

Impact of female education on the decision to use contraceptives in Rawalpindi, Pakistan

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Objective: To determine the impact of female education on the decision to use contraceptives in Rawalpindi, Pakistan.

Methodology: This cross section study was carried out at Gynecology and Obstetrics Unit, PESSI Hospital, Rawalpindi, from January, 2014 to April, 2014. Eighty-one patients were selected by consecutive sampling after informed written consent and acquiring Hospital ethical committee approval. The survey interview tool was a semi structured questionnaire. The FP methods used included condoms, IUCDs, oral contraceptive hormonal pills or injections.

Results: Husband's education level shows that there were 14% primary, 40% secondary, 14% FSc, 19% graduate and 15% post graduate participants in the study. In comparison, the women's education distribution was 27% primary, 17% secondary, 19% FSc, 14% graduate and 23% post graduate. There was no significant association of husband's education level with the decision of not using the contraceptive method. The access to knowledge about contraceptives

was directly proportional to the level of education ($p < 0.05$), whereas the concern for the side effects regarding the contraceptives increased as the educational level increased. Reasons like menopause, or desire to have more children, or secondary sub-fertility were independent of educational level of wife ($p > 0.05$). Similarly, the opposition from husband or in laws and beliefs in religious prohibition were also found to be independent of the wife's educational level ($p > 0.05$).

Conclusions: Health related concerns or fear of side effects regarding contraceptives sometimes tend to increase as educational level of wife increases. There is a need to holistically approach this gap between awareness and application of contraceptive agents, by concurrently imparting knowledge as well as ownership, so the deep rooted fears of side effects could be allayed. (Rawal Med J 2014;40: 71-74).

Key Words: Knowledge, contraceptive agents, educational status, unwanted pregnancy.

INTRODUCTION

Awareness regarding contraception is universal in Pakistan. More than one-third of currently married women of reproductive age are using a method of contraception, with most women using a modern method (26 percent).¹ The two modern methods in demand are the male condoms and female sterilization (9 percent each). Ten percent of episodes of discontinuation occurred because the woman experienced side effects or had health concerns. Twenty percent of currently married women have an unmet need for family planning services, with 9 percent having an unmet need for spacing and 11 percent having an unmet need for limiting.¹

Fertility and contraceptive use in developing

countries are associated with various markers of socioeconomic status,² most prominent of which is women's education.^{3,4} Improving women's education has been seen as one way to increase their status and autonomy.⁵⁻⁹ A number of studies, using data from both developed and developing countries, show that female education is associated with a decrease in fertility.¹⁰⁻¹²

A strong relation between female education and fertility and a relatively weak one between male education and fertility would imply that it was indeed the woman's education which had the primary or even sole impact on reproductive behavior, with men's reproductive goals being immaterial or even contrary to women's as is often implied in the literature.¹³ The aim of this study was

to examine the impact of female education on the couple's decision to use contraception.

METHODOLOGY

This cross section study was carried out at Gynecology and Obstetrics Unit, PESSI Hospital, Rawalpindi, from January 2014 to April, 2014. A total of 81 participants were interviewed regarding their contraceptive practices. Patients were selected by consecutive sampling techniques. Hospital Ethical committee approval was obtained and Informed written consent was taken from all patients. A questionnaire was filled from the women coming to the antenatal and gynecology outpatient department of hospital. Chi square test was applied to determine the difference in proportion between these categorical variables and p value was taken as significant at or <0.05 .

RESULTS

The husband's education level shows that there were 14% primary, 40% secondary, 14% FSc, 19%

graduate and 15% post graduate participants in the study. In comparison, the women's education distribution was 27% primary, 17% secondary, 19% FSc, 14% graduate and 23% post graduate.

There was no significant association of husband's education level with not using the contraceptive method. The association of method related reasons and reasons of opposition to use the contraceptives with husband's education were assessed (According to the results of this study the wife's literacy level showed significant ($p\text{-value} < 0.05$) association with two reasons of not using contraceptive methods: one reason was lack of knowledge about any method and the other was concern about side effects (method related reason). The access to knowledge about contraceptives was directly proportional to the level of education, whereas the concern for the side effects regarding the contraceptives increased as the educational level increased, perhaps due to more awareness.

Table 1. Association of wife's literacy level and actual contraceptive use.

Reasons	Wife's Literacy Level					p-value
	Primary	Secondary	FSc	Graduate	Post Graduate	
Are you not using due to fertility related reasons?						
Menopause	2	1	1	0	0	*0.418
Sub fertility/infertility	0	0	0	0	1	
Wants more children	6	1	2	0	4	
None	11	10	10	10	11	
Are you not using because you are opposed to use/opposition to use?						
Husband opposed/inlaws opposed	2	0	1	1	1	*0.88
Religious prohibition	2	2	0	1	1	
None	15	10	12	8	13	
Not using due to lack of knowledge?						
Knows no method	0	0	0	2	0	**0.016
None	19	12	13	8	15	
Not using due to method related reasons?						
Health concerns/fear of side effects	1	0	1	4	3	**0.037
None	18	12	12	6	12	

p values are not significant (*0.418 and *0.88). p values are significant (**0.016 and **0.037)

The FP methods used included Condoms, IUCDs, Oral contraceptive hormonal pills or injections.

It was found that reasons like menopause, or desire to have more children, or subfertility were independent of educational level of wife ($p > 0.05$). Similarly, the opposition from husband or in laws and beliefs in religious prohibition were also found to be independent of the wife's educational level ($p > 0.05$). Lack of knowledge was found to be significantly ($p\text{-value} < 0.05$) associated with wife's education (directly proportional), so lack was knowledge for any contraceptive method was comparatively high in women having less education. It was seen that health related concerns or fear of side effects increased as educational level of wife increased ($p\text{-value} < 0.05$) as shown in Table 1.

DISCUSSION

Reducing total fertility is expected to play an important role in achieving both the national development goals of the National Development Plan and the Millennium Development Goals.¹⁴ Women's education has the most prominent role as reported from South Asia and elsewhere.^{3,15} Several studies have indicated that the educated women have more freedom in decision making and action on a range of domestic and extra-domestic matters.¹⁷⁻²⁰

A pregnancy may be a physiological phenomenon, but in the rural Pakistan, the whole process is intimately bound up with gendered ideologies. A large number of the reproductive health studies carried out to explore whether the educational level is a dominant factor to affect the decision in couples regarding contraception.²¹ In our study, we observed that opposition to contraceptive use by the husband or in laws was not significantly ($p\text{-value} > 0.05$) associated with wife's education level.

An interesting observation in our study was that the use of contraception decreased as the education level increased. From our study, two major patterns for decreased contraceptive use emerge that are fairly generalizable. These were the decline in use of contraception by the woman due to lack of knowledge regarding the various methods of contraception, and the decline in use of contraception due to fear of side effects. Not surprisingly, the lack of knowledge was found to be significantly ($p < 0.05$) associated with the woman's education, with the deficiency of knowledge being comparatively high in women having less

education. Also, in the Pakistan's social context, a 'culture of silence' surrounds these issues pertaining to the knowledge of reproductive matters.²²

The decision of not using any contraceptive method due to method related health concerns or side effects was found to be significantly ($p < 0.05$) increased as educational level of woman increased. This is in contrast to the findings of Bbaale and Mpuga¹⁴ who observed that use of contraceptives increases with education level. Numerous studies have indicated that with more exposure to higher education, women acquire more information about their bodies as well as reproductive health matters, their autonomy is increased and make informed choices.^{12,23}

Religious prohibition was not significantly ($p > 0.05$) associated with woman's education. The common public, health decision makers and public health professionals mostly believe that religious beliefs and proscriptions limit the use of Family Planning (FP) in Pakistan. However, the PDHS 2006-7¹ showed that, among nonuser of FP, religious reasons accounted for around 5% of nonuse. It would be worthwhile to critically study the efficacy and utility of previous efforts to overcome religious resistance in Pakistan and other countries.¹

CONCLUSION

We aimed to identify the ways in which the woman's education influenced the gender order autonomy of women in Pakistan and thus, influenced women's use of contraception. There are promising signs that the reproductive health literature is beginning to engage with newer sociological contributions, however, more need to be done.

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REFERENCES

1. National Institute of Population Studies (NIPS) [Pakistan] and ICF International. 2013. Pakistan Demographic and Health Survey 2012-13. Islamabad, Pakistan, and Calverton, Maryland, USA: NIPS and ICF International.
2. Saleem S, Bobak M. Women's autonomy, education and contraception use in Pakistan: a national study. *Reproductive Health* 2005;2:2-8.
3. Bradley SEK, Croft JD, Westoff CF. 2012. Revising unmet need for family planning. DHS Analytical Studies No. 25. Calverton, Maryland: ICF International.
4. Franny A. 2013. Gulu women economic development and globalization. http://www.globalgiving.org/pfil/9326/Quarterly_Report_April_June_2013.pdf
5. Jejeebhoy SJ, Sathar ZA. Women's Autonomy in India and Pakistan: The influence of Religion and Region. *Population Development Rev* 2001;27:687-712.
6. Government of Pakistan. 2010. National Program for Maternal, Newborn and Child Health (2006-2012), Government of Pakistan's Initiative for Millennium Developments Goals 4 and 5. Islamabad, Pakistan: Ministry of Health.
7. Government of Pakistan. 2013. Pakistan Economic Survey, 2012-13. Islamabad, Pakistan: Finance Division, Economic Advisor's Wing.
8. Government of Punjab. 2013. Strategic Plan for Maternal, Newborn and Child Health (MNCH), Punjab-Pakistan 2013-15.
9. Hasan Q, Bosan AH, Bile KM. A review of EPI progress in Pakistan towards achieving coverage targets: present situation and the way forward. *Eastern Mediterr Health J* 2010;16(Supplement):31-38.
10. Sackey HA. Female labour force participation in Ghana: the effects of education. African Economic Research Consortium Research Paper 150, Nairobi, 2005.
11. Mahmood A. 2012. Birth spacing and family planning uptake in Pakistan: evidence from FALAH. http://www.popcouncil.org/pdfs/2012RH_FALAH-EndlineReport.pdf
12. Vavrus F, Larsen U. Girls' education and fertility transition: an analysis of recent trends in Tanzania and Uganda. *Economic Development Cultural Change* 2003;51:945-76.
13. Basu AM. Why does education lead to a lower fertility? A critical review of some of the possibilities. *World Development* 2002;10:1779-90.
14. Bbaale E, Mpuga P. Female Education, Contraceptive Use, and Fertility: Evidence from Uganda. *Consilience: J Sustainable Development* 2011;6:20-47.
15. Fikree F, Khan A, Kadir M, Sajjan F, Rahbar M. What influences contraceptive use among young women in urban squatter settlements of Karachi, Pakistan? *Int Fam Planning Perspec* 2001;27:130-6.
16. Al Riyami A, Afifi M, Mabry RM. Women's autonomy, education and employment in Oman and their influence on contraceptive use. *Reprod Health Matters* 2004;12:144-54.
17. Kabeer, N. Resources, agency, achievements: reflections on the measurement of women's empowerment. *Development Change* 1999;30:435-64.
18. Maqsood F. 2009. Effect of socio-cultural exclusion and community level factors on reproductive level: comparison between urban and rural Pakistani women. Lahore, Pakistan: University of Punjab, Department of Social and Cultural Studies.
19. Ministry of Health (MOH) [Pakistan]. 2013. National Program for Family Planning and Primary Health Care. Islamabad, Pakistan: Ministry of Health.
20. World Health Organization (WHO). 2006b. Report of a WHO technical consultation on birth spacing. http://www.who.int/making_pregnancy_safer/publications/policy_brief_birth_spacing.pdf
21. Mumtaz Z, Salway SM. Gender, pregnancy and the uptake of antenatal care services in Pakistan. *Sociol Health Illness* 2007;29:1-26.
22. Siddiqi S, Haq IU, Ghaffar A, Akhtar T, Mahaini R. Pakistan's maternal and child health policy: analysis, lessons and the way forward. *Health Policy* 2004;69:117-30.
23. World Health Organization (WHO), United Nations Children's Fund (UNICEF), and United Nations Population Fund (UNFPA). 2004. Maternal mortality in 2000: estimates developed by WHO, UNICEF, and UNFPA. Geneva, Switzerland: World Health Organization.