

**EARLY MARRIAGE AMONG WOMEN  
IN PAKISTAN**

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Thesis  
entitled

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**EARLY MARRIAGE AMONG WOMEN IN PAKISTAN**

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**ABSTRACT**

In South Asian societies, including the Pakistan, the mean age at marriage is increased over the last 20 years. However, in Pakistan, the legal age at first marriage for women is still only 16 years. Therefore, early marriage has become not only a social practice, but also a social problem. The probability of early marriage is mainly dependent on social pressures, lack of women autonomy and decision-making power, religious and cultural beliefs, and illiteracy. This study mainly focuses on the causes and consequences of early marriage in Pakistan. The objective of this study is to explore the relationship between socio-economic factors, demographic factors, health care services and early marriage amongst women in Pakistan. The study uses secondary data from Pakistan Reproductive Health and Family Planning Survey, 2000-2001. A sample of 1394 women, aged 15-49 years, who had been married at same point in their lives, were used for the analysis. Univariate and Bivariate analysis with chi-square statistics were used to analyze the data.

The study result clearly reveals that all socio-economic and demographic variables have a significant relationship with early marriage. It was found that women, who marry early at an age below 16 years, mainly live in rural areas. Not only, they are mainly illiterate or have only primary education but also their husbands are in the same position. These women have less autonomy regarding their mobility out of the home and less decision-making power. The findings of this study also show that utilization of health care services is adversely affected by teenage pregnancies in Pakistan. Health seeking variables have a significant relationship with age at first marriage. As women empowerment is significantly correlated with a higher age at first marriage, it also leads to greater ability to utilize the health care services.

The findings of this study recommend that the Government should put extra efforts to increase the awareness among the people about the adverse effects of teenage pregnancies and early marriage. Policy should be formulated to increase the legal age of first marriage. A greater proportion of the national budget should be allocated for the women's education in order to encourage them to continue their education as high level as possible.

**KEY WORDS:**                    EARLY MARRIAGE /AGE OF WOMAN AT BIRTH OF  
 CHILD / EDUCATIN /WOMEN AUTONOMY / HEALTH  
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## CHAPTER 1

### INTRODUCTION

#### 1.1 Problem Statement & Justification

Early marriage is a social institution in South Asian societies especially in Bangladesh, India, Pakistan, Nepal, and Sri Lanka. In some parts of West and Eastern Africa, Latin America and Eastern Europe, there is also a common practice among girls to marry early (UNICEF, 2000). A teenage mother is a person, who is no longer a child and is not yet fully an adult. In other words, this is the formative and immature stage of mothers, with regard to reproductive and sexual health. Due to early marriage, teenage girls, who are the most neglected and vulnerable group. There are enormous consequences of teenage pregnancies including the increased number of maternal and infant mortality. Various studies in different countries have shown the relationship between higher infant mortality and early motherhood (Mosley & Chen, 1984, Savitridina, 1997; Adhikari, 2000).

In recent years, several studies have been conducted in the South Asian region, which was mainly focused on the causes and consequences of early marriage; Adhikari, 2000; Ali, 2000; Bhatti et al., 2000; Hakim, 2000; Sathar & Jalil, 2000; Chaudhary, 2001). Teenage pregnancy is a topic of immense interest among the social scientists all over the world. In Pakistan, the probability of early marriage is mainly dependent on many factors such as teenage girls who live in rural areas are more likely to be uneducated or less educated. They are socially pressured to marry early and have and have less autonomy and less decision making power about their lives and have no permission to visit alone in any place. Moreover, 20 percent of young mothers have their first child before the age of twenty, as girls start to marry before the age of 14 (Population Council, 2001-2002).

Although in Pakistan age at marriage has been rising among girls gradually but still it remains high within this conservative society. Especially, girls do not participate

fully in decision-making process about their lives. So, during marriage, mostly parents make decisions to choose the life partners (Adolescent and Youth Survey, 2001-2002) because they think that early marriage offers protection for their daughter or more generally offers the care of a male guardian. A study found that most young mothers have no knowledge about health seeking care; as a result, a large number of women suffer from unnecessary risks associated with childbearing, indicating a high burden of disease and death.

Early marriage and childbearing are getting more concern due to the adverse health effects of childbearing at young ages (UN, 1992). Reproductive health services, especially maternal and child health care are very poor in Pakistan. The most recent survey, Pakistan Reproductive Health and Family Planning Survey (PRHFPS, 2000-2001), also indicates that age at marriage in Pakistan is mainly affected by early marriage, the low education level of parents, a poor service delivery system, low rate of attendance in antenatal and postnatal care services, low access to primary health care services and a lack of information about reproductive health. All these factors make the situation harder, especially when many females marry before 16. In Pakistan, about two-third of pregnant women received no antenatal care and almost 77 percent of births occur at home, usually attended by untrained birth attendants (PRHPF, 2000-2001 & UNFPA, 2003).

In Pakistan, the legal age at marriage is very early in comparison to other countries. Officially, it is 16 years for females and 18 years for males (Hakim, 2000). The overall impact of this situation is further magnified in the rural areas because the age at marriage is slightly lowered for both men and women. Due to the religious and cultural beliefs, parents often feel somewhat relieved after the marriage of their daughters (Hakim et al, 2001; Population, 2001-2002). Moreover, 18 percent of female ages 15 to 19 years have married to men 10 years older (Pakistan Contraceptive Prevalence Survey, 1994). Same study indicates that teenage married women face social pressure, as a consequence of early marriages, to have child immediately after marriage in order to prove their fertility.

A study in India describes consequences of early marriage that the mortality is high among infants, who are born to teenage mothers. This happens because of the psychological immaturity of teenage mothers, who do not have experience in taking

care of their children. Furthermore, the higher incidence of death also relates to the physiological immaturity of the reproductive system of these young mothers. Their reproductive systems are not mature enough to manage the process of pregnancy and childbirth (Jain & Visaria, 1988). Similarly, the World Health Organization (WHO) reported that early marriage and childbearing are playing an important role on the probability of dying among the infant, because of substantial and adverse health effects on the immature bodies of the young mothers at the time of delivery (WHO, 1992).

In Pakistan, the reproductive health problems are mainly higher among the younger mothers in comparison to the mothers who are older in age. Although there are numerous reasons for this issue, one of the most important factors is the young age of the mother. A mother is the person who usually takes major responsibility for the cares of the child, starting from the time of fertilization through the process of pregnancy and childbirth, even after childbirth. Therefore, early marriage behavior, in regard to infant health care, is crucial, and this behavior influences the physiological and psychological readiness of the young mother to handle situations and to make the right decisions in regards to her child health issues.

Although, age at marriage is increasing throughout the world but still in Pakistan, substantial numbers of teenage girls still marry earlier. So, it is needed to explore the relationship between early marriage and different socioeconomic & health seeking factors. There are few studies on age at first marriage that clearly identifies the consequences of early marriage among women. Some studies identify that socioeconomic factors such as female labor force participation, formal education, urbanization and acquisition mainly influence women's age at marriage. In those countries where there are high proportion of women with secondary education, the probability of marry at an early age is lower (Nugyen, 1997).

Keeping in view the challenges faced by Pakistan in young mother's reproductive health, we need to develop strategies to build a critical policy and program implications to increase the age at first marriage. So, in this study, early marriage will be considered as a key factor in order to identify the relationship between early marriage and other socioeconomic & health seeking factors.

In Pakistan, many preventive programs have focused on reproductive health care but no program has ever concentrated on teenage motherhood. There is a lacking of research in this field, which leads to creating the demand to explore the relationship to identify the related factors responsible for the consequences of early marriage, from the point of view of reproductive health and the social context.

Understanding the influences of different factors on early marriage can also help to develop a strategic plan for maternal health care in Pakistan. In addition, this will help to improve the quality of life of the women. In Pakistan, children are exclusively born within wedlock, so if the findings of this study can support the argument on biological immaturity of the teenager mothers as the cause of the high premature pregnancies, then this study will help the policy makers to increase the national and legal age at marriage, which, in turn, may bring a great change in the women's reproductive health care of the country. Furthermore, the outcome of this study can aid the government to review the present strategies and to formulate effective policy & strategies to achieve the targets that have been set for improving the women's reproductive health care of the whole country.

## **1.2 Background of the Study**

The Islamic Republic of Pakistan is the sixth most populous country in the world after China, India, the former USSR, USA, Brazil and Indonesia. The population increased from 34 million to 132 million between in 1951 to 1998; the estimated population of over 149 million in mid 2003 and around half of its population is below the age of 20 years (Economic Survey of Pakistan, 2001-2002). Two-thirds of the population lives in rural areas where access to basic needs such as primary health care and education are inadequate. Pakistan is divided into four provinces, Punjab, Sindh, Balochistan and Northwest Frontier (Pakistan Demographic Health Survey, 1998). Pakistan is comprised of several ethnic groups and they are heirs to the cultural legacy. More than 97 percent of the population is Muslim and the character of the country is strongly marked by Islam. The overall literacy rate is estimated to 31 percent and among rural women is below 25 percent (Pelon, et al., 2000). The female literacy rate in Pakistan is among the lowest in the world and approximately 72 percent of women have never attended a school.

Marriage patterns vary in every part of the world. In literature, there is no specific definition for early marriage or for late marriage. Most of United Nations publications refer to early marriage for women as approximating singlulate mean age at marriage (SMAM) of 21 years or younger (United Nations, 1990). But in Pakistan, early marriage is considered when the marriage of female occurs at the age younger than 16, because of the legal age of marriage for female is 16 years. However there have been some reasons for a continued preference for teenage marriages and their effects. Mostly the socio-cultural determinants and perception of female autonomy associated with early marriages. In Pakistan, marriage within the family provides less autonomy for the girls, who are married at teenage has face considerable pressure and interference from in-laws especially decision making and mobility (Hussain, 2000). It have been found that women who were teenage marriages have relatively more restrictions on their mobility, decision making, such as restrictions are perhaps reflective of the more conservative societal norms (Pelon, et.al., 2000).

Globally, age at marriage is reducing, almost everywhere. In Pakistan, the average age at marriage is increasing for both men and women. Empirical studies in developing countries in general, and in Asia in particular, basically support Goode's, explanation. At the aggregate level, there are strongly relationship between level of education, degree of urbanization and likelihood of young women delaying their first marriage (Minh, 1997). Education appears to be the most important predictor of changing marriage patterns.

In Pakistan, where the demographic transition is still under way, marriage norms have been uniformly very favorable to high marriage prevalence and early marriage. Marriage is almost universal in Pakistan, both for males and females. This is reflected by the high proportion (92.5 percent) of the population who were ever married in the age group 45-49 years (Pakistan's Population Statistical Profile, 2002). According to recent survey, the singlulate mean age at marriage by sex 27.1 among boys and 22.7 for girls (PRHPS, 2000-2001).

Despite a general tendency of declining age at marriage in the world, there is still enormous variation among regions and countries. Therefore, the International Conference on Population and Development (ICPD) Cairo stressed the government

and non-government organization to design programs to meet the special health needs of adolescents mothers by establishing appropriate adolescent programs (ICPD, 1994).

It is found that in South Asian societies, including Pakistan, the mean age at first marriage has increased over the last 20 years. However, in Pakistan, age at marriage has gradually declined during the last three decades since independence in 1947 (PRB, 2001), it still higher as compared to others developing countries.

**Table 1.1** Percentage of married girls aged 15-19 years, average age of first marriage by sex for selected Countries

Country	Year of census or survey	<u>Average age at first marriage</u>	
		Males	Females
Bangladesh	1981	23.9	16.7
India	1981	23.4	18.7
Ireland	1988	26.7	25.3
Maldives	1985	22.1	17.9
Nepal	1981	21.5	17.9
Pakistan	1981	24.9	19.8
Sri Lanka	1981	27.9	24.4

**Source:** United Nations (1991).

During the first half of the twentieth century until 1970, in most Asian countries, the typical pattern was one of early and universal marriage, especially among women. Since, 1970, however, Asia has experienced a trend towards later age at marriage. In all Asian countries, except most of those in South Asia, the current female singulate mean age at marriage (SMAM) is over 20 years (Minh, 1997). Table 1.1 also shows a considerable difference between males and females in terms of major demographic related to the pattern of age at first marriage. The proportion of ever-married women for females is lower than for males.

Improving age at marriage in a society is not an easy task since it depends on various factors such as socio-economics and demographic situation, health care practices, attitude and behavior (Pant & Acharya, 1997). In fact, there are plenty of evidences of reduced risk of sickness. Much of the variations between developed countries and developing world in health care seeking among women can be explained by differences in provision and utilization of essential obstetric care (UNICEF, 1995).

### **1.3 Research Question**

What is the relationship between socio-economic, demographic and health care services and early marriage among women in Pakistan?

### **1.4 Objective**

To explore the relationship between socio-economic, demographic, health care services & early marriage amongst women in Pakistan.

## **CHAPTER 2**

### **LITERATURE REVIEW**

The purpose of this chapter is to review the theoretical literature on early marriages to investigate the relationship between early marriage socio-economic, demographic and health care services in Pakistan. Evidence for relationship between early marriage and other factors emerges from many settings around the world especially in South Asia. Second, various studies have tried to determine why some women in Pakistan marry early. Pakistani society is very traditional, and parents can influence the timing of marriage. It is very important to understand the early marriage phenomenon and relationship on several different levels. A large literature describes the effects of age at marriage and other socioeconomic and demographic factors on early marriage. On the other hand potential feedbacks in this system have been largely ignored. In this regards, it is necessary to explore the level of influence of early marriages percentage on the age at marriage using the existing scope of literature and to suggest new approaches on the above-mentioned issue to assist the Government and policy-makers working in this field.

#### **2.1 General Overview**

The phenomenon of early marriage has long been a part of demographic analysis but most of the researches focus on mainly on age at first marriage. Early marriage has been considered relevant for public policy issue because of marriages are expected to results in childbirth with in a few years of couples living together (Adhikari, 2000). During the first half of the twentieth century until 1970, in most Asian countries the typical pattern was early marriage, especially among women. Since 1970, however, Asia has experienced a trend towards later age at marriage (Minh, 1997; Adhikari, 2000). In the past, a number of studies have been done in different countries to find out the factors affecting age at first marriage. But there are few studies that paid fully

attention on consequences of early marriage. Some of the studies are reviewed in this chapter.

In this study, the socioeconomic, demographic and health care seeking factors have been defined as responsible for the early marriage. Socioeconomic, demographic, health care seeking and early marriage are reviewed here to formulate the conceptual framework and hypothesis of this study.

### **2.1.1 Socio-economic and Demographic Factors**

There are certain socioeconomic and demographic factors that are associated with age at first marriage namely, age of women, women's education, husband's education, place of residence and women autonomy. Following factors were reviewed from previous studies.

In contrast some studies point out that the age of the women has no significant effect on the health of the mother or on the birth outcome. The poor effects having been attributed to the low socioeconomic status associated with teenage pregnancy. This picture is further magnified in developing countries where high short spacing, premarital pregnancy, disadvantage groups such as blacks, illiteracy and school dropouts predominate (Cramer, 1987; Mangold, 1983; Geronimus et al., 1994). The age of the women is highly associated with the age at first marriage of woman. Studies in various countries have consistently shown that infant mortality is closely related to maternal age. Many other factors are also related to age at marriage, such as socioeconomic and teenage mothers biological factors. The maternal age may not have accounted for the social and environmental effects that are related to women and childbearing (Geronimus et al., 1994).

One study in Nepal highlights the social and demographic consequences of early marriage and childbearing among women age 15 to 19 and 20 to 24 years. Teenage marriages were common in Nepal in the past, although the situation has been rapidly changed and age at marriage has been increased from 15.4 years (in 1961) to 18.1 years (in 1991). At the same time almost 44 percent of all girls were married in 15-19 age group and they have a double risk of own death due to teenage pregnancy (Adhikari, 2000).

Another study in Nepal has also shown an association between teenage pregnancy and hypertension and anemia as a result of teenage pregnancy. Similar study found that fetal loss and abnormal deliveries were higher among teen mothers, as well as it showed the adequate social, economic support and good access to prenatal care factor determining higher mortality for mothers of all age groups (Ahmed et al., 1994).

Frazer et al., (1995) found young mothers 13-24 years old most white and middle class Americans, showed that young age conferred an increased risk of adverse pregnancy outcomes that was independent of important confounding socio-demographic and health factors. However, this study will focus on the most important variable - age at first marriage toward early marriage, and other variables, to which extent there is a correlation with dependent variable. The higher incidence of death is the reason of physiological immaturity with the reproductive system of these young girls, who are not mature enough to manage a birth. Young mothers also have been seen to have higher chances of delivering babies with low birth weight because they are too young to become pregnant. Children who are born to teenage mothers have a low-risk survival due to poor health. This is needed to discourage teenage marriages and to avoid teenage pregnancies. About 60 percent of teenage pregnancies throughout the world are unplanned because of the age of mothers; those are not physically or psychologically ready for childbearing (Government of Bangladesh, 1998).

Education is a basic way to improve the quality of life. One of the aspects of the social development is literacy among reproductive age, which seems to be associated with the level of age at marriage. Many studies found that the strong positive effect of maternal age has seen to be overcome by the presence of maternal education (Pebley & Stupp, 1987; Schkolnik, 1991). The maternal educational level can affect the age at marriage by influencing her choices and increasing her skills in health care practices related to nutrition, hygiene, preventive care, and disease treatment (Mosley, 1984; Behm, 1991). Paternal education is reducing an infant's risk of dying and also it was found that educated mother may care for their children differently from more poorly educated mothers, even if both have the same economic resources (Pebley, 1984).

There have been many attempts to explain the change in the pattern of age at marriage. Goode's modernization theory (1963) emphasizes the impact of

industrialization on marriage patterns. It is argued that modernization operates at both societal and individual levels by affecting marriage timing. Modernization theory hypothesizes that, in the processes of modernization individuals with higher social status (more education, modern occupational roles etc) want more freedom, and thus tend to marry later in life.

Women education is the second most important variable presented as a socio-economic factor of this study. A study in rural Bangladesh found that children of mothers with no education experience 5.3 times the IMR compared to children whose mother had completed seven or more years of school (D'Souze, et al., 1984). Number of years of formal education is related to change in a woman's status, which increases her decision-making capacity, specially the health care activities for her children.

In Pakistani society educational attainments are a reflections of socio-demographic status of women. Thus educational attainments can be used as a measure of higher knowledge of the world and when they marry they have unrestricted relationship with their husbands. Higher education may change a woman's attitude to her family and to the community and permit her to act more effectively on her knowledge. In this regards Hakim found that women with no education on average, marry four years earlier than women with secondary education (Hakim, 2000). While the state of education in Province Punjab is actually poorer than in the rest of Pakistan and if you compare it with Indian Punjab, then it is found that the literacy rate is 68 percent, which is almost double to Pakistani Punjab (44 %). However, in Pakistan, female literacy is 32 present of the total population and the lowest amongst the South Asian region (Kadi, 1987).

Teenage mothers by virtue of their young age are generally less educated than older mothers. Becoming a mother at a very young age obviously interrupts the education chances, thus most teenage mothers never complete their schooling (Finkel and Finkel, 1983). Several studies showed that the illiterate women are married earlier than those who were literate. All these possible indicators show that educational attainments increase the knowledge and confidence of the woman in childrearing skills and survival.

Husband's characteristics also play a key role in determining the age at marriage of women in traditional society. Education of husband's is a strong social-economic

character influencing on reproductive health of women but it has been found to be secondary importance as compared to the women's education (Sathar & Jalil, 2000; Scholnik, 1991). A husband's higher education was interpreted to represent higher income scales, better living conditions, positive change in attitude towards child health, improved decisions taken for child care and a possible increase in the sense of responsible fatherhood (Schkolnik, 1991; Hill, 1991). But Hill, (1991) again inferred paternal education, like maternal education, has no significant effect if it is less than primary schooling level.

In Pakistan, education of father increases from no education to secondary and above (Hakim et al., 2000). For father, particularly in the urban areas, educational level usually correlates with his income. Moreover, in many cases the father's education may also influence attitudes and, thus, preferences in choice of childcare services because this effect more likely to be most significant for child survival (Mosley & Chen, 1984).

In short, parental education affects age at marriage through the various mechanisms. Some of them operate through the social conditions associated with nature of the father's work. Others operate directly, in ways, which are similar to the effects of maternal education (Behm, 1991). There is a probability that the relative importance of these two groups of mechanisms depends upon the contextual stage of development, the socio-economic level of the households and the social class to which it belongs toward the age of mother.

Early marriage is more common in rural areas than in urban areas, in the case of cities and towns. One study results shows that the proportion of women who married early is higher in the cities and towns than in rural areas. This could be explained by the number of women who migrated from rural to urban areas (Savitridina, 1997). Migration can occur before marriage, or soon after marriage, or long after marriage. The place of residence is also determined by the series of socioeconomic factors, which are closely linked to the causes of death of child.

A cross-national study by the United Nations, (1988) indicates the patterns of timing of marriage, i.e. marriage took place earlier in rural than in urban areas. Because, at the individual level, urbanized, modernized population subgroups and

individuals have better economic condition, which are associated with changes in marriage norms, they tend towards later marriage.

It was found that degree of urbanization of the place of residence is usually negatively related to age at marriage because women who live in rural areas more likely to marry earlier compared to those who lives in urban areas (Minh, 1997). In Pakistan, these two settings are quite different from one another. For example, modern amenities of life such as good roads, an efficient transportation system, shopping centers and variety of educational institutions are commonly available in the urban areas more than in rural ones. Similarly modern health facilities are available only in the urban areas. All these facts have an impact on the behavior of inhabitants (Ali M., 2000). Taking into account all the above-mentioned it can be concluded that the place of residence is highly related to accessibility to health services.

In the case of Pakistan it was observed that the reproductive health problem is higher in rural areas as compared to urban areas in Pakistan, especially, in the agricultural sector, the complication among young mothers are slightly higher. Thus, it is easy to assume that the place of residence may have significant impact on early marriages. At the same time geographical differences are also examined that they are to be significant or not. The question whether these differences could be related to variations in the health infrastructure is beyond the area of this study.

The term 'autonomy' has widely different meanings into Pakistani and regional languages. Among Pakistani society, women have some restriction to mobility and have less autonomy to make household and health decision on their own and her child (Hussain, et al., 2000). One of the reviewed existing studies described the young mothers' mobility, alone outside home. The study explained the facts that the young mothers who had no permission to go outside of home and also they practice traditional Pardha were to be 1.5 times more likely to experience infant death than those mother who had permission to go outside and did not observed traditional Pardha (Sathar & Jalil, 2000). Similar study also pointed out that the meaning of social norm is that women autonomy, because teenage mothers are hesitant to discuss health problems and they without treatment unless they are severely ill. The effect of women autonomy could be assumed to be associated with health practices and child rearing practices (Sathar, 2000). The major reasons for decision-making among teenage

married women are decision-making and mobility. It is necessary to mention that they are positively associated with pregnancy and childbirth problems. Hence, in case of young mothers for recognition of the warning signs in pregnancy and childbirth and the problems in neonates for which immediate medical care is essential (Faisel, 2001). Moreover, women have no power to make a decision on their marriage and pregnancy due to the lack of women empowerment.

A study in rural Punjab described the status of women namely freedom of movement, decision making authority and access to financial resources which are expected to be associated with reduced maternal risks (Durrant & Sathar 2000). In other words there is definitive evidence from the example of rural Punjab Pakistan that women's autonomy has strong negative influence on age at marriage toward her health care seeking behavior.

### **2.1.2 Age at First Marriage**

In this study, the factor which is supporting the young mother have been conducted as cross-sectional and have concentrated only in those areas of Pakistan, where teenage motherhood is widely lower. In the same way the health's factor likes, health complication of teenage mothers, have a relationship between age at marriage.

The age at which women marry is one of the important factors in the framework of population growth issues. It was found that women who marry early will on average, have a longer exposure to the risk of becoming pregnant and early childbearing (Adhikari, 2000). A study result in Indonesia shows that 70 percent of ever married women in Java married early, although age at first marriage increases from the older group of women to the younger group of women.

The age at marriage has been rising for girls in Pakistan since the 60s. But there are striking differences. With more education, girls tend to marry later and therefore they tend to have children later in comparison with their other counterparts. There is no complete study in Pakistan to examine the age at first marriage as predictor of early marriage. Early marriage and early childbearing are common behavioral pattern for Pakistani women.

One study in Indonesia shown that early marriage among women has more negative than positive effects. From a demographic perspective, early marriage

lengthens the duration of the period a woman is at risk of getting pregnant (Savitridina, 1997). Further more, the age at first marriage between Sundanese and Javanese in Indonesia reflects the cultural view and a girl who is not yet married by age 17 is an “old maid” who will disgrace her parents.

One of the most important factors is the age of mother at birth of child. One study in Malaysia has show that babies borne to teenage mothers (less than 19 years old) had high risk to die during the first year of their life and it was interpreted to be a biological effect and health care seeking factors that might cause infant deaths would not normally show up until later in infancy (DaVanzo, 1984).

In this study the age at first marriage will be explored as a dependent variable, which will explain the relationship age at marriage.

### **2.1.3 Health Care Seeking**

South Asia is the only region of the world where men outnumber women in the total population This discrepancy of women relative to men stems from various forms of lifelong discrimination against girls and women, particularly from the health care services. Discrimination is reflected in the female infant and child mortality rates, which are higher for girls than for boys (Visaria, 2002). However, along with socio-economic, early marriage and health care seeking variables such as antenatal and postnatal care, place of delivery and mother immunization have a considerable effect on age at marriage. The detailed review of health care seeking factors is in following.

A measure of health service use that has been shown to be important in accounting for differential infant mortality rates in prenatal and postnatal care of young mothers. Antenatal care refers to pregnancy-related care provided by a health worker either in a medical facility or at home. Appropriate antenatal care is necessary to improve maternal health. Many health care services can be delivered during an antenatal visit, such as tetanus-toxoid, injections, and advice on appropriate nutrition and treatment for anemia and can have a negative effect on the health of the fetus, and identification of high-risk mothers. Antenatal care has been shown to have the strongest impact on infant survival since health workers can identify and treat the leading risk factors during antenatal visits (Ahmed et al., 1994).

A recent antenatal care trial shows that four visits can produce maternal and child health outcomes that are just as favorable as more frequent antenatal contact regimes (Behm, 1991). Health care problems are common among private practitioners and mostly the public sector or Dais and lay peoples carry out deliveries.

A recent study in Bangladesh describing the health seeking behavior among young girls aged less than 20 who had complications, nearly half of the adolescents did not seek any type of assistance for maternal complications and one third opted for some non-facility assistance. Only one fourth of adolescent went to any facility or doctor for their pregnancy or delivery related complication (Government of Bangladesh, 1998)

Analysis from the National Family Health Survey Uttar Pradesh of India, Rajna et al., (1998) found that among the health service variables antenatal care of the mother during pregnancy as well as assistance at delivery played an important role in explaining the survival of infants during first year of life. As expected, they found that woman who had received antenatal care showed significantly lower odds of dying. In Pakistan, only 35 percent of women received any antenatal care form doctor and 28 percent had received postnatal care (Hakim, et al., 2001). The higher infant mortality of teenage mothers is related to the inadequate care they usually received during the antenatal period and during deliver.

Immunization of the mother with tetanus toxoid during pregnancy transfers antibodies against the spores causing tetanus in the newborn period, when the baby has no antibodies of its own. The vaccine is said to confer hundred percent immunity to the disease (Jain & Visaria, 1988). It is estimated that 0.5 million deaths are prevented annually in the South East Asia Region. India, Bangladesh and Indonesia contribute about 90 percent of deaths prevented in the region (WHO, 1996). The maternal tetanus toxoid coverage in Pakistan has been reported to be only 23 percent in Demographic and Health Survey, 1990-91. A study found that tetanus toxoid immunization in the three rural areas to be lower than the national average and also increasing childbearing in these areas (Fikree et al., 2000). Mothers who received tetanus toxoid immunization would greatly decrease the number of newborns who develop tetanus. The decline was mainly due to the results of significant increase in immunization coverage of the pregnant women with the protective dose of tetanus toxoid between the years 1989 and

1994, from 27 percent to 48 percent respectively (WHO, 1996). This fact emphasizes the importance of immunization of mother during their pregnancy.

The relationship between the use of service of deliveries and age at marriage as well as teenage pregnancy has been found in a number of studies. Pregnancy, particularly in adolescent, is associated with many life-threatening risks (Siddiqua & Kabir, 2002). It is generally observed that mothers who deliver in hospital are less likely to face with death of their children than mothers who deliver at home under the care and supervision of a traditional birth attendant (Pebley, 1984).

Most pregnant women in Pakistan, India and Bangladesh deliver at home by the help of untrained birth attendant (Dai). Birth attendant is often a family member rather than a TBA. A study in Bangladesh indicates that only 8 percent of women nationwide had a medically assisted delivery. Only 6 percent of rural and 35 percent of urban women use medial assistance during delivery (Pelon et al., 2000). Moreover, the study finding shows that around 44.4 percent of married female aged less than 20 visited in Government/health center/maternal and child welfare center and only 16 percent visited NGO and private health facilities in Bangladesh.

Pakistan has a specific traditional culture of birthing in its rural areas. This culture comprises predominance of traditional values, beliefs and practices related to pregnancy and childbirth; reliance on untrained traditional birth attendants and older women of the family for assisting in the delivery; lack of awareness regarding MCH issues; lack of faith in the modern medical system; weak position of young mother's; physical, social, economic and cultural barriers to accessing and utilizing essential obstetric care are the problems.

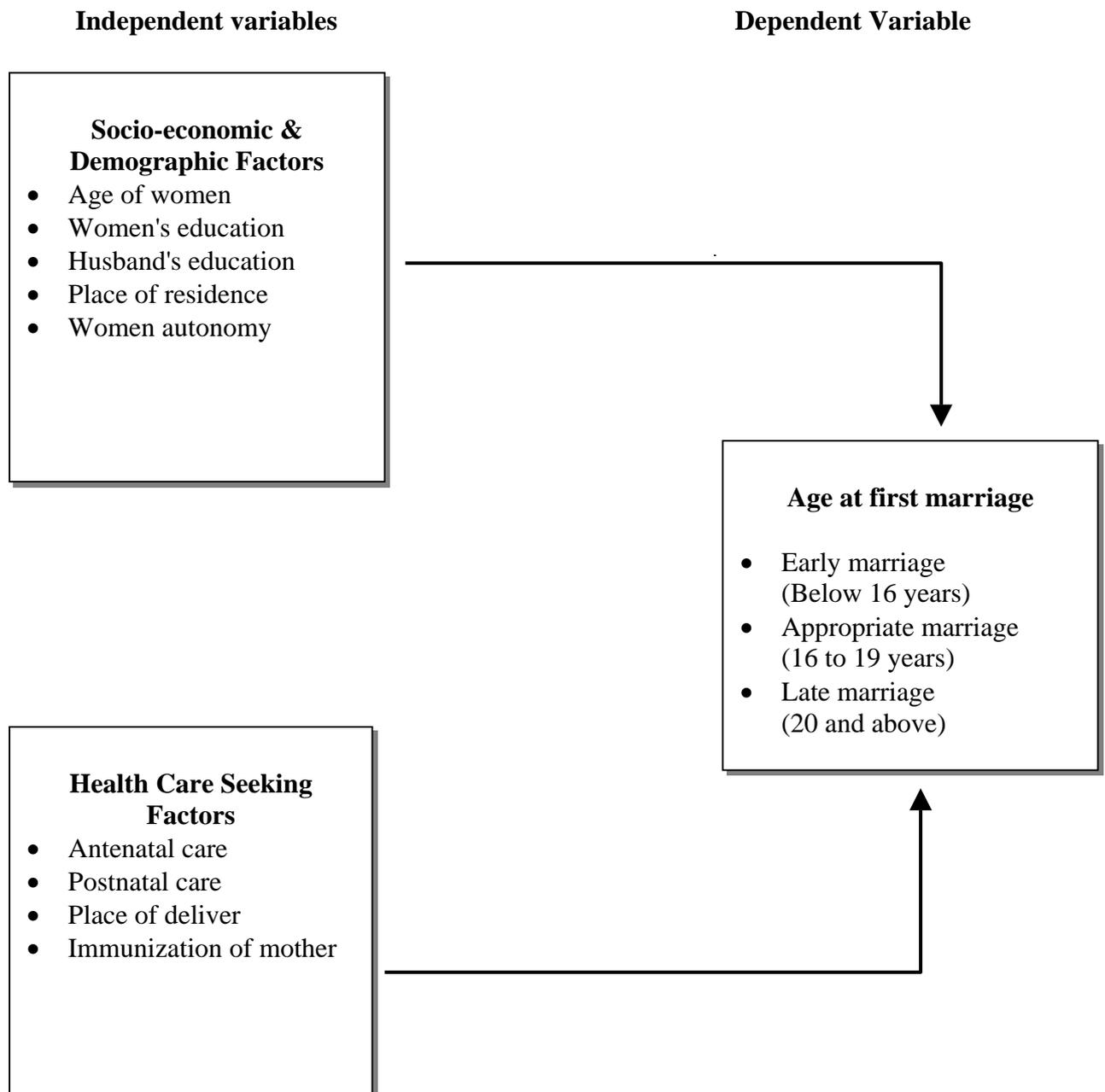
Safe delivery of a newborn is seen to be dependent on the availability of trained personnel for assistance during delivery. In Pakistan, a very substantial percentage of birth deliveries take place at home with the help of Dais or traditional birth attendants. Almost 77 percent of women had delivered their babies at home out of all deliveries and only 23 percent of deliveries occurred in government and private hospitals. In Nepal, less than 10 percent of deliveries take place in a health facility (Visaieia, 2002). Over the last decades the proportion of deliveries conducted by a trained person has not shown any improvement. Although the one study data shows that education is positively correlated with deliveries in hospitals, that is, women with high education

are more likely to deliver their babies in hospitals (Hakim et al., 2001). Safe delivery of a newborn by motivated Dai was seen to prevent a number of complications such as hypothermia, hypoglycemia and infections during the infant period (Costello, 1993; Ibrahim et al., 1992 & Hakim, et al., 2000). Often untrained attendant at birth leads to incapacity to deal with resulting infections and complications of childbirth.

## **2.2 Conceptual Framework**

From the literature review it was found that there is a number of factors that affect early marriage. This study investigates the relationship between early marriage and socioeconomic and health services factors that effect early marriage in Pakistan. Early marriage is the dependent variable to explain the subsequent effect among married women. Though, socio-economic status such as age of mother, educational level of the respondent and their husbands, place of residence and woman autonomy are some of the well-established explanatory variables that are responsible for determining the incidence and patterns of early marriage.

**Figure 1 Conceptual Framework for analyzing the relationship of various influencing early marriage among women, in Pakistan**



## **2.3 Research Hypotheses**

- Socioeconomic -demographic factors have significant positive relationship with early marriage.
- Health care seeking factors has significant positive association with early marriage

## CHAPTER 3

### RESEARCH METHODOLOGY

#### 3.1 Source of Data:

This study used secondary data from the Pakistan Reproductive Health and Family Planning Survey (PRHFPS) conducted in 2000-2001 by the National Institute of Population Studies (NIPS), Islamabad, Pakistan. The PRHFPS was a national level sample survey. It interviewed 6857 households in four provinces of Pakistan. In these households, 7411 ever married women aged 15-49 years were interviewed. The aim of this survey was to assess the reproductive health and family planning programme. The survey followed a two-stage sample design obtained from Federal Bureau of Statistics (FBS), Government of Pakistan. At first stage 367 primary sampling units (PSU) were selected in both rural and urban areas with probability proportional to size (PPS). In the second stage, a random sample of households was selected from each of the PSU, and 6857 ever-married women of the selected households were interviewed, indicating a response rate of 93.5 percent.

Two types of questionnaires were used in Pakistan Reproductive Health and Family Planning Survey (PRHFPS), 2000-2001: the Household Questionnaire and the Individual Questionnaire. The Household Questionnaire listed all usual residents of each sampled household. The main purpose of the Household Questionnaire was to list some basic information such as their relationship to the head of the household, sex, age, education and marital status of all household members; and to identify women who were eligible for the individual interviews, that is, ever married women age 15 to 49 years.

The Individual Questionnaire was administered to all ever-married women aged 15-19 who were usual resident or who were present in the household the night before the survey. The individual questionnaire was developed in such a way that it could obtain information on the following topics:

### **3.1.1 Research Design**

A quantitative research methodology is employed to see the association of socioeconomic -demographic factors, health care seeking factors and probability of infant dying on early marriage in Pakistan.

### **3.1.2 Sample Size**

The survey interviewed 6857 ever-married women aged 15-49 year from 7411 nationally representative households. The total number of live births in the three years preceding the survey 5811. This study selected only those women whose delivered their child on last one year of the study period. Therefore, the total number of 1394 cases, which are analyzed for this study

## **3.2 Method of Analysis**

The first analytical point of this study is to investigate the reasons and consequences between early marriage and socioeconomic and demographic factors in Pakistan. Moreover, estimates of health risk factors on early marriage are also required for analysis of ever-married women. The indicators, which can be used to estimate the probability of infant dying for different women age groups, also need priority attention.

This study classifies age at first marriage into three categories. Firstly, an early marriage refers to a women who marry at age below 16 years age. Secondly an appropriate marriage refers to a woman who marry between the age group of 16 to 19 years old. Lastly, a late marriage refers to a woman who marries at age 20 years and above.

Descriptive and inferential statistics is used to explore the background characteristics of the sample population, such as socio-economic, reproductive and health care services factors. The purpose of this chapter is not only to describe the characteristics of the research design, but also to explain the method of analysis using cross tabulations and Chi-square test in order to examine the bivariate relationship between dependent and independent variables.

### **3.3 Operational Definitions**

For assessing the association of early marriage and five socio-economic & demographic variables and four health care seeking and one dependent variable. The variables, operational definition of dependent and each independent variable presented as follows:

#### **3.3.1 Dependent Variable**

##### **3.3.1.1 Age at First Marriage**

Age at first marriage (early marriage) is explained to age of first marriage of woman. Firstly, all ever-married women who are below 16 years considered as being teenager mothers in this study. Secondly, an appropriate marriage refers to those women who married between the age group of 16 to 19 years old. Lastly, a late marriage refers to a woman who marries at age 20 years and above.

#### **3.3.2 Independent Variables**

##### **3.3.2.1 Age of Women**

This variable refers to age of the woman when she was married and measured by their completed age at the time of interview. Four categories is used, firstly, teenage women (under 19) years old, secondly, young women (20-24) years old, thirdly, young adult women (25- 34) years old and lastly adult women (35 -49) years old.

##### **3.3.2.2 Women and Husband Education**

The education variables of women and their husbands categorize into four categories by years of schooling. A zero refers to no education; 1-5 years refers to primary level, 6-10 years refers to secondary level, 11 years and above refers to a higher level of education. All levels of education have been divided according to the education system of Pakistan.

##### **3.3.2.3 Place of Residence**

It is categorized as urban and rural.

#### **3.3.2.4 Women's Autonomy**

This variable refers to women's decision making, whether she has a permission to go outside house or not. It is divided into four categories; has a permission to go any place, outside home or market, health center or hospital and relatives or friends home.

#### **3.3.2.5 Antenatal Care**

It refers to visit to prenatal clinic (Health services staff) for check up during pregnancy. Whether the women received any antenatal care services from any health personnel during pregnancy.

#### **3.3.2.6 Postnatal Care**

Whether the mother received any postnatal care from any health personnel after childbirth.

#### **3.3.2.7 Immunization of Mother**

Mother received tetanus toxoid or not.

#### **3.3.2.8 Place of Delivery**

Place where the child was delivered. It is categorized as at home, government or private health facilities (hospital or health center).

**Table 3.1 Summarized descriptions of dependent and independent variables.**

<b>Variable Name</b>	<b>Operational Definition</b>	<b>Measurement scale</b>
<b>Dependent variable</b>		
<b>Age at marriage</b>	Age at marriage of women Below 16 (early marriage), 16 to 19 (appropriate age) and 20 and above (late marriage)	<b>Ordinal</b> 1=below 16 2=16-19 3=20 and above
<b>Independent variable</b>		
<b>Age of women</b>	Age of women in complete year at the interview time	<b>Ordinal</b> 1 = under 19 years 2 = 20 to 24 years 3 = 25 to 34 years 4 = 35 to 49 years
<b>Education of husband/woman</b>	Level of education completed year by the women	<b>Nominal</b> 1 = no education 2 = primary education 3 = secondary education 4 = higher and above
<b>Place of Residence</b>	Place of residence of women	<b>Nominal</b> 1 = urban 0 = rural
<b>Women 's autonomy</b>	Women’s decision making power	<b>Nominal</b> 1 = need Permission 2 = don’t need Permission 3 = depends
<b>Health Care Seeking Factors</b>		
<b>Antenatal Care</b>	Whether the mother received Antenatal care (ANC) service or not	<b>Nominal</b> 0=received 1=did not received
<b>Postnatal Care</b>	Whether the mother received postnatal care (PNC) service or not	<b>Nominal</b> 0=received 1=didn’t received
<b>Place of delivery</b>	The place where the child was delivered	<b>Nominal</b> 1=home 2=government health facility 3=private health facility/others
<b>Immunization of mother</b>	Whether the mother received tetanus toxiod (TT) during Pregnancy or not	<b>Nominal</b> 1=didn’t received 2=partial completed 3=fully received immunization

### **3.4 Limitation of the Study**

The study used secondary data from Pakistan Reproductive Health and Family Planning Survey conducted National Institute of Population Studies (NIPS) in 2000, which covers 15-49 years all ever-married women. The questionnaires were developed for all reproductive age group women. The main limitation of this study is that there is the only last three-birth of woman.

## **CHAPTER 4**

### **RESEARCH FINDINGS**

This chapter presents the results of the study, which are discussed in three sections. The first section describes the characteristics of married women in Pakistan. The second section presents the results of bivariate analysis, which includes the cross tabulation between each of the independent variables included in the study, with the dependent variable. In the third section, the results from bivariate analysis are summarized and study hypotheses are discussed.

#### **4.1 Univariate Analysis**

Univariate analysis includes the frequency distribution of the ever-married women by selected socioeconomic & demographic characteristics and health care seeking factors.

##### **4.1.1 Socio economic and Demographic Characteristics of Women**

Table 4.1 displays the percentage distribution of ever-married women by different socioeconomic and demographic factors.

A majority of these women, are the young adult women's as they are in the age group of 25-34 years old. The teenage women who are aged under 19 years are the lowest group (7.6 %) The mean age of women of these women is 27.53 years (Table 4.1). According to this study, slightly three quarters of women (74 %) is uneducated. Secondary education among married women is 11 percentage and only 3.5 percent of women have higher education. It is shows that education level is very low among these women ( Table 4.1)

Less than one-third of the women's husband is graduated from secondary education level, whereas 43 percent had no education and only 29 percent of their husbands have secondary education. During the last three-decades, we can note that

generally men have been better educated than women, and though the education levels of men and women have improved in recent times, the gender difference in education is still be around.

Early marriage is more common in rural areas than in urban areas. Regarding the place of residence, it is worth to mention that almost more than two-third (76.4 %) of respondents are from rural areas. Regarding women empowerment, Pakistani women's have less autonomy in decision-making process and mobility, market, hospital or health center, even to relatives or friend house. Sixty percent of women need permission from their husbands or from any other senior family members to go outside of their home. Only 16 percent of women do not need permission from their husband or any senior family member even to go to market. The study results show that 82 percent women need to ask for seek permission from their husband or any senior family member even before going to hospital. The others women (84.4%) have to ask for take permission to visit their relatives and friend. These results indicate that Pakistani women have less autonomy in decision-making process and mobility.

**Table 4.1 Percentage distributions of women by socioeconomic and demographic characteristics**

<b>Characteristics</b>	<b>Frequency (n=1394)</b>	<b>Percentage (%)</b>
<b>Age of Women</b>		
Teenage women(>19 )	106	7.6
Young women (20-24)	361	25.9
Young adult women (25-34)	716	55.7
Adult women (35 and above)	151	10.8
<b>Mean age of women</b>	<b>27.53</b>	
<b>Women's education</b>		
No education	1029	73.8
Primary	168	12.0
Secondary	149	10.7
Higher	49	3.5
<b>Husband's education</b>		
No education	595	42.7
Primary	222	15.9
Secondary	404	29.0
Higher	173	12.4
<b>Place of Residence</b>		
Urban	1065	76.4
Rural	329	23.6
<b>Women autonomy</b>		
<b>Out side home</b>		
Need permission	832	59.7
Doesn't need permission	504	36.2
Depends	58	4.2
<b>Market</b>		
Need permission	1058	75.9
Doesn't need permission	221	15.8
Depends	115	8.2
<b>Health centers / Hospital</b>		
Need permission	1143	82.0
Doesn't need permission	161	11.5
Depends	91	6.4
<b>Relatives/Friends home</b>		
Need permission	1176	84.4
Doesn't need permission	151	10.8
Depends	67	4.8

As obviously mentioned, health care seeking factors especially the antenatal care (ANC), postnatal care (PNC), immunization of mothers and place of delivery practices are taken as the explanatory variables for reproductive health analysis of this study. Table 4.2 presents the percentage distribution of women, by the health care seeking factors, mainly when they are seeking health care during pregnancy, childbirth or postnatal period.

Antenatal and postnatal care, regarding health care seeking during the last pregnancy period, it was found that 50 percent of mothers received antenatal check up from health personal and almost 69 percent of all women didn't receive postnatal care (Table 4.2).

Health care seeking behavior for institutional delivery purpose is very rare in Pakistan, since traditionally, home have been becoming the most common place for deliveries. Table 4.2 shows that the rest of the women have delivered at home (77 %) and less than one third of all women reported their delivery at Government and private health facilities.

As an important component of antenatal care (ANC) in Pakistan, it is ensuring that pregnant women and children are not adequately protected against tetanus. Table 4.2 shows that coverage of TT immunization in Pakistan is very poor. It is noted that more than half of women (65.4) didn't receive any immunization during the pregnancy. Only 3.6 percent of women are completely immunized (Table 4.2)

**Table 4.2 Percentage distributions of women by Health care seeking factors**

Characteristics	Frequency (n=1394)	Percentage (%)
<b>Antenatal Care</b>		
Received form health personnel	704	50.5
Didn't received	690	49.5
<b>Postnatal Care</b>		
Received form health personnel	430	30.9
Didn't received	964	69.1
<b>Place of Delivery</b>		
Home	1074	77.1
Government Health facility	150	10.7
Private Health facility/other	170	12.2
<b>Immunization of Mother</b>		
No immunization	912	65.4
Partial completed	433	31.0
Fully completed	50	3.6

Regarding age at first marriage, more than 40 percent of women are married in appropriate age group (16-19). The finding also shows that nearly 26 percent of women in Pakistan are married below 16 years and 34 percent of women are married when they are 20 years old and above. The results show that the mean age at first marriage among ever-married women in Pakistan is 18 years (Table 4.3).

**Table 4.3 Percentage distributions of women by age at first marriage**

<b>Characteristics</b>	<b>Frequency (n=1394)</b>	<b>Percentage (%)</b>
<b>Age at first marriage</b>		
Early marriage (below 16)	361	25.9
Appropriate marriage (16-19)	563	40.4
Late marriage (20 and above)	470	33.7
<b>Mean age at first marriage</b>		<b>18.23</b>

## **4.2 Bivariate Analysis: Association with early marriage in Pakistan**

As the main purpose of this study is to assess the factors affecting early marriage among women in Pakistan, here an attempt has been made to examine the relationship between each of the independent variables with dependent variable i.e., age at first marriage. As it has been explained earlier that the study will examine correlation of early marriage with two sets of independent variables. The following section would present the results of bi-variate technique of analysis, that is, cross tabulation between age at first marriage with socio-economic & demographic, and health seeking care variables, including chi square test.

### **4.2.1 Socio-economic, demographic factors and age at first marriage among women**

The study includes six socio-economic and demographic variables such as age of women at birth of child, current age of women, place of residence, women education, husband education and women autonomy.

#### 4.2.1a Age of women and age at first marriage

According to the Table 4.4, there are variations in age at first marriage among married women in different current age groups. The dynamics of marriage pattern helps to understand the process at different ages at first marriage when a change in the current age of married women is investigated with of the changes that take place in the age at first marriage.

Fifty one percent of women who are currently under the age of 19 years, got married when they were under 16.

The result shows that this relationship is significant at the level of 95 percent confidence interval.

**Table 4.4 Age at first marriage by age of women in Pakistan, 2000 -2001**

Age of women	Age at first marriage (%)			Total	
	Under 16	16-19	20 and above	%	(n=1394)
< 19 (Teenage women)	50.9	49.1		100.0	106
20- 24 (Young women)	25.0	53.3	21.7	100.0	360
25-34 (Young adult women)	25.4	33.0	41.6	100.0	776
35-49 (Adult women)	12.7	41.3	46.0	100.0	150
<b>Chi-square</b>	<b>135.765***</b>				

#### 4.2.1b Women's education and age at first marriage

The relationship of age at first marriage by women literacy status is prominent in Pakistan. According to Table 4.5 there is correlation of age at first marriage among women obtaining different levels of education. Among the women who have no education, the highest percentage (42.6) as compared to 20 years old and above (26.3 %) and 31 percent women are married below the age 16 years. The women, who have primary education and secondary education, are married at 20 years old or above (42.6 %) compared to below 16 years (18.7 %). Fifty percent of women with secondary level of education were married at the age of 20 and above. So, this study found that the women who have higher education, have a higher percentage of age at marriage compared to those who marry in early age (below 16).

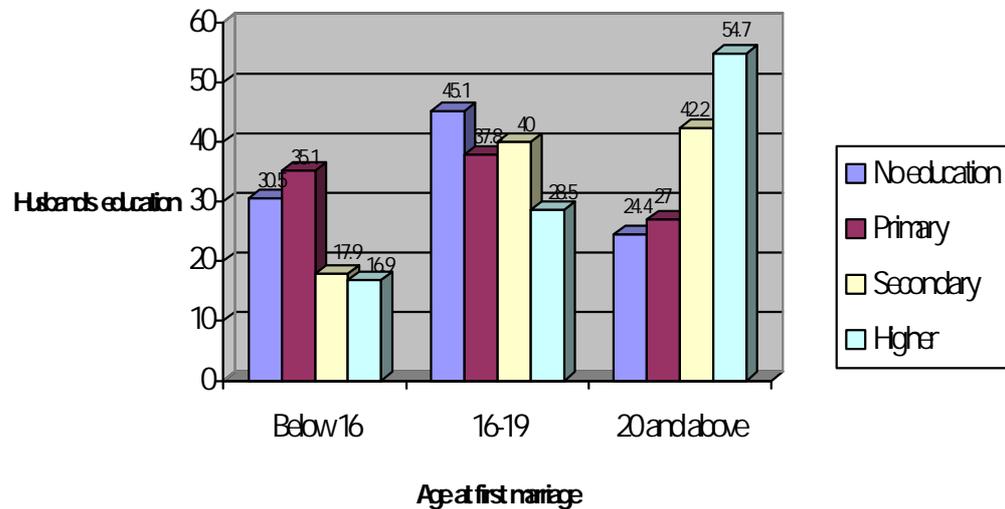
**Table 4.5 Age at first marriage by level of women education in Pakistan, 2000-2001**

Level of education	Age at first marriage %			Total	
	Under 16	16-19	20 and above	%	(n=1407)
No education	31.1	42.6	26.3	100.0	1029
Primary	18.7	39.8	42.6	100.0	166
Secondary	6.0	36.9	57.0	100.0	149
Higher +		8.3	91.7	100.0	48
<b>Chi-square</b>				<b>154.720***</b>	

**4.2.1c Husband's education**

The data on educational attainment for the respondent's husband demonstrate that the level of the husband's education is also influenced age at first marriage among women in Pakistan. The women's husband who were married at the age of 20 and above are more highly educated than the women's husband who marry at the age below 16 years. This is a very common situation in Pakistan that most men look for women who have an education that is lower than or equal to that of their own education. Women who married early have husbands who mainly have no education or only primary education. From the Chi Square statistics text, it was found that the husband's education has the significantly positive relationship with the age at first marriage.

**Figure 2: Age at first marriage of women by education of husband in Pakistan**



#### 4.2.1e Place of residence

As expected, it has been observed that early marriage is higher in rural areas compared to its counterpart i.e., the urban area. Table 4.6 shows a comparison of different age at first marriage by place of residence of mother. According to this table, nearly half (42.4 %) of women who are living in rural areas were more likely to get married between 16-19 years age. Fifty one percent of women who live in urban areas got married at the age of 20 and above. This is an evidence, to point out that woman who are living in urban areas, are getting married late in comparison to those who live in rural areas. The relationship between place of residence and age at first marriage is statistically significant at the critical level of 0.0001 or in 99.9 percent confidence interval.

**Table 4.6 Age at first marriage by Place of residence in Pakistan, 2000-2001**

Place of residence	Age at first marriage (%)			Total	
	Under 16	16-19	20 and above	%	(n=1394)
Rural	29.0	42.4	28.5	100.0	1065
Urban	15.8	33.7	50.5	100.0	329
<b>Chi-square</b>	<b>57.436***</b>				

#### **4.2.1f Women autonomy**

A series of questions were asked about the decision-making role of women in mobility and health seeking affairs. As for example, whether women need permission to go outside of the homes alone or not. This study attempts to observe the correlation of the decision-making role of women with the age at first marriage. Almost all series of question about the decision-making role, has found that the women who married either at the appropriate age or at the age of 20 and above, do not need permission to go to places such as the market, a relatives or friends home and hospital or clinic in comparison to those women who have a permission and those and they were married at the age below 16. They did not need to get the permission from their husband or any other senior member of their family. It shows that the decision-making power of women is strongly correlated with age at first marriage process compared to those women who marry late.

Two-thirds of the total number (1058) of women have no permission to even go to the market compared to those who have permission and this number (220) is very low. However, the relationship between permission to go to the market and age at the first marriage is found statistically insignificant. Regarding permission to visit the hospital, the results show that more than two thirds of the total number of women must need a permission before visiting the hospital compared to those who do not need permission. Although the relationship had been found not to be statistically significant.

It has been found that the women, who married under the age 16, even to visit their relatives and friends, need permission. The Chi-square statistic shows a statistically insignificant association between these two groups.

**Table 4.7 Age at first marriage by autonomy of women in Pakistan, 2000-2001**

Women autonomy	Age at first marriage (%)			Total	
	Under 16	16-19	20 and above	%	(n=1394)
<b>Any place outside home</b>					
Need permission	29.2	39.1	31.6	100.0	831
Does not need permission	21.0	41.4	37.6	100.0	505
Depends	20.3	49.2	33.5	100.0	59
<b>chi-square</b>	<b>14.094***-</b>				
<b>Market</b>					
Need permission	25.9	39.9	34.2	100.0	1058
Does not need permission	22.3	39.5	38.2	100.0	220
Depends	33.0	47.0	20.0	100.0	115
<b>chi-square</b>	<b>12.520</b>				
<b>Hospital/Clinic</b>					
Need permission	27.2	40.1	32.7	100.0	1143
Does not need permission	20.0	42.5	37.5	100.0	160
Depends	20.0	40.0	40.0	100.0	90
<b>chi-square</b>	<b>6.390</b>				
<b>Relatives/friends home</b>					
Need permission	26.1	41.0	32.9	100.0	1177
Does not need permission	26.5	36.4	36.4	100.0	151
Depends	21.2	40.4	42.4	100.0	66
<b>chi-square</b>	<b>3.447</b>				

### 4.3 Health care seeking factors

Table 4.8 presents the relationship between the ages at first marriage with health care seeking factors. As obviously mentioned, health care services, especially the antenatal and postnatal care, place of delivery and immunization of mother are taken as the independent variables to analysis the relationship with age at first marriage in this study. According to the Table 4.8, there are variations in different ages at first marriage and antenatal care. It is found that the women who married either at the appropriate age or at the age of 20 and above, received antenatal check up. In comparison to those who married early, at the age below 16 years. The bivariate analysis has confirmed that ANC visit has statistically significant positive association with different age at first marriage in Pakistan.

In this study the relationship between age at first marriage and postnatal care is also observed, especially between the women who are getting married earlier and those who are getting married late. From the table 4.8, it was found that less than one third of the total sample (430) mothers have received postnatal care. More than two thirds of women, who didn't received postnatal care, were married either at the appropriate age or at the age of 20 or above. The statistics result show that the visit for postnatal care

has formed a statistically and significantly positive relationship with the age at first marriage. Those women who have received assistance from the trained professional during delivery are small in numbers. It was found that the women, who married at or above the age of 16 years, attended either government or private health care facilities for delivery in comparison to those who married below the age 16 years. Though the proportion of children delivered at health facility was very small, is the relationship between age at first marriage and place of delivery is statistically significant? As expected, TT immunization has been found to be an important ANC service affecting young mothers. The results in Table 4.8 shows that more than half of the women of the total sample did not receive immunization at all. It was found that the women who had received full immunization, married either at or above the age of 16 years. In comparison who did not receive fully or partially completed immunization. The relationship between TT immunization and age at first marriage was found statistically highly significant ( $P < 0.001$ ).

The results of bivariate analysis between the health care seeking factors and age at first marriage is presented in the Table 4.3 as follow:

**Table 4.8 Age at first marriage by health care seeking factors in Pakistan, 2000-2001**

Health care seeking factors	Age at first marriage %			Total	
	Under 16	16-19	20 and above	%	(n=1394)
<b>Antenatal check-up</b>					
Received	20.5	44.6	35.0	100.0	693
Doesn't received	31.3	36.2	32.5	100.0	715
<b>Chi-square</b>					<b>22.392***</b>
<b>Postnatal care</b>					
Received	28.8	42.3	35.9	100.0	430
Doesn't received	24.6	39.5	28.8	100.0	964
<b>Chi-square</b>					<b>7.044***</b>
<b>Place at delivery</b>					
Home	27.9	40.7	31.3	100.0	1075
Government	20.1	36.2	43.6	100.0	149
Private	18.1	41.5	40.4	100.0	171
<b>Chi-square</b>					<b>16.646***</b>
<b>Immunization of mother</b>					
No immunization	30.4	37.3	32.3	100.0	912
Partially completed	17.3	46.0	36.7	100.0	433
Fully completed	18.0	50.0	32.0	100.0	50
<b>Chi-square</b>					<b>28.925***</b>

## **CHAPTER 5**

### **DISCUSSION, CONCLUSION AND RECOMMENDATIONS**

The purpose of this chapter is to discuss the major findings of this study and to formulate recommendations for further research on this issue as well as to suggest recommendations for policy formulation and program implementation for enhancing the legal age at first marriage in Pakistan.

It has been mentioned earlier that early marriage has long been a part of demographic analysis but most of the researchers focus on mean age at first marriage, where there is still need to explore, both for developing countries and developed countries as well. The main purpose of this study is to assess the impact of socioeconomic, demographic, and health care seeking factors on early marriage in Pakistan.

For the analysis of early marriage, this study has included 10 independent variables and an attempt has been made to examine the effect of these variables on early marriage in Pakistan. Both of the hypotheses are supported by the study findings and they confirmed that socio-economic and demographic, and health care seeking factors play important role behind early marriage.

#### **5.1 Discussion and Conclusion**

The results of bivariate analysis showed that all the six socio-economic and demographic variables, namely age of women at birth of child, current age of women, women education, husband education, place of residence and women autonomy, have statistically significant relationships with early marriage. Early marriage among women in Pakistan is most pronounced in rural areas. This finding is consistent with the findings of United Nations (1988) and Minh (1997), where they also found that the place of residence is significantly related to age at marriage and women more likely to

marry early in rural area than in urban areas. Education has a positive relationship with age at marriage. The relationship between education (both for women & husband) and age at first marriage is positively significant. It has also been found that researchers around the globe agreed on the fact that education has a strong positive relationship with age at marriage (Hakim, 2000; Savitridina, 1997).

This study also found a significant relationship between women autonomy and the age at first marriage. Women autonomy is found as one of the very important factors for determining the age at first marriage. Many studies have pointed out that, in Pakistan, young mothers do not have free mobility alone outside of the home because of the conservative society and cultural norms. The major barriers for decision-making capacity among teenage married women are due to lack of empowerment and less autonomy (Hussain et al., 2000; Sathar & Jalil, 2000; Durrant & Sathar, 2000).

However, as expected, early marriage is found significant for higher socio-economic status and better access to the health services. These results suggested that mothers, who have high level of education and empowerment, have a better practice to visit the health personnel and health services. This pattern increased with the higher age at marriage. Mosley (1984) and Behm (1991) also found that the maternal educational level can affect the age at marriage by influencing the women's choices and increasing her skill in health care practices related to preventive care and health treatment. The bivariate analysis also supported the hypotheses of this study.

It was found that the women, who received ANC services from any health personal, married at or above the age of 16 years compared to those women, did not received such services during pregnancy. The bivariate analysis also confirmed that antenatal checkup had statistically significant positive relationship with level of age at first marriage in Pakistan. This probably had happened because of the Pakistani conservative society and social norms. Due to cultural barriers, girls have no permission to go outside alone and to take a decision for herself. Even, also due to social norms, teenage mothers hesitate to discuss their health problems with their family members, even their husbands. Though the proportion of mothers, who delivered at health facility either government or private, was very low, but this findings is observed significantly higher among the women who married at or above the age 16 years. The results suggested that delivery assistance by health personnel is one of the

important factors, which was influenced by the age at first marriage. This findings is consistent with the study in Bangladesh (GOB, 1998) where they found that the health seeking behavior among young girls is lower and mostly young mothers didn't receive any antenatal care to health personal.

As expected, it was found that the age at first marriage is higher among the women (at or above 16) who received PNC services from the health personnel compared to those mothers who did not receive such services after the childbirth.

The findings of this study is weighed with the facts that the information on health care seeking factors just took concern about the visits for ANC and PNC and the doses of TT during pregnancy. All four independent health care seeking factors have a significant relationship with the age at first marriage. Hence, age at first marriage in Pakistan is mainly influenced by poor maternal education, lower autonomy, and teenage ages of mothers at birth of child. The study concluded that the women, who have higher education and live in urban areas, delay the age at first marriage in comparison to non-educated women. The women who marry at or above the appropriate age, are attending the better health care services in comparison to those who marry at early age. Higher women autonomy leads to lower chances of getting married at the age below 16 years. So the age at first marriage in Pakistan is mainly influenced by the poor level of women and the husband's education, place of residence, lower women autonomy.

## **5.2 Recommendations**

From the finding of this study, we can see the positive association among socio-economic and demographic variables and age at first marriage. As revealed by the analysis, not only the socio-economic and demographic but also all of the reproductive health services variables have demonstrated a significant impact on age at first marriage. Based on these results, the study suggested the following recommendations to formulate appropriate policies and to initiate suitable programs for increasing the legal age at first marriage in Pakistan:

- In this study, low legal age at first marriage is considered as one of the factors that cause early marriages. The existent policies on increasing the legal age at

first marriage do not appear to be functioning well. So, efforts must be made to increase awareness among the people about the adverse effects on such teenage pregnancies and more attention should be given to enforcing to increase the legal age at marriage.

- Premarital counseling messages should be dispersed throughout the country through mass media. These messages should increase awareness among the people about detrimental effects on young motherhood and should encourage people, who marry young, to try to initiate families after attaining the prime reproductive ages only. Secondly, long term plans of starting premarital counseling services, which concentrate on giving family planning advice, should be initiated.
- Efforts to improve the education levels of women in the country should be intensified, since higher education may work towards increasing age at marriage among young women in Pakistan. Allocate a greater proportion of the national budget to education, and include educational facilities also for the secondary level.
- Encourage parents to give equal opportunities to daughters as well as sons in gaining higher education and also encourage young women to continue education to as high a level as possible. Educated women have better access to information. Education also provides women with greater decision-making power within the family and enhances their status in society.
- It has also been observed that unfortunately, both the decision making power and mobility as well as levels of practices were found very poor among Pakistani mothers. A special information, education and communication (IEC) program should be piloted reaching to all peoples and couples of reproductive ages, especially for teenage couples.

### **5.3 Further Studies**

A qualitative study on why early marriages are favored in the country is required to come up with good strategies to decrease teenage motherhood in Pakistan.

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