# PERCEPTION TOWARDS REPRODUCTIVE HEALTH PRACTICES AMONG EDUCATED WOMEN IN ISLAMABAD




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## FINAL APPROVAL OF THESIS

This is to certify that we have read the thesis submitted by Ms.Tooba Kanwal, it is our judgment that this thesis is of sufficient standard to warrant its acceptance by the Quaid-i-Azam University, Islamabad for the award of the Degree of "MSC in Sociology ".

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## ABSTRACT

*This research study explored the perception towards reproductive health practices among educated married women in Islamabad. The research wanted to find out the reasons behind women health issues regarding their reproductivity. Furthermore, family planning, child spacing, sex preference and women health used as thematical highlights in this research. The researcher explored appropriate factors or reasons of having different kind of child spacing and family planning decisions among couples. The researcher wanted to analyze value of biological gender preference and perception of Pakistani families towards women's reproductive health concerns. Family planning is one of the common practices in urban areas, so researcher supposed to gather exact perception and practices towards family planning in Islamabad. Moreover, researcher was supposed to gather perceptions about modern contraception usage among educated married women and to analyze differentiate between usage of traditional and modern mode of treatments for reproductive health issues of married women. Researcher applied contemporary theories on women body shaping and shaming consciousness, sex preference in Pakistani society, preferable cost of child among couples or parental investment. Foucauldian discourse analysis by Michel Foucault, Objectification Theory by Fredrickson and Roberts and Human Capital Theory by Gary Backer are applied.*

*The Researcher applied quantitative research methodology and area of study was capital territory Islamabad. In this research purposive sampling used because of feminine topic and close-ended questionnaire tool for data collection was applied while collecting data and non-random sampling was used for data collection. A sample size of 100 women were chosen by researcher who are educated and married. Sampling population was chosen from capital territory of Islamabad for date collection. Data was analyzed by SPSS (Statistical Package for Social Sciences), descriptive and inferential statistical*

*procedures were used to explore the data. The researcher has shown models and frequency tables to analyze collected data and for applied theories. The results revealed that educated women are more conscious towards their reproductive health, cost of child and family planning but some spouses and families are supportive regarding their reproductive issues, but some are not. Furthermore, societal socio-economic stimulus influence on educated married women in Islamabad.*

***Keywords:*** *women health, educated women, reproductive health, sex preference, family planning, and child spacing.*

## Table of Contents

List of Tables

# Chapter No. 1

# INTRODUCTION

Reproductive health is one of the most crucial issue of women all around the world. People in South Asian countries usually do not show their interest for healthy reproductive life of women. Women are humiliated directly like sexual abuse, short interval child spacing for getting son, less family planning, less usage of contraceptive result in hazardous reproductive disorders and diseases. The main objective of research is to hunt perceptions of educated women towards their reproductive health after marriage in Islamabad and the perception for concept of family planning, child spacing, sex preferences and reproductive health among married educated women. Women in rural and urban areas may examine as differential experiences or perceptions towards reproductive health, especially in developing regions.

If we look at the human world's history the world population remained below 300 million. Sometimes after the year 1600 it slowly started turning upward, accompanied with the improvement of agriculture and other technologies and then with the industrial revolution the world population grew faster than before the eighteenth century. History examined that the earth took eighteen centuries to reach first one billion inhabitants, increase of population continued into the twentieth at a much faster pace, since the World War II the earth has experienced the steepest population in the human history. The reason behind the population growth in the Middle Ages (1700 onward) was the revolution in agricultural and industrial sector. The agricultural revolution was one factor from where the population growth started slowly and then the next main factor was the industrial revolution, after that time period the technology started boosting up, which decreased the mortality rate because of inventions and development in the field of health sector. The development in health sector decreased the mortality rate, which resulted in population growth. Along with the development in medicines, one another factor in population growth in the era of industrial revolution was the limitation of labor force. Industries needed for more labor at that time period and population was not enough to work for

industries. Therefore, the government did not make any policy to control population growth. By the passage of time countries observed the problems of over population and trying to control population growth. Now over population is the world's phenomenon that mostly countries are facing in the world, rather than some specific regions or countries. Third world countries in the strong grip of high growth in population. It is estimated that 7.053 billion population exist in world by united states census bureau and continues to grow by 82 million per year. During the half century the world's population grew more than double. Between 1960 to 2010 the world's population rose from 3 billion to 6.8 billion. In other words, there has been more rapid growth in population from last fifty years. Currently the rate of population increase is 1.2 percent per year, that means the planet's human population is going to double in 58 years. Estimated population of Asia is 4360 million with crude birth rate of 18 percent per thousand and death rate of 7 percent per thousand yearly. Infant mortality rate is 54 percent per thousand with total fertility rate of 2.6 percent and usage of contraceptive is 64 percent, according to world population data sheet (2017) Pakistan is one of the developing countries in South Asia having 2.10 million population with crude birth rate of 28 per thousand and crude death rate of 8 per thousand. The population growth rate of Pakistan is 2.1 percent with infant mortality rate of 68 per thousand and the total fertility rate is 3.6, thus it shows that an imbalance between birth and death rate in Pakistan.

The greatest problem of our time is the rapid growth of population, especially in developing countries where the population growth matters, because it has enormous impact on the human life. It would not be wrong to say that the most urgent conflict that contemporary world is facing today is not between the states and ideologies but among the pace of human growth race and the lopsided rise in the population, production of resources and it is necessary to support mankind in peace, prosperity and dignity. Today women health should be essential in the world as it will control rapid growth of offspring in developing

countries. It can be seen that there is different type of families who accept and do care about women and child health but some are not concerned for it. Some people are concerned with quality of child as compare to quantity of offspring. Some couples think rationally in urban areas for son preference to stable their stability and some are only focus on family planning and child spacing to secure women's health. In this research all concepts like women health, techniques for having kids or not, usage of modern and traditional contraceptive, child spacing, family planning acceptance or rejections, cultural believes for pre-natal and post-natal stages of women and child, sex preferences among different countries, mechanical medication methods of women are discussed. The perception, thinking, rationalization and stereotype concepts among educated and illiterate people towards reproductive health is included.

### 1.1 Life cycle perspective for reproductive health

According to WHO's explanation of reproductive health, especially highlights the significance of an individual's right to keep maintain their sexual health status. Sexual well-being is the combination of having one's emotional, rational and social aspects of sexual being in direction of positive personality development, communication, relationships, care and love. There are significant three fundamental principles of sexual well-being. Firstly. the capability to enjoy and control sexual and reproductive behavior, secondly the liberty from embarrassment, guilt, anxiety, fear and further psychological factors that may weaken sexual relationships among people and third is the liberty from organic or biological disease that affects the sexual and reproductive function. Additionally, reproductive health suggests the precise right for satisfying and harmless sex life and reproductivity, especially among women. This also contains the capacity to reproduce but also the personal freedom is included to decide for it that when, how and if women will often to do so. Men and women both have ultimate right to be informed and to have accessibility for harmless, effective, reasonable and acceptable methods or

techniques of family planning that are not against the rules and law. Reproductive health pays extremely for physical and psychosocial comfort, well-being and closeness between individuals but poor reproductive health is often related with disease, sexual abuse, feelings and health exploitation, unwanted pregnancy and death. Reproductive health is considered as a vital feature for healthy human development and for general health. Healthy childhood reflects peoples' reproductive health, adolescence stage is critical and sets the phase of adulthood for health for both men and women to their healthy reproductive years in life span. Rather, for sexual relation men and women follows healthy, protective and safe life cycle and it remains important in many different phases of development of their kids also. Each individual's reproductive health needs may vary at each stage of life. Though, there is important cumulative result across the life course and each stage has significant implications for upcoming well-being. Health problems may occur when incapability to arrangement of reproductive health at any stage of life may present. The components of overall adequate health are healthy reproductive systems, progressions and functions. There are many internal and external factors that challenge an individual's capability to sustain their reproductive health. Several factors directly affect how an individual can sustain his or her reproductive health at well status. Whereas some factors are pre-determined among individuals such as genetic vulnerability to specific disorder or disease and further factors such as behavior of people is link with the maintenance of reproductive health and involvement of an individual in risky practices. Furthermore, the natural and physical environment risks also influence on reproductive health, where an individual live. Some occupational experiences like works with risky pesticides can also have adversative effects in reproductive life of people.

### 1.2 Reproductive health issues

The World Health Organization describes the primary term or issue of infertility as the incapacity to bear or reproduce offspring, whether the outcome of the powerlessness to conceive a child, or the inability to bring a child to after full term of 12 months of sexual intercourse without using any contraceptive. Primary infertility or sterility term used in many medical studies and the term primary infertility is specifically used to define a condition where a couple is not capable to conceive baby. Secondary infertility is described by WHO as the incapability to conceive a second child after giving a first birth to their child. Secondary infertility has shown link with a high geographical association with primary sterility. Productiveness defines the capacity to conceive after several years of exposure to hazard of pregnancy. Fecundity is frequently estimated as the time essential for a couple to attain pregnancy. The capacity among couple to conceive after two years of attempting to become pregnant is refer to fecundity or productiveness of couples. Basic difference in fertility and fecundity is that the fertility defines the accurate production of live children, whereas the fecundity defines the ability to produce live offspring. Fecundity cannot measure directly though it may measure clinically and it may be evaluated by the time span between a couple's choice to attempt for the purpose of conceive and for getting a successful pregnancy. Some detailed or specific reproductive health problems directly define the health of an initial pregnancy or the fetus development in utero. The World Health Organization defines some reproductive health problems that term as congenital abnormalities and genetic abnormalities which mostly diagnosed in aborted fetus of ladies at birth of child or in the neonatal period of time. Congenital abnormalities sometimes appear as birth defects later. An ectopic pregnancy defines difficulty in the early phases of pregnancy when a fertilized egg is implanted in outside of the uterus cavity. Fallopian tube uses for majority of ectopic pregnancies, but may also happen in the uterine cervix, ovary or in abdomen. An ectopic pregnancy may result in

life threatening for the woman sometimes if not treated correctly. When an infant does not live complete expulsion unluckily from the mother or after completing twenty weeks of pregnancy age, fetal death arises which also known as stillbirth expiry of an infant. Furthermore, lack of vital signs such as lack of fetal breath, heartbeat problem, lake of umbilical cord pulse or lake of definite movement of voluntary muscles cause death of stillbirth child.

According to Langer et al. (2015) the health of girls and women is in transition over the time and even it has improved significantly in the past few decades in several urban and rural areas. But still there are some significant unmet needs of women. The population ageing and alterations in the societal determinants of health increased the existence of disease problems that are linked with reproductive health, sick nutrition and infections, and also developing of epidemic of long-lasting and non-communicable diseases. At the same time, the women's health in worldwide significances they have been changing themselves from a minor focus on maternal and child health to the wider framework of sexual health and reproductive health and to the concept of women's health all around, which is originated on life-course method of women reproductive health. The extended vision of life-course incorporates health tasks that affect the women beyond their reproductive years and those women who are shared with men, but with appearances and results that affect women disproportionally due to biological, gender and for the other social determinants.

Pakistan has significantly poorest pregnancy results worldwide, while comparing maternal, fetal and newborn outcomes with other low and middle-income countries and that is meaningfully worse rather than other numerous low-resource countries. According to Aziz et al. (2020) there were 91,076 births estimated in Pakistan and 456,276 births were calculated in the other global regions of Indian, Kenyan and Zambian low and middle-income countries collectively, from 2010 to 2018. The maternal mortality ratio in Pakistan was

estimated 319 per 100,000 live births with comparison of an average of 124 between the other low-income countries estimated by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division (2015). Whereas the Pakistan's neonatal mortality rate was 49.4 per 1,000 that estimated by comparison of live births of 20.4 ratio which was estimated in the other low-middle income countries. The rate of stillbirth in Pakistan calculation was 53.5 per 1000 births with comparison of 23.2 estimated ratio for the other regions of low-middle income countries. Preterm childbirth and low birthweight child rates were also noticeably higher than the other countries collectively UNICEF (2018). It is examined by authors that the mostly Pakistan had significantly higher rates of stillbirth death and neonatal mortality rather than other low and middle-income countries such as India, Kenya and Zambia. It is also examined that medical care centers in Pakistan for pregnant women and their newborns was worse. Basic reasons were identified for such poorer outcomes that the mostly Pakistani reproductive-aged women are largely illiterate, undernourished, weaker and they usually deliver a high ratio of preterm and low-birthweight babies by force or by desire of their mate.

### 1.3 Family planning initiatives

Family planning achievement is to improve access to the Sustainable Development Goals (SDGs), as they chiefly linked with the women's empowerment, gender equity, maternal and newborn health premises and quality education. As Hackett et al. (2020) stated that approximately 214 million women estimated in the Global South in 2017 who desired to avoid pregnancy and were not using any modern contraceptive technique. They estimated that 39 percent of women of Sub-Saharan Africa and Southern Asia in developing places account for wish to avoid pregnancy and 57 percent of those women were estimated for not in need of modern contraception. To report the unwanted need, it is important to recover both of access and acceptance of modern contraceptive approaches, which decrease unintentional pregnancies

and endorse healthy timing to conceive and spacing of child births. The unparalleled population growth of Pakistan collectively increases uncommon resources that has shown serious health issues, economic and societal implications for country and rising rates of poverty and possibly terrible environmental consequences. According to author Pakistan was from one of the few Asian countries in the 1960s to implement a national Family Planning (FP) program, even though its implementation examined uneven. But recently in 2020 Family Planning pledge the government transformed its commitment and enlarged investments for family planning techniques substantially. Family planning may help to rise inter-pregnancy intervals between offspring, stated by Ganatra and Faundes (2016). Despite all those commitments which are discussed above by government of Pakistan's development on FP has delayed practically and fertility decay has been slower rather than in most neighboring country areas. It is estimated that approximately one out of five Pakistani married women have an unmet need for FP and the usage of modern contraceptive prevalence rate continued static between 2012 was 26 percent and 25 percent calculated in 2018 respectively. Family planning techniques in urban Pakistan, specifically modern contraceptives are broadly accessible and maximum methods can be accessible freely or without any charge through governmental facilities. The contraceptive usage estimation is low in urban Sindh province and modern contraceptive prevalence rate is 28 percent. This supply-uptake gap among people is community-based family planning interventions that usually deliver home-based knowledge, education and counselling that may be an essential strategy among them to generate and encounter the latent claim for modern contraceptives. While such creativities grip potential and few have been thoroughly tried and tested. According to Belaid et al. (2016) previous assessments of usage and acceptance of family planning techniques provide some indication that demand for generation interventions donate to enlarge acceptance of modern contraception in low and

middle-income countries, but usually such estimations are infrequent and may vary in value and display mixed results. They stated that such programs deviate significantly in characteristics of their application and implementation, with planned beneficiaries, intervention mechanisms and implementation distance. Moreover, assessment indicators and concluded measures are not consistent for modern techniques of contraceptive and family planning.

### 1.4 Childbirth intervals

The childbirth interval recommendation is twenty-four months gap between pregnancies should be apply by couple, said by WHO (2005) and shorter interval should be appropriate for six months if pregnancy is over in abortion or miscarriage. But If the mother has faced prior child with C-section or operation so it is advisable for couple to wait from a year to three years before going to giving birth again, because it would be in the risk of uterine break in the mother while giving childbirth. It is assumed that if pregnancy intervals will longer than 5 years that will cause high risk of pre-eclampsia.

The concept of birth spacing was developed since early 1980s as a crucial concept for improvement of maternal and child health, to activate birth spacing practices among couples in low-income or in developing countries and to portray attention for main focus on this norm in favor of long birth intervals of infant in West Africa, stated by Duclos (2019). The concept and such practice of reproducing the children too closely spaced in time is ethically fated and predicts negative resulting series suggestions for family well-being. While there are noticeable positive results due to birth spacing between children including recognizing the health benefits of longer birth intervals. Moreover, it was noticed that the followers from the same demographics, the concept of birth space believe that the practice of using contraception after childbirth to delay other births could contribute to empowering women socially. By contrast in some regions, the concept and practice of stopping short birth intervals is also seen as strengthening family well-being by letting allow the women to care

more entirely to their family. The authors examined that the women's and men's understanding towards birth intervals judgmentally reflect on the demographic idea of birth spacing or birth intervals between children. Their findings strengthen the relevance of the concept of birth spacing to involve with women and men about family planning services. The taboo of birth intervals in some areas also suggest that their social norms stigmatize short birth intervals and can regulate restrictions that may face by women to control their body. The birth spacing or inter-pregnancy interval includes that how rapidly after preceding pregnancy a woman will become pregnant or will gives birth again to offspring. According to Shachar and Lyell (2012) there are several health risks like birth defects, schizophrenia, and autism which are associated with pregnancies positioned closely together and those located far apart, but the popular health risks are linked with child births that happen too near together or with prior child.

There are plenty of evidence that are associative with short birth interval of child and adversative maternal and child health consequences as well as infants and maternal mortality. As stated by Pimentel et al. (2020) Short childbirth interval is very common among those women who live in low and middle-income countries. While there are some identifying actionable features of short birth interval, which is essential to discourse the problem. According to authors' knowledge and examination total forty-three initial documents 2802 met inclusion criteria, 30 of them were observational lessons and 14 were published after 2010. Total twenty-one studies were coming from Africa, from Asia 18 studies were calculated and four studies from Latin America. All these studies or papers were most commonly discovering education and the age of the mother, some previous pregnancy outcomes, breastfeeding premises, contraception usage, socio-economic level, equality among couples' health and sex of the previous child, but positive and negative links with short birth intervals, shorter breastfeeding time period and female gender of previous child

were main factors that were reliably associated with short birth interval. They stated that advancement of breastfeeding can help to decrease short birth interval and it has many other benefits for child and mother.

**1.5 Sex selection**

Sex selection among couple is the effort to control the sex of their offspring to attain a desired sex or gender. It can be accomplished by family belongings in some ways, like couple follow some pre-post implantation of starting time period of an embryo as well as at childbirth. There are such parents who prefer to have a son rather than daughter in many countries. This concept can find through sex ratios of children in various countries, Seager (2009). It is estimated that biologically sex ratio of offspring is around 95 girls to every 100 boys. This calculation commonly evens out due to the higher boys' infant mortality rates. Although, in different countries of South Asia, East Asia and the Caucasia's sex ratio of children was examined severely slanted. The desire for having male kids is particularly severe in China, Nepal, Pakistan and India. It is examined that the son preference over daughters have connection with number of reasons. Especially in South Asian countries, it is examined that son preference is related to factors of economics, religion, social and culture. Parents believe that having a son guarantees for their families are economically strong and secure because they are not supposed to giving them dowry payments and other materials for someone's house. Furthermore, there are some countries where discriminatory practices are common among female and male child, like women inheritance, ownership or land control by law. Such women who have a son guarantees that the family will not have to fear about the legal or illegal outcomes if something will be going to happen with them. The parents in some countries are conscious about the probable hardship of their daughter that would have to bear in her life and therefore they prefer to have more son as compare to daughters in order to not see their daughters suffer such complications. Furthermore, mostly the son preference consequences in female abortion of fetus and pre-natal sex selection.

According to the United Nations Population Fund (2012) the consequences behind gender selection are due to some factors and provide a thoughtful imbalance for sex ratio as well as to plan future trends of happy family. Firstly, son preference is a branch of household structures in which girls and women are regulated by marginal social, economic and symbolic position, moreover they enjoy fewer rights of them accordingly. Families of different household structures may focus on the security and safety of their homes in which sons are likely to provide care and support to their parents and female siblings throughout their life. People indulge with technological development from which parents can diagnosis the sex of their unborn child and low fertility consequences which rise the need for sex selection by decreasing the probability of having a female child in smaller families. But UNPF stated that the local fertility limitations and spontaneous fast fertility weakening below replacement levels and tend to force those parents who want for both son and a small family size to resort to sex collection.

### 1.6 Objectives

To know the perception of educated women in decision making regarding child spacing.

To identify the reasons behind delaying pregnancies and sex preference among educated couples.

To know the reasons why certain couples, subscribe to the notion of child gap and others not.

To identify the family planning and trend of contraceptives among educated women.

### 1.7 Statement of the problem

The statement of the problem is the perception towards reproductive health among educated women in Islamabad.

### 1.8 Significance of the study

Reproductive health deals with the reproductive processes, functions and system at all stages of life of women. It is a crucial part of general health and central feature for human development, especially for women health development. Women good reproductive health emphases on infant, adult hood and adolescent health. Women reproductive years affect the new generation as well as the health of newborn is largely depends on the mother's nutrition status and her access for health care. Although most reproductive health issues may occur during women's reproductivity years but modern techniques are introduced to cure such crucial health problems that can hurdle women's reproductive health as well as the health of child. However, men also have to attempt their responsibility regarding women's reproductive health care and decision making for reproductivity so that their child will be healthy. The highest achievable level of health is not only a fundamental human right for all in the world, it is also a social and economic imperative because human energy and creativity are the driving forces of development. There are several common innovations to safe women's reproductive health and to attain child intervals for the betterment of their children's future like modern and traditional contraceptives, child spacing techniques with the equal consent of couple and family planning initiatives. Such type of creativity and energy to safe women's and children's health and future cannot be generated by sick, tired people and consequently a healthy and active population becomes a prerequisite of social and economic development of a family as well as for society.

There are several alternative healing system practices for women's reproductive health care and usage of medicines also consider as compulsory in many countries from many decays. In developed regions biomedical health care is

available but all people believe in their own mental construction regarding reproductivity of women. So, the basic interest of researcher is to find different techniques and role of couple for accessing the reproductive health practices regarding reproductive health issues, child spacing, sex preference and family planning. Researcher can fine accurately rate of practicing the modern and traditional ways for reproductivity concerns among couples. One is the most significant role for family planning is men, who may enforce or make decision for having child or not and to take care about spouse reproductive health. On the other hand, modern contraceptives impact on the health of women are addressed. Another important discussion is the significance and side effects of sex preference among families may affect women health badly. There are different calculations for effectiveness of different alternative healing practices that may use by couples for child spacing, family planning, to having daughter or son and for women health care in the world. Women may suffer from several chronic diseases due to not having safe sexual intercourse or by taking several biomedicines. Some people are only limited with traditional ways of healing and caring for reproductivity of women because they think scientific methods are fake or not safe for them and for their child also. There are further state's introduced policies regarding child spacing, family planning techniques which may follow by couples in many regions. Furthermore, the reproductive health care and future planning regarding ideal family depends on different families or couples from different regions or countries.

# Chapter no. 2

# REVIEW OF THE RELEVANT LITERATURE

According to population policy (2017) the Pakistan is the 6th most populous country of the world with a population of over 207 million. Its population is growing at an annual rate of 2.4 per cent and at the current rate of growth the population will double in the next 37 years. 57 percent of the population has increased from last 19 years. The country Pakistan evoked for suggestions and implications of rapid population in the early 1960s and has implemented the philosophy of family planning through a comprehensive Family Planning Scheme, that was launched in 1965 as an integral module of the Five-Year Plan (1965-70) to lower fertility with voluntary contraception.

High population rate was led by a continuously high birth rate and rapidly declining mortality rate and situation has been confronted almost alike by all the provinces. According to 2017 census average population growth rate has declined from 2.6 percent in 1998 to 2.4 percent in 2017. However, Islamabad Capital Territory has highest population growth rate of 4.91 percent, Census of Pakistan (2017). The population of Islamabad is increased from 0.81 million in 1998 to 2.0 million in 2017, and the current metro area population of Islamabad is 1,129,000 that is a 3.11 percent increase in 2020 from 2019. The Population Growth of Islamabad capital territory is almost 1.7 million in 2020 approximately, and it's expected to exceed almost 2.2 million in 2030. The projection of population exercise is carried out on a longer timeframe under different scenarios that further explains as the fertility variations can make changes on the population size, age distribution and numerous related outcomes, besides the effect of speedy urbanization in the world.

Sexual and reproductive health is important for health and survival of people, for economic development and also for the health of humanity. Some decades of research have shown thoughtful and measurable benefits of investment in sexual and reproductive health. Governments also have committed to such

investment through international agreements. But there is no progress shown practically until now. The reason behind no progress is inadequate political commitment and resources, determined discernment against women and girls and an unwillingness to address sexuality issues comprehensively and openly in regions. Further studies of Starrs et al. (2018) examined that including 2030 Agenda, health and development initiatives for Sustainable Development and the universal health coverage movement typically focus on particular components of Sex and reproductive health like contraception tools, maternal, newborn health and HIV/AIDS. From some past decade countries have accounted remarkable gains in these areas, but the gains have been seen as unpracticed and unequal among countries and within the countries and also services have often fallen short in coverage and quality. Furthermore, people have deficient access and protection towards sexual and reproductive health services. There is need for more progress to adopt more wide-ranging view of sexual and reproductive health and need to tackle neglected issues such as sexual relationship, abortion issues, gender-based violence and diversity in sexual orientations and gender identities. According to the presented evidences in report is more than 30 million women do not give birth to infant in health facility by each year in developing areas, more than 45 million women and new born have insufficient or no antenatal care, and more than 200 million women wish to avoid pregnancy for the first time or again and again pregnancy but they do not use modern contraception. Approximately 25 million unsafe abortions or miscarriages are estimated yearly around the world, and more than 350 million men and women are estimated who need treatment for the curable sexually transmitted infections (STIs), nearly 2 million people are newly infected by human immunodeficiency virus (HIV). Moreover, at some point approximately one in three women face intimate partner violence or non-partner sexual violence. Ultimately, almost all estimated people in the world 4·3 billion

of reproductive age will have insufficient sexual and reproductive health services over the development of their lives.

### 2.1 Women's Reproductive Health

Various studies have demonstrated that longer birth intervals and mother's health are directly proportional to one and other i.e., the longer the birth spacing, the better will be the mother's health. (Rutstein 2005; Davanzo et al 2004; Agudelo & Belizen 2000). The WHO technical consultation team agreed on birth spacing as suggested that the mother should wait at least 24 months before attempting next pregnancy (WHO 2006). Decision-making regarding child birth and child spacing involves a complex discussion and negotiation between married couples. The attitudes and intentions of both the couples may influence the decision regarding child spacing. However, conversation on gap to next birth between spouses remains uncommon. Analytically, in Pakistan the reproductive health concentration among couples is not subjective and male partner shows less interest for decision making regarding child birth and child spacing. Usually, husbands are not comfortable to use contraceptive e.g., condom while having sexual intercourse. They do not even show responsible attitude and intention towards child spacing which is essential for mother and child health. Many Pakistani cultures believe in such custom to have sexual intercourse after marriage without discussion with female partner's agreement. If they conceive male partner use to ignore health of mother and his child.

According to authors, the internet has become one of the most common sources of getting reproductive health information, worldwide 5 percent estimated for all internet searches are health-related Eysenbach et al. (2003). Even in Pakistan the women who have access to internet, manually use to hunt their initial and risky problems on Google regarding their reproductive health. Furthermore, there are also Pakistani women who compel to stay in guide of their family's female elders who have blind believes in their own past experiences regarding

reproduction practices, sex preferences and for child and mother's health. Many women usually use the internet for several issues related to their pregnancies but they do not discuss the information with their health care provider.

Gao et al. (2013) stated that the 91.9 percent majority of women had access to the Internet in china. 88.7 percent most of them was being using it to retrieve health information or guidance and began from the beginning of the pregnancy. In Google searching two main points are searched: fetal development and nutrition in pregnancy that were the two most often mentioned topics of interest. More than half of the women regarded information reliable. The major important condition for judging the honesty of web-based material was that if the facts and evidences were consistent with information from other sources as well, the second most important principle was that if references were provided. According to his study most 75.1 percent of the women did not discuss the information with midwives, they usually retrieved from the Internet with their health professionals. The communal source to get information among Chinese women related to pregnancy was internet and the same source use in the western countries. Health professionals should be competent to monitor Chinese pregnant women to high-quality, web-based information and then take the chance to discuss this information and evidence with them during gynecological visits, consultations and childbirth education classes. Health care providers could recruit a discussion on what their clients have learnt or absorbed from the internet, as even though some information is evidence-based there is also a flow of misleading information.

According to Mustafa et al. (2015) write that healthy timing and spacing of pregnancy (HTSP) is a family planning intervention to help women to delay, space or limit their pregnancies to achieve the healthiest outcomes for women, newborn, infants and children regardless of the total number of children. It has been documented that parental outcomes and child survival can be improved

mainly by lengthening inter-pregnancy intervals. It was estimated that over one million maternal deaths were averted between 1990 and 2005 because the fertility rate in developing countries has declined and by reducing high parity births family planning is being contributing to reducing the maternal mortality ratio. But we can see that inter-pregnancy intervals among male partners in Pakistan or in developing countries have less focus, that risk the mother's internal health as well as the health of upcoming and previous children. On the contrary, birth to pregnancy intervals of less than 18 months are associated with risk of low birth weight, preterm birth, and small size for gestational age, and stillbirth. Despite the increasing awareness and acknowledgement about child's birth spacing is improving women's maternal and child health outcomes, there is little evidence on effective, scalable and sustainable plans for child's birth spacing mostly in developing countries particularly in rural areas like Pakistan. Moreover, there is a need to set evidences in creative ways to support program and policy pronouncement at multiple levels: from community to policy arenas of Pakistan. By authors findings tell that the majority spouses knew about some modern contraceptive methods, but the overall use of contraceptive was very low. Information and use of any contraceptive methods were particularly at low level. The reasons for not using family planning and modern contraception involved incomplete family size, negative perceptions towards contraceptives, in-law's disapproval regarding use of contraceptive tools, religious concerns, harmful side-effects and lack of access to the quality services. The majority couples preferred private facilities over the government health services as the later were refer to as derided. There is need for qualified female healthcare providers, especially for long term family planning services at health amenities instead of camps arranged occasionally. Addressing or recognized issues and matters around their affordability, their access, obtainability and sociocultural barriers about modern contraception as well as involving the men that will help

to meet the needs and requirement to ensure that the women and couples achieve their childbearing and reproductive health goals.

The reason why the interval longer than five years is less healthy is a little known. The researchers from the Demographic and Health Surveys (DHS) suggested that after five or more years of not having children, mother may lose the protective benefits of previous childbearing, such as the lessened risk of pre-eclampsia and eclampsia. Thus, mothers may be just likely to experience the health problems and issues associated pregnancy as first-time mothers and their children also could be just as likely to experience health problems or a higher risk issues that refers to death as first-born infant. Many women in developing countries suffer from reproductive health problems such as pelvic inflammatory disease and uterine fibroids and are less fertile. These women may become pregnant only at lengthy intervals and their higher risk for pregnancy complications could be due to underlying reproductive health problems, not because of longer intervals. According to above mentioned details it can be seen that maternal good health after pregnancy and child birth is due to not only the cares in every pregnancy period but also appropriate birth spacing of 3-5 years as the results suggested.

**2.2 Child spacing**

A study in Uganda by Blanc et al. (1996) institute relatively little evidence of negotiation among couples about child spacing births rather than about stopping childbearing altogether. Overall, only 39 percent men and 31 percent of women always discussed the timing of the next birth with their spouse, compared with 47 percent of men and 45 percent of women who have discussed that having no more children. But the reproductive life plan (RLP) tool is implemented in practice and explore the utility for patient counselling in primary health care hospitals, Andersson and Tydén (2019) conducted clinical study. They conclude that the RLP (reproductive life planning) is well implemented among the respondents and the majority considered it to be a useful tool. Almost all

respondents in survey reported a positive attitude towards the tool of RLP and the website of reproductive life span for counselling and their ability to use them in practice. The majority of respondents were agreed about implementation of the RLP, Use of the RLP also made it easier for midwives to support clients in forming reproductive goals, they give family planning advice that was 81 percent implemented, give advice about how to improve health before pregnancy and advice about how to preserve fertility. In Sweden, several midwives are also used to be motivational interviews with women when conversing lifestyle changes, which can explain or estimate their positive experiences of the RLP. While eastern women do not provide as such reproductive life plan for the sake of her own safety as well as for her children. Even we came to know that men do not support their women while she is conceiving or facing troublesome for her child. Uneducated women are not capable to handle gynecological problems that are prohibited and suggested by our medical care taker or by gynecologist, before pre-natal and after post-natal stage of baby birth nowadays. Men do not take interest in child spacing after birth of first child, they usually take interest in having sexual relation with their spouses to fulfil their desire.

Moreover, in the study by Stern et al. (2015) the midwives had an RLP (Reproductive life plan) booklet that is for help and assist them in counselling, which was much appreciated. The most common cause for not using contraceptives in between couples or one of the spouses either men or women was difficulty in obtaining and desire of more children. As the results showed that the socioeconomic differences among population did not affect the most currently used contraceptive choice i.e., condoms thought to be the best method. But the upper-class socioeconomic people are slightly higher in use of condoms amongst the women, the reason of it was birth spacing and their own physical health. The use of contraceptives reflects the positive attitude towards family planning, those women or men who did not use any contraceptive methods or

maybe switched from one form to another form of method either they are feared of its side effects or had health concerns. Analytically we observed that partners are uncomfortable to use any of contraceptive and they do not take care of hazardous diseases, that later may influence to couple's reproductive health. Although overall family size is comparatively homogeneous in Pakistan, women of more modern backgrounds seem to space their children more closely than traditional women. Age at marriage play a crucial role not only in determining the length of the first interval, but also that of subsequent intervals. An unexpected finding in Pakistan was that ever users of contraception had distinctly more rapid spacing of their births than never users. While complementary information regarding RLP can add easily to the website, the midwives suggested that it could be linked to the existing Swedish platform especially for health care counselling. Furthermore, a few midwives stated that some of women or couples have not used website even due to lack of time. But referring women to the website prior to the visit could be a time-saving strategy and can facilitate counselling. Mostly women want to wait for next pregnancy after experiencing a stillbirth, abortion or neonatal death but such women who live with children wish to wait for longer periods of time rather than those women who have no living children. There are also such women who prefer birth or next child spacing interventions led by clinical providers and for inclusion of their spouses. Many other influences on the family size and birth spacing were noted in the population that are interventions to promote birth spacing and improve maternal and neonatal health and it need to involve male partners and knowledgeable health care providers to be effective for child spacing and women health.

After study of Kopp et al. (2018) revealed that women face reproductive desires and challenges in birth spacing after experiencing poor obstetric outcome. Many women were afraid of marital conflict if they are not agreed with their husband's desire to try again for another pregnancy sooner than they

themselves desired for it, that is explaining gender imbalance in reproductive decision-making among married couples. Mostly women have sensed that involvement of their husband in birth spacing educational interventions would be helpful and would help them to realize the need to wait for longer periods between pregnancies, even with poor obstetrical outcomes. In developing countries, especially in Pakistan and India women face elders' demand for more children to fulfil home's noiselessness and women are indirectly compel to take care of their elders to stay in home peacefully. Some women try to avoid short-term pregnancies but their husbands do not interest to use modern contraceptives while having sex. Child birth spacing is little tricky for such couples who believe in cultural customs and do not obey modern contraceptives.

An international research has originated significant link between short birth intervals and the risk of infant mortality specially in developing countries, recent work of Molitoris et al. (2019) shows that when, how and where birth spacing matters for child survival. Their study formed several important conclusions about the relationship between baby birth interval length and infant mortality in under developing and developing countries persists even after applying within-family methodology by authors to account for unobserved heterogeneity among mothers. Authors found that if the birth interval length of child is below 24 months, the probability of dying is much higher and this pattern was extremely high consistent across regions of all over the world. There is no evidence founded for birth intervals longer than 60 months are associated with high chances of death. The major improvements in the probability of survival of infant can be seen from increasing space until at least 36 months or even continued to decline at intervals longer than 48 months. The findings from researcher's international comparison showed that the significance of birth spacing as a determinant of infant mortality decays at more advanced levels of development. As WHO also recommended for child spacing

between three and five years apart that could helpful for the health of infant and mother. Apparently educated experienced women and men are in favor of birth intervals for the betterment of their economic position as well as to provide better basic needs to their alive children. Some educated newly married couples take such guidelines for their reproductive family planning and child spacing from their well settled families to spend happy life style or to have ideal family in future.

Studies shows that when the length of interval or time between two births is less than two years, the new born is likely to die on average or twice in infancy as compare to a child who born after a long birth interval. Short birth interval adversely affects the child's survival chances for at least the first four years of life. The babies who born after a three-to-four-year interval have the best chances of survival as stated by UNICEF. According to studies it was originated that the women with 27-32 months child birth spacing were founded less likely to encounter third-trimester bleeding (after delivery bleeding), placenta previa ( when the placenta is in lower uterus and bleeds), placenta abruption (when the placenta bleeds regardless of location), premature rupture of the membranes (tearing of the amniotic sac surrounding the fetus), anemia and puerperal endometritis (uterus infection after pregnancy) than those with 9-14 month-birth spacing. Moreover, the women with 27-32 months birth spacing were less likely to encounter pre-eclampsia (pregnancy-induced hypertension and high levels of protein in urine), eclampsia (convulsions or seizures with pregnancy-induced hypertension and high level of protein in urine) and gestational diabetes mellitus (high level of glucose in blood during pregnancy) than those with 69-month birth spacing. It can be concluded that the child birth spacing relates to the health of mother and newborn infant, and the birth spacing should be of appropriate time period. Such curable diseases are often observed in developing countries but many couples in under developing regions do not show concern about reproductive health problems, that off course hurt themselves and their

children also. Hypertension, insomnia, diabetes and depression are common diseases among women in Pakistan because of their spouse's careless attitude and her own weak immunity. Women do not think about their selves during their pregnancy circle, they are compelled to provide pleasure, happiness and peaceful environment to whole family or in-laws. Some women also want to have more children without a two years space between children, so they do not believe in child spacing and modern contraceptives, they just believe in God and destiny that it is decided how many children we would have.

**2.3 Family Planning**

The Family Planning (FP) is a vital component part of Sustainable Development Goals (SDG) and it contributes directly to SDG targets. In Pakistan, use of contraceptive has remained stagnant or inactive from the past 5 years. This change has been seemed very slowly when it was compared to the FP2020 pledge. The Pakistani project Sukh initiative was perceived and implemented to alleviate these challenges or hurdles by providing accessibility to quality contraceptive methods in some of underserved areas of Karachi, Pakistan. A recent study was conducted to understand the experiences and perceptions of men and women towards acceptability and use of contraceptive. Furthermore, Saleem et al. (2020) study was explained the need for trained and qualified male and female healthcare providers and well-established health facilities as well along door-to-door services, that would be very helpful for spouses' family planning decision. Use of Contraceptive may help individuals and couples to realize their basic need and right to decide freely and responsibly if, when and how many children to have they should. We can see mostly the couples who have fewer children, they can provide good education and health facilities to their children, as it gets affordable to them easily. As we examined that the use of contraceptive methods are 5 percent in Pakistan (34 percent by 2017-18) according to Pakistan demographic and health survey (PDHS) and 35 percent in 2012-13. This change of using contraceptive has been slower when

compared to the FP (family planning) 2020 pledge-55 percent CPR and 2.6 TFR estimated by 2020. The study informed that men and women both were informed about FP procedures but women were more conscious or aware of FP information. By studies we came to know that mostly women suggested that the Sukh initiative should bring some strategies for men that can help men broaden their perspective towards FP, the men somehow feel left out from the FP programs. Therefore, male participants have expressed deep interest in initiatives for men in their communities that would cater to their Family Planning needs. After study we conducted that men not only think and do care in almost all the FGDs mentioned that FP use is most beneficial to their children and family in terms of the provision of food and education, but now they are equally concerned for the health of their women due to repeated and closely placed pregnancies. The reasons for such change in behavior against large family size is related to low financial resources, increasing interest in educating children and health concern of spouses. Regarding the contraceptive benefits females believes that birth spacing was beneficial for both mother and child. The study participants stated that condoms and pills were methods of child spacing and FP that was considered to be the most successful, easiest to adopt and best method for females from all the social classes. The OCPs method of contraception by females from upper and middle class was reported as greatest health side effects. Some of respondent females never discussed contraceptive methods to their husbands but with their doctor and family friends and get information from media as well. Whereas some females according to the author are practicing contraception after a joint approval by both husband and wife, but some husbands disapproved the use of contraceptive and they do not take care of his wife's reproductive health care. By Saurabh Shrivastava and Saurabh, (2012) explained results showed that a country which is culturally similar to Pakistan, over all the most popular choice condoms was not match up or not used according to the results from a research done in India. Copper T was

reported to be the most preferred method in India. But there are many people in subcontinent who often use condoms but some are not comfortable to use any contraceptive, they believe it could leave harmful effects later in reproductive system. In contrast De Irala et al. (2011) favored use of contraceptives to more developed countries were found oral contraceptives, that were most popular in European women, and in Germany 54.3 percent, France 50.5 percent and Sweden 34.6 percent for oral contraceptives which is in consistent with the results of our study which also reveals that oral contraceptives are the most heard contraceptives as well in Pakistan estimated 84 percent, while study done in Sudan by Umbeli et al. (2005) exposed that contraceptive pills were the most commonly used method among couples. To conclude synthesis that the FP has now become a common topic of discussion, so the existing pressures of communal norms, religion and families are changing and paving different ways for small family norms. The study recognized that the trained and qualified female and male healthcare providers and well-established health facilities alongside door-to-door services are needed for couples in Pakistan and in the world also. As taking pills for not having or for conceiving child is common practice in Pakistan either it suits to couples or not, they only focus on their desire regarding family planning.

Use of high-quality contraceptive services are important for women and couples to enable them either they want number of children or they do not want more children. These are useful for avoiding unplanned pregnancies, births, and abortions. Additionally, modern conceptive use may help many men and women to prevent from cure disease like STIs, HIV as stated by Prevention gap report (2016). The researchers stated that use of modern contraceptive focus on reproductive biology, correct use and evidence of efficacy and these contraceptives are well-defined for sterilization, intrauterine devices (IUDs); hormonal implantations, injections, pills, male and female condoms, modern fertility awareness methods like such methods that include a defined protocol

for use, such as the Standard Days Method, and emergency contraception pills. Analytically use of modern contraceptives like female condom is not in use in Pakistan, injections and emergency contraceptives use rarely. Modern fertility awareness is less in eastern Muslim couples, they use to have believe in God for family generation and reproductive matters as well as use home remedies and oral contraception.

When we see all around the world since 1980s the modern method of contraceptive is increased progressively in Africa, Asia, Latin America, Europe and in the Caribbean. Department of Economic and Social Affairs (2015) examined that more than half of all married women in the world and in region were using modern contraceptive methods, excluding in Africa where it is estimated at 32 percent. Approximately nine out of ten married couple rely on modern contraceptive means in the world but in Africa injectable tools are more common among married couples and female sterilization is more common or useful in Asia, Latin America and the Caribbean.

Family planning is more crucial from last some decade; Ali et al. (2012) stated that after analyzing results by recent survey in nineteen developing countries 38 percent women on average has stopped using reversible methods of contraception in the first year of use. The reason behind leaving are side effects or several health and 20 percent women discontinued reversible methods of contraception. It is evident that not only women also men face trouble after using reversible methods of contraceptive, so they avoid to take health risks. Couples do not find good caretaker in developing areas, rather responsible, careful and sincere doctors or midwife can be seen in private or expensive areas. Government do not have a strategic initiative plans or team to guide newly married couples for family planning. Even state introduced Moto of (Bacchy do hi acchy) some years ago, but it is not applicable properly in Pakistan because of some religious and cultural customs which are moral towards them.

## 2.4 Women Health

Women always need health care and approach the health care system more than men. Although this is because of their reproductive health and sexual health needs. Women also face more long-lasting and curable non-reproductive health issues such as cardiovascular disease, STIs, hormonal implantations, cancer, mental illness, depression, diabetes, PCOS and osteoporosis. Women are the main part of any state to whom population can grow and country can develop. According to studies there are many different systems or plans to secure women's reproductive health as well as her physical health that also affect child and her future. Family planning, contraceptives, child spacing and safe sexual intercourse can safe women health. But status of women in Pakistan is poor. Women have many problems almost in all sectors of life, from corruption to least education, from career to health women have minor right in all stages of life.

Women health after marriage may depend on planning. Family planning is one of the common causes to get healthy reproductive life ahead among couples. According to Saleem et al. (2020) the available Family Planning services in an area in relation to cost and quality of services of contraceptives can found. Nearly in every FGD, men's opinion was that the use of condoms is easy, free of side effects and easily available and other methods such as IUCD and implants from the private sector are expensive and treatment of side effects gets even more expensive, and then there is waiting, travel and cost of transport also included as a barrier for use of FP methods. Women expressed their concerns about the affordability of the family planning methods, like cheaper methods are preferred such as condoms and pills. Women also mentioned side effects such as feeling of general tiredness, breakthrough bleeding, bloating, amenorrhea, weight gain, low BP and weak eyesight are related to injection, IUCD and implant as the main deterrent for their use. In case of any side effects, they discuss with private health worker or visit government-run facility. Only

10% of women might be using injections because of its cost and side effects. It is important to educate men, women, Family Planning providers including CHWs about the side effects of FP methods and their management. The women also should know about the side effects and also their management of long-acting family planning methods. Men and women both have complained in several interviews about the bad attitude of the staff at public health facilities. The bad attitude of governmental staff and administration makes them compel to consult the private sector which is more expensive but the role and attitude of the provider is good, surroundings are clean and the method of choice for checkup is also available. Spouses responded by saying for ideal FP services that services should be closer to their homes and should be free of cost or of minimal cost, there should be proper counseling, staff should talk with respect, should show caring attitude, be cordial and have a soft demeanor. medicines should not be expired, there should be less waiting time and side effects must be treated free of cost. Women are supposed to taken care of all the household chores so ideal timings for facilities mentioned were in the afternoon from 3 to 4 p.m. Men also mentioned while interviews that they are on job all day and are back in the late afternoon or early evening, they should have separate clinics in the evening, and men should talk to male, they also mentioned that having informational pamphlets that they can view it in their own privacy.

Zuberi et al. (2015) explained that awareness of contraception among married couples was found lowest in the lower socioeconomic class. Whereas the elite classes were using a high percentage of contraceptives. Most commonly reported reason for using contraceptives was birth spacing and not wanting more children as the ideal family was completed, stated by females. In Pakistan there are different type of families, some elites believe in their status and try to make sure that they could have less children as they want more investment to maintain their class in society. But some elites do not believe in such mentality, they use to believe in their religious and cultural customs and reproduce more

children for more working hands or by thinking that they are blessed by God. We can see Pashtun families have much more children either they are elite or not. They do not believe in modern contraceptives and family planning. They mostly use natural methods for reproductive system and for the safety of women's health.

But this study clearly illustrates that the overall use of artificial methods of contraceptives is higher rather than the other natural methods in this country as the people are using natural methods like withdrawal and abstinence. The general opposition towards contraceptive methods is minimal the decision of not using is based on some other factors and not the low awareness level. Awareness and knowledge for contraceptive is really important because lack of knowledge certainly affects a women's choice for the use of contraceptive. Amazingly mostly population had heard about OCPs but its utilization was very small as upper and middle socioeconomic group, they considered it a method with greatest side effects. A previous study by Marvi and Howard (2013) done in Pakistan, exposed that health care concerns and side effects were main hurdles in the way of using the modern methods of contraception that is claimed that women may not be able to get pregnant and it can be classified as a side effect. This definitely highlights that the governmental state needs to remove the fear of females and couples regarding the hurdles and side effects that are associated with the use of contraceptives. This higher fertility attitude is attributed to the indigenous culture in favor of large families, as in Pakistan it prevails in many cultures. It also agrees with the Islamic religion ways which totally rejects the concept of limiting the family size, and Muslims do not challenge or agree to go against their religious ways.

Socioeconomic dissimilarity seems to affect the choice of contraceptive tools globally too since in Sudan, a resource poor country was mostly using OCP's like other financially stable and strong countries like Germany, France and Sweden. The socioeconomic status mostly depends on the man's source of

income and generally males are the more obvious care takers of the family. Thus, family planning campaigns or services should be equally directed or to be absorbed towards men and women. But some positive responses estimated towards contraceptive usage and socioeconomic disparities did not affect the contraceptive usage as much as it was expected from the gap. However, keeping in mind the Pakistan's heterogeneous culture in mind that is imperative not to forget that sociological and cultural variations may contribute to the variances in the choice of use of different contraceptives. If the lower socioeconomic groups do family planning, the education campaigns are focused for them, the contraception prevalence rate will be increased and this will lead to a consequent fall in population growth rate of Pakistan. It is imperative that such educational campaigns are carried out for middle and upper both socioeconomic couples in Pakistan as the high population growth is the root of most of the problems and hurdles faced by Pakistan.

Some studies show that short birth intervals do not give chance to mothers to store her nutritional reserves after childbirth, after conceiving next child and after breast feeding, that affects mother's energy, weight and body mass index. Same issues observed in Pakistani families, if mother have their next child while they are breastfeeding to their child, they are often less able to produce breast milk for previous child. When children are weaned too soon so their growth suffers, they are more likely to suffer from diarrheal disease and skin infections, and they are thus at a great risk of dying. A mother's poor nutrition in turn affects fetal nutrition, growth of child and increase risk for survival of infant. Shorter intervals of childbirth associated with an increased risk of premature birth but some studies have showed no such association. Both premature delivery and fetal growth retardation may result in less weight baby birth, who are at greater risk of dying in infancy. Women need to rest from two to three years between childbirth. Islam also permits temporary child spacing that defines the specific time between childbirth as 30 to 33 months.

## 2.5 Sex Preferences

Son preference is the predominant factor in developing countries especially South Asian countries including Pakistan and its effect is most noticeable when the fertility is on transition. The desire of more children or preferences of baby boy is the most common reason for least utilization of contraceptives. Hence, if the aim of Government of Pakistan is to encourage citizens for having a smaller number of children per family that also result in improving mother's health, attention of couples and clinical caretaker is needed to be paid towards promotion of child's birth spacing methods that do not affect the fertility of a female.

In Nepal (a country in South Asia) where the fertility has declined and the son is valued highly.

Rai et al. (2014) examines the parent's gender preference for children, it effects on fertility, reproductive behaviors and it is necessary to reduce son preference for the health and well-being of children and women. The high sex ratio at last birth for those who have decided to stop child bearing or used permanent contraceptives proposes the childbirth-stopping behavior was determined by son preference and can be inferred that the son preference activities exist in Tharu community which is in Nepal. But this might not be completely attributed to the son preference as the sex ratio at birth in human populations is fundamentally a biological constant and for every 1000 males born, there will normally be between 950 and 975 females, nevertheless son preference and child rearing practices are favoring survival of male children that could be determinants for this skewed ratio. In Nepal and in other Asian regions son preference has also been verified by other studies too and higher sex ratio signifying the son preference behaviors that has been seen in analysis of data from Nepal demographic and health survey in 1996, 2001, 2006 and in 2011. There has been important and significant fall in the number of girls as compared with boys among second-born children where the firstborn child was female.

Son preference for the offspring also ranges according to cultural contextual background even within the country or in other countries as well. It is observed that married couples claim to contraceptive practice for antifertility is being affected by sex structure of the children, having number of children and sex of the last children suggests to the parents' reproductive behaviors towards more or less children influenced by sex preference for infants. Pakistani couples have influence of their cultural morals, they usually focus on baby boy not on other circumstances like mother's health, alive children's rights. Even mostly couples tackle pressure of their family and society for having their first child, it would be male and if it would not be male then couples always try to have short interval pregnancy for having male child. This is risky for alive and upcoming child, as well as for the health of mother. Families in Pakistan feel stronger to have male child, because men consider as superordinate, bread winner, decision maker and head of the home for life span.

It is implying that education, motivation and awareness might be significant factors for the exercise of contraceptive use when coupled with existing free family planning services that women can have enough money to afford contraceptive tools at minimum cost. It has been examined that gender preference for children affects reproductive behaviors and health in other countries as well. Patterns of contraceptive usage are concluded to be indicative of a specifically strong preference for sons in Nepal, Bangladesh, India, Egypt, Jordan and Tunisia. In Nepal usually a woman who have all sons are five times as likely to use contraception tools or methods as the women who have no sons. Women are partially unlikely to adopt sterilization method if they do not have an adequate number of sons. We can examine that son preferences influence fertility differentials for both men and women, and it is examined that among couples a desire for number of sons is very common in South Asian countries. The birth spacing following male child is (3.01 vs. 2.71) that is longer than that following female child. It suggests that the couples want to complete the ideal

family by planning another birth as earlier that could be possible after the birth of daughter whereas after the birth of son. Couples take longer time usually to plan another birth. If an additional drop in productiveness of women is achieved without an equal decreasing in son preference, the use of sex-selective abortion is likely to rise, stated by Leone et al. (2003). Contrary, Pakistani couples cannot take decisions by their own regarding child spacing and for their desired ideal family. Some usual plan to get son and some plan to get more children by believing on their destiny. Women have minor role regarding child spacing biological preferences and family planning. It is observed that women have no right to take care of her child, to decide his/her name in Pakistan. Male partner does not take care of her they usually leave her in such conditions.

Other studies have already shown some of the troublesome effect of sex selective abortion which can led to excess males. Even the health care providers have faith in that illegal sex selective abortion is growing which may lead to serious abortion complications among women. It is also examined that some women compel to abort their female child because of the pressure of her husband and from her husband's family. They demand for son and believe in female childbirth influence on their cultural customs and progressive matters. Mostly men blame on women if they have more daughters rather than son. Even research claimed that only men's cells influence on biology of each child either it is son or either daughter. But it is very common fatigue for women to produce son for husband, for his family and for society for the sake of her own peaceful life. There are also some men, who believe in destiny and scientific methods, and they love to have daughters but scenario of our society and culture compel to them for having more son except daughters. There is complicated association of sex arrangement and sex of the last child with reproductive behaviors and fertility purpose as size of the family, educational level, age of the couples also play dynamic role to determine reproductive behaviors of women and men also, that could outcome of decreasing trend of fertility and small family norm

pressure in the society. After observation of such type of issue in Asian countries, there is requirement to reduce gender preference for children as proved by family planning practices that is inspired by fertility choices, practices of shorter birth spacing following female child that could harm the health of mother as well as the health of children. This will also decrease the mental illness and stress of couples raised due to dilemma of the small family norm and particularly son preference in the society.

The findings of Blau et al. (2016) about son preferences in United states is the fertility do not propose that son preference on part of natives overall, whereas they examined some evidence about those immigrants that having a girl increases future fertility rate for them, mostly for such immigrants and second-generation people from the countries where women have a lower status in their society. Perhaps sex preference can assist as another substitute choice for physical exercise of son preference nearly a decade ago, studies advised that the United States might see rises in such actions only because of the technological advances or techniques for sex selection. Therefore, they have examined the impact of first child sex on the second child sex among those couples who have at least two children, and they found that the impact of the sex structure of first two offspring on the sex of third child among those couples who have at least three children. Overall, they examined that there is no significant evidence for son preference through sex selection for citizens and for immigrants also collectively. The ratios for boy and girl preference estimated between 1.034 and 1.058 by authors. The association between the sex structure of past and future births among native couple seem like to be constant with a genetic tendency of upcoming children to be of the same sex as prior child. It is stated that for natives, that the second child is somewhat less likely to be male if the initial child was a girl rather than if the first child was a boy then second child is more likely to be boy among all married and other women in United states. Similarly, if the first two children were boys then the third upcoming child is more likely

to be male but if the first two children were girls or mixed then third one child is more likely to be female. Somehow the differences of having girls or boys are not significant across the family types. There is no evidence of sex selection among citizens overall from 2008 to 2013. Furthermore, the variances in the sex ratio for immigrants assumed a male first birth vs. a female first birth that are statistically significant. The findings for immigrant couples also do not advise sex selection for their second child and they are more constant with genetic tendency for families with a first female child and then to have more female children. It is examined that sex preference ratios are lowest for those immigrant couple who have two girls but they are again constant with genetic arguments. Such immigrants who have two boys are relatively high for sex selection rather than with those who have one boy and one girl. But, the pattern for the third child in immigrant couples does not propose to sexual choices either for diversity or for boys. Perhaps most importantly after findings it is examined that a female first child decreases future fertility among native women as well as among the aggregate population which are immigrants and pooled natives. This finding may vary from past studies which found in time period of 1960s to 1980, it was recognized as having a first baby girl led to higher fertility levels among the aggregated population in United states. As in time period of 1960-2000, it has examined that first child girl may rise the probability of female headship among natives and the aggregate population. But all such estimated effects have decreased by the time. It is founded that among native families who have first child female raises the fertility level and upon disaggregation by education with a high school degree also has a strong positive effect on female headship. Thus, some of evidence proposed that son preference in fertility decisions remains for this subgroup of natives, which is now encompasses a relatively small share of married population particularly. The findings for fertility among natives are son preference has decayed over the time and some evidence claimed that women did not share men's preferences

regarding sons. Therefore, changes in fertility may reflect an increase in women's bargaining power in the family, perhaps due to increased participation in the female labor force and relative wages. Another possibility is that the cost of raising girls has increased and the fertility of son has increased significantly. This is a good idea in view of increasing proportion of the girls in education. There are positive effects as estimated by the native people for female first birth on female headship among immigrants. However, in contrast to native group authors find that for immigrants having a first-born baby girl significantly increase future fertility of women and are constant for son preference for fertility for immigrants. In addition, such fertility preferences are strong for immigrants from such countries with a lower status of women and also appear to carry more than the second generation. It is also estimated that the effect of having a girl on female headship remained stronger among first and second generation of immigrants from such source countries with a lower status of women. Overall, we can say that the sex selection or preference for sons looks diminished among US natives and also sex selection among native and immigrants have not found as much but it could spread among the broader population of Chinese, Nepal, Korean or Asian Indian origin.

Gender inequality is a crucial topic of concern from many decades. Studies by Wang et al. (2019) empirically measures the existence of son preference and eldest son preference in China, from the perspective of an individual's educational attainment. They used the data set of China Family Panel Studies 2010 for their findings. Authors discover that sons obtain more education rather than daughters, and the gender education gap for rural residents resulted greater than the residents who live in urban areas. It is estimated that the education obtained by sons is significantly higher except daughters' educational level, either sons are elder or younger than daughters. There is no significant variance between the eldest and younger son's education. The gender education gap narrows and expands over the time as the number of siblings increases. But in

Pakistan it is also examined that parents create difference in educational attainment for their male and female child. In rural areas females not even have right to get primary education. They usually invest costs for son's educational expenditures and other living expenses also. It can be seen that the people who live in semi urban regions in Pakistan, desire for elder son and his perfect future than daughters. There are several stereotypes believes for daughters in families that is why women mostly degrade and people make them feel minor or dependable on others. They cannot desire for daughter because of the cultural customs and society morals.

In parts of Asia, the South Caucasus (a region at border of Asia and Europe) and the Balkans, which is a geographical region of south east Europe. As authors Kumar and Sinha (2020) stated that sons are strong enough to trigger momentous levels of sex choice that consequently resulting of the additional mortality of girls' rate and twisting child biological ratio can seems in favor of boys. It is estimated that every year 1.8 million girls fell into "missing" list because of the extensive use of sex selection practices in these regions. The unescapable use of such practices is reflective of unusual injustices that girls face directly, and also would likely to have negative implications for efforts to develop women's status within the upcoming future. It is examined that governments have engaged for direct measures such as prohibition of prenatal sex selection technology and provided financial incentives to such families who have girls. In fact, bans on the use of sex selection technology may unintentionally get worse the status of the individuals, whose plan to protect and financial inducements to families with girl's proposal only for short-term benefits at most. There are also other regions where son preference does matters or for some regions this concept lessened like South Korea sex-selective ratio went back to normal levels in the mid-2000s, after nearly two decades of significant elevation but at that similar time, the sex-selective ratios at birth started a swift and dramatic increase in Vietnam. There are general terms that

are drivers of gender inequality and children sex selection in Asia, it is classify that factors underlying the sex preference, countervailing social forces, public policies and catalyzing its implementation. Although, both countries explained some steps to recover gender equality and status of daughters. But only government of South Korea prodded by civilian society. In many Asian countries sex ratio at birth remains extremely skewed because of son preference or sexual selection. However, the ratio of son preference in South Korea has decayed, that was beginning in 1990s but reached on the natural range in 2007 by Choi and Hwang (2020). They examined the variations in child gender effects on the fertility and parental investment during time period of lessening sex ratio at birth and it is observed that gender discernment on the extensive margin of fertility like sex-selective abortions by couples and son-biased stopping rules have almost disappeared among recent partners, who take interest in son preference rapidly. Even though parental inputs on the intensive margin for their sons is to invest more for boys except girls. Authors estimated that boys obtain higher expenditures on expensive private academic education and other needs, who have mothers with smaller number of hours of labor supply and they employ fewer time on household chores comparatively girls. But in South Korea evidence proposed the weakness of son preference and gender gaps estimated narrowed substantially over the past two decades. The wish for male offspring is widespread in India, even people believe that son preference affects fertility behavior and intrahousehold allocation of resources in family and in society as well. By economic theory it is predicted that gender discrimination is less in wealthier households except in poorer place. But in Indian context demographers and sociologists have claimed in the Indian context that wealth can exaggerate bias at worse level. According to statistical models of son preference, it is assessed that higher absolute wealth is strongly related with lower son preference except those who have relative wealth.

The studies of Jayachandran and Pande (2017) compares the child height-for-age in India and Africa. India observed strangely as high rate of child stunting and intrafamily allocation decisions are as a key factor. Authors found that India's children height disadvantage emerges with second-born children and increases with birth order. Furthermore, children decline faster because of investments in succeeding pregnancies and higher birth order in India rather than Africa. They noticed a specific significant mechanism that regulate India's abrupt birth order slope in child height, that is eldest son preference among couples. An important factor of son-biased fertility stopping directions link eldest son preference and the observed birth order slope in child height. It is estimated that comparative to Africa, roughly two-thirds of India's child height deficit by India's sharper birth order rise. And one-half credited to eldest son preference in India. Malnutrition is ultimate obsolete problem in India but still it is seeming like decades away from this achievement. Moreover, inequalities in the birth order persist over time. It does not seem that the preference of Parents for their son and unequal investment in children is decreasing. Even wealthier families in India show an abrupt birth order rise except inferior ones. If the problem of chronic malnutrition is solved in wealthier people then other important human capital investments remain irregularly allocated within families. Son preference cause women illness sometimes because of less intervals and high rate of abrupt birth order rise. Results show that morbidity and mortality among adult women in India held and explained by son preference. According to Milazzo (2018) examined that those women who have a first-born baby girl have lower survival and it is observed that having a first-born girl results into fertility behaviors medically known to upset women's survival. Even the women who have a first-born baby girl, those have severity of anemia. All these outcomes are severely worse for women with each successive female birth. So, we can say that these channels can explain reasons behind the missing mothers with first-born girls regardless of discrimination in

allocation of food or iron supplements. However, missing mothers may have severe physical domestic violence, that would increase after birth of first baby girl in South Asian regions.

Son preference applies a strong impact on contraceptive and fertility decisions in many South Asian countries. Channon (2017) observed that Pakistan's fertility rate remains high but use of contraceptive is low for son preference especially in illiterate people and in rural areas. Equivalence development and choice of contraceptive method are gradually connected with the sex structure of children. In Pakistan authors found that many couples desired for two sons at least and also desired for one daughter. Studies suggest that 19 percent higher the occurrence of modern contraceptive use among parous women in the absence of son preference have estimated in 2012-2013. The use of permanent method of contraceptive was very low among those women who have no sons but use of contraceptive increased meaningfully in those women who have with of sons. Results suggested that the tie between number of sons and use of temporary methods was weak, whereas son preference had little relationship to use of traditional method among couples in Pakistan. The connection of son preference among parity developmental procedures and modern contraceptive use has become stronger, especially in developed urban areas of Pakistan. It can be difficult to sustain the transfer of fertility unless there is lack of preventive behavior and discriminatory use. Although the people of Bangladesh and the state of West Bengal in India have discussed common cultural practices with Ghosh and Begum (2015) about usage of contraceptive and son preference interest. They have different attitudes towards contraceptive adoption and practice. According to authors the use of modern contraceptive methods amongst women and couples of the two Bengals were changed from each other. The usage of natural technique significantly observed higher among women and couples in West Bengal as compared to that of their counterparts in Bangladesh. The findings show that greater trust on natural methods among women of West

Bengal is connected to their higher preference for sons as compared to that in Bangladesh. Analytically in western developed countries women and couples have no concern for having son or daughter, even their family generation ties usually weaker. But in eastern developing and in under developing countries son preference or childbirth is an essential importance in families.

In India, son preference is also a crucial dilemma, since 1980s lots of female are supposed to abort their fetuses because of an abnormally high rate of infant girl mortality. The reason behind abortion of women fetuses is preference of son.

According to Robitaille and Chatterjee (2018) research examines that decisions for not having baby girl or for abort woman's fetus is based on child's mothers' and fathers' respective roles. By means of the third National Family and Health Survey (NFHS-3) data of India, it is demonstrating that abortion regarding sex-selection is most commonly use among couples, if both spouses prefer sons or if only the fathers prefer sons, but if only mothers prefer sons then sexual selection is ignored by men usually. It is observed that not only in India but in other regions mostly couple prefer son and are sex selective. The cultural customs and morals influence intensely on couple's mind set, that is why they use to give happiness their elders as well by giving them sons. Many parents stated that we prefer son because he can construct career or later can take care of his parents for life span. For daughters it is stereotype that daughters are not our home's part for life span they will leave our house for another family then why we should invest on her or why should we provide her higher education because in the end she will supposed to do all house chores. Daughters are home maker for her husband's place, they cannot stay with us for whole life. Such type of mind set parents have in their cultural customs that is why mostly parents try to reproduce more son as they will protect them in their life span. There are also some parents who do not believe in such type of stereotype they

believe in "all human beings are equal", they try to make their home on basis of equality and equity for socialization of their children.

Pakistani couples prefer for consuming more sons rather than daughters. Son or daughter existence may influence on fertility and contraceptive conduct in Pakistan. According to the studies son preference has turned more powerful association with the practice sex preference of continuing to have more children until couples have reached to their wanted number of sons and daughters, from the past two decades. According to the findings the determination of son preference may undermine Pakistan's capacity to encounter its development goals which also include the transition to lower fertility rates. Whereas authors have recognized a strong sex preference for especially sons in other parts of Asia, China, India and Nepal. Some studies have discovered that the level of son preference existence in Pakistan and a variety of social and economic factors cause to get importance towards son preference. It is believed in Pakistan or in other Asian regions that inheritance passes and shift by existence of male children or father. People believe that the payment of dowries for girls arrange by male homeowner or bread winner. They can show themselves financially burdensome and on the other hand women's limited labor force participation frequently prevents them from contribution of family income. According to estimated ration from PDHS, people desired to have different number of children including son or daughter. Their desire for ideal family and for more children ratio was highest among those who have no sons. In Pakistan women idealize their family with four children in 2012-2013, and 62 percent women were estimated for having more children because they had no sons, they were interested in having sons. Furthermore, 24 percent of women were those who have four sons but desired for more children including daughter. So, it seems that preference of sons in Pakistan prevails and number of children depends upon the use of contraceptives and fertility rate. The link between son preference and contraceptive behavior measurement based on usually four

categories like none, temporary modern method such as any modern technique except sterilization, permanent modern technique and traditional technique. It is examined that contraceptive use may differentiate significantly because of the number of boys and girls that parents have. Use of all contraceptive techniques was estimated lowest among those women who had given birth only girls or daughters. According to recent estimated data in Pakistan such women who have three daughter and have no sons were not interesting to use modern or any traditional contraceptive technique. On the other hand, such women who have three sons and no daughters were likely to use contraceptive techniques. This disproportion has grown even at broader level in Pakistan when comparison of women with four daughters and having no sons to those women who have four sons but no daughter. Total estimated ratio of the prevalence of modern contraceptive is 19 percent higher among those women who have given birth to daughters in 2012-2013 in the absence of son preference. We can say that many families are gradually constructing reproductive choices in Pakistan that mostly based on the number of sons they have and desire of ideal life. While this reproductive trend of having sons disturbs Pakistan's capacity to make its expected transition for lower birth rates and meet other developmental targets. Pakistan can generate refining access to reproductive health care services for the development of such strategic goals and plans by which it can address that what are the basic causes of son preference among families or in couples, as well as the try to abolish the unfair gender biasness and norms that maintain significant perceptions in society, such as the sons are more valuable except daughters.

**Assumptions**

1. Researcher assumed that women reproductive health is a tragic situation among Asian people. Families or couples are somehow conscious about

women health, but some are not regarding reproductive health practices and issues.

2. Women empowerment regarding child planning or their reproductive health is somehow better than before, but there are also such families who do not focus on women health regarding their reproductivity.
3. Furthermore, women consider as depended, dowry burden or subordinate member of family in Pakistani societies. Son is preferable in Asian regions than girls, women are pressurized to produce more sons than daughters by their partner or relatives.
4. Child spacing is not common among couples, but some urbanized and well-educated people show concern towards it to get their own ideal family size timely. Communication gap regarding reproductive health of women is common among married couples because of family rules and pressure of having children.
5. Asian communities like to have more sons for the betterment of their socio-economic status, for protection, power and for future development of kin. Fertility rate is now increased among educated women because of late marriages so they usually prefer less but quality children to complete their ideal family size.
6. There are some mental, physical reproductive health risks among women like body shaming, appearance anxiety, abortions, eating disorder, sexual dysfunction, stomach reduction and chronic health problems which can easily be seen among today's married women for having no kids, more kids, no sons or more daughters, and by socio-economic pressure.

# Chapter no. 3

# THEORETICAL FRAMEWORK

### 3.1 Objectification Theory

Objectification theory proposed by Fredrickson and Roberts in 1997. It is a framework for understanding the concept of women that women are consider as an object in others' mind and they perceive it. The experience to be a woman in a culture is body shaming and shaping by which women is inspired. The concept of theory suggests that girls and women are socialized more than boys and men to internalize an observer's point of view as their own primary view of their physical selves. The meaning of to be an objectified is imposing a social meaning to being a female that explains how to use your body to show shaming and its shaping according to the desire of society, and then treats you according to women's physical appearance. Rae Langton further added properties of self-objectification approach that is the women may treat or identified in different categories with their body or with body parts, that is why women perceive to reduce their body size. Women judge by a person primarily on their looks or appearance for others is refer to the property of appearance reduction. Furthermore, society is supposed to treat a woman as a silent person who is not permitted or capable to speak for her own life, right and prosperity.

If we see the concept of dehumanization and objectification, that is linked with physical appearance, body shaming and shaping of women and the objectification is further linked to the societal demand regarding women who is consider as an object or to appear something different, special or to acceptable for the eyes of others. Objectification theory suggests that girls and women are typically socialized to internalize an observer's point of view to their physical selves or body shape and that can lead to habitual body monitoring, which sometimes increase fatty, chubby, less attractive women's chances for shame and anxiety, decrease chances for ultimate motivational states that weaken awareness of internal bodily states. The effect of objectification on women extends beyond the women's negative perceptions and thinking. Accumulations of such practices may increase mental health risks like depression, anxiety,

health dysfunction and eating disorders that excessively affect women's body shape and then they feel anonymous among people of society. Objectification theory also highlights that changes in these mental health risks among women appear to arise in step with in their life long planning and in the female body. Psychologists understand the ways of contextual factors such as women physical objectification influence women's lives and enhance the problems if they are not suitable or look good to people that bring them to therapy and psychologist try to manage their mental health problems, cope up with women's psychiatric problems and try to manage counseling periods to resist physical objectification experiences by society. In addition, it can be seen that psychologists are encouraged to observe diversity and oppression issues under patriarchal system at interpersonal, environmental and institutional levels. They try to advocate social justice for less attractive, fat or body shaming women problems in communities.

### 3.2 Application

Objectification theory applies in our society that people assume many women are physically objectified by society and used as an object to be valued for its use by others. When a woman's or female's body or body portions are singled out and separated from her as an individual and she viewed as physical object to male or men, then physical and sexual objectification occurs by patriarchal society because of the appearance of body shape of women. Theory also suggests a mediation model that explain how self-objectification cause mental health risks of women because of the negative psychological outcomes from society. More specifically, self-objectification may arise women's anxiety about physical appearance. Like fear about when and how women's body will be looked in front of people and how it is evaluated, that decrease opportunities for highest motivational conditions among women and reduce awareness of internal feelings of their body like hunger, stress and stomach reductions among women. The increased body shame chances among women are like the emotion

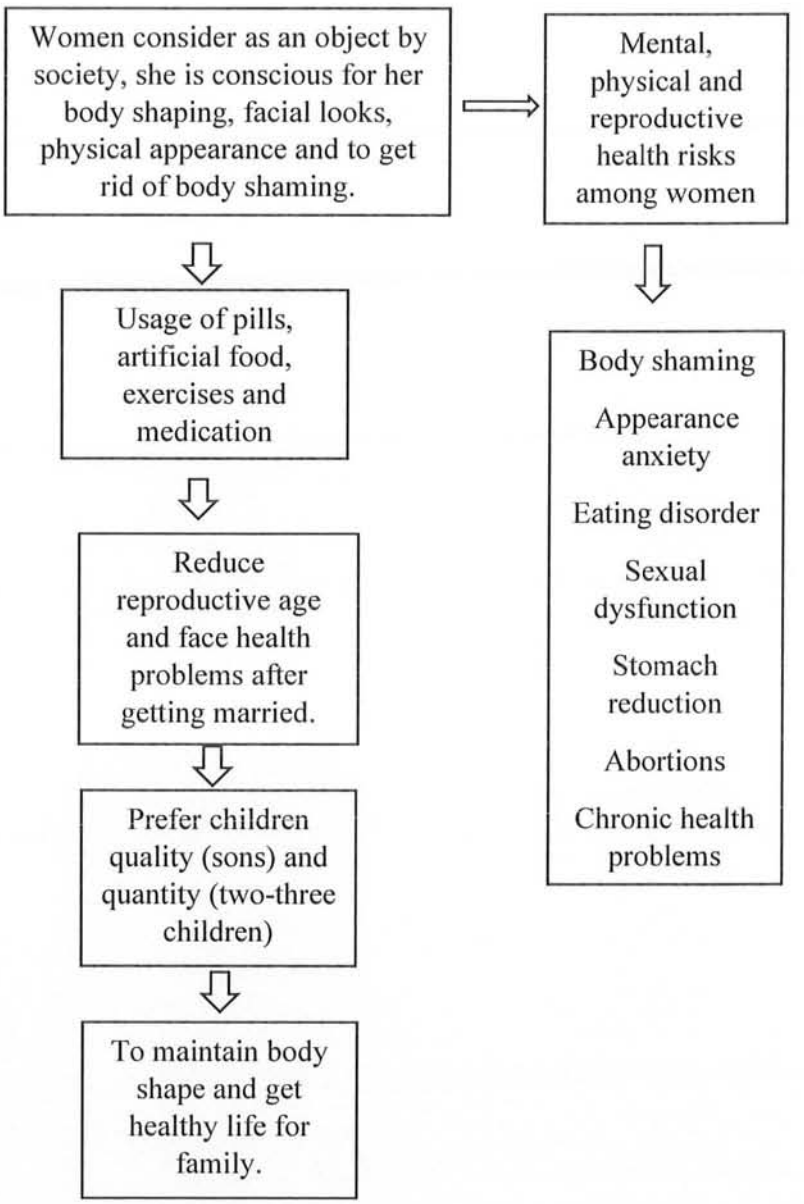
that results from measuring a female body looks by cultural standard and growth of women's anxiety about their physical appearance and safety consciousness e.g., they fear about being raped which can lead to eating disorder, depression and reproductive health dysfunctional consequences.

While applying the concept of objectification theory on females' physical appearance, body shaping, facial looks consciousness and body shaming, it is evident that the external physical objectification by society for women can influence negatively on women's mental health and enhance psychological consequences of mental health risks because of self-objectification appearance in patriarchal society, anxiety increases by body shape or shame and women are also conscious about their physical safety. The girls who are in their teenage use to take pills, exercises and medicated advanced treatments in order to maintain their body shape and reduce body shaming because they are conscious for their physical looks and to obtain the ideal size figure. Somehow, females are compelled to take unhygienic or risky medication treatments or exercises to get rid of body shaming and to obtain ideal body shape because they know that women are conscious and consider as an object or as a decoration piece in society. The usage of such practices or pills for body shaping affect reproductive health of females when they get married. So, the women reproductive health is weaker than past women by usage of artificial food intake, medications, pills and exercises. Females' reproductive health age is reduced as they are busy to attain higher education so families are intended to produce valuable and less children. In order to maintain the family balance these married women are interested to give birth to the male offspring for the sake of their economic status, family desire and to enhance their kin system in future.

It can find that the women consider as an object everywhere practically, from the women's interpersonal experiences to media and to specific environments to subcultures in the world. For example, the women's representations in the media including commercials, television programs, movies, music lyrics,

videos, magazines, sports media, video games and in other internet sites discovered that women are shown as an ideal figure physically and objectified manners as compare to men. Women dressing revealing and provocative clothing in different fields portray in such ways that highlight their body parts and ideal body shape to the world that is also desired shape for men. It is considered that women are a decorative object for men and society. In addition, women bear the target of body shaping and shaming remarks, annoying, taunting comments and deprecating words to describe women can affect women's mental health and women also stresses for their ideal body shape consciously.

**3.3 Model of Self- objectification theory**




Source: Self constructed

### 3.4 Human Capital Theory

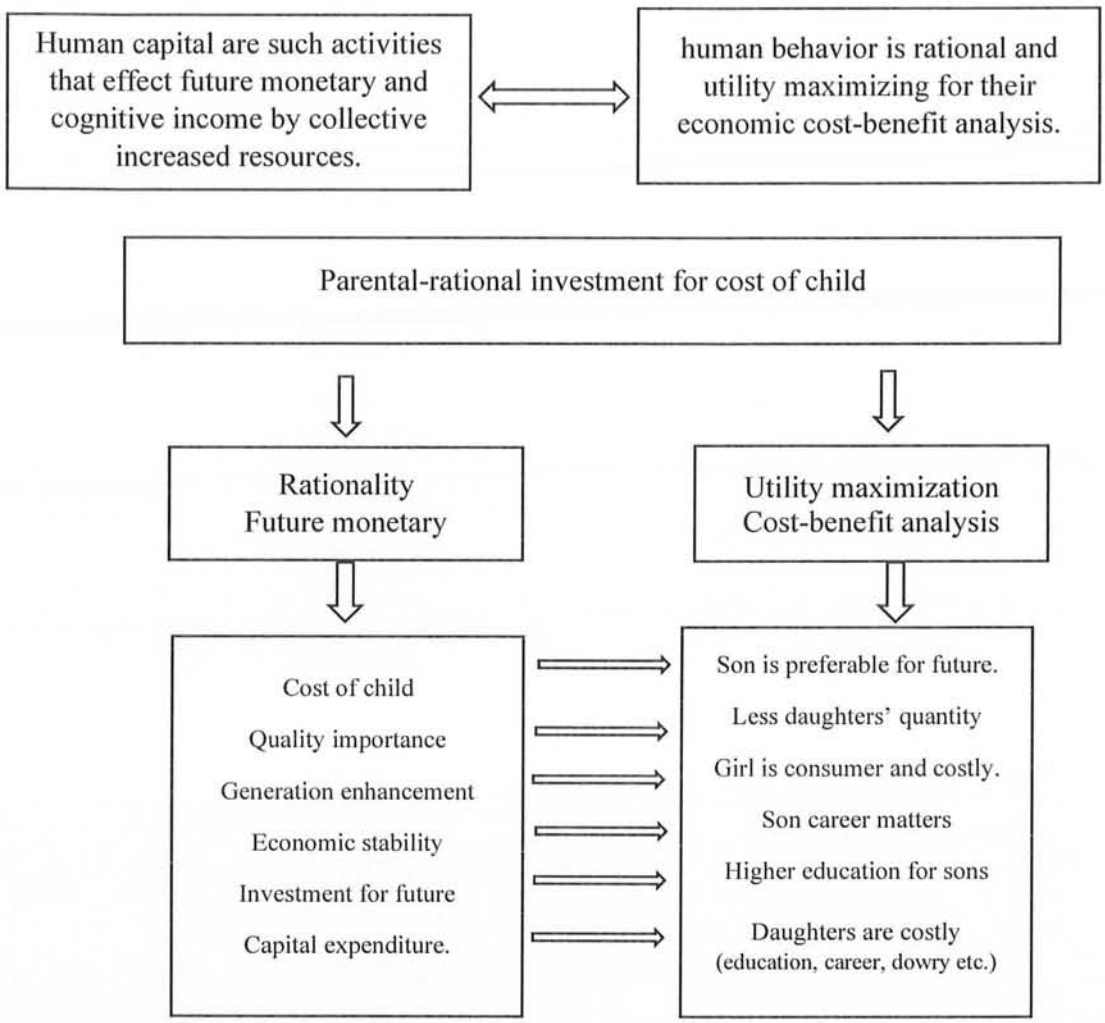
Gary Becker was an economist and social scientist. He conceptualized his work by using human capital as a key factor. He explained concept of human capital in 1964 as such activities that effect future monetary and cognitive income by collective increased resources among people. Although, its chief methods were schooling, on-the-job training, medical care, migration and searching for information about objects' cost, prices and incomes. Becker claimed that many diverse types of human behavior can be seen as rational and utility maximizing for their economic cost-benefit analysis. Human capital theory explore that how educational attainment rises the productivity and efficiency of employees and by increasing the level of economic cognitive stock of productive human competence, which is a product of inborn skills and investment in human beings. Basically, human capital is considered as the stock of behaviors, informational knowledge, social and personality attributes like creativity alive in the ability to perform intellectual labor to produce economic value. During 1970s in Chicago, Becker mostly focused on the family, birth rates and family size. He develops his understanding of how economics works within a family specifically by family covered issues during his times were marriage relations, divorce, altruism to other family members and investments of parents in their children. Throughout all his researches applies basic economic assumptions such as maximizing behavior, preferences and equilibrium to the family. He examined several determinants for marriage, divorce, family size, parents' provision of time period for their children and deviations in wealth over several generations.

### 3.5 Application

While applying the human capital approach in cost of child, parents invest on their children by considering them capital source of economic stability in future. In Pakistan parents' thoughts are rational, they think that son will be the helper and caretaker for investment and costs which they are investing in their male

child to maximize their utilities in future. However, the cost of female child considers as high wastage of utilities because female child will not stay with parents always and she would supposed to go to another home after marriage with expenses. They estimate that Investment or cost of educational, technical abilities, health well- being and other utilities will not provide benefit to parents later from daughters. So parental investment is rational base in which parents favor the one gender who can share and enhance their capital and generation as well. Furthermore, the son preference has significant role in determining the number of children among couples. The discriminated quality of male and female children may influence on economy of parents and their investment also, so they mostly prefer less quantity of children with quality-based gender i.e., son preference except daughters. As parents believe that female cost higher than male child because female is a consumer but not a permanent member of their family, will move to another home and son may enhance generation and provide cost-benefit later when he will set his economic career. In South Asian regions female children obtain lower level of education as compare to male siblings in accordance with son preference, son consider a house owner, decision maker and bread winner in future. It is also assumed by families that having more female childbirth increases the probability of having more children, which costs more capital expenditure of their health, education and other needs. People invest more on son to get future monetary and intellectual income as compare to female child.

### 3.6 Model of human capital theory




Source: Self constructed

### 3.7 Propositions

- Body shaping consciousness among women consider as an object in other's mind. The experience to be a woman in a culture is body shaming by which women is inspired due to environmental settings.
- The women are self-objectified due to their physical appearance or by their body size or parts. That is why women are conscious to be appear as an effective and attractive object in society.
- Women treat as a silent object, who is not able to speak for her right of prosperity.
- People think rationally regarding human capital investment, cost of child and prefer more sons rather than girls to monitor their future smoothly without facing socio-economic hurdles.
- Girls are consumer and costly for parents, they investment more on sons than girls to get cost benefit analysis and utility maximization in future.

# Chapter No. 4

# CONCEPTUALIZATION AND OPERATIONALIZATION

### 4.1 Conceptualization

It is a concept that refers to the procedure of clarification of one's concept with existing word and examples. Researcher is supposed to break the particular research topic into variables and define it with the previous existing knowledge accordingly, that is called conceptualization. Each variable and concept consist of many dimensions and indicators to specify both variables in research.

#### 4.1.1 Perception

Perception is the process of awareness regarding anything. It is a process which help the person to understand or to get informed by a particular stimulus. In this research the concept of perception is used for the awareness and knowledge creation regarding new advancement in reproductive health of women in family planning, child spacing, sexual relationship, contraceptive use and medical or traditional ways of healing for their reproductive health issues.

According to Schacter (2011) it is the process by which people explain some sensory impressions into coherent and unified view of the world existence around them. Through necessarily based on incomplete and unverified information, perception is equated with reality for most practical purposes and guides human behavior in general.

According to Lumen (2021) in Boundless Psychology perception is the set of methods that we use to make sense for different stimuli we have existed with us. Our perceptions built on how we interpret diverse sensations. The procedure of perception begins at that stage when we receive specific stimulus for a certain statement from the environment and interpret that stimulus by our senses.

According to Donaldson (2017) perception is a popular optical illusion used to explain differences in perception of stimuli.

In Macmillan dictionary (2019) the ability to understand and make good judgements about something or a particular way to understand something or a concept.

In Collins online dictionary (2021) individual's perception towards something is the way that he/she thinks about it or have impression of it. Individual senses and interprets information from the external world by mean of sensory receptors.

### 4.1.2 Reproductive Health Practices

According to WHO (2018) reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.

According to National Institute of Environmental Health Sciences reproductive health (2019) refers to the condition of male and female reproductive systems during all life stages. These systems are made of organs and hormone-producing glands, including the pituitary gland in the brain. Ovaries in females and testicles in males are reproductive organs, or gonads, that maintain health of their respective systems. They also function as glands because they produce and release hormones.

Reproductive health is a societal norm as stated by Watson (2015) that the issue of infertility produces a social stigma, isolation and altered perceptions of gender roles.

According to Encyclopedia in Reproductive health (2016) every person's reproductive health is the maintenance of the health of his or her reproductive systems, which include respectively the penis and the testes, and the vagina,

uterus, and breasts. The reproductive health spectrum also includes pregnancy and infertility.

### 4.2 Operationalization

It is a process of clarification that use in social sciences with conceptualization and the main reason behind this is to clarify the conceptual definition of the particular problem of statement in research. Definitions of particular concept are used to be familiar with topic, but some confusion occurs when direct definitions are used in the research. So, researcher clarifies the phenomenon by the help of theoretical framework and by collected data analysis and that process is named as operationalization. The operationalization of recent research concept of "perception towards reproductive health among educated women" is as follows:

#### 4.2.1 Perception

The researcher has analyzed data by married educated women to find out perception towards reproductive health such as perception of having children, child spacing, reproductive health issues, family planning, sex preference and women socio-psychological health.

In questions no. 13, 14, 18, 20, 21, 25, 27, 30, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 43, and 44 researcher conduct data about child spacing, contraceptive usage, family planning, women health, modern contraception and ideal family size with measurement of three-point scale of great extent, some extent and not at all. While question no. 15, 17, 31, 45 and 46 researcher find out ideal family size, which is 4 after data analysis, current children rate, abortion scaling and preferable sons and daughters with the measurement of five-point scale of zero, one, two, three, four or more.

Furthermore, researcher get demographics of respondents with the help of question no. 1,2,3,4,5,6,7,8 and 9 to get accurate unit of analysis on the basis of research topic. By findings, all women were educated and married, mostly were

higher educated like on the measurement scale of masters and above and mostly were belongs to joint family system.

In question no 10 and 11 researcher find out the age gap between spouses with the measurement of five-point scaling of 18 to 25 age, 26 to 30, 31 to 35, 36 to 40 and 41 to above. Mostly respondents were measured in 18 to 30 age gap among spouses.

In question no 12 researcher analyses type of marriage with measurement of two-point scale that is love and arrange marriage. Mostly responses were arrange marriage. In question no. 16 researcher conduct ratio of infant mortality that is not as much as it was before in Pakistan, and in question 29 family planning opinion is measured by three-point scaling which is good, bad and do not know, mostly women have shared good opinion regarding family planning.

### 4.2.2 Reproductive health practices

In question no. 19 researcher analyses first child-birth time period after marriage of respondents that is measured on four-point scale of less than a year, 1-year, 2 years, 3 years and More than 3. Mostly 1 to 2 years time period is measured to giving birth of first child after marriage with given data of respondents.

In question no. 22 and 23 researcher is supposed to find out such reasons or factors by which some respondents favor child spacing or some do not, measurement of these questions is on six-point scaling for favoring child spacing like education, economy, health, socialization, all of them and Any other, for non-favored factors measurement scaling is five-point like source of power, source of income, religion, all of them or any other reason. To analyze results, it is measured that mostly couples favor child spacing because of child's health at first then education, socialization and economy. Furthermore, mostly women do not favor child spacing because of Islam or some religious values.

In question 24 researcher analyses the gap between prior and new-born child on four-point measurement with 1-year, 1.5 to 2 years, 2.5 to 3 years, 3.5 and above. Mostly respondents have only one year gap between prior and new-born babies or some have 1.5 to 2 years gap.

In question no. 26 researcher analyses of having knowledge for contraceptives by which source among respondents and measurement scaling is five-point doctor, friends, husband, relatives, any other source. By findings researcher analyses that mostly women came to know about contraceptives through their husband, relatives and some are known by their friends.

In question no. 28 researcher analysis different contraception methods which respondents use, measurement of seven-point scale is condoms, IUDs, oral contraceptives, pills, injections, any other and none. By data analysis condoms are highly in use among married couples, then injections and pills in Islamabad.

In question no. 42 researcher find out mode of treatment regarding women's reproductive health which is based on measurement of five-point scaling that is allopathic, hakeem, traditional remedies, homeopathic and any other. Mostly data show that women usually adopt allopathic mode of treatment regarding their reproductive health issues.

But in question no. 14, 18, 20, 21, 25 and 27 researcher found data about both variables regarding perception and reproductive health practices, reproductive health centers, child spacing, birth rate and ideal children size, contraceptives usage and perception.

# Chapter No. 5

# RESEARCH METHODOLOGY

Methodology is a concept that forms techniques or methods to be used in the research of a particular statement. Each research may depend upon the nature of the study and circumstances in that particular field and uses of different methods for data collection is depends upon the research topic. This research statement of the problem is "perception towards reproductive health among educated women in Islamabad". This topic was motivated to do research among educated women because researcher would like to find, is reproductive health attitudes and behaviors may vary in developed city of Pakistan? Or what is the present situation of women regarding their reproductive health, sex selection, contraceptive techniques, child spacing and for family planning? This research is supported by using the following methods, tools and techniques to collect reliable and valid information.

### 5.1 Quantitative research

This study covered the basic components of research, i.e., description and explanation to fulfill primary as well as secondary sources were consulted to get proper information as well. Researcher have chosen the quantitative nature of study according to topic. This topic supposed to cover accessible books, journals and relevant websites while having work on it. Moreover, sincere effort was made to distribute a structured close ended questionnaire among educated married women in different areas of Islamabad, institutions and in female employers of any organization.

### 5.2 Universe

This research study was conducted in Islamabad. Islamabad is a capital of Islamic Republic of Pakistan. The area of study was any urban setting of

Islamabad and the married educated women either she is enrolled in job or not but must be educated. Access of educated women was easy because of social media and from personal contacts by whom it is possible to forward questionnaire among other educated women who lives in Islamabad. Only women are selected to gather accurate data about statement of the problem because men would not be comfortable to share their personal opinions regarding reproductive health of women, contraceptive usage, sex preference and family planning.

### 5.3 Sampling Technique

Sampling refers to the subset of the whole population, and researcher selected educated married women from Islamabad. In this research purposive sampling was used because of feminine topic. The all respondents were female because the research topic about married and educated woman. This study was completed in limited time period so educated married women were selected from social media and from consent of family friends.

### 5.4 Tools for data Collection

The most commonly used method is the executing the survey method. The close-ended questionnaire for population was found most appropriate for data collection. This method was used in the demographic profile of married educated women and their perception about family planning, child spacing, sex preference, reproductive health and for modern or traditional contraceptives. present study due to the following reasons: essential for the collection of such type of data. Moreover, the researcher tried to establish a direct and personal contact with the respondent while getting information from them about statement of the problem.

### 5.5 Pre- Testing

A pre-testing of five questionnaires were directed to the married educated women and with some other female teachers to avoid the vague and errors in

the questionnaire. Formal close-ended five questionnaire were filled by respondents for pre-testing. After getting data from five questionnaires some of response categories were changed slightly.

### 5.6 Data Analysis

In this research study data have been collected once and in the second step conducted the analysis of provided data, that is collected through selected population. The researcher collected the raw data during research. After getting raw data and eliminating the missing data researcher will use a specific technique and tools that are used in research study to draw the accurate result. Researcher have used the statistical package for social science (SPSS) to analyze and find appropriate results as population has given in raw data.

### 5.7 Opportunities and Limitations of the study

The major limitation of the study was on the false information which might have affected the reliability of the data because females are somehow not comfortable to share their personal experiences with researcher. While getting raw data from population, researcher found her in a difficult situation because it was quite personal to share personal data about populations' married life and difficult to reach the proper filled questionnaire by women. The researcher has distributed the questionnaires to educated married females and share questionnaire online also. But the returning ratio of filled questionnaire was quit less than expectation. The errors were the lack of the time and lack of the cooperation of some women and employers as well as incomplete or complete participation of respondents also might have affected the results. The most problematic area for the researcher was the lack of cooperation of respondents as they feel hesitate to share their reproductive experiences.

### 5.8 Ethical concerns

Researcher built trust on selected respondents that their identity would be anonymous and filled data will be confidential by direct involvement of

researcher. Researcher did not attempt such act or behavior which consider to be illegal from her respondents. All collected responses are purely unbiased and researcher presented herself with care and responsibility for privacy of respondents' personal provided data.

# Chapter No. 6

# RESULTS

**Table 1 Marital status of the respondents**

| Category | Frequency |
|---|---|
| Married | 94 |
| Widowed | 3 |
| Divorced | 3 |
| Total | 100 |

The above table describes the marital status of respondents. The table shows that majority of respondents 94 percent were married, 3 percent were widowed and 3 percent were divorced by whom data is collected for accurate perception towards reproductive health practices. So, 94 percent respondents were married.

**Table 2 Family status of the respondents**

| Category | Frequency |
|---|---|
| Nuclear | 33 |
| Joint | 64 |
| Extended | 3 |
| Total | 100 |

The above table illustrates the family status of respondents. The table shows that majority of respondents were belongs to joint family system. Nuclear family status respondents were 33 percentage, and 3 percentage respondents were from extended family system. The major finding is 64 percent respondents were belong to joint family system.

**Table 3 Age of the respondents**

| Category | Frequency |
|---|---|
| 20 to 25 | 27 |
| 26 to 30 | 44 |
| 31 to 35 | 25 |
| 36 above | 4 |
| Total | 100 |

The above table describes the age of respondents. Most respondents with 44 percentage were between the age of 26 to 30 years, 27 percentage respondents are between 20 to 25 age and remaining 25 percent respondents are between the age of 31 to 35. Lastly only four respondents are in the age of 36 and above years old.

**Table 4 Educational status of the respondents**

| Category | Frequency |
|---|---|
| Primary | 2 |
| Middle | 1 |
| Matric | 1 |
| Intermediate | 25 |
| Graduation | 22 |
| Masters and above | 49 |
| Total | 100 |

The above table illustrates the educational status of respondents, as it is estimated that 49 percentage respondents are highly educated with degree of masters and above, on the other side middle or matric level education is achieved by only 2 percent females. 22 percentage of respondents are graduated, 25 percent are intermediate and only 2 percent respondents are primary pass.

**Table 5 Head of the house of respondent**

| Category | Frequency |
|---|---|
| Husband | 54 |
| Husband's father | 25 |
| Husband's mother | 9 |
| Yourself | 6 |
| Your father/mother | 3 |
| Any other | 3 |
| Total | 100 |

The above table explains the head of the house that show that 54 percent husbands are owner or bread winners of house and 25 percent are husband's father. Least percentage of head of the house is 3 percentage in categories of female's parents and any other source of bread winner.

**Table 6 Occupation of the respondents**

| Category | Frequency |
|---|---|
| Housewife | 62 |
| Govt. Employee | 19 |
| Private job | 14 |
| Other | 5 |
| Total | 100 |

The above table describes the occupation of respondents and 62 percentage respondents are housewives, 19 percent are government employee, 14 percent females are on private occupation and at last 5 percent females are on another occupation.

**Table 7 Monthly income of respondent or bread winner's income**

| Category | Frequency |
|---|---|
| 5001 to 10000 | 3 |
| 10001 to 20000 | 15 |
| 20001 to 30000 | 14 |
| 30001 to above | 68 |
| Total | 100 |

The above table illustrates the income of female respondents or the income of bread winner of family to estimate the economic status. The 68 percentage respondents are earning from 30001 to above by themselves or by another member of head of the house and only 3 percent respondents are earning 5001 to 10000 income. On the other hand, 14 percent bread winners' income is from 20001 to 30000 rupees.

**Table 8 Respondent's year of marriage**

| Category | Frequency |
|---|---|
| Less than 6 months | 4 |
| More than 6 months | 10 |
| One to 3 years | 28 |
| 4 to 6 years | 31 |
| 7 to 9 years | 8 |
| 10 years and above | 19 |
| Total | 100 |

The above mention table estimates the year of marriage of respondents that highlights 31 percentage are between 4 to 6 years of marriage and 28 percent respondents are in between 1 to 3 years of marriage. 19 percent respondents are married from 10 and above years and 4 percentage females are married by less than 6 months.

**Table 9 Religion of respondent**

| Category | Frequency |
|---|---|
| Muslim | 95 |
| Non-Muslims | 5 |
| Total | 100 |

The above table describes religion of respondents which shows that 95 percentage women were Muslim and rest 5 percent were Non-Muslim.

**Table 10 Respondent's age at the time of marriage**

| Category | Frequency |
|---|---|
| 18 to 25 | 68 |
| 26 to 30 | 27 |
| 31 to 35 | 4 |
| 36 and above | 1 |
| Total | 100 |

The above table describes the respondents' age at the time of marriage. 68 percentage respondents are between 18 to 25 age at the time of their marriage and 27 percent respondents are in 26 to 30 age, 4 percent respondents are at 31 to 35 age and 1 percent is 36 to above age at the time of marriage.

**Table 11 Spouse age at the time of marriage**

| Category | Frequency |
|---|---|
| 18 to 25 | 38 |
| 26 to 30 | 47 |
| 31 to 35 | 15 |
| Total | 100 |

The above table illustrates the age of respondents' spouses at the time of marriage. It is examined that 47 percent male spouses are in between the age of 26 to 30 at the time of marriage and 38 percent are at the age of 18 to 25 and 15 percentage spouses are in 31 to 35 age at the time of marriage.

**Table 12 Type of marriage practiced by respondent.**

| Category | Frequency |
|---|---|
| Arrange marriage | 62 |
| Love marriage | 38 |
| Total | 100 |

The above table explains the type of marriage among respondents. 62 percentage women have practiced arrange marriage and 38 percentage women had practiced love marriage.

**Table 13 Respondent's knowledge for reproductive health**

| Category | Frequency |
|---|---|
| great extent | 43 |
| some extent | 47 |
| not at all | 10 |
| Total | 100 |

The above mention table describes the knowledge about reproductive health among respondents. It is examined that 47 percentage were on some extant level, 43 percentage on great extant level and only 10 percent respondents do not know the knowledge of reproductive health of women.

**Table 14 Respondent often visit any women reproductive health center.**

| Category | Frequency |
|---|---|
| great extent | 19 |
| some extent | 33 |
| not at all | 48 |
| Total | 100 |

The above table illustrates the percentage to visit any kind of reproductive health center. The 48 percent respondents have never visited health clinic, but 19 percent respondents visit health centers great extant, and 33 percent are on some extant category for visiting reproductive health clinic.

**Table 15 Distribution of number of children in case of abortions.**

| Category | Frequency |
|---|---|
| great extent | 42 |
| some extent | 45 |
| not at all | 13 |
| Total | 100 |

The above table describes the knowledge about child spacing among respondents. It is examined that to some extant 45 percentage respondents know about child spacing and to great extant 42 percentage have knowledge and lastly 13 percent respondents have no knowledge about child spacing.

**Table 16 Respondent's children ever died.**

| Category | Frequency |
|---|---|
| Zero | 76 |
| One | 16 |
| Two | 7 |
| Three | 1 |
| Total | 100 |

The above table describes the rate of abortions among married respondents. Maximum 76 percentage respondents have never faced abortions, but 16 percent respondents have faced one abortion and 7 percent have aborted 2 babies.

**Table 17 Current children rate of respondent**

| Category | Frequency |
|---|---|
| Yes | 12 |
| No | 88 |
| Total | 100 |

The above table illustrates that 88 percentage respondents have not face infant mortality, but 12 percent respondents have faced child mortality.

**Table 18 Knowledge about child spacing.**

| Category | Frequency |
|---|---|
| Zero | 34 |
| One | 35 |
| Two | 18 |
| Three | 9 |
| Four | 3 |
| Five | 1 |
| Total | 100 |

The above mention table describes the current children quantity among respondents. Maximum 35 percent respondents have only one child and 34 percent have no child yet, but 9 percent have three children and 18 percent have two kids. Lastly only one respondent has five children currently.

**Table 19 Respondent gave birth to first child after how long marriage.**

| Category | Frequency |
|---|---|
| less than a year | 14 |
| 1-year | 46 |
| 2-year | 19 |
| 3 year | 6 |
| More than 3 year | 6 |
| Total | 91 |
| Newly married | 9 |
| Total | 100 |

The above table explains the time duration of having kid after marriage of respondents. There are 46 respondents who gave birth to child after 1 year and

19 have given birth after 2 years of marriage. There are 9 respondents who are newly married but have no kid right now. Lastly 6 percent respondents gave birth to child after 3 or more years.

**Table 20 Satisfaction of current birth spacing among children.**

| Category | Frequency |
|---|---|
| great extent | 49 |
| some extent | 35 |
| not at all | 16 |
| Total | 100 |

The above mention table describes the satisfaction of respondents regarding childbirth space among their children. To great extant 48 percentage respondents are satisfied, 32 are some extant but 14 respondents are not satisfied with birth spacing among their children. On the other hand, 6 percent respondents have no kid yet because of their reproductive health problems or because they are newly married.

**Table 21 Respondent favor child spacing.**

| Category | Frequency |
|---|---|
| great extent | 54 |
| some extent | 36 |
| not at all | 10 |
| Total | 100 |

The above table describes that 54 percent respondent's favor child spacing and to some extent 36 percent favor, but 10 percent respondents do not favor child spacing.

**Table 22 Reasons for favoring child spacing.**

| Category | Frequency |
|---|---|
| Education | 8 |
| Economy | 3 |
| Health | 33 |
| Socialization | 5 |
| All of them | 45 |
| Any other | 6 |
| Total | 100 |

The above table explains different categories in favor of child spacing by respondents. Total 45 percent Respondents argue that child spacing have great influence on education, health, socialization, and economy but 6 percent marked any other reasons for child spacing and 33 percent respondents mentioned the reason of health in child spacing.

**Table 23 Reasons for not favoring child spacing.**

| Category | Frequency |
|---|---|
| Source of income | 13 |
| Source of power | 3 |
| Religion | 31 |
| All of them | 13 |
| Any other | 40 |
| Total | 100 |

The above mention table illustrate percentage of those respondents who do not favor child spacing because of some reasons like 13 percentage respondents believe that they do not believe in child spacing because offspring are source of income, power and prohibited in Islam. Most of 31 percent respondents do not accept or favor it because of religion factor. On the other hand, 40 percentage respondents have shown any other reasons for not preferring the child spacing.

**Table 24 Couples should wait for next pregnancy.**

| Category | Frequency |
|---|---|
| 1 year | 7 |
| 1.5 to 2 year | 36 |
| 2.5 to 3 year | 47 |
| 3.5 and above | 10 |
| Total | 100 |

The above table describes that 47 percentage women believe that couple should wait 2.5 to 3 years for next pregnancy after giving birth to prior child and 10 percent respondents are 3.5 to above, but 36 percent respondents respond 1.5 to 2 years gap for next pregnancy after prior child. Total 7 percent respondents marked 1 year gap for next pregnancy.

**Table 25 Knowledge about contraceptives.**

| Category | Frequency |
|---|---|
| great extent | 37 |
| some extent | 53 |
| not at all | 10 |
| Total | 100 |

The above mention table illustrates the knowledge about contraceptives among women. 53 percent women have knowledge on some extant and 37 have great extant but only 10 percent respondents have no knowledge about contraceptives.

**Table 26 Source of knowledge for contraception.**

| Category | Frequency |
|---|---|
| Doctor | 30 |
| Friends | 16 |
| Husband | 32 |
| Relatives | 6 |
| any other source | 16 |
| Total | 100 |

The above mention table describes that how respondents came to know about contraceptives and 32 percentage respondents have acknowledged by their husbands, 30 percent by doctors, 6 percent by relatives, 16 percent by friends and by another source.

**Table 27 Usage of contraception.**

| Category | Frequency |
|---|---|
| great extent | 26 |
| some extent | 45 |
| not at all | 29 |
| Total | 100 |

The above table describes respondent's use 45 percent contraceptives on some extant, 26 percent on great extant and 29 respondents do not use contraception or are not comfortable to share their experience of using contraceptives.

**Table 28 Usage of which contraceptive method is common for respondent.**

| Category | Frequency |
|---|---|
| Condoms | 70 |
| Oral contraceptives | 4 |
| Pills | 4 |
| Injection | 7 |
| Any other | 11 |
| None | 4 |
| Total | 100 |

The above table illustrates different types of contraceptive which respondents use. Results find that 70 percent respondents use condoms, 11 percent use another method, 7 percent use injections, 4 percent use oral contraceptives and pills and lastly 4 percent respondents do not use any kind of contraceptive method.

**Table 29 Opinion for family planning**

| Category | Frequency |
|---|---|
| Good | 83 |
| Bad | 6 |
| Do not know | 11 |
| Total | 100 |

The above table explains family planning opinion of respondents. Mostly 83 percent respondents have good opinion about family planning, 11 percent do not have accurate or enough information about family planning and only 6 percent have bad opinion about family planning.

**Table 30 Respondent's last child planned or not.**

| Category | Frequency |
|---|---|
| great extent | 41 |
| some extent | 27 |
| not at all | 27 |
| Total | 95 |
| Newly married | 5 |
| Total | 100 |

The above table describes planned child of respondents and 41 percent respondents have practiced planned child, 27 percent have practiced it on some extant and 27 percent respondents have not practiced planned infant. There are 5 percent respondents who are newly married but have not practiced any child planning yet.

**Table 31 Respondent's opinion for appropriate number of children.**

| Category | Frequency |
|---|---|
| 1 | 3 |
| 2 | 20 |
| 3 | 38 |
| 4 | 35 |
| more than 4 | 4 |
| Total | 100 |

The above mention table describes the desired number of children. The most appropriate number of children are 3 in respondents' opinion are 38 percentage, having 4 children are 35 percent, 1 for 3 percent, 2 for 20 percent and more than 4 children are appropriate for 4 respondents.

**Table 32 Respondent often discuss ideal family size with partner.**

| Category | Frequency |
|---|---|
| great extent | 67 |
| some extent | 22 |
| not at all | 11 |
| Total | 100 |

The above table describes ideal family size discussion with partners. Total 67 percent Respondents discussed ideal family size with their partners, 22 percent on some extant and 11 percent have not discussed it ever by their partners.

**Table 33 Family planning influence child's personality.**

| Category | Frequency |
|---|---|
| great extent | 78 |
| some extent | 18 |
| not at all | 4 |
| Total | 100 |

The above table illustrates that how much family planning influence on child's personality according to respondents. They respond that 78 percent are agreed with it strongly and 18 percent on some extent, but 4 percent deny the statement.

**Table 34 Child spacing influence child's social development.**

| Category | Frequency |
|---|---|
| great extent | 67 |
| some extent | 29 |
| not at all | 4 |
| Total | 100 |

The above mention table describes that 67 percent respondents greatly argue that child spacing influence on social development of child and 29 are on some extent but 4 percent respondents are not agreed.

**Table 35 Child spacing influence child's psychological development.**

| Category | Frequency |
|---|---|
| great extent | 70 |
| some extent | 26 |
| not at all | 4 |
| Total | 100 |

The above table explains that 70 percent respondents believe that child spacing influence on child's psychological development on great extent and 26 are on some extant but 4 percent do not believe in it.

**Table 36 Child spacing influence mental development of children.**

| Category | Frequency |
|---|---|
| great extent | 70 |
| some extent | 24 |
| not at all | 6 |
| Total | 100 |

The above table explains that 70 percent respondents believe that child spacing influence on child's mental development on great extent and 24 are on some extant but 6 percent respondents do not believe in it.

**Table 37 Respondent often discuss child spacing practices with partner.**

| Category | Frequency |
|---|---|
| great extent | 59 |
| some extent | 34 |
| not at all | 7 |
| Total | 100 |

The above table describes that 59 respondents have often discussed child spacing practices with their partners on great extant and 34 have discussed it some extant but 7 percent have not discussed it ever with their partners.

**Table 38 Respondent often face side effects of modern contraception.**

| Category | Frequency |
|---|---|
| great extent | 23 |
| some extent | 33 |
| not at all | 44 |
| Total | 100 |

The above table explains that 44 percent respondents have not ever faced any side effect of modern contraceptives, but 33 percent are on some extent and 23 respondents faced side effects of modern contraceptives.

**Table 39 Practice of traditional mode of contraceptives.**

| Category | Frequency |
|---|---|
| great extent | 25 |
| some extent | 40 |
| not at all | 35 |
| Total | 100 |

The above table describes that 40 percent respondents practice traditional mode of contraceptives some extent and 25 percent practice it on great extent, but 35 percent do not practice traditional mode of contraceptives.

**Table 40 Respondent ever visit professional doctor regarding modern technique of contraceptives.**

| Category | Frequency |
|---|---|
| great extent | 28 |
| some extent | 27 |
| not at all | 45 |
| Total | 100 |

The above mention table explains that 45 percent respondents have not ever visited professional doctor regarding modern technique of contraceptives, but 27 percent on some extent and 28 percent have visited professional doctor regarding modern technique of contraceptives greatly.

**Table 41 Satisfaction of husband with usage of modern/traditional contraceptives.**

| Category | Frequency |
|---|---|
| great extent | 39 |
| some extent | 42 |
| not at all | 19 |
| Total | 100 |

The above table describes that 42 percent respondents claims that their husbands are on some extent satisfied with usage of modern/ traditional contraceptives, but 39 percent are satisfied on great extent and 19 percent husbands are not satisfied with usage of modern/ traditional contraceptives.

**Table 42 Respondent believe mode of treatment regarding reproductive health.**

| Category | Frequency |
|---|---|
| Allopathic | 62 |
| Hakeem | 1 |
| Traditional remedies | 14 |
| Homeopathic | 12 |
| Any other | 11 |
| Total | 100 |

The above table describes that 62 percentage respondents believe in allopathic mode of treatment for reproductive health issues, 1 percent for hakeem,14 percent for traditional remedies, 12 percent for homeopathic and 11 percent respondents believe in any other mode of treatment for reproductive health issues.

**Table 43 Modern contraception are expensive rather than home remedies.**

| Category | Frequency |
|---|---|
| great extent | 31 |
| some extent | 54 |
| not at all | 15 |
| Total | 100 |

The above table explains that 54 percent respondents said that modern contraceptives methods are expensive rather than home remedies some extent, but 31 percent claimed it greatly and 15 percent respondents are not agreed with that modern contraceptive methods are expensive rather than home remedies.

**Table 44 Modern contraceptive usage is better than traditional remedies.**

| Category | Frequency |
|---|---|
| great extent | 52 |
| some extent | 41 |
| not at all | 7 |
| Total | 100 |

The above table describes that 52 percent respondents are greatly agreed that modern contraceptive usage is better rather than traditional remedies and 41 percent are agreed some extent, but 7 percent respondents are not agreed with that the that modern contraceptive usage is better rather than traditional remedies.

**Table 45 Opinion of respondent for having number of male children.**

| Categories | Frequency |
|---|---|
| One | 20 |
| Two | 48 |
| Three | 27 |
| Four and more | 5 |
| Total | 100 |

The above table describes that 47.5 percent respondents prefer two male children for completion of their ideal family size but only 5.0 percent want to have four male children to get more socio-economic power in society, 26.7 percent want to have three sons and 19.8 percent respondents prefer only one male child.

**Table 46 Opinion of respondent for having number of female children.**

| Categories | Frequency |
|---|---|
| Zero | 18 |
| One | 60 |
| Two | 22 |
| Total | 100 |

The above table illustrate that 59.4 percent respondents prefer only for one daughter, but 17.8 percent do not want any daughter in their family because they feel daughters as economic and emotional burden and 21.8 percent respondents prefer for having two daughters in their ideal family size.

# Chapter No. 7

# DISCUSSION, CONCLUSION AND SUGGESTION

## 7.1 Discussion

With the help of filled questionnaires the researcher found multiple analytical responses regarding perception towards reproductive health and health practices. It was estimated that mostly couples have practiced arrange marriage but are concerned with reproductive health practices. There is such type of couples who are well educated and well aware of reproductive health issues of women and child but they did not practice any kind of family planning and child spacing methods by which women can safe their mental and physical health as well as child's mental, social, psychological and environmental socialization. The researcher found that modern contraceptive usage and child spacing is common and acceptable in Islamabad except rural areas of Pakistan. Women are concerned with their reproductive health and try to practice family planning. The researcher analyzed that couples delay pregnancies because of the major factor of health of child and mother but also because of giving their children good education, socialization and financial support properly. The researcher found that mostly respondents were Muslims and findings showed that respondents have pressure or influence of culture and Islamic ritual or believes regarding family planning, child spacing and abortions. That is why major finding for not favoring child spacing was Islam which was analyzed by the researcher.

The researcher found that respondents are concerned with less quantity and best quality of children. Respondents were interested to have less daughters with higher rate of sons as well as total three or four number of children are marked by them for ideal family size. Furthermore, it was found that mostly respondents use modern contraception rather than traditional or home-made remedies and respondents gave favor to allopathic mode of treatment for their reproductive health issues or practices because of modern and technical innovations educated or acknowledged women believe in technical modes. The researcher analyzed that condoms are one of the most common method of contraceptive which

couple used while having sexual relationship then pills or injections used by rest respondents who do not use condoms. Moreover, modern contraception methods are not expensive analyzed by the given data of respondents. Mostly respondents argued that their husbands are satisfied to some extent with usage of contraceptive while having sexual intercourse, but mostly respondents are still using modern contraceptives rather than traditional mode of contraceptives.

### 7.2 Key Findings

1. The majority finding of marital status were estimated 94 percent respondents who were married.
2. 64 percent respondents were living in joint family system.
3. Mostly 44 percent questionnaires were filled by those respondents who were in the age of 26 to 30.
4. It was estimated that 49 percent respondents were highly educated with degree of masters and above.
5. Major finding of head of the house were 54 percent and 62 percent respondents were housewives.
6. The major finding of income was the respondents were earning 300001 to above by themselves or by another member of house.
7. Mostly 31 percent respondents have four to six year of marriage and 95 percent respondents were Muslims.
8. The major finding of type of marriage was 62 percent respondents had practiced arrange marriage.
9. The respondents have 47 percent knowledge about reproductive health to some extent and 48 percent respondents have never visited to women reproductive health center.
10. The major finding of facing abortions is 76 percent respondents have never faced abortions but only 12 percent respondents' children were died.

11. 35 percent respondents have one child currently but only 3 percent have four children.
12. Total 45 percent respondents have knowledge about child spacing and 46 percent gave birth to child after getting married but 48 percent respondents are satisfied with their childbirth spacing to great extent.
13. Total 54 percent respondents favored child spacing to great extent but 31 percent did not favor it with mentioned factor o Islam or religious rituals.
14. The 45 percent respondents marked education, economy, socialization and health factors in favor of child spacing but major finding was 33 percent health factor.
15. According to major finding 47 percent respondents believe that couple should wait for 2.5 to 3 years for next pregnancy after giving birth to prior child.
16. The major finding about acknowledgement of contraception were 53 percent respondents have knowledge for contraceptives to some extent.
17. Mostly 32 percent respondents got to know for contraception by husband and 45 percent respondents often use contraception to some extent.
18. Total 70 percent respondents use condoms method and 83 respondents have good opinion regarding family planning.
19. Total 41 percent respondents had planned child on great extent and 38 percent respondents prefer three children for ideal family size.
20. Total 67 percent respondents discussed ideal family size with their partners.
21. The major finding of family planning influence on children's personality were 78 percentage to great extent.
22. The major finding of child spacing influence on children's social development were 67 percentage to great extent.

23. The major finding of child spacing influence on children's psychological development were 70 percentage to great extent.
24. The major finding of child spacing influence on children's mental development were 70 percentage to great extent.
25. Total 59 percent respondents have discussed child spacing practice with their partners to great extent.
26. Total 44 percent respondents have never faced side effects of modern contraceptives and 45 percent have never visited to doctor regarding modern techniques of contraception.
27. Total 42 percent husbands are satisfied with the usage of modern/traditional contraceptives to some extent.
28. Allopathic mode of treatment was applied 62 percent by respondents for reproductive health issues.
29. Total 54 percent respondents argued that modern contraception is expensive to some extent rather than home remedies.
30. On the other hand, 52 percent respondents argued that modern contraceptive usage is better than traditional remedies.
31. Total 48 percent respondents preferred two male child and 60 percent respondents preferred only for one female child for having ideal family size.

### 7.3 Conclusion

By taking some core objectives researcher undertook research work on the topic "perception towards reproductive health practices among educated women" the research study is aimed to investigate the reproductive health practices and perception regarding child spacing, family planning, sex preference and women health issues to find out the role of education in decision making of reproductive health practices among educated couples. Along with the role of education it further investigates the factors involve in decision making regarding delaying or not opting delayed pregnancy mechanism by educated couples.

The study results show that higher educated women are more aware of family planning, modern contraception, child spacing and biological health issues. Educated and well aware women also try to practice the birth control to make suitable birth spacing among children. But in Asian countries women are depended on their partners and relatives for giving birth to child either they are educated or not. Furthermore, there are some of nuclear families who can easily make decisions regarding child spacing and they understand the socio-economic benefits of having child intervals and family planning and as well as the associated risks or problems of birth without considerable gap. Being an educated couple, they think rationally by keeping an eye on reality and think logically regarding reproductive health practices.

In our society religion and cultural practices are deeply rooted and strong, it is difficult to change the mind set of individuals. Hence, education may play a vital role to drive the people to think positively, rationally and logically. Birth controlling is become a pressing concern of developing countries like Pakistan because of over population. It must be one of the prime objectives of state to emphasis on education to aware the masses to ensure the gap to avoid the health and financial risks.

The researcher investigated the reasons that is why educated couples delay pregnancies and why they give preference to child spacing and son preference. Our study reveals that health is one of the major factors considered by educated couples as a reason to give birth space between their children.

Producing more sons is preferred by educated women now a days because of socio-economic and environmental influences, couples are pressurized by religious, cultural and social rituals for having daughters like they relate to socio-economic burden, dowry burden and also considered as girls are made for other's home and are other's property. By findings people favor to have more sons than daughters because sons are considered as caretaker, bread winner, family protector and economic owner of capital investment.

Lack of child spacing and less usage of modern contraception have negative effects on mother's social, physical and mental health, after findings it is also estimated that it is also effects on children's mental, social, psychological upbringing or socialization. So, educated women are well aware about these issues and try to avoid such situations, they prefer child spacing but if their partners are supportive. However, some of educated couples seems not favoring child spacing because of religious and cultural rituals. Furthermore, they believe that having more children in less birth intervals means more socio-economic stability chances in future. They consider their children as a source of income and power in society.

It is also find that there is a huge gap in desired number of children between educated couples and in illiterate couples. The uneducated couples have higher number of children rather than today's educated couples. But now this trend has greatly changed, mostly couples prefer to have maximum four or three children with more sons and less daughters or for having equal number of children either they are highly educated or less educated.

Child mortality and abortions are one of the common practice in Pakistan, but findings illustrate that its ratio is less among educated women in Islamabad because of low fertility rate, late marriages, well health practices and well economic support. Furthermore, educated women are well aware of physical ups and down before and after conceiving baby. Partners are career oriented and status conscious, so they first try to maintain their socio-economic status then plan to enhance their family size which may also depends on low quantity and higher quality.

The modern usage of contraception method is preferable among educated women rather than traditional methods of contraception. By findings researcher describes that condoms are on first level of measurement then pills or injection usage is common among educated partners. Couples have less communication gap regarding child spacing, family planning and usage of modern contraception in Islamabad because of education.

Many of educated women prefer allopathic mode of treatment regarding their reproductive health practices because of advanced technical mechanism, well economic status and increased rate of professional doctors. Findings describes that people still use traditional or homeopathic mode of treatment to some extent but allopathic mode of treatment is highly practiced among urbanized women.

It is also estimated by findings that couples have practiced love marriage but all are not practicing healthy reproductive health practices because some of male partners do not comfortable with usage of modern contraception and child spacing that leads to women's reproductive health hurdles, disease or illness.

The first childbirth among educated women is measured with the gap of one to two years after marriage, that illustrates the importance and awareness of women health and family planning practice acceptance among urbanized couples. But in Pakistan women are dependent upon societal and cultural

customs that are strictly supposed to follow by women but in some families their rituals are totally based upon couples either they practice it or not, for having first baby soon after marriage is usually preferred by family but in case of late marriage women also prefer to conceive first child early to complete their ideal family size as soon as possible because of low fertility rate or fear of infecundity.

Reproductive health is also an understood factor in the context of healthy and strong relationships in which there is existence of an understanding of the balance between fulfillment and risks among couples. Reproductive health contributes massive physical and psychosocial comfort, sharing and closeness between opposite gender individuals. On the other hand, poor or bad reproductive health relationship is frequently associated or linked with depression, disease, illness, abuse, physical and emotional exploitation, unwanted pregnancy, abortions and death. So, researcher finds out lastly that it is important to keep in mind that reproductive health status or importance may be determined by occurrences and exposures from in utero development until the final stages of life.

### 7.4 Suggestions

Awareness about reproductive health issues should be encouraged and spontaneous women health or fitness should be one of the common concern of our society. Sustainable guidance should be provided to the people against such type of evil customs by which women and child face hurdle through media and social campaigns that might reduce the ratio of such practices by which women face physical or mental torcher. The rate of fertility is getting low day by day because of late marriages and unhygienic food consumption, parents and youngsters should focus on their food in-take to safe their reproductive health for later. Pakistani well settled generation is involve in bad habits such as taking drugs is one of the common practice among male or female youngsters, they should reduce such type of addictions to safe and secure their marriage or happily married life and for their healthy children as well. The rate of female education should be higher before to accomplish their career and parents should alter their girls are burden ritual to make their daughters independent. Our state should provide lots of opportunities to the women to fulfil their educational and career dreams properly that might limit the ratio of cultural pressure of having daughters. There is a need to develop such methods to address those girls who are at risk of reproductive health problems and to address women's concerns regarding women reproductive health issues to eliminate unsafe abortion. So, there is a requirement having an integrated, comprehensive approach involving health workers and civil society groups. Efforts are also required to protect pregnant women or new-born child. Services for reduction of sexual and domestic violence should be accessible in all regions of Pakistan either rural or urban. Special health care units in rural-urban areas of Pakistan should be established in each unit or colony and reasonable social welfare centers also establish in our country. The need for unsafe abortions can be eliminated through policies which are designed in the social context of women and those which are closer to social norms and tradition. Our religious leaders should

enable reproductive health programs and services to reach more conservative groups in society and thus contribute effectively to bring positive change in the attitude of Pakistani society towards reproductive health. Women's right of having child or not should be highlighted because 90 percent women in Pakistan give birth to child with the pressure of husbands or family. Furthermore, women should provide financial support after giving birth to child and for their reproductive health rights. Further data collection and research is also required to explore the socio-economic health issues of women and children. An equal relationship among women and men is significant for having ideal and happy family so men should protect and value their wives in society including emotional, sexual relation, respect for the integrity of the person, require mutual respect, constant and shared responsibility for sexual behavior and its consequences. Women should have great access to education and resources to empower them to make decisions about their sexual and reproductive practices including child spacing, family planning, safe abortions, pre-natal and post-natal care and management of pregnancy and child-birth intervals. Our state should enhance modern technical hospitals quantity, labor rooms, medical equipment and professional care takers for pregnant women as well as for health of both mother and child. Decisions regarding child should be taken by partners to vanish communication gap among couples. Lastly, women should be treated as a human being not as a property of someone.

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# ANNEXURE

Respected respondents,

I am student of M.sc from department of Sociology in Quaid-I-Azam University Islamabad. My topic statement is "Perception towards reproductive health among educated women in Islamabad". I am requesting you to respond this questionnaire as your responses will have great importance for my appropriate findings and to find the current scenario regarding reproductive health practices' perception among educated women. Your answers will treat confidentially and this paper will use only for the purpose of research to get accurate findings of my topic.

Thank you!

Regards

Tooba Kanwal

## QUESTIONNAIRE

## PERCEPTION TOWARDS REPRODUCTIVE HEALTH AMONG EDUCATED WOMEN IN ISLAMABAD

**Form no._____**

**Information of respondent**

1. Marital status
   a. Married b. Widowed c. Divorced d. Separated
2. Family system
   a. Nuclear b. Joint c. Extended
3. Age
   a. 20 to 25 b.26 to 30 c. 31 to 35 d. 36 to above
4. Educational status
   a. Primary b. Middle c. Matric d. Intermediate e. Graduation

   f. Masters and above

5. Head of the house
   a. Husband b. Husband's father c. Husband's mother

   d. Yourself e. Your father/mother_____ f. Any other_____

6. Your occupation
   a. Housewife b. Govt. employee c. Private job d. Daily wager e. Other
7. Your monthly income/bread winner's income?

a. Less than 5000 b. 5001 to 10000 c. 10001 to 20000

d. 20001 to 30000 e. 30001 to above

8. Year of marriage

a. Less than 6 months b. More than 6 months c. One to 3 years

d. 4 to 6 years and above e. 7 to 9 years f. 10 years

**Information regarding reproductive health practices**

9. Your religion

a. Muslim b. Non-Muslim

10. Your age at the time of marriage

a. 18 to 25 b. 26 to 30 c.31 to 35 d. 36 to 40 e. 41 to above

11. Age of your spouse at the time of marriage

a. 18 to 25 b. 26 to 30 c.31 to 35 d. 36 to 40 e. 41 to above

12. Which type of marriage have you practiced?

a. Arrange marriage b. Love marriage

13. How much knowledge do you have about reproductive health?

a. Great extant b. Some extant c. Not at all

14. Have you often visited any women reproductive health center?

a. Great extant b. Some extant c. Not at all

15. If you have faced abortions, then specify number(s) of child.

a. Zero b. One c. Two d. Three e. Four or more

16. Have your children ever died?

a. Yes b. No

17. How many children do you have currently?

a. Zero b. One c. Two d. Three e. Four f. Five

g. More than five

18. How much do you know about child spacing?

a. Great extant b. Some extant c. Not at all

19. If you have child, then how long after your marriage you gave birth to your child?

a. Less than a year b. 1-year c. 2 years d. 3 years e. More than 3

20. How much satisfied you are with the current birth spacing among your children?

a. Great extant b. Some extant c. Not at all

21. How much do you favor child spacing?

a. Great extant b. Some extant c. Not at all

22. If you favor child spacing, then mark the reason.

a. Education b. Economy c. Health d. Socialization

e. All of them f. Any other

23. If you do not favor child spacing, then mark the reason.

a. Source of income b. Source of power c. Religion d. All of them e. Any other

24. How long should a women/couple wait for next pregnancy after giving birth to prior child?

a. 1-year b. 1.5 to 2 years c. 2.5 to 3 years d. 3.5 and above

25. How much do you know about contraceptives?
    a. Great extant b. Some extant c. Not at all
26. How did you know about contraceptives?
    a. Doctor b. Friends c. Husband d. Relatives e. Any other source
27. How often do you use contraceptives?
    a. Great extant b. Some extant c. Not at all
28. Which contraceptive method do you use often?
    a. Condoms b. IUDs c. Oral contraceptives d. pills
    e. injections f. any other g. None
29. What is your opinion for family planning?
    a. Good b. Bad c. Don't know
30. Was your last child planned?
    a. Great extant b. Some extant c. Not at all
31. What is the most appropriate number of children in your opinion?
    a. 1 b. 2 c.3 d. 4 e. More than 4
32. Have you often discussed ideal family size with your partner?
    a. Great extant b. some extant c. Not at all
33. How much family planning influence child's personality?
    a. Great extant b. Some extant c. Not at all
34. How much child spacing influence on child's social development?
    a. Great extant b. some extant c. Not at all
35. How much child spacing influence on child's psychological development?

a. Great extant b. some extant c. Not at all

36. How much child spacing influence on child's mental development?

a. Great extant b. some extant c. Not at all

37. Have you often discussed child- spacing practices with your partner?

a. Great extant b. Some extant c. Not at all

38. Did you often face any side effects of modern contraceptives?

a. Great extant b. Some extant c. Not at all

39. How much do you practice traditional mode of contraceptives?

a. Great extant b. Some extant c. Not at all

40. Have you ever visited professional doctor regarding modern techniques of contraceptives?

a. Great extant b. Some extant c. Not at all

41. How much satisfied are your husband with usage of modern/ traditional contraceptive?

a. Great extant b. Some extant c. Not at all

42. Which type of mode of treatment you believe in for your reproductive health?

a. Allopathic b. Hakeem c. Traditional remedies

d. Homeopathic e. Any other

43. How much expensive modern contraceptive methods are rather than home remedies?

a. Great extant b. Some extant c. Not at all

44. How much better modern contraceptive usage is rather than traditional remedies?

a. Great extant b. Some extant b. Not at all

45. How many male children do you prefer?

a. Zero b. One c. Two d. Three e. Four or more

46. How many male children do you prefer?

a. Zero b. One c. Two d. Three e. Four or more