Unravelling the Complexities of Reproductive Health Services Utilization: A Mixed-Method Analysis of Socio-Economic and Cultural Factors among Women in Sargodha, Pakistan

Bushra Syed Rasool [1*] Yasir Nawaz Manj [2]

[1] PhD Scholar (Sociology), Department of Sociology and Criminology, University of Sargodha, Sargodha, Punjab, Pakistan. Email: bushysyed22@gmail.com

[2] Chairman, Department of Sociology and Criminology/Dean, Social Sciences, GC Women University, Sialkot, Punjab, Pakistan. Email: Yasir.manj@gmail.com

ABSTRACT: In-depth understanding of sexual and reproductive health is vital for overall well-being. Sadly, many girls and women worldwide, especially those in impoverished nations, have limited or no access to reproductive health services. Numerous barriers exist, including restrictive policies, discrimination, stigma, and enduring cultural traditions, all of which impact reproductive health. This study was designed to thoroughly examine the socioeconomic and cultural factors influencing women's reproductive health in rural Punjab, Pakistan. The research reviewed key social determinants of women's reproductive health indicators, such as awareness of their reproductive health rights, access to healthcare within their cultural setting, education, employment, political and social participation, income, and employment awareness concerning reproductive health, as well as decision-making regarding fertility. Both theoretical and practical perspectives were explored to understand the link between socioeconomic and cultural factors and women's reproductive health. The chi-square test was employed to analyze statistical significance and associations during data processing. The research primarily utilized a quantitative approach, with the descriptive survey method as the study design. Well-structured interviews were conducted to collect data from 384 respondents selected through a multistage sampling technique from rural Punjab. Findings indicated statistically significant differences in awareness, media exposure, education, literacy, profession, religion, working conditions, access to health centres, participation in political and social activities, poverty, and more. Results showed pronounced disparities among women, highlighting high illiteracy rates, minimal education attainment, lack of health facilities and transportation, limited social and political engagement, low awareness of health rights, restricted decision-making power, and early marriages.

KEYWORDS: Reproductive Health, Awareness, Poverty, Socio-Economic and Cultural Factors

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Corresponding Author
Bushra Syed Rasool
✉ bushysyed22@gmail.com

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Introduction

Reproductive health is therefore, a crucial aspect of overall human development and a significant component of general health. The health of a person during their early years, adolescence, and adulthood influences the health of their offspring and lays the foundation for good health for both genders after they reach reproductive age (Currie et

al., 2016; Ocasio et al., 2024). The mother's reproductive health and availability to reproductive healthcare services have a significant impact on the newborn baby's health. The idea of reproductive health is crucial, especially for young girls and women who will give birth to children in the near future. The General Recommendation of the CEDAW Committee Urges States to prioritize "sex education and family planning as means of preventing unwanted pregnancy." The CESCR General Comment 14 explains that the States are immediately required to take purposeful, specific, and tangible steps towards fulfilling the right to health during pregnancy and childbirth. Maternal health care is similar to a fundamental duty. That cannot be derogated from under any circumstances (Müller, 2017).

Women's reproductive health depends on a network of endocrine signals' coordinated reactions that serve various functions in the body of a woman, including the secondary reproductive organs like the breast, but also play a major role in ensuring successful procreation (Athar et al., 2024). Any disorderly effects have significant disorderly effects, consequently, not just to stimulus fecundity, but to possess extensive consequences on the health of female. Additionally, given that women bear the burden of bearing the child through the entire subtle determinative phases of fetal and emerging life up until delivery, implications of the mother's adoptions for the child's future reproductive health. An endocrine organ must maintain the placenta in this situation functions, allowing the transmission of material from the mother to the kid. The significances of endocrine disturbance for ovarian function, for menopause and puberty, and for benign irregularities of female reproductive tissues, together with uterus (fibroids, endometriosis), breast (cysts), and ovary (premature ovarian failure, POF, polycystic ovary), fibro adenoma) (Darbre, 2020).

Sargodha, a major city and district in the Punjab province of Pakistan, is characterized by a blend of urban and rural demographics, with a significant agrarian base. Although Pakistan has been making national and provincial attempts to address maternal and reproductive health indicators, high maternal mortality and fertility rates remain a challenge to the country. The use of professional RHS such as antenatal care (ANC), skilled birth attendance (SBA), postnatal care and family planning services is paramount in turning around these trends.

The existence of infrastructure gaps, however, is accompanied with the underuse of available services, pointing to an even deeper problem present in social fabric. This study goes beyond a naive supply and demand theory to deconstruct the obscure and largely unrecognized obstacles that women in Sargodha have to deal with. The proposed study will offer a comprehensive view of how and why socio-economic and cultural factors determine reproductive health decisions by adopting a mixed-methods design.

Literature Review

The reproductive health of women is one of the most significant aspects of general well-being that includes a number of elements such as maternal health, access to family planning, safe childbirth, and the ability to make informed choices about family planning (World Health Organization, 2021). Yet, it is not biological determinants that solely determine the reproductive wellbeing of women. Socio-economic and cultural factors have an indisputable influence over the experiences and success of women reproductive health (Pallikadavath et al., 2020; Upadhyay et al., 2017). The interdisciplinary interaction between socio-economic and cultural factors has a considerable effect on the access to the reproductive healthcare services and the ability to exercise the reproductive rights and the health and well-being of women in various societies (Sen, 2015; Sudhinaraset et al., 2016). Learning about these determinants not only is essential to the promotion of gender equity but also the enhancement of the overall wellbeing and health of women globally (World Bank, 2021)

This literature review seeks to establish the relationship between socio- economic status, cultural beliefs and the reproductive health of women. It aims at offering an integrative analysis of the complex problems that affect the

reproductive health outcomes of women and how the determinants interact and affect one another. Nevertheless, the problems of access to safe abortion services can be faced by people with lower SES, and they face increased risks of health problems (Henshaw et al., 2017; Jones et al., 2019). It is necessary to examine the multifaceted and complex factors that are behind socioeconomic differences in access to reproductive healthcare to mitigate the situation. These disparities are caused by a number of key reasons. The limitation of finances is a widespread obstacle to reproductive healthcare services. The poor individuals might have difficulties covering the expenses of prenatal care, contraception, and abortion services, especially in those countries where universal healthcare is not or is partially lacking (Gipson et al., 2017; Sonfield et al., 2017). High out-of-pocket payments can deter individuals to access care they require, leading to the delayed or weakened reproduction health results.

Reproductive Health Security

Safe abortion and enhancing maternal health facilities with the aid of or participation in the MDG for improving maternal health and national and international development aims and objectives can reduce the risk of maternal death and mortality," states the World Health Assembly's Global Strategy on Reproductive Health, which was adopted in May 2004. The WHO's Research and Development Program for Human Reproduction (HRP) examines how individuals resist unsafe abortions through four interconnected activities, including study on sexual and reproductive health and analysis of all people's living standards. Accumulating evidence indicating the main reasons of the death for women at the ages of 15 and 49 is significant obstacles to pregnancy and childbirth, like in Pakistan, 20% of women passed away during above age. (Pakistan Demographic and Health Survey 2006-2007). Furthermore, cultural factors are the fundamental causes of newborn and mother mortality and socioeconomic structures that discriminate against women, mainly those who are deprived and members of relegated clusters. Mother healthcare facilities in Pakistan vary greatly depending on the socioeconomic group. Women's position and their access to health care can be impacted by a number of factors, including poverty, ethnicity, culture, and religion. The truth is that inadequate management is a significant obstacle to reducing Pakistan's rates of maternal and newborn health mortality. Wider social, cultural, and political variables are at play in specific situations that impact women's access to healthcare (Khan et al., 2010).

Poverty

Inequality in wealth and rights is another factor that puts women at higher risk of poverty. When this complicates their ability to use the health provisions, particularly during pregnancy and other crucial times, the issue worsens in underdeveloped countries like Pakistan. When women are expected to manage their careers in addition to taking care of their homes, getting pregnant, and giving birth, the problem gets worse. While home women receive minor favors, the majority of women in families receive poor treatment. (World Bank. World development report 2004). Numerous incidences of sexual violence have been documented in South East Asia. For example, all 57 young women and girls in the Philippines who had a sexual experience did it inadvertently or without consent. Entering into sexual relationships based on economic status, when access to healthcare services is severely limited. Most of these relationships involve women who are used for reproductive purposes. Like exercising sexual restraint. According to Yoruba ethnographic research conducted in Nigeria, the modern era offers opportunities for the use of contraceptives, helps prevent fertilization, and views childbearing as a form of rest, which is contrary to western liberal ideology and the biological sciences' understanding of biological (Pearce, 1995).

Social Environment

Geographical location plays a significant role in shaping access to reproductive healthcare. Poor populations, which are in the countryside or underserved, are frequently deprived of health care in their immediate surroundings, and thus the reproductive healthcare services are more difficult to access (Popinchalk et al., 2019; Singh et al., 2020). Disparities are also increased by the lack of medical facilities in these areas. There are enormous obstacles to reproductive healthcare access that may be posed by societal and cultural norms and attitudes. There is a risk of stigmatization of reproductive health services and family planning, which may deter families and especially marginalized groups to use the services (Blanc et al., 2016). Such stigma may give rise to secrecy and fears of being judged, which hinder the open conversation on reproductive health decisions and requirements. The effects of socioeconomic inequalities in the access to reproductive healthcare are deep and widespread as they impact on different spheres of people lives and health. The lack of access to contraception also leads to increased cases of unintended pregnancy in the poor populations. Unexpected pregnancies may cause negative economic, social, and health consequences to people and their families (Bearak et al., 2018).The unavailability of family planning resources will prevent people in the effectiveness in the ability to control their reproductive options. Prenatal care, which is frequently related to socioeconomic inequalities, is a major risk factor to the health of maternal and infant health. Studies have indicated lower socioeconomic individuals have a higher probability of having poor maternal and infant health outcomes, such as increased maternal and infant mortality and morbidity (Krieger et al., 2018; Singh et al., 2019). Poor access to prenatal care may lead to complications and health disparities that are avoidable. Limitations to safe abortion services may prompt people to resort to unsafe methods, which are life-threatening to their health and welfare (Popinchalk et al., 2019; Singh et al., 2020). The issue of socioeconomic differences in the accessibility of the abortion is especially troubling because those who have less resources can choose unsafe procedures, which can result in complications and related health issues as well as even death. A solution to the socioeconomic differences in the access to reproductive healthcare is important to promote health equity and ensure that no one lacks access to the services required by their reproductive health. These discrepancies can be alleviated using a number of measures. The financial burden of reproductive healthcare can be reduced among disadvantaged people by undertaking financial assistance programs and increasing the proportion of people covered by health insurance. The programs must also be expansive in the services they offer such as contraception, prenatal care, and abortion services among others and cost should not be a limiting factor (Goldman et al., 2018; Taylor et al., 2020).

Access to reproductive healthcare is also worsened in low and average income nations due to the effect of socioeconomic disparities. Poverty and lack of proper healthcare facilities can restrict even the provision of basic reproductive health services in these locations. The figures provided by the World Health Organization (WHO) that approximately 214 million Lack of access is the primary factor that makes women in underdeveloped countries who do not want to become pregnant not use effective birth control (World Health Organization, 2021).

Cultural and Societal Norms

Cultural and societal norms may also serve as healthcare access facilitators provided, they are associated with the principles of equitable and patient-cantered care. As an example, the cultures, in which regular check-ups and preventive care are valued, will experience high rates of healthcare utilization and enhanced health outcomes (Juckett, 2013; Philbin et al., 2018). Such standards will promote people to visit the doctor to be detected with health issues and manage them early. Besides, some communities have culturally specific healthcare practices, such as traditional medicine or indigenous healing methods, which may form part of healthcare access (Chau et al. 2007). Acknowledging and honoring these practices has the potential to improve the trust between healthcare providers and patients, which would ultimately lead to increased access to and involvement in healthcare (Smith et al., 2020;

Wen et al., 2015). In other cases, access to healthcare can be affected positively by societal norms which support and maintain family cohesion. The cultures with more emphasis on family participation in making healthcare choices might make people pursue medical services and follow treatment regimens (Kagawa-Singer et al., 2010). Good family networks may also offer both emotional and logistical support including the transportation and childcare barriers. On the other hand, cultural and social beliefs tend to be quite a barrier to medical care as well. Among the most frequent impediments, there is stigma about some medical conditions, including mental illnesses, HIV/AIDS, or drug use disorders (Ahmedani, 2011; Earnshaw et al., 2013; Logie et al., 2018).

In addition to this, cultural differences present language and communication barriers that may restrict quality access to healthcare provision. Idioms and expressions, as well as the culture-specific ways of communicating can cause misunderstandings between a patient and a provider (Ngo-Metziger et al., 2018; Wieland et al., 2016). The outcome of language discordance may be insufficient medical history, misdiagnosis, and treatment compliance.

Healthcare systems and providers should focus on cultural competency and patient-centered care to deal with the barriers to healthcare access caused by cultural and societal norms. Cultural competency is the ability to appreciate the cultural and social norm of various groups of patients in order to provide adequate and effective healthcare services (Betancourt et al., 2003; Campinha-Bacote, 2002). Healthcare providers should be trained on cultural competency to enhance healthcare access. It is possible to extend the cultural competency programs and increase the knowledge of various cultural backgrounds of the providers, so that they can provide more culturally sensitive care (Paez et al., 2018). Also, the healthcare organizations may encourage workforce diversity, which means providers must be representative of their communities (Betancourt et al., 2016; Nápoles et al., 2018). Another significant practice that can help to reduce the effects of cultural and societal norms as a barrier to accessing healthcare is patient-centered care that emphasizes collaboration, discussion, and shared decision-making between the patient and healthcare benefactors (Epstein et al., 2015; Stewart et al., 2003). By making patients feel heard and respected, chances are high that they will break cultural and societal barriers to care are overcome.

Awareness about Reproductive Health

One of the elements of patient-provider communication is essential to healthcare awareness and quality. The providers having good communication abilities can build rapport with the patients, provide an open and safe environment to discuss with the patients and also involve the patients in making choices regarding their care (Stewart et al., 2003). Patients when given the chance to be heard and are more likely to adhere to treatment regimens and seek care when they need it when they feel appreciated (Cowan et al, 2007).

The sharing of medical knowledge is only a part of good communication, and there should be active listening, empathy, and engagement with a patient. Listening to the concerns of the patients will allow the providers to learn more about what they need and desire, which is especially essential in managing chronic conditions and complex care (Mejia et al., 2019). Moreover, patient anxiety and overall healthcare experience can be reduced with the help of empathetic communication (Derksen et al., 2019). Another important element of healthcare quality is patient engagement. By involving patients in the process of shared decision-making and explaining to them in a straightforward fashion their health conditions and possible treatment methods, the providers have the power to be made to take charge of their health management (Carman et al., 2013). Patients who are engaged in their medical treatment are likely to adhere to their treatment plans, participate in preventive health and make prudent health choices (Gurtner et al., 2019).

Communication and engagement with patients are not universal strategies. The communication style of the healthcare providers must be adjusted to suit the needs and preferences of the patients. As an illustration, it is possible to have patients who like extensive explanations and who would be willing to participate in the decision, as well as those who like the more directive style. Cultural competence can also be discussed as a factor in effective communication, since the providers need to vary the communication style so that it could meet the cultural norms and expectations of the different patient groups.

Healthcare organizations can assist healthcare providers to have effective communication skills by use of training programs and continuous professional development. These programs may improve the quality of provider-patient interactions, which in turn will increase access to healthcare and patient satisfaction.

Objectives of the Study

1. To find out the socio-economic and demographic condition of the participant
2. To explore the level of autonomy of the respondent about their reproductive health.
3. To investigate the level of awareness among women about their reproductive health

Research Hypothesis

1. Socio-economic factors have a significant and positive influence on women reproductive health.
2. There is a significant and positive role on lack of awareness of reproductive health on the ratio of maternal mortality.

Statement of the Problem

The issue with reproductive health has remained apparent in every society on the planet from the past to the present. Although the nature and scope of women reproductive health have changed with time and between societies, although women have generally always had a lower status than men. From a theoretical, logical, and common sense perspective, the subjugation of women worldwide is not the result of a few, pervasive reasons. However, a plethora of causes have played a role in the global growth of female subordination. The patriarchal social structure is the most prevalent in Pakistani society. This system restricts women's freedom to participate in social, political, and religious activities within society and has an inflexible division of work. The place of women in this patriarchal society is clearly defined in terms of daily tasks. Women are given priority in the home in connection with not being enjoyable. However, for the family to function well, individuals must be cared for as they age and bear and raise children. The social determinants of health, including education, work, political engagement, decision-making, resource management, and access to healthcare and employment opportunities, are major determinants of reproductive health. In a system where women face discrimination, such a position for women in the home and in society is seen unacceptable (Tisdell, 2002).

Theoretical Framework

This study is guided by a theoretical framework adapted from the Socio-Ecological Model (SEM). The SEM is ideal for this research as it moves beyond individual-level factors to illustrate how a woman's decision to use Reproductive Health Services (RHS) is nested within and influenced by multiple, interacting systems. The framework posits that RHS utilization is the outcome of a complex interplay between individual, household, community, and health system factors. The framework is depicted in the following diagram and explained in detail below:

Methodology

A sequential explanatory mixed-methods design was adopted.

Quantitative Phase

A cross-sectional survey was administered to 300 women of reproductive age (15-49 years) across selected urban and rural union councils of Sargodha. A stratified random sampling technique was used to ensure diversity. The questionnaire collected data on demographics, socio-economic status (SES), education, employment, and the utilization of specific RHS.

Qualitative Phase

Following the analysis of quantitative data, 30 in-depth interviews (IDIs) and 4 focus group discussions (FGDs) were conducted with a purposively selected sub-sample of survey participants. This phase aimed to explore the lived experiences, perceptions, and decision-making processes surrounding RH. Key informant interviews were also held with healthcare providers and community leaders.

Data integration occurred at the analysis stage, where qualitative narratives were used to explain and contextualize the quantitative patterns.

Data Analysis

Table 1

Association between Lack of Awareness of the Participants and their Reproductive Health

Lack of awareness of reproductive health	Women Reproductive health			
	Low	Medium	High	Total
Low	70	28	11	109
	45.3	47.7	7.0	100.0
Medium	112	24	15	151
	26.3	46.3	27.5	100.0
High	31	33	60	124
	42.6	42.6	14.8	100.0
	213	85	86	384
Total	34.7	46.0	19.3	100.0

*Chi-square = 20.15 d.f. = 4 P-value = .000** Gamma = .144* ** = Highly significant

Table 1 depicted that the participants' ignorance of their reproductive health. The chi-square result indicates a strong correlation between the participants' reproductive health and their lack of awareness. A significant positive correlation between the variables is shown by the gamma value. It implies that individuals' reproductive health was higher when they lacked awareness. According to the above table, participants' reproductive health was classified as low (45.3), medium (47.7), and high (7.0) if they had low awareness; similarly, participants' reproductive health was classified as low (26.3), medium (46.3), and high (27.5) if they had medium awareness; and finally, participants' reproductive health was classified as low (42.6), medium (42.6), and high (14.8) if they had high awareness. This suggests that **H0** is rejected and **H1** is approved. Thus, it is agreed upon that women's reproductive health is positively impacted by a lack of knowledge regarding reproductive health.

Table 2

Association between Socio-economic Influences on Women's Reproductive Health

Socio-economic factors	Women Reproductive health			Total
	Low	Medium	High	
Education	41	60	89	190
	59.3	25.9	14.8	100.0
Income	34	84	13	131
	45.7	41.4	12.9	100.0
Employment	14	04	16	34
	37.4	57.9	4.7	100.0
Business	20	3	6	29
	12.3	50.8	36.9	100.0
	109	151	124	384
Total	34.7	46.0	19.3	100.0

Chi-square = 68.30 d.f. = 8 P-value = .000** Gamma = .420 ** = Highly significant

The relationship among the socioeconomic characteristics of respondent's education and reproductive health is shown in Table 2. The chi-square score demonstrates a strong correlation between socioeconomic status and the health of their reproductive system. A significant positive correlation between the variables is shown by the gamma value. In other words, women with more education had better reproductive health than women who have less education. The income and employment table indicates that women with higher levels of qualification (those with a graduate degree or above) had medium levels of reproductive health (22.6) and high levels (51.6). Thus, it is agreed upon that socioeconomic circumstances have an essential impact on women's reproductive health.

Findings and Discussion

The Economic Prism: Poverty and Financial Dependency

Quantitatively, a strong positive correlation was found between household wealth quintile and the use of SBAs and ANC. Women from the lowest SES bracket were 3.5 times less likely to deliver in a health facility than those from the highest. Qualitatively, this was not merely about the direct cost of services. Participants expressed anxiety over "hidden costs"—transportation, medicines, and the loss of daily wages for a male companion. One woman from a rural village stated, *"Even if the hospital is free, getting there costs money. My husband cannot miss a day of work to take me for a check-up when I am not even sick."* Financial dependency on husbands or fathers-in-law emerged as a critical factor, stripping women of the agency to make independent health-related expenditures.

The Power of Knowledge: Education and Health Literacy

The survey confirmed that a woman's education level was the single most significant predictor of RHS utilization. Women with secondary education or higher were significantly more likely to use modern contraception and seek ANC. The qualitative data illuminated why. Uneducated women frequently held misconceptions, viewing family planning as "un-Islamic" or a cause of long-term illness. They relied on information from older female relatives or *dais*, who often perpetuated myths. In contrast, an educated participant shared, *"I read about the benefits of spacing children for my health and the baby's. I discussed it with my husband, and we visited the lady health worker together."* This highlights education not just as literacy, but as a tool for critical thinking, spousal communication, and challenging harmful traditions.

The Cultural Cage: Purdah, *Gherat* (Honor), and Decision-Making Hierarchies

The most complex barriers were cultural. The norm of *purdah* (seclusion) restricts women's mobility. Seeking healthcare often requires permission from a male guardian (husband or mother-in-law) and a male companion for travel. This creates significant logistical and social hurdles. The concept of *gherat* (shame or honor) was particularly potent concerning gynecological issues. Women expressed extreme discomfort at the prospect of being examined by a male doctor, and many families considered it a matter of family honor. As one mother-in-law asserted, *"What will people say if my daughter-in-law goes to a male doctor? It brings shame on the family."* This often led to a preference for unskilled *dais* who were female and known within the community, despite the associated health risks.

The Gatekeepers: Male Dominance and the Role of Mothers-in-Law

Quantitative data showed that only 22% of women reported being the primary decision-maker regarding their own healthcare. Qualitative interviews confirmed that the husband is typically the ultimate authority, especially for financial decisions like facility-based delivery. Meanwhile, mothers-in-law wield immense influence over daily household matters and childcare practices, often advocating for traditional methods over modern medicine. A young bride explained, *"My mother-in-law says she delivered all her children at home with the dai. She asks me why I think I am special and need a hospital."*

Conclusion and Recommendations

Women's health needs are not adequately and ineffectively met by the nation's health policies and services. In particular, the field of reproductive health care is essential to addressing the expanding health requirements of women and children, which are inadequately defined and addressed by population and health policies. Attempts to create health policy were made often. Despite this, Pakistan has consistently signed agreements like the 1985 Nairobi Forward Looking Declaration. Every component of health is an essential human right. Inequality in health is caused by a number of factors that affect people's health and have intricate linkages with other cultural and social aspects of a society. Social determinants of health play a crucial part in health issues; their effects on women's fertility and childbearing must be taken into consideration when making decisions and developing policies at both the macro and micro levels. Based on previous research and solid data, this study attempts to identify the socioeconomic determinants that impact women's reproductive health. Which gave Gender equality, equity, and women's empowerment a high priority and served as justification for changing development and population policies in order to achieve sustainable development and improve reproductive health? Policies, initiatives, and commitments to guarantee women's reproductive health requirements have all been systematically insufficient to address these socioeconomic and health implications. The study's findings showed that rate of illiteracy is very high and that the proportion of women and girls who have completed elementary, secondary, and higher education is very low, Large numbers of women in rural areas were discovered to be unpaid laborers, to have little or no access to health services, to participate little or not at all in social and political activities, and to marry young. The findings also showed that women in rural Punjab had a low status. Because these rules inculcate girls as inferior than boys, they inhibited celebration of female births. Women's social and personal lives are governed by these cultural norms, which also prevent them from participating in decision-making processes and limit their social mobility. Most women in the nation accept that they will always be beaten by their husbands. The following conclusion, which is consistent with the study's goals, can be drawn from the aforementioned findings. First, compared to women who are in charge of making their own health decisions, it may be argued that women whose partners make all health decisions had more children than is desired. Second, compared to women in the wealthiest homes, those in the

poorest households were more likely to support fertility above the recommended threshold. Additionally, this study concludes that women's employment situation has a substantial influence on their fertility decisions since jobless women are more likely than employed female to have number of children than is optimum. Lastly, compared to women with higher levels of education, those without any formal education were more likely to be more fertile.

As a result, the following suggestions have been made for policy purposes:

To promote women's decision-making autonomy in the family, the government and other stakeholders must first expand empowerment initiatives that explicitly target reproductive women, such as fashion design and basic computer literacy. Women's socioeconomic well-being must also be maintained and enhanced by the government and policymakers through widespread school enrollment and the development of entrepreneurial skills. Lastly, in order to change some religious and cultural practices that restrict women's status and prevent them from making decisions about matters pertaining to their reproductive health, the government, religious leaders, and traditional authorities must work together.

Therefore, more research is required to examine the connection between women's autonomy to exercise their sexual and reproductive health and exposure to message content relating to these topics.

As with other elements of health, promoting the health of women's reproduction and childbearing requires taking into account the social factors that have a significant and indirect impact on their health. The most significant socioeconomic variables that impact reproductive health and childbirth, according to several research conducted globally, are Micro and macroeconomic determinants (household well-being index, median family earnings, national income criteria, expenses for living and education, costs associated with reproductive and maternity healthcare, and discrimination based on race, ethnicity, or nationality (with a focus on immigrants, racial, and religious minorities) and sociocultural issues (employment, educational attainment, family socioeconomic and cultural class, sociocultural standards like the ideal number of children in a household, gender preference, common age for marriage and sexual activity, and marital status), and socio-geographical elements (nation, province, and area of residence, as well as urban status). These factors should receive particular consideration when developing health-related policy across the nation. These are some recommendations for enhancing Punjab, Pakistan's rights to reproductive health. Preventing early marriage requires taking measures that specifically target the relevant social groups. By means the government should construct additional health care facilities close to every hamlet as a dynamic and effective communication tool to change parental behavior and increase awareness of the true costs associated with early marriage. Therefore, the centers are easily accessible to rural women to raise the standard of health.

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