Exo/ Endogamous	Nuclear/ Joint Family	Wife Edu	Earning Wife	Children	Strong Natal Family	Green Card Sponsor
Sub # 1	Ismaili	Love	Exogamous	Joint	PhD	Y	1B/1G	N	Husband
Sub # 2	Sunni	Love	Exogamous	Nuclear	Assot Teaching	N	1G	Y	Wife
Sub # 3	Sunni	Arranged	Endogamous	Joint	B.A	N	None	Y	Wife
Sub # 4	Shia	Arranged	Exogamous	Joint	B.S	Y	2B/1G	N	Husband
Sub # 5	Shai	Love	Exogamous	Nuclear	RN	Y	2B	N	Husband
Sub # 6 **	Sunni	Arranged	Exogamous	Nuclear	College	N	2B/1G	N	Husband
Sub # 7	Sindhi	Arranged	Endogamous	Nuclear	School	N	1B/1G	N	Husband
Sub # 8	Sunni	Arranged	Exogamous	Nuclear	Master	N	1B	N	Husband
Sub # 9	Sunni	Arranged	Exogamous	Nuclear	Master	Y	3B/1G	N	None
Sub # 10	Ismaili	Arranged	Exogamous	Nuclear	MBBS	Y	3G	N	Husband
Sub # 11	Sunni	Arranged	Same Community	Joint	Master	N	1B/1G	Y	Wife
Sub # 12 #	Sunni/ Sindhi	Arranged	Endogamous	Nuclear	School	N	2B/2G	N	Husband
Sub # 13	Sunni	Arranged	Exogamous	Nuclear	College	N	2B	N	Husband
Sub # 14	Sunni	Arranged	Exogamous	Nuclear	B.A	N		Y	Wife
Sub # 15 **	Sunni	Arranged	Exogamous	Joint	College	N	1G	N	Husband
Sub # 16 **	Sunni	Arranged	Exogamous	Joint	College	N	None	N	Husband
Sub # 17	Pathan	Arranged	Exogamous	Nuclear	Master	N	2B	Y	None
Sub # 18	Sunni/ Punjab	Arranged	Exogamous	Nuclear	Master	N	1B	N	Husband
Sub # 19 *	Sunni	Arranged	Exogamous	Nuclear	College	N	1G	N	Husband

Thirteen of the nineteen participants, belonged to the Sunni group, that is considered as a privileged set, the rest were either Shia, Ismaili and Punjabi. Most of the participants said, their marriage was arranged by their families, and they had never met their spouse before, while only three said they had love marriage with the consent of both side of the families. The majority of participants were tied to exogamous marriage, meaning husband do not belong from the girl's family (not a cousin marriage), only three said they had cousin marriage (endogamy), while one participant was married within her cast community (Bihari), considered same as endogamous. Of the four endogamous marriages, three participants had multiple other support factors involved to cushion their married life, bargaining power, decision making and independency. However, only one participant, although cousin marriage and bearing two sons, was still experiencing a stressful married life, including, verbal and domestic abuse from husband. The noticeable reason being, wife was older than her husband and in south part of Pakistan (Sindh), the younger the wife, more the age difference, more is the respect husband gets from community. Although not living a happy and peaceful life, and neither any hope of change in the future, nevertheless, they had no other option, since wife is a first cousin and husband is going to keep her until the end of life. Among the three unhappy participant women lacking any type of support system, the common traits were, lack of professional education, employment, exogamous marriage and no natal family support. Moreover, two participant women were living in a joint family, one was childless and other had a daughter only. Through participant observation it was apparent that, the childless women made her place in the household by providing full time nursing service to a bedridden mother in-law and aging father in-law. While the women with one daughter adjusted by being molded the way her in-laws wished. The third unhappy woman participant was living in a nuclear set-up and had one son, two daughters but still undergoing verbal and physical abuse.

A plausible reason being, this was a second marriage for both the woman and her husband. Six themes emerged from our data analysis related to Pakistani immigrant women's ability to better negotiate for her needs. These included the wives: education, working status (employed or not), green card sponsor, family arrangement, styles of decision making, and gendered health decision. We discuss each in turn below.

3.1 Educated woman 'mazbootaurat'

Of the fourteen women with some sort of support system, the most important and widespread support factor is educated women. This term 'mazbootaurat' or 'strong woman' when explored among this Pakistani community, appeared to be employed as a synonym for an educated woman. The higher the level of education, the more confident she is, as well has more decision-making authority. "That is all up to me (routine household decision) ….I decide and take care of everything…indoor and outdoor." (Age 37, in U.S 4 yrs, PhD, Subject #1). Education has not only vested them with better development of mind, but also empowered them to bargain and negotiate for their needs and resources. These professionally educated wives, have the authority to negotiate and make a household decision, in consultation with their husbands, especially for their children's health, education, extracurricular activity, social mobility, household purchases, husband's health and at the very end, their own health. For example one woman noted, "[the importance of my health is] not the highest priority...first is my son's health then husband and at last it is me….I do not care for myself a lot" (Age 34, in U.S 3 yrs, subject #8). Educated wives were more verbal and good communicators, with the ability to pass their message and thoughts, across the family system. Unlike being told to be quiet, a common phenomenon practiced on woman among Pakistani community, these women made their thoughts acknowledged and accepted.

"...both my in-laws and husband as well as my family are educated that is why we can communicate and understand each other much better compared to uneducated families where everyone wants to dominate one another and wants to impose one's own choice on other.' (Age 27, in U.S 7 yrs, subject #2)

Educated wives had the capacity or the tool, to use words and examples in such a way, that made their husbands understand and agree on wife's demand (good negotiators). These women were confident enough to say, they can sway their husbands to accept their argument. One women noted, "He is not career oriented, not ambitious, more towards the lazy side, the dependent type of guy. A 'strong wife' 'mazbootaurat' is what he needs to keep the family moving smoothly. Otherwise on his own, it will be a disaster"(Age 37, in U.S 4 yrs, PhD, subject #1). Education has conferred upon these women the ability to relate between good and bad, between right and wrong decision, as perceived through the lens of their husbands. "…he knew I was well educated and by marrying me his future kids will have a better future too and we can raise a good generation…" (Age 37, in U.S 4 yrs, PhD, subject #1)

Among most of the participants, where wife holds a terminal degree of a PhD or a Master's (seven participants), the husband is generally less educated than wife, and this provides an extra cushion to the freedom, bargaining power and independency of wife. Less educated husband tend to be more passive, as they are well aware that, if their wives leave them, there are no guarantees they will find a second well educated wife. In addition to that, if their wife is earning an income, they don't want to close the door to incoming dollars. These men inevitably challenge their wives much less compared to men with less educated wives. Lack of graduate level education, limited women's bargaining power in the home.

"…I had no professional education, so no job, no money, totally dependent….in such a circumstances the only option left was to suffer the way others want….this is why it is so important to educate your daughters, make her independent so she can fight the world and live the way she wants to rather than other people deciding for her…." (Age 37, in U.S 6 yrs, some college, subject #6)

Education appeared as a powerful tool, that can break the cycle of dependency and abuse against participant women. It has the power to transform women, making them more aware of their rights and privileges. Participants highlighted that, education has not only bestowed them with economic independence, but also, improved their standing within family and society. Education is utilized by respondents as a tool, to enable them to impact on, a number of discriminatory practices, such as at the hands of husband or in-laws, thereby resulting in change for the better.

3.2 Income Earner

Five of the 14 women were well settled and working, either as a professional or in another capacity, and bringing money home. They made decisions on their own after negotiating with their husband, and had the resources at hand to do so, compared to women who were not earning and were financially dependent on their husbands. All five of the working women, strictly followed the cultural trend of asking their husbands for final decision (although the primary decision maker is the wife herself) and associated greater self-satisfaction in doing so. In two of the cases, (subject #4 & #9) the women were the only ones earning income in the household, yet they would look forward for a confirmation from the husband for final decision making. They described this as a safety factor, in case, some things do not work out well in the future, wife will have a protective shield of having done a joint decision making, and it was not wife's fault all alone. "…but I discuss every issue so in case something goes wrong I'm not the only one to be blamed…" (Age 28, in U.S 2 yrs, subject #4). Yet another explanation was that, whenever husband's confirmation, backing and support is present, things work out well (it is taken as a sign of good luck) "...I know for sure when I have taken a decision without my husband's consent I have suffered so I always discuss with him…" (Age 39, in U.S 2 yrs, subject #9).

The bottom line is, women earning income, could negotiate and make things happen the way they wanted to. The most common situations they encounter were, switching jobs, making changes to self-business, moving to another apartment, addressing their children's health care, managing school fees and paying the car mortgage. In a few cases, they alsodecided for husbands and in-laws. In these situations, when the wife decides she pays. The husband has to contribute nothing. On many occasions, the husband acts passively and quietly agrees, telling the wife to do as she wish, so that he does not have to contribute financially. "…my husband like me being an independent person….he wants me to do everything so that he can only look after his job….he say's you can take care of everything so he don't have to do anything…" (Age 36, in U.S 8 yrs, subject #13). Husband's, tend to be gentle, kind, and caring and in some cases letting the wife take charge of paying the bills and other expenditure. In one case a husband asked his wife to invest her money in his business.

"…He pays me through pay stub into my account and he withdraws as he wants to….for example if he paid me $2500 he would inform me that I deposited this amount in your account but I need money to invest in the business so I am taking $2000 out… you can use the remaining amount…. So it is like that…" (Age 28, in U.S 2 yrs, subject #4)

Working women in our data set, were involved in making all major household purchases, daily expenditures, children's needs, as well as social visit to family and friends accompanied by gifts. Respondents approved that their earning power has brought about phenomenal changes in their lives, by enhancing their self-worth,their status and autonomy in the family and society, providing them with better career opportunities and allowing better upbringing of their children. Becoming an income earner, has strengthened them as a woman by reducing their economic dependency.

3.3 Strong natal/nuclear family Vs Extended family

Of the fourteen firmly stable women, five attributed their stability and negotiation to their strong natal families. All women who have their well settled parental home here in the United States, appears to be in a very steady and stable situation. None of the women interviewed mentioned any extent of dependency on their husband, because all their needs as well as their children's necessities, are well taken care of by their parents or siblings. The needs include driving to the doctor's appointment, grocery or job interview, baby-sitting, cooking etc. Not only their needs are taken care of, but the presence of an influential natal system, provides them with more autonomy, the security and peace of mind that most of the other participants dearly wished for.

"…Of course, all my family is here, my parent's siblings and they are all well settled...I don't have to worry about anything…if it is baby sitting or needing a ride to the doctor or grocery etc…they are always here especially my brothers to support me….it is a huge blessing…" (Age 27 years, in U.S. 7 yrs, subject #2)

"...When a wife brings her husband to live with her parents and sibling house it is considered okay because the concept behind is that the girl is more safe, more powerful because her family is supporting her husband and in a better position compared to if she was residing with her in-laws'….(Age 38, in U.S. 9 yrs, subject #3)

A few of the husbands were financially supported directly by the natal system (paid in cash each month), while others were financially supported indirectly (either wife gets cash benefits or grocery and clothes shopping for kids and wife). "….so like my family even supports my husband financial as well as in other ways so as to ensure their daughter stays happy with her husband…" (Age 38, in U.S. 9 yrs subject #3). Almost all husbands in such cases were here in the U.S. alone, (without their parental system) and acted in a low profile (submissive) manner, in presence of such strong wife's support system. It appeared that husbands understood or realized, keeping a low profile is more beneficial for them, rather than clinging to the status quo of dominant authoritative male, that worked well back in Pakistan.

Natal families keep a constant eye on their daughter and her kids, to ensure their life is moving in a steady pace, and in case of any turbulence, they at once jump in to control the situation (a very unusual system only possible in the U.S. rarely witnessed in Pakistan).

"…..I was always surrounded by my brothers and my mother like they were my body guards…the slightest sound I make or the moment I get up to do something they just rush towards me to help me and to make sure I was fine and happy etc…" (Age 38, in U.S 9yrs, subject #3)

Wives with their natal family's support, are better able to concentrate and take care of their own health, a topic seldom discussed or emphasized on, in a routine life chore. A few of the women acknowledged, that their busy life and responsibilities do not offer them this luxury, and it is possible only in one's parents' house. A 28 year old women said, "I tell my husband first about any health problem and then he takes me to the doctor…if he is busy then my brothers or my father are always there for me and my children…"(U.S 8yrs, subject #14)

"… at that time, I was residing with my parents and my husband plus in-laws were not here…so, I was able to focus on my health and my child...I stayed with them for three years and my father or brother used to do all the driving from hospital to home or whatever I needed. They would care for my health, my diet, my baby's doctor's visit and everything…" (Age 37, in U.S 5 yrs, subject #11)

Women were also influenced by the type of family system in which they reside, such as nuclear family system, is positively associated with the level of their autonomy and decision making/negotiating power. Thirteen participants lived as a nuclear family, and enjoyed more decision-making responsibility. While six participants resided in a joint family household and showed some concerns. Respondents described, the extended or joint family, as having a negative impact on women's lives. The joint family system often did not provide enough space for spousal understanding and could prevent the husband from being supportive towards his wife. One participant added "….usually we do it together and my in-laws stay out of it but I do feel in some cases if my in-laws do not like the idea and interfere they can influence my husband and make it difficult for me to participate with my husband alone….' (Age 28, in U.S 8yrs, subject #14). Another participant was of the opinion "…he (husband) used to say he dint believe in all that family views but I think he was influenced with all that viewpoints of my in-laws…..that was the reason for our turbulent relationship…'(Age 37, in U.S 4yrs, subject #1).

In brief, presence of a strong natal family in U.S., that has deeper ties with community and society, in turn strengthened their daughter's status in the husband's house. Such daughters or wives are less threatened to be abused or mistreated. On the contrary, they enjoy more peace of mind, tranquility and security. Strong relationship with natal family, also has a positive effect on women's health and that of their children. Such comprehensive natal coverage is associated with greater freedom for women, more decision making and autonomy.

3.4 Wife sponsored green card

Four women were sponsoring a green card for their husbands. In each case the husband at once packed up and left Pakistan. It was observed, and covertly apparent that, no Pakistani wants to miss an opportunity to marry a green card holder girl.

"..You know this is a fact when girls like us reside in the United States 99 percent of marriages that take place outside of US is based on the greed to get a green card (permanent resident card). You should always keep in mind if marrying someone from Pakistan that it is only because of my status to sponsor him a green card..." (Age 38, in U.S 9 yrs, subject #3)

Wives who were sponsor of green card, also simultaneously had strong natal families, and as a result, their husbands were more dependent on wives than vice versa. Such wives were better settled in their homes, had peace of mind, more decision-making power and good access to resources of all types including health. Women attributed their good standing as a wife and empowered status, to number of factors; first, the prospect of getting a fast-greencard is irresistible, and one-time opportunity, hence good enough to keep the husband obliged. Second, as men is the sole individual immigrating to the U.S. leaving behind his family, it is him who needs to adjust with the wife's family (usually it is vice versa, where women has to adjust and compromise in husband's family, after marriage). And finally, the presence and support of a natal system, ultimately shields the women, from any sort of mistreatment or injustice, at the hands of her husband. According to one participant who said woman as a "wife has more authority than responsibility, for a change..." (Age 37, in U.S 6 yrs, subject #6).

3.5 Styles of decision making:

Pakistani immigrant women's decision making, was clearly related to the context in which they lived, their education, their income and ability to sponsor a green card. Those with more social and economic capital had more scope of negotiation and roles in decision making at household level. As noted by one participant "…(who decides for me?) it is always going to be me and my husband will support my decision" (Age 37, in U.S 4yrs, PhD, subject # 01). Another participant added "…now I can drive…I know the system here and I am more independent…I take my own health decision as well as for my children…..I was always this type….never compromised on health…my husband supports me…" (Age 37, n U.S 5yrs, Master degree, subject #11)

The majority of participants wanted their husbands to be the final decision maker. Women noted, they were accustomed to this culturally imbedded structure and wished to abide by it. In contrast to these comments, prolonged participation observation revealed that although the primary decision maker was always the wife, (with the strong support systems) she would portray and present her decision as if it were her husband's, in order to maintain the spousal/family respect. This perspective is supported through following statements, '…I think the culture is deeply embedded in our system, although my husband is very caring and understanding but still I feel more comfortable leaving the decision-making part for him. I let him decide what is better for our daughter, our future.…' (Age 27, in U.S 7yrs, subject #2)

Some of the women explained this phenomenon, of putting their husbands upfront as the decision maker, although the primary decision maker is the wife herself in a different manner;

"….my husband decides in all matters…. I do have the right to take a decision but I willingly leave it for my husband to make the decision because he is more educated, he has more experience…. I feel satisfied and secure when he makes a decision…'.(Age 25, in U.S. 1 year, subject #7)

A 35 year old woman noted, "we discuss with each other and try to do it jointly but ultimately my husband makes the final decision because he knows the system better….. he has more exposure and he was living here before me, so he better understands….' (in U.S. 3 yrs, subject #8)

In short, family size or number of sons, type of marriage (cousin or outside family) or wife's caste, did not appear to play any significant role in the decision-making process.

3.6 Gendered health decisions:

In the current study, all respondents almost equally share a same style of prioritizing health, including their own and family health. First and most crucial is their children's health, followed by their husband's health and at the very end is their own health. A 36-year-old woman noted,

"…health is very important for me not for myself but for the children….here we are alone no joint family system….kids are my responsibility…. who will take care of them….so kids come first because of them I feel my health should stay good…" (in U.S. 3 yrs, subject #12).

When asked about the importance of their own health, participants claimed that their health is very precious, and important to them, because they are the caretakers of their children, their husband, and the household. They want to stay healthy, in order to maintain the family, and run their daily errand's.

"...it is important in the sense that if I get sick then all the household responsibility will fall on my husband's shoulder. …. he works morning till evening….it will be very stressful for him….that is why it is important for me to stay healthy to support my family…" (Age 25, in U.S. 1 yr, subject #7)

Nevertheless, to stay healthy none of the women follow any particular regimen, or well-health routine, and when they are confronted with some sort of ill health, they at once turn towards home remedies. When home remedies fail, that is a suitable time they consider visiting a doctor.

"….the most important is my children's health and husband health…. I just want to be up and running to serve them…..so whenever I have some health problem I take few tablets from my own medicine box and that keeps me good and running….' (age 39, in U.S. 2 yrs, subject #9)

"…my health is most important for me but I don't really do anything for it…..when I get sick I wait and do self-remedies and do not go to the doctor immediately…..but if I don't get better and there is no way then I go see a doctor…..' (Age 37, in U.S. 8 yrs, subject #16)

This is true for all women, whether they are their own decision makers or not. Although having the resources at hand, and the facilities for back up, yet women in the study followed none of the health protective or preventive measures. They wanted to stay healthy without working towards it. "...health for me is very important otherwise who will take care of my three kids…..I don't do anything specific to keep myself healthy but it is important for kids..." (age 28, in U.S 8yrs, subject #14). However, when ill health strikes children or husband, women as a mother or a wife, always push/ rush them to the doctor's clinic. In a way, all these circumstances restate gender roles, and reinforces gender inequality. "..when it comes to visiting a doctor I do take kids when the need arise but not for myself……reason being long wait time, affordability, who will cook for us, who will baby sit other kids.." (Age 37, in U.S 6yrs, subject #6).

4. Discussion:

The findings from this study suggest, there are several factors that operates in diverse ways and at various levels, to provide women the platform, where she can attempt to achieve the height of her autonomy, by way of practicing her power of negotiation. Women become eligible to exercise this power, by means of economic and social capital. Education being one of them. The term 'mazbootaurat' or 'strong woman' when explored among this Pakistani community, appeared to be employed as a synonym for an educated woman. The higher the level of education, the stronger negotiator ('mazbootaurat') she is, and makes a better-informed decision about her children's health, family health, children education and household purchases, a finding previously reported (Jejeebhoy & Sathar, 2001; Acharya et al., 2010; Fatima, 2014; Mumtaz & Salway, 2007; Shahnaz & Kizilbash, 2012).Education not only bestowed them with information and knowledge, but also made them a good communicator. Through this quality, women were able to disperse their thoughts and views, across their family system. Husband or in-laws find it hard to silence a verbal wife, and it appeared, husbands tend to accept the silence part for themselves. Few of the husbands tend to enjoy taking the passive role or backseat, that is traditionally assigned for the women because, there seem to be a factor of fear of losing an educated and in some cases earning wife. In our study, almost all well-educated wives were accompanied by less educated husbands. A phenomenon that could possibly be intentional, arranged by parents of the husband at time of marriage; may be a new finding among Pakistani married couples, as it has not previously been reported in the literature. Only one respondent acknowledged in words, that her in-laws were aware of their son's limited ability and were relieved to get him married to an educated wife.

Consistent with other studies, our next finding supports that, income earning women, enjoys more autonomy and has more space for bargaining her needs (Rabbani & Rizvi, 2008; Kabeer, 1999; Sathar & Shahnaz, 2000; Arooj et al., 2013; Ahmmed & Chakraborty, 2012).Women's involvement in economic activities, in a way, act as a major source of liberation from the servitude of the patriarchal system/structure. Wives who were bringing money home, were equally involved with their husbands in decision making, and many a times completely controlled decision making with their husbands, who submissively accepts the bargaining of wife. When women make independent decision, they also cover it financially on their own.

Presence of a strong or influential natal family, stands out to be a powerful instrument, in providing women the power of bargaining with their husband and in-laws(Chatterjee & Lambert, 1989; Sabir, 2015).In addition to that, it adds a shield for the daughters (wives), hence the concept of 'safe daughters' emerged.

A natal family is considered strong or influential when they are well settled in the U.S. both, financially and socially, with deeply rooted community ties. When under the care of natal system, women have the opportunity to focus on their own health, keep their well women visits, and eat a good diet. A new concept that emerged from the study demonstrates, not only shielding of daughters by natal family, but also financially supporting the son in-laws with cash payment each month. Once again in this situation, husbands keep a low profile to enjoy the benefits of automated family raising, free from all responsibilities. A perception seldom witnessed in Pakistan, in fact considered a taboo for both, the son in-law and his parents.

Wife's sponsored permanent residency is another way woman in this particular community found, economically and socially secure. Wives who also had strong natal families, were doubly powerful as they organized their position.

U.S. green card holder women are considered a jack pot lottery to families residing in Pakistan, who can literally trade their son in marriage for a green card. Although not reported or documented by others, this is a common practice, by men and their families, seeking financial security.

Women who had some sort of support instrument, alone or in combination, were in a better bargaining position and hence decision making, compared to those without any support Abou-Shabana & Samir, 2003; Chatterjee & Lambert, 1989; Kabeer, 1999). Interestingly, women portrayed their husbands to be the final decision maker, but in actuality, wife was the primary decision maker. Women have been helping men save face for a long time however, it is not reported in the literature much. This aspect was related by some women to the deeply imbedded cultural system and traditions, where male members are in command of this particular domain, and the wives wish to help the husbands maintain some aspect of authority figure and their spousal/family respect. When viewed through a cultural lens, a 'good women' is characterized as being tolerant, calm, empathic, unselfish, one who can coordinate, cooperate and most of all compromise. While other women reinforced this feature (of false presentation of husband as decision maker) to, having a higher self-satisfaction, as a sign of good luck, husbands are more experienced and mature, or to have a protective shield in case the decision turns out to be wrong. Furthermore, type of family specifically nuclear family, was positively associated with the level of women negotiating power, decision making and autonomy, on the other hand, extended or joint family was perceived as having a possible negative impact on women's lives, and this was attributed to lack of space for spousal understanding that could probably prevent the husband from being supportive towards his wife (Khatwani, 2017).

Another finding of the study showed that, women did not negotiate with husbands on their own health. All women valued their health, and wanted to stay healthy at all cost, in order to better serve their children, husband, and the household. When children or husband fall sick, they are at once taken to the health facility. A choice made by the women, influenced by the long-standing tradition, custom, culture and norms. Women were less likely to prioritize their own healthcare needs. It is worth mentioning at the end, that this study rendered some of the historic traditional Pakistani traits for example family size, number of sons, endogamous marriage and wife caste, as unworthy or meaningless, in elevating immigrant Pakistani women's autonomy and bargaining power (Winkvist & Akhtar, 2000; Basu, 2012; Mumtaz & Levay, 2013).In other words, immigration alters the importance of different determinants, of autonomy and bargaining power, when women change countries, based on the requirements of new country.

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5. Conclusion:

This study was an attempt to fill the void, created by lack of research on married Pakistani immigrant women's domestic negotiation process, and the factors that supports or hinder this process of decision making, in order to access and utilize resources including health for her own well-being as well as her family.

In Pakistan, women decision making power is limited to patriarchal ideology, where they generally possess low negotiating authority and autonomy. In this context, the present research explored the variables to identify and explain the variation in women's decision-making patterns. We observed that, women's education especially higher level (PhD/Master) and employment, have significant positive effect on wife's negotiation and decision-making power. This was followed by two other chief determinants that act as a catalyst in wife's bargaining power and autonomy, namely, strong/influential natal family and wife sponsored permanent residency. The family make up, whether nuclear (exert positive) or joint (exert negative effect), is another element in determining wife's negotiation and decision-making power. Study proved the long established traditional determinants of women negotiating power such as family size, number of sons, endogamous marriage (cousin) and caste system to be non-significant in the context of a new region perhaps.

Needless, to say that, Pakistani immigrant women's negotiation and decision-making domain, remains a largely undiscovered field and more research needs to be done, to determine practically, and analytically, a woman's experience in a new country, bagged with eastern traditions and settling in a western system.

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