The Professional Medical Journal
www.theprofesional.com

ORIGINAL PROF-2600

REPRODUCTIVE HEALTH;

PERCEPTIONS, ATTITUDES AND PRACTICES AMONG YOUNG FEMALES IN FAISALABAD DISTRICT, PAKISTAN

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Article received on:
23/07/2014
Accepted for publication:
28/11/2014
Received after proof reading:
17/01/2015

ABSTRACT… Reproductive health is concerned with the people's ability to have a satisfying and safe sex life ensuring their capability to reproduce with a liberty of making a decision that if, when and how often they have to do so. **Objective:** (1) To examine the females perceptions, attitude and practices about reproductive health services. (2) To determine the level of their empowerment to take decisions and make choices regarding their own reproductive health. (3) To determine the level of the quality, availability and accessibility of reproductive health services and to suggest some measures for policy makers to improve the reproductive health state of young mothers in district Faisalabad. **Study Design:** A sample of 600 young married females of age 15-32 years were selected through multistage sampling technique. **Period:** 2009. **Setting Area:** Rural and urban area of District Faisalabad. **Material and Method:** Uni-variate (frequency distribution and percentage) and Bi-variate analysis (Chi square and Gamma Statistics) was carried out. **Results:** Most (44.0%) of the respondents belonged to age category of 26-30 years; 35.5% were married up to 18 years; 39.3% had passed up to 5 years marriage duration; 71.8% had primary and above level of education. Majority (65.9%) had up to Rs.10,000 per month income, 49.2% possessed 6-10 family members, 73.5% beard at least 2 and above live children, 74.0 % perceived family planning good,79.7% had knowledge of FP and 26.0% practiced FPM (Family Planning Method). The most common FPMs were condom (33.3%) and tubectomy (21.8%) while 41.0% faced side effect because of FPM during their reproductive life. A huge majority (79.8%) of the respondents received ANC, 87.8% made regular visits for medical checkup and 48.8% got ANC from Pvt. Hospital during last pregnancy. Bi-variate analysis showed highly significant relation among age at marriage, awareness level, monthly income, education, number of pregnancies, number of children, number of visits to medical centre, availability of RH services, cultural hindrance and age of respondents vs. their reproductive health. **Conclusions:** Although most of the females were young & educated mothers with good reproductive health experience and perceived FM good but still lacking in practicing FMPs which indicates that we need to pay more attention towards female empowerment and decision making authority status at domestic level.

Key words: Attitude, Contraceptive Practice, Reproductive health Knowledge, young Females,

Article Citation: Tarar MA, Akhtar S, Zafar MI, Muhammad S. Reproductive health; perceptions, attitudes and practices among young females in Faisalabad district, Pakistan. Professional Med J 2015;22(1):081-099.

INTRODUCTION

The World Health Organization defines reproductive health as 'a state of physical, mental and social well being at all matters relating to the reproductive system at all stages of life. Reproductive health is concerned with the people's ability to have a satisfying and safe sex life ensuring their capability to reproduce with a liberty of making a decision that if, when and how often they have to do so [1]. It is correlated with the rights of men and women to have the information and easy access to such methods of family planning, which are safe, effective, affordable and acceptable generally along with appropriate health care services, which ensure to go through pregnancy and childbirth safely[2, 1]. The young girls are forced into early marriages [3,4,5,6,7,8,9] and into sexual relations, which destroy the general

as well as reproductive health and increase their risk of getting exposed to HIV/AIDS[4,10,11] besides minimizing their opportunities of attending school [12,4,13,14,8,9.].

The women of reproductive age in developing countries suffer in shape of death or disability because of the complication during pregnancy and childbirth. According to an estimate held in 2000, the death toll of women reached to 529,000 due to the complications of pregnancy and childbirth[4]. For every woman who dies, roughly, 20 more suffer serious injury or disability between 8 to 20 million a year. A mother's death can cause devastation for the children who are left behind falling a prey to poor health, poverty and exploitation without having motherly love and protection. While a mother's disability can dwarf all her contribution to the family as well as economy in her efforts put forward to fight against poverty[4]. Still about 16 million female adolescent of age 15-19 become mother and are at risk of health complications i.e. HIV/ STD and STI[5,6,8,9.]

MATERIAL AND METHOD

The present study was undertaken in district Faisalabad in 2009, the 2nd most populated city of the Punjab province and 3rd of Pakistan. The study was projected to gain knowledge and information on attitudes and trends regarding utilization of reproductive health care amenities in young females from eight towns {Lyall Pur Town (Taj Colony UC 208, Islam Nagar UC 209, and Hujwari town UC 212), Iqbal Town (Chak 224 Fatahwali UC 237, D Type Colony UC 253 and Samna Abad UC 260), Madina Town (Amin Town UC 203, Islamia Park UC 207, and Abdullah Pur UC 218), Jinnah Town (Chak 217 R.B. UC 274, Ghulam Muhammad Abad UC 279, and Raza Abad UC 282), Jhumra Town (Chak 157 R.B. UC 11), Sumundari Town (Chak 478 G.B UC 108 and Chak 475 G.B UC 109), Jarana wala Town (Chak 65 G.B. UC 37, Chak 237 G.B. UC 55, and Chak 24 G.B. UC 64), Tandlianwala Town (Chak 425 G.B UC 77, and Chak 293 G.B. Bhatay UC 79)} of District. Faisalabad. Total population of young females age (15-32) years, was 888532 [15]. Respondents were selected from eight towns of city Dist. Faisalabad that has 289 Union Councils.

A sample of 600 young married females of age 15-32 years were selected through probability proportion to size. Multistage sampling technique was used. At the first stage 20 union councils were selected at random from eight towns of district Faisalabad proportionately. At the second stage, one village/ colony from selected each union council was selected randomly and at third stage 30 young mothers aged (15-32) were selected from each village/ colony through convenient sampling technique. Uni-variate (Frequency & Percentage) and bivariate (Pearson Chi-square & Gamma Statistics) analysis was carried out interpret the results.

RESULTS AND DISCUSSION

Socio-Economic Information of the Respondents

Socio-economic characteristics of the respondents like age, education, income, age at marriage/ marriage duration, household status and facilities play an important role in awareness, adoption and better reproductive health of females. The data relating to these aspects are presented and discussed as under:

Age of Respondent and her Husband

Age is an important factor in determining the behavior of human being. It indicates the ability to do work and attitude of a person towards various social and economic aspects of life. Age refers to the number of years completed by an individual since her/his birth. Age factor is very important to influence one's behavior; it widens the vision of an individual through experience. The respondents were asked about their age and data in this regard are presented in Table VI.1.

Above mentioned table depicts that most of the respondents (44.0%) belonged to age group of 26-30 years and 29.7% were up to 25 years old while 26.3% were 31 years and above. On the other hand majority of the respondents' husbands (57.8%) was 31 years and above, 32.0% belonged to age group of 26-30 years and only 10.2% of the respondents' husbands were up to 25 years old.

Age categories (years)	Respondents		Husbands	
	Freq.	%	Freq.	%
Up to 25	178	29.7	61	10.2
26-30	264	44.0	192	32.0
31 and above	158	26.3	347	57.8
Total	600	100.0	600	100.0

Table VI.1: Distribution of the respondents according to their age and their husband's age
Mean age of the respondents = 27.81 Std. Dev.= 3.58
Mean age of the respondents' husband = 32.64 Std. Dev. = 5.49

Youth is currently in focus through research studies in all social issues due to energetic part of population. The findings of comparative case study in two socio-economic classes (slum & posh) on mother health (aged 15-49) indicates that most of the respondents (i.e. 32 and 46.0%) were in the age group of 25 to 29 years, respectively[16] and similarly present research also shows that 44% are almost in same age group. While in an urban area research study "Factors affecting mother and child health care in district Faisalabad, Mustafa[29] found that 44.5% females belonged to age group of 30 years.

Age at Marriage

Age at marriage is an important factor in reproductive health issues. Higher fertility is related to young age and young females had more need of care regarding their reproductive health and their new born babies. It is considered very vital in the study of fertility and contraceptive behaviour, because it is more related to cultural than demographic aspects[17]. In Pakistani culture, sexual activities can be initiated after marriage and early age marriage is primary reason for that[18]. Age at marriage varies within and among societies, depending upon the norms, values, and belief about marriage, which a society possesses. In our society early age marriages are still prevailing. Mostly in rural areas women are not allowed to get secondary or higher education as declared by Naz et al. (2009). When they reach to their reproductive age, women were married in early ages because their parents are unaware of the problem of early marriages such as social, health and psychological problems and their impacts on the health of young women. The data in this regard are presented in

Age at marriage (in years)	Freq.	%
Upto 18	213	35.5
19-22	254	42.3
23 and above	133	22.2
Total	600	100.0

Table IV.2: Distribution of the respondents according to their age at marriage
Mean age at marriage = 20.08 Std.Dev.= 3.15

Table IV.2.

Table IV.2 shows that most of the respondents (42.3%) had the age of 19-22 years at the time of marriage, 35.5% were up to 18 years old while 22.2% were 23 years and above when they were married. Total Fertility Rate (TFR) has strong ties with age at first marriage. Early age marriage promotes fertility trend and mostly people (69%) were married between 15-19 years of age[16]. This study shows a little bit difference because currently 42.3% females were married within age of 19-22 years and more than two-thirds (35.5% + 42.3%= 77.8%) of the females were married before the age of 22 years that is a sign of less knowledge about reproductive health and trend of early age female marriage in Pakistani society. Similar results were found in an urban area research study by Ahmed[37]. Mudasar[45] in her research study also showed the rural culture and marriage age pattern of females. In rural areas parents still married their daughters in early age as shown in study findings that majority respondents' age at marriage was 14-18 years. It was also noted that majority (72%) was married by the age of 20 and every woman was married by the age of 25 while the mean age at first marriage for contraceptive user slightly above 20 years[17, 19]. While in another study in Nigeria, Shraddha and Bharti[19] found that most of respondents reported that they got married when they were 15-19 years old. Rani[53] reported similar results too. In India a study about "awareness among women towards aspects of family planning in Kullu disrrict of Himachal Pradesh" Sharma et al.[56] interviewed the married women aged 18-30 years and found that 74% were married at the age between 18-25 years while, in another research study entitled "impact of maternal health services on mother and child health," Arshad[38] identified same results

that slightly more than half of the respondents (51.3%) married at the age between 21-22 years and 38.7% married up to age of 20 years while only 8.7% married after 22 years of age.

Duration of marriage (in years)	Freq.	%
1-5	236	39.3
6-10	203	33.8
11-15	129	21.5
16 and above	32	5.3
Total	600	100.0

Table IV.3: Distribution of the respondents according to the duration of marriage

Mean duration of marriage = 7.74 Std.Dev.= 4.57

Table IV.3 depicts that most of the respondents (39.3%) had 1-5 years duration of marriage at the time of interview, 33.8% had 6-10 years duration and 21.5% had 11-15 years duration while only 5.3% had 16 years and above duration of marriage at the time of marriage. These results are contradictory to those of Sunmola et al.[42] who found that 92% of the respondents reported the duration of marriage between 1-6 years and small duration of marriage indicates less experience of reproductive issues. While in present study about 60% of the respondents had marriage duration of 6 years and above that indicates their sufficient experience of reproductive issues.

Education of respondent/ her husband

Education is a key to implementing social, attitudinal and behavioral changes[20]. Amongst the users of antenatal care services (ANC), there appeared to have a change in their rhujanaat (aspirations) which was being driven by a combination of increased awareness of the utility of ANC and a financial and social ability to access services. Women's education emerged as most prominent factor leading to an appreciation of utility of ANC use[21]. Husband wife's education also plays an important role in several demographic phenomena like desired family size, knowledge and maternal health care, consensus regarding decision-making etc[52]. Education was organized as single most powerful variable in unifying fertility behavior. Ensuring that girls who got education, had considerable impact on fertility behavior, including the postponement of marriage and first pregnancy, and the number of children. Rich young females had more mass media exposure and school enrollment so because of this, they had more positive attitude to adopt reproductive health services as compare to poor and less educated ones. Education helps in achieving good health. Education and fertility have a close relationship. Well educated females have more health exposure and practice more family planning FP services for better reproductive health. Data regarding education of respondent and her husband are presented in Table IV.4.

Education categories	Respondents		Husbands	
	Freq.	%	Freq.	%
Illiterate	169	28.2	99	16.5
Primary	98	16.3	66	11.0
Middle	55	9.2	71	11.8
SSC	116	19.3	182	30.3
HSSC and above	162	27.0	182	30.3
Total	600	100.0	600	100.0

Table IV.4: Distribution of the respondents according to their education and their husbands' education

Years of schooling of the respondents = 7.07 Std. Dev. = 5.27

Years of schooling of the respondents' husbands = 8.58 Std. Dev. = 4.70

Table IV.4 shows that 28.2% of the respondents were illiterate, 16.3% got primary education, 9.2% had passed middle level schooling, 19.3% had passed the level of SSC, 27.0% had got HSSC and above education. While 30.3% respondents' husbands had got HSSC and above education, 30.3% passed SSC level of education, 11.8% had passed middle level schooling, 11.0% got primary education and only 16.5% were illiterate. Similar results were found in an urban area research study "factors affecting mother and infant health in district Faisalabad[37]. Mudasar[45] in her research study also showed the rural culture and education pattern of females. In rural areas parents still discourage the education of their daughters as shown in study findings that majority respondents (62.5%) was still illiterate. Rani[53] reported that in most countries, poor young females made early age marriage, restricted from schooling and gave

birth to one child earlier than rich females.

Occupation

Occupation plays a vital function in our lives, we have very apparent and responsive concept about which jobs are better and which are worse[22]. Occupation may be defined "as the specific activity with the market value which an individual continually pursue for the purpose of obtaining a steady flow of income. According to Govt. of New Zealand[23] an occupation is a set of jobs that require the performance of similar or identical sets of tasks by employed people aged 15 years and over. An occupation is a set of tasks executed or planed to be carried out by an individual for an employer (as well as self-employment) in return for payment or profit. Data related to occupation of respondent and her husband is presented in Table IV.5.

Occupation	Respondents		Husbands	
	Freq.	%	Freq.	%
Housewife	572	95.3	-	-
Govt. service	8	1.3	76	12.7
Pvt. Service	13	2.2	191	31.8
Any other (own business, tailor, labor, driving etc.)	7	1.2	62	10.4
Agriculture/farming	-	-	79	13.2
Own business	-	-	192	32.0
Total	600	100.0	600	100.0

Table IV.5: Distribution of the respondents according to their occupation and their husband's occupation

Table IV.5 depicts that an overwhelming majority (95.3%) of the respondents was house wives, 1.3% were Govt. employees, 2.2% were attached with private service and only 1.2% were engaged in others (own business, tailor etc). It means that only a small fraction of the respondents was engaged in cash paid jobs while a vast majority was performing traditional duties like handling the domestic affairs, looking after their children and husband by staying at home. On the other hand with respect to occupation of respondents' husband, most of them (32.0%) had their own business, 31.8% had private service, 13.2% were farmers, 12.7% were Govt. employees and remaining 10.4% were engaged in other occupations like labor, driving etc. Pakistani norm for women is to stay at home and look after children and husband. To join the labour market and mobility is restricted commonly for women. In an urban area research study Ahmed[37] found that majority of the respondents (84%) were house wives while in another research study entitled "impact of maternal health services on mother and child health," Arshad[38]identified similar results that majority (76.7%) of respondents were house wives and remaining 23.3% were working women. Mudasar[45] in her research study also showed the rural culture and female's occupation. In rural areas parents still discourage the education of their daughters and attainment of any job/ service as shown in study findings that majority (87.5%) of the respondents were house wives. People think that women should remain in house and look after domestic affairs and care the children. Zafar et al.[17] concluded almost same result (85%). In a study in Nigeria Sunmola et al. [42] found that most of the persons (34.8%) were employed as civil servants whereas others were engaged in trade (18.3%) or farming (25.5%). While in an urban area research study Mustafa[29] found that 45% respondent's husband were businessmen. Mudasar[45] in her research study also showed the rural culture and occupational pattern of males. In rural areas people do not pay attention on education so when a child reaches the age of earning, due to lack of education he cannot attain Govt. job and ultimately he has to adopt the occupation of labor or such other type in which there is no need of good education as 31.7% were laborers. While, in another research study Arshad[38] identified similar results that half of respondent's husband (50.0%) were businessmen and out of the remaining, 34.7% were attached with private service.

Income

Income of the respondents is defined as the enumeration received periodically for work or services performed[24]. Standard income level fixed by the government of Pakistan is 8,000 rupees per month it is also called as poverty line. Income of a person shows his/ her life standard. Strong economic condition has positive effects on

health of a person and poor economic status of respondents is an important factor to decrease the adoption of contraceptive methods. Due to poor socio-economic status women were avoiding to adopt contraceptive methods. Total family income level of the respondents from all sources is shown in Table IV.6.

Monthly family income (Rs.)	Freq.	%
Up to 5000	103	17.2
5001-10000	292	48.7
10001-15000	101	16.8
Above	104	17.3
Total	600	100.0

Table IV.6: Distribution of the respondents according to their monthly family income
Mean Income = 11444.50 Std. Dev. 8457.36

Table IV.6 shows that near about half (48.7%) of the respondents had monthly income of Rs.5001-10000, 17.3% had more than Rs.15000, 17.2% had up to Rs.5000 while remaining 16.8% earned Rs.10001-15000 per month from all sources. Data indicates that almost two thirds of the respondents (17.2%+48.7%=65.9%) had maximum monthly income up to Rs. 10000 that is quite inadequate for good survival and better living. According to Robert et al. (1997) about 15% of the population has such a low income that they are precluded from an adequate standard of living. This is directly related to malnutrition, illiteracy, and large family size, which create a self-perpetuating circle of events resulting in an overall increase in size of the population. Rani[53] reported that in most countries, poor young females made early marriage and they had less mass media exposure and more economic dependency than rich youth. Similar findings were made in an urban area research study in which Ahmed[37]found that 39% of the respondents had Rs.10000 or above monthly family income while, in another research study Arshad[38] identified similar results that majority of respondents (67.3%) had less than Rs.10000 per month family income from all sources and among them more than half earned less than Rs.5000 per month.

Family Membes

The true meaning of marriage is only fulfilled if the couple conceives and bears children. People consider their child to be a source of power and pride, and children act as insurance for their parents in old age. The most important aspect of bearing children is an insurance of family continuity. A rapid growth has occurred in population size, and it has not been possible to control this expansion even with active governmental intervention. Government has given priority to control family size and has fully funded family planning programme. Mostly women now have free access to different methods of contraception, provided be official health institutions[25,26] and the total fertility rate of a Pakistani women is 3.8 children during her reproductive period that indicates mean size of a nuclear family will be 5-6 members[26]. The data regarding total number of family members are presented in Table 4.7.

Total no. of persons in family	Freq.	%
1-5	208	34.7
6-10	295	49.2
11 and above	97	16.2
Total	600	100.0

Table IV.7: Distribution of the respondents according to their total family members
Mean no. of family members=7.35 Std. Dev.=3.57

Table IV.7 shows that almost half (49.2%) of the respondents had 6-10 family members, 34.7% had 1-5 members and remaining 16.2% of the respondents had 11 and above persons as family members in their home. Similar results were shown by Govt. of Pak.,[26] that still in Pakistan a nuclear family had more than five members (mean family size).

Alive/ died Children

Children are the future builder of every nation. Future of the nation depends upon the healthy and active population of country. Today's children would turn up into healthy nation of tomorrow and contribute in the development of country[15]. The preference for male (son), in term of economic and social benefits as a contributor to the family income has a key position in Pakistani society. They attain more social status and less

dependency as compare to daughter on their parents in Pakistani society. Desire for son is a factor of low contraceptive prevalence[27]. Rani[53] reported that most poor young females made marriage by age 18 and birth at least one child by the age 19 years. They were less informed about mistimed birth, and utilization of maternal health services and contraception. The data regarding birth and death of children is presented in Table IV.8.

Total live children	Freq.	%
1	159	26.5
2	147	24.5
3	129	21.5
4	94	15.7
5 and above	71	11.8

Table IV.8: Distribution of the respondents according to their total alive/ died children
Mean live children= 2.74 Std. Dev.= 1.63

Table IV.8 shows that most of the respondents (26.5%) had 1 live child, 24.5% had 2 children, and 21.5% had 3, 15.7% had 4, while 11.8% had 5 and above live children. These results are similar to those of Desai and Tarozzi[44], Sunmola et al. [42], Ahmed[37], Arshad[38] and Mudasar[45]. According to Desai and Tarozzi[44] mean desired family size was 4.83 in two regions (Oromia and Amhara) of Ethiopia where women married earlier, began childbearing sooner, had more birth and wanted to have more children. In a study in Nigeria, Sunmola et al. [42] found that the respondents from polygamous families openly explain sibling size range of between 0 and 25 and a huge majority (74.2%) of them had one to eight siblings whereas Ahmed[37] found that most (39%) of the respondents had 3-4 babies. while, in another research study Arshad[38] reported similar results that most (38.7%) of respondents had 3-4 children and 37.3% had 5 and above children while only 24.0% had 1-2 children. Mudasar[45] in her research study also showed similar findings that majority (59.2%) of respondents had 4-6 children. People think that more children are gift of Allah Almighty and source of power in rural settings. More members of family can earn more and had a prestige and social status in community.

Family Planning

To motivate the females, to have a favorable attitude towards family planning or to adopt family planning behaviour, knowledge of family planning always plays a vital role. Knowledge about the family planning and utility of antenatal care (ANC) is a prerequisite for appropriate use of those health amenities to make the mother-child health safe and sound. However, in the Pakistani socio-cultural context, knowledge of reproductive matter is considered 'shameful' and a 'culture of silence' surround these issues. In addition, flow of information of all types is moderated by class and gender relations. Knowledge in its broadest sense, therefore, can be considered a dimension of women's gendered position and it is important to explore how it relates to attainment of antenatal care and family planning amenities. Data about different aspects of family planning is presented in Table. IV.9.

Perceive family planning	Freq.	%
Good	444	74.0
Bad	156	26.0
Total	600	100.0
Reasons for bad perception		
Prohibited by Islam	136	87.2
Desire for more children	110	70.5
Not suitable for health	98	62.8
Against the culture	81	51.9
Lack of knowledge	72	46.2
Husband oppose	85	54.5
Not affordable	51	32.7
n= 156 (26%) who perceived Family Planning bad		
Knowledge about FPMs for birth interval		
Yes	478	79.7
No	122	20.3
Total	600	100.0
Source of information about FPMs		
Friends	21	4.4
Family	84	17.6
Doctor/Nurse/LHV/TBA	221	46.2
Media	152	31.8
Total	478	100.0
n= 478 (79.7%) who had information about FPM for birth interval		

Practicing FPMs	Freq.	%
Yes	156	26.0
No	444	74.0
Total	600	100.0
Method under utilization		
Tubectomy	34	21.8
IUD	19	12.2
Injection	21	13.5
Condom	52	33.3
Norplant	2	1.3
Oral pills	11	7.1
Natural method/with drawl	17	10.8
Total	156	100.0
n= 156 (26%) who used FPM		
Did you face any side effect?		
Yes	64	41.0
No	92	59.0
Total	156	100.0
n= 156 (26%) who used FPM		
Side effects of FPMs		
Bleeding	37	57.8
Weight loss	5	7.8
Swelling/rash	22	34.4
Total	64	100.0
n= 64 (41.0%) who faced side effect of FPMs		
Source of treatment regarding side effects from FPM		
Lady doctor	5	7.8
Pvt. Clinics	36	56.3
TBAs/Dai	20	31.3
Any other (Hakim, Homeopath, Peer etc)	3	4.6
Total	64	100.0
n= 64 (41.0%) who faced side effect of FPMs		
Practicing choice of f FPMs		
Own Choice	137	87.8
Others(Husband)	19	12.2
Total	156	100.0
n= 156 (26%) who used FPM		
Who opposed your choice?		
No one opposed it	137	87.8
Husband	19	12.2
Total	156	100.0
n= 156 (26%) who used FPM		
Source of treatment regarding reproductive health problem		
Doctor	109	69.9
LHV/Nurse	47	30.1
Total	156	100.0
n= 156 (26%) who used FPM		
Main source of their family planning services or supplies		
Govt. health facility/ FWC	23	14.7
Lady health worker/ LHV	40	25.6
Pvt. hospital or clinic	75	48.1
Pvt. Physician	4	2.6
Any other (Medical store, NGO Clinic & NGOs field worker) Any other (Medical store, NGO Clinic & NGOs field worker)	14	9.0
Total	156	100.0
n= 156 (26%) who used FPM		
Reasons for not using FPMs		
Prohibited by Islam	235	52.9
Desire for more children	278	62.6
Not suitable for health	275	61.9
Against the culture	230	51.8
Lack of knowledge	215	48.4
Husband oppose	196	44.1
Not affordable/costly	217	48.9
Not available in locality	197	44.4
In laws oppose	237	53.4
n= 444 (74.0%) who did not use FPM		
Local area availability of contraceptive/ FPM		
Yes	205	34.2
No	395	65.8
Total	600	100.0
Level of mutual understanding between husband and wife for family planning		
Good	315	52.5
Satisfactory	268	44.7
Unsatisfactory	17	2.8
Total	600	100.0

Table IV.9. Distribution of the respondents according to their perceived attitude towards different family planning aspects during their reproductive life

The data given in Table IV.9 present that majority (74.0%) of the respondents perceived family planning as "good", while remaining 26.0% of the respondents perceived it "bad". Similarly Desai and Tarozzi[44] found the intention to use the family planning method higher in Oromia where 71% of nonusers said that they perceived family planning good and intended to use contraceptive in future; the corresponding figure of Amhara was 46% (Oromia and Amhara two regions of Ethiopia) in their study. Daniel et al.[48] found in PRACHAR Project that women in intervention areas had learnt that fertility diverge during the menstrual cycle; early child bearing can be risky and for delaying first birth, utilization of family planning service and method is secure and needed that show their good perception regarding family planning.

Data in Table IV.9 also indicate the reasons responsible for bad perception about family planning. The reason perceived by respondents were that family planning is prohibited by Islam (87.2%); desire for more children (70.5%); not suitable for health (62.8%); against the culture (51.9%); lack of knowledge (46.2%) while husband opposed it (54.5%) and "not affordable" (32.7%). Above mentioned data indicate that Islamic beliefs, cultural importance of male member (desire for son) and negative effects on health were the strong factors because of which majority of the population in research area perceived it bad.

The data presented in Table IV.9 depict that majority of the respondents (79.7%) had information about family planning methods for birth interval while remaining 20.3% replied that they had no information about family planning methods for birth interval. Yahaya[57] found similar findings that majority (68.1%) of respondents had knowledge of existing methods of birth control and most of them had rarely adopted. Buckley et al.[43]studied young females of 15-24 years and found opposite results. Females had less information and adoption of RH services in study area. Abiodun and Baloqun[35] studied female students of age 15 to 24 years and found more than 78% had experienced sexual intercourse, about 68% had unintended pregnancy while 25% ever used any contraceptive method. Majority got contraceptive information from friends & relatives. In a study in Nigeria, Sunmola et al. [42]stated that more than half of respondents had knowledge of family planning methods for birth interval while in another study 88.5% of the high school students said that they had knowledge of contraception and learned at least one method of contraception[28] while in a study conducted in district Faisalabad 52.5% mothers had knowledge/ information of family planning[29].

Data in Table IV.9 narrate that a large majority (79.7%) had information about family planning methods of which most of the respondents (46.2%) had got information from medical personnel (Doctor/Nurse/LHV/TBA), 31.8% got it from media, while 17.6% learned it from family members and remaining 4.4% of the respondent got information from friends and peers. In a reproductive health knowledge study among secondary school students, the researcher found that 57% mentioned hospitals (Doctor/ Nurse/ LHV/ TBA) secondly, most of them reported schools and similar proportion replied that sources of contraceptive information were media (television or Radio). While few of them mentioned newspapers, magazines, parents and friends[28]. In another research study Sunmola et al. [42]found that more than half of respondents had information about family planning methods and one-third obtained it through the doctor, one-third from media and only 6% through Planned Parenthood Federation of Nigeria (PPFN). Buckley et al. [43] investigated 15-24 years young females to study accessibility of reproductive health knowledge in Kazakhstan throughout the 1990s. Results showed that huge majority did not have access to family planning information. Among those who had access, few got information from family & health personnel. Abiodun and Balogun[35] studied 15-24 year females of a school and found that 25% had ever practiced a contraceptive method and most of them got information from friends and relatives.

Table IV.9 also presents the practicing attitude of any family planning method. Majority (74.0%) of the respondents was not practicing family planning method while only 26.0% of the respondents or their husbands were practicing family planning method. Rani and Lule[54] reported that often poor young females got early marriage in most countries of world and are less likely to report a mistimed birth, to be practicing contraception, to use maternal health services. Ndyanabangi et al.[47] found in her research study that use of family planning methods was also higher among in-school adolescents. Majority (61%) of sexually active in-school youth reported having ever used a family planning method while only 17% of the sexually active out-of-school youth ever used a family planning method. Level of education about family planning methods was found more among in-school as compare to out-of-school youth while in another Ahmed[37] found that majority (58.5%) of the respondents used the family planning method. Mudasar[45] mentioned that majority (75.8%) of the respondents did not adopt the family planning methods which indicates the adoption of family planning methods in rural culture. Abiodun and Balogun[35] studied 600 female students of 15 to 24 years old; all had knowledge of contraception while 25% ever practiced any contraceptive method. Friends and relatives were more common source of information. According to world population data sheet, there was less utilization of reproductive health services throughout Pakistan. Only 30% married women of 15-49 years were practicing all methods of contraception while 22% were using modern methods. Most of the communities are not aware of reproductive health services, thus not availing theses facilities[30].

Data given in Table IV.9 also indicate that 26.0% of the respondents used the family planning methods, of which one-third (33.3%) of the respondents used the condom, 21.8% practiced tubectomy, 13.5% used the injection, 12.2% used the IUD, 10.8% practiced the natural method/ withdrawal as family planning method, whereas 7.1% used the oral pills and a small proportion of the respondents (1.3%) practiced the norplant as family planning method. In another study the oral pills were the most reported (91.5%) method of contraception followed by condom (54.8%), injectables (32.8%), and rhythm (25%). During focus group discussions, abortion and utilization of roots and leaves of some plants as methods of contraception were also reported. Roots and leaves of plants were available from herbalists in the village[28]. In another research study, Arshad[38] found similar results that most of respondents had used condom (38.8%), injection (23.5%), pills (18.8%), IUD (18.8%) while remaining 43.3% did not adopt any family planning methods. Ndyanabangi et al. [47] found condom followed by the use of oral pills, safe period, and withdrawal as common contraceptive method in Ugenda. Respondents in both groups (in-school and out-of-school), but more in the out-of-school group stated that oral contraceptives are dangerous for the health of the women and can lead to malformation of new born too. Yahaya[57] found RH situation in a study that majority (68.1%) of the respondents had knowledge of birth control methods and most common methods were abstinence, breastfeeding and use of condoms while traditional methods were rare in practice. Near about 50% reported their husband's disapproval of contraception utilization.

Table IV.9 indicates that 26.0% (156 respondents) of the respondents practiced the family planning method. Out of it, 41.0% of the respondents faced some side effects from family planning method while majority (59.0%) of the respondents did not bear any side effect from family planning method. Similar findings were found by Ndyanabangi et al. [47] who found side effects of contraceptives in the study area. In both groups, more respondents of the out-of–school group stated that oral contraceptives were dangerous for the health of the women and could lead to malformation of new born too while in another study Abiodun and Baloqun[35] interviewed 600 young females students of 15-24 years who all were well informed about contraception, and fear of side effects was mostly reported as barrier for non utilization.

Data in Table IV.9 point out the response of respondents regarding the side effects of family

planning methods. Total 64 respondents (41.0%) faced side effects from utilization of family planning methods. Out of them, majority (57.8%) of the respondents faced the problem of bleeding and 34.4% experienced swelling/ rash while 7.8% lost their weight as side effect of family planning methods.

Table IV.9 indicates that out of 64 respondents (41.0%) who faced some side effects from family planning method adoption, majority of the respondents (56.3%) got treatment from private clinics, 31.3% got treatment from traditional birth attendant (TBAs/ Dai), 7.8% got treatment from lady doctors and remaining 4.6% of the respondents got treatment from others (Hakim, Homeopath, Peer (a religious person) etc) for the side effect of family planning method.

Data presented in Table IV.9 show that 26.0% of the respondents used the family planning method and majority (87.8%) of them practiced it on their own choice while 12.2% were influenced by their husbands. Mudasar[45] in her research study also showed the similar results about adoption of family planning methods. According to her only 10.0% of the respondents were influenced by their husbands while only 5.0% of the respondents themselves decided the adoption of family planning method. According to research some other factors also influenced the adoption of contraceptive i.e. in-laws, friends etc. More adoption of family planning method is associated with education of females as shown in research study conducted by Mudasar[45] in which she tested the hypothesis that educated females are adopting more family planning services and found highly significant association between the variables with Chi-square value 29.97, level of significance 0.000** and gamma value 0.743. But Pakistani society is male dominated so majority decisions of females are influenced by males. Yahaya[57] stated that almost two-thirds of respondents learned birth control methods and they used willingly abstinence, breastfeeding and condoms as contraceptive.

Table IV.9 also narrates only 156 respondents practiced the family planning method. Out of them, an overwhelming majority (87.8%) of the respondents did not face any opposition from any side and practiced it on their own choice while 12.2% of the respondents were influenced by their husbands in the choice of family planning method and they were using it as their husbands' choice. Yahaya[57] conducted a study on reproductive health. Data analysis showed that females had rarely adopted traditional ways of birth control and 45% reported their husbands' disliking/ condemnation regarding contraceptive utilization during intercourse. Results indicate that scenario is going to be changed as in study area small proportion (12.2%) of respondents reported husbands' disliking and influence in adoption of contraceptives.

Data in Table IV.9 depict that total 26.0% used contraceptives and out of them, majority (69.9%) of the respondents asked that in case of any reproductive health problem, they visited the doctor for treatment while 30.1% got treatment from LHV/ Nurse for reproductive health problem.

Data given in Table IV.7 also indicate that 156 (26%) respondents used the family planning services or supplies and out of them 48.1% of the respondents attained family planning service from private hospital or clinics, 25.6% attained it from LHW/LHV, 14.7% got it from government health facility/ hospital, 2.6% attained it from private physician, while 9.0% of the respondents got it from others (medical store/NGOs field worker/ NGO clinic). In 2002, more than 34 million (56%) of the 61.6 million females of age 15-44 years consulted private doctors for family planning or related medical services and nearly 13.5 million (22%) visited publicly funded clinics. An important aspect of the public clinic system is that they served estimated 4.2 million; 5.4% million females in the 365 days before the 1995 and 2002 survey (Mosher et al., 2004). Similar findings were made by Kibret[28] in the study of RH knowledge, attitude and practice among students. The main source of contraceptive supply/ availability was mentioned such as health centers (35.5%), hospitals (28.5%), clinics (23%) and other places (13%).

Table IV.9 demonstrates the reasons for not using the family planning methods because majority (74.0 %) of the respondents were non adopters of contraceptives and out of these 52.9% said that it was prohibited by Islam, 62.6% had desire for more children so they did not use it, 61.9% declared it unsuitable for health, 51.8% thought it against the culture, 48.4% pointed out that lack of knowledge was the reason, 44.1% were those whose husbands opposed them to practice it, 48.9% reported it costly, 44.4% reported non availability of contraceptives in their locality, and 53.4% argued that their in-laws opposed it. Abiodun and Balogun[35] studied 600 female students of 15 to 24 years old. Almost all were unmarried and learned about contraceptive methods. More than two-thirds experienced intercourse. Only 25% ever practiced contraceptive method and fear of side effects of modern contraceptive was found to be the cause of non utilization. In another research study, Arshad[38]identified similar results that majority (54.0%) of the respondents responded that medical facilities were not affordable, 76.7% claimed that there was no medical facilities in their area i.e. private paramedics/ clinics.

Table IV.9 also indicates that majority of the respondents (65.8%) reported non-availability of contraceptive while 34.2% confirmed the availability in their surrounding/ locality. Similar findings were made by Heard et al.[51] who conducted a study to identify the interrelationship of access and utilization of modern contraception. A large increase in contraception utilization was observed during 1992 to 2000. Results showed that utilization of modern contraceptive was positively associated with physical proximity to RH services facilities.

Data in Table IV.9 depict that majority (52.5%) of the respondents stated that they had a good level of mutual understanding for family planning, 44.7% of the respondents had a satisfactory level of mutual understanding, while only 2.8% respondents replied that they had unsatisfactory level of mutual understanding for family planning

Attitude towards Pregnancy/ Antenatal care Prenatal care is the complete care that should be given to a female from her family and it should be taken by female herself throughout the pregnancy[29]. Some socio-cultural and religious factors actually influence the use of maternal health services in Pakistan or elsewhere in South Asia[31, 32]. Health services are available in Pakistan through several sources like MCH centers, hospital, family welfare centers, LHW/LHV and "Dais" or local traditional birth attendants (TBAs) though illiterate, ill-trained and ill-equipped[29]. At the level of the household, young women's subordinate position has been argued to be an important factor limiting access to pregnancy/ ANC related healthcare[31, 32]. Females who practice prenatal care in initial stage of pregnancy as compare to those who attain a little or no antenatal care have better birth outcome[29]. In Northern India, Bangladesh and even in Pakistan, older women i.e. Mother in-laws have been found to make decision about whom to consult and what steps to take during pregnancy and delivery since they are consider to have the knowledge and experience of birthing[31,34,32,58]. Data regarding antenatal care is presented in Table. IV.10.

Table IV.10 indicates that majority (79.8%) of the respondents received ANC during their last/ current pregnancy while 20.2% did not receive. These results are similar to those of Ahmed[37], Mudasar[45] and Arshad[38]. Ahmed[37] found that majority (64%) of the respondents had got ANC during their last/ current pregnancy. Mudasar[45] in her research study also showed that 65.8% rural women had the facilities of paramedics/ clinic in their area and 50.8% females responded that they visited them for receiving ANC during their last/ current pregnancy and found them affordable. In another research study, Arshad[38]reported similar results that majority (60.0%) of respondents had received ANC while remaining 40.0% did not attain it during their last/ current pregnancy.

Received ANC in their last/ current pregnancy	Freq.	%
Yes	479	79.8
No	121	20.2
Total	600	100.0
Did you go regularly for medical checkup during pregnancy?		
Yes	527	87.8
No	73	12.2
Total	**600**	**100.0**
Source for medical checkup?		
Nurse/LHV/LHW	176	33.4
Dai/TBA/mid wife	61	11.6
BHU/RHC/Dispensary/MCHC	6	1.1
DHQ/THQ	27	5.1
Pvt. hospital/clinic	257	48.8
Total	**527**	**100.0**
n= 527 (87.8%) who went for checkup		

Table IV.10: Distribution of the respondents according to their perceived attitude towards different antenatal care (ANC) aspects during pregnancy

Table IV.10 also indicates that a large majority (87.8%) of the respondents replied that they visited the doctor regularly for medical checkup while 12.2% of the respondents did not visit doctor regularly for medical checkup during pregnancy.

Data given in Table IV.10 further depict that most (48.8%) of the respondents went to a private hospital/ clinic for medical checkup, 33.4% of the respondents visited the Nurse/ LHV/ LHW, 11.6% visited TBA/ Dai/ Midwife while only 1.1% of the respondents went to basic health unit (BHU)/ rural health centre (RHC)/ dispensary/ mother child health centre (MCHC) and remaining 5.1% of the respondents visited the district head quarter (DHQ)/ tehsil head quarter (THQ) hospital for medical checkup.

Family Income Vs Reproductive Health

Hypothesis: Higher the income of the respondents, better will be reproductive health

Table IV.11 indicates the relationship between the independent variable i.e. monthly income of the family and the dependent variable i.e. reproductive health of female. Less than half (46.7%) of the respondents had monthly income up-to Rs.10,000. The results further recorded that majority (58.2%) of the respondents had low level of reproductive health while 22.9% had high level of reproductive health. The table also states that 15.2% of respondents had monthly income above Rs.15, 000 and had low level of reproductive health, but 60.8% of the respondents of same category had high level of reproductive health. It means that respondents who had higher level of income had higher level of reproductive health. The value of Chi-square is significant at 0.05% level of significance which states that there is association between monthly income and reproductive health of female. Gamma value indicates positive relationship between independent and dependent variables. Therefore the hypothesis is accepted. These results are similar to those of Ahmed[37]who found a significant association between family income of the respondents and the use of antenatal care services. The Chi-square value (6.51) shows significant association. The level of significance is .03. The gamma value (0.225) indicates a positive relationship between the variables. Data clearly indicate that high family income had strong relationship with utilization of reproductive health services as compare to lower family income. High income alleviates social status, deceases the poverty and increases the utilization of reproductive health services[37]. In another research study, Arshad[38] identified similar

Monthly income of the family	Reproductive Health			Total
	Low	Medium	High	
Up to 10000	163	53	64	280 (46.7%)
	58.2%	18.9%	22.9%	100.0%
10001-15000	36	45	68	149 (24.8%)
	24.2%	30.2%	45.6%	100.0%
Above	26	41	104	171 (28.5%)
	15.2%	24.0%	60.8%	100.0%
Total	225	139	236	600 (100%)
	37.5%	23.2%	39.3%	100.0%

Table IV.11: Association between income of the family and reproductive health of female

Chi-square = 108.07 d.f. = 4
Significance (P) = .000**
Gamma = .535 **. Highly significant

results that higher income promotes reproductive health and provides better medical facilities that ultimately support the women to have good health with Chi-square value (42.09) along with high level of significance (.000**).

Education Vs Reproductive Health

Hypothesis: Higher the level of education of the respondents, better will reproductive health

Education level of the respondents	Reproductive Health			Total
	Low	Medium	High	
Illiterate	117	33	19	169 (28.2%)
	69.2%	19.5%	11.2%	100.0%
Primary	44	26	28	98 (16.3%)
	44.9%	26.5%	28.6%	100.0%
Middle to Matric	48	51	72	171 (28.5%)
	28.1%	29.8%	42.1%	100.0%
Intermediate	11	23	48	82 (13.7%)
	13.4%	28.0%	58.5%	100.0%
Graduation and above	5	6	69	80 (13.3%)
	6.3%	7.5%	86.3%	100.0%
Total	225	139	236	600 (100%)
	37.5%	23.2%	39.3%	100.0%

Table IV.12: Association between education of the respondents and their reproductive health

Chi-square = 187.99 d.f. = 8

*Significance (P) = .000***

*Gamma = .621 **. Highly significant*

Table IV.12 indicates that the relationship between the independent variable i.e. education of the respondents and the dependent variable i.e. reproductive health. Less than one-third (28.2%) of the respondents were illiterate. The results further recorded that 69.2% of the respondents had low level of reproductive health while 11.2% of same category had high level of reproductive health. The table also states that 6.3% of respondents had graduation and above education and had low level of reproductive health, but 86.3% of the respondents of same category had high level of reproductive health. It means that respondents who had higher level of education had higher level of reproductive health. The value of Chi-square is significant at 0.05 percent level of significance that states association between education and reproductive health of female. Gamma value indicates positive relationship between independent and dependent variable. Therefore the hypothesis is accepted. Similar findings were shown by PDHS (1991), Kaur and Pattanak[49], Broek[40], Buckley et al. [43], Arshad[38], Ahmad[37]and Mudasar[45]. According to PDHS (1991) educational attainment level in a society is an important indicator of its social development. More significant effect on fertility and contraceptive behaviour has shown by more educational attainment. Kaur and Pattanaik[49] pointed out that education in general and female education in particular put a strong influence on contraceptive use. Higher education supported decline in fertility and child mortality and increase better female reproductive health. Ahmed[37]also narrated a significant association between education of the respondents and use of antenatal care. The Chi-square value (7.91) shows significant association. The gamma value (0.271) indicates a positive relationship between the variables. Data clearly indicate that educated females had more antenatal care utility as compare to uneducated female. Mudasar[45] tested the hypothesis "Educated respondents will be receiving antenatal care/ services during pregnancy" and found a highly significant association between the variables with Chi-square value (29.97), level of significance (.000**) and gamma value (.743). Broek[40] studied rural African females to assess the impact of females' education on their pregnancy outcome, mortality and behaviour towards health. In this descriptive population-based study, by using structured questionnaires, all women settled in the catchments area of a RHC in southern Malawi were selected. Females were less educated than men. Education, repeated medical visits, settlements near health centers and assistance of trained health worker resulted successful pregnancy outcome. Buckley et al. [43] studied 15 to 24 years old females to access RH knowledge in Kazakhstan and found huge majority of females without FP information access and had low level knowledge of maternal health. Few who had access among those few got information from family and medical personnel. Mass media and peer information source were also reported as used

channels. Access to family planning information and reproductive health knowledge significantly approached through higher education. During 1990s, contraception knowledge and prevalence increased in Kazakhstan but level of education and information channel access varied the knowledge level. While in another research study Arshad[38] identified the association between education and utilization of reproductive health services and found similar results that higher education level promote reproductive health through better utilization of medical facilities that ultimately support the women to become healthy with Chi-square value (44.76) along with high level of significance (.000**). All above mentioned studies showed similar results to present study.

Number of pregnancy Vs Reproductive Health

Hypothesis: More the number of pregnancies of the respondents, worse will be the reproductive health

Number of pregnancies	Reproductive Health			Total
	Low	Medium	High	
1-2	84	65	146	295(49.2%)
	28.5%	22.0%	49.5%	100.0%
3-4	86	48	76	210 (35.0%)
	41.0%	22.9%	36.2%	100.0%
5 and above	55	26	14	95 (15.8%)
	57.9%	27.4%	14.7%	100.0%
Total	225	139	236	600 (100%)
	37.5%	23.2%	39.3%	100.0%

Table IV.13: Association between number of pregnancies and reproductive health of female

Chi-square= 41.38 d.f.= 4

*Significance (P)= .000***

*Gamma = -.350 **. Highly significant*

Table IV.13 indicates that less than half (49.2%) of the respondents had 1-2 no. of pregnancies. The results further recorded that 28.5% of the respondents had low level of reproductive health while 49.5 % of same category had high level of reproductive health. The table also states that 57.9% of respondents had 5 and above no. of pregnancies and had low level of reproductive health, but 14.7% of the respondents of same category had high level of reproductive health. It means that respondents who had more the number of pregnancies had low level of reproductive health. The value of Chi-square is highly significant at 0.05% level of significance, which states a strong association between No. of pregnancies and reproductive health of female. Gamma value indicates positive relationship between independent & dependent variable. Therefore, the hypothesis is accepted. These results are similar to those of Chattopadhyay and Parasuraman[46] and Santelli et al.[55]. Santelli et al. [55] examined the measures of pregnancy intention in United States. Factor analysis pointed out the desire and misiming as key dimensions of pregnancy intention and overdue and non-care as two smaller non-dimension of pregnancy intention. Desire to continue the pregnancy leads toward more number of children and more pregnancies affect the reproductive system of adolescents. Chattopadhyay and Parasuraman[46] found similar results in their research study "Hindu-Muslim differentials in reproductive choice and son preference: A comparative study of selected states of India". Researcher investigated whether the demand for son is a factor for higher demand for children or lesser use of contraception among Muslims, and carried out regression analysis introducing interaction terms of religion and number of sons. They found that irrespective of religion, all women demand more children in all states. Demand of more children increases the number of pregnancies that indicate the less use of contraception and portrait the worse condition of females' health.

Number of visit to medical center Vs Reproductive health

Hypothesis: More the visit to medical center, better will the reproductive health

No of visits for Medical checkup during pregnancy	Reproductive Health			Total
	Low	Medium	High	
Once a Month	134	105	176	415(69.2%)
	32.3%	25.3%	42.4%	100.0%
Twice a month	43	10	50	103(17.2%)
	41.7%	9.7%	48.5%	100.0%
Thrice a month	25	5	2	32 (5.3%)
	78.1%	15.6%	6.3%	100.0%
More than thrice a month	23	19	8	50 (8.3%)
	37.5%	23.2%	39.3%	100.0%
Total	225	139	236	600 (100%)
	37.5%	23.2%	39.3%	100.0%

Table IV.14: Association between number of visits for medical checkup and reproductive health of female
Chi-square=51.99 d.f = 6
*Significance (P)=.000***
*Gamma = -.257 **. Highly significant*

Table IV.14 indicates that the value of Chi-square is highly significant at 0.05 percent level of significance which states an association between No. of visits for medical checkup during pregnancy and reproductive health of female. Gamma value indicates negative relationship between independent and dependent variable. Therefore, the hypothesis is accepted. Similar observation was found by El-Kak, et al.[50] during their research study. Findings indicate that out of 1869 women, almost one-forth reported RH problems; of these, 6 out of 10 females visited private clinics for treatment and care. Health insurance, younger age, and severity and time length of problems had association with utilization of reproductive health amenities. Poverty induces females to practice public and subsidized facilities so they have to visit medical center so many time for their treatment of RH problems.

Awareness level Vs Reproductive health

Hypothesis: Higher the awareness level, better will be the reproductive health

Awareness level	Reproductive Health			Total
	Low	Medium	High	
Low	88	10	1	99 (16.5%)
	88.9%	10.1%	1.0%	100.0%
Medium	120	91	122	333 (55.5%)
	36.0%	27.3%	36.6%	100.0%
High	17	38	113	168 (28.0%)
	10.1%	22.6%	67.3%	100.0%
Total	225	139	236	600(100.0%)
	37.5%	23.2%	39.3%	100.0%

Table IV.15: Association between awareness level of the respondents and their reproductive health
Chi-square=184.19 d.f.=4 Significance(P)=.000**
Gamma = .728 **.Highly significant

Table IV.15 indicates that the value of Chi-square is highly significant at 0.05% level of significance, which states an association between awareness level of the respondent and reproductive health of female. Gamma value indicates positive relationship between independent and dependent variable. Therefore, the hypothesis is accepted. These results are similar to those of Babalola and Babavaro[39] and Robertson[41]. According to Robertson[41], females must be aware of reproductive health because simple problem or non-caring attitude can affect their overall health and especially of young females. Over times; attitude changes and females in early age pay less attention to reproductive health but with passage of time become more aware and serious. Babalola and Babayaro[39] assessed a communication program in northern Nigeria and 819 sexually experienced females were interviewed. Communication campaign was found effective source for maternal health knowledge. Awareness about contraception increases its utilization and promotes women's reproductive health.

Availability of reproductive health services Vs Reproductive health

Hypothesis: More availability of RH services, better will be the reproductive health

Availability of contraceptive	Reproductive Health			Total
	Low	Medium	High	
No	173	94	128	395 (65.83%)
	43.8%	23.8%	32.4%	100.0%
Yes	52	45	108	205 (34.17%)
	25.4%	22.0%	52.7%	100.0%
Total	225	139	236	600 (100.0%)
	37.5%	23.2%	39.3%	100.0%

Table IV.16: Association between availability of contraceptive and reproductive health of female
Chi-square=26.53 d.f.= 2 Significance (P)=.000**
Gamma = .358 **. Highly significant

Table IV.16 indicates that the value of Chi-square is highly significant at 0.05% level of significance, which states an association between availability and access of contraceptives and reproductive health of female. Gamma value indicates positive relationship between independent and dependent variable. Therefore, the hypothesis is accepted. Similar results are found Agampodi et al.[36]. They studied reproductive health care services, barriers and their effect on reproductive health in semi urban Sri Lanka. They found non-availability of RH facilities as major obstacle. Youth had frustration about non-availability of reproductive health services. The study found that availability of RH services were directly associated with better reproductive health.

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