A QUANTITATIVE STUDY ON THE RELATIONSHIP BETWEEN EDUCATION LEVEL AND FAMILY PLANNING KNOWLEDGE AND ATTITUDES AMONG MARRIED WOMEN IN ISLAMABAD, PAKISTAN

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ABSTRACT

Family planning knowledge, attitudes, and practices among married women in Islamabad, Pakistan, were quantitatively investigated using a cross-sectional survey of 300 participants. A systematic questionnaire was used to survey married women in Islamabad, Pakistan, to determine the relationship between education level and family planning knowledge and attitudes. The data, which described the demographics, level of knowledge, and attitudes toward family planning, were analyzed using descriptive statistics (frequencies and percentages).These results showed that there was a strong general knowledge of family planning and poor knowledge with regard to specific modern processes. The views were generally favorable on the advantages of family planning that which had an advantage on the maternal/child health. Nevertheless, such socio-cultural resistance continued, because it is thought to be incompatible with religious or cultural ideologies. The existing practice was not optimal, and the major impediments were fear of side effects and cost. The research gained the conclusion that accurate knowledge, fewer misconceptions, and a positive, autonomous reproductive attitude were strongly linked with higher educational attainment. The results indicated a severe gap between awareness and regular practice that should be addressed through formal, specific educational interventions. The findings showed a significant discrepancy between awareness and routine practice, which calls for formal, targeted educational interventions.

Keywords: Family planning, Education, Contraceptive use, Married women, Reproductive health, Islamabad.

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CHAPTER ONE:

INTRODUCTION

Family planning is a voluntary decision and way of life, informed by knowledge, attitude, and responsible decisions by couples and individuals (Souza et al., 2011 Family planning is the deliberate use of contraceptive methods by a couple to reduce or space out the number of children they have (Wani et al., 2019). By lowering the number of pregnancies and abortions, this service reduces maternal and neonatal mortality, among other positive effects on women's health (Asif et al., 2021). Even though the use of contraceptives has grown over time, there is still a knowledge, attitude, and practice gap. Religious convictions, fear of adverse effects, and a lack of education and information are some of the reasons people choose not to use family planning methods (Mahamed et al., 2012). Family Planning knowledge and practice are linked to higher levels of attainment and education, which is also the primary contributor to individuals' attitudes and behavior (Mahamed et al., 2012). The total number of individuals worldwide is 7.92 (World Bank Group, 2025) and is predicted to be 9 billion by 2045. (Wani et al, 2019). Family planning is the concept intended to address problems associated with Overpopulation and other related social problems. Pakistan, for example, the 5th most populated country (having over 247.5 million people), also has over 28,000 maternal deaths each year, which accounts for over 50% of maternal deaths worldwide; hence is considered that the problem is serious (Mustafa et al, 2015).

Without lack of control, overpopulation has been an issue for decades in Pakistan, which negatively impacts the availability of limited resources and creates challenges in many sectors, including healthcare and employment (Waheed). It is not likely that it will improve in the near future. Factors that influence decisions concerning family size include one's education level, knowledge, and attitudes (Asif et al., 2024). Generally, educated couples are more knowledgeable about the various contraceptive methods, their benefits, side effects, and proper usage, whereas those who are poorly educated and unknowledgeable about contraceptives have almost no elementary knowledge concerning what contraceptives are and how they function (World Health Organization: WHO, 2023e). The attainment of advanced education fosters a deeper comprehension of reproductive health as well as facilitates the making of more considerate and enlightened decisions. Education and knowledge, however, aren't the only things that matter.

Attitude significantly impacts things because individuals who are more predisposed to learn and use contraceptives, as well as incorporate family planning into their lifestyle, often are positive about the use of contraceptives (Asif et al., 2024).

In reproductive health and family planning, one of the most important aspects is the development and use of contraceptives or birth control. There are different kinds of contraceptives, and there are different health benefits. In the case of condoms, injectables, IUDs, and oral pills, as well as permanent procedures like sterilization, Health benefits include planning families, reducing, and reducing maternal and infant mortality ratios. Thus, overall outcomes are improved (World Health Organization: WHO, 2023c). Even though the use of contraceptives can be seen in ancient and modern times, modern contraceptives became more widely used during the 20th century. Several reasons explain the accessibility of birth control, such as women's rights movements, national policies aimed at controlling the population, and global health initiatives (Ahmed et al., 2024d). Women's health in Pakistan has been in a critical state, suffering and enduring a high maternal and child mortality ratio to date. On the other hand, (Asif et al., 2024) Ignorance, religious beliefs, socio-cultural practices, and rigid mindsets of the people are the factors that contribute to high population growth (Mustafa et al., 2015).

In the 1960s, Pakistan was among the first developing countries to launch a family planning program (Asif et al., 2024b), but even after 50 years, the country continues to struggle with spreading awareness and changing the mindset of people to increase the use of modern contraceptives (Jamali & Simon, 2024c). Pakistan's population is increasing by about 2.4% every year (WPP UN 2022). On average, women have 3.6 children, 3.9 in rural areas and 2.9 in urban areas. Only 34% of married women use any form of contraception (25% modern methods, 9% traditional), and for the past five years, this rate has remained unchanged (World Health Organization: WHO, 2023d). The current contraceptive prevalence rate (CPR) stands at just 34%, which is immensely lower than that of its bordering countries, Bangladesh at 62% and India at 56%. Cultural barriers, inconsistent political support, and failures in service delivery are the major factors behind this slow uptake (Ataullahjan et al., 2019).

In Pakistan, women are usually responsible for family planning, This is mainly because of cultural discomfort, and many men feel uneasy discussing their sexual health with female

gynecologists, (Ahmed et al., 2024d) especially in rural areas, where sex is still considered a taboo subject, open conversations about reproductive health are often considered inappropriate especially with female doctors leading to the frequent exclusion of men from related discussions and services (World Health Organization: WHO, 2023d). As a result, men's involvement in family planning remains limited to date, further hindering improvement in reproductive health initiatives. (Ahmed et al., 2024). With Family planning, we can significantly reduce the risks of maternal and neonatal mortality by lowering the number of unintended pregnancies and abortions (Mustafa et al., 2015c). It is important to overcome deep-rooted social, traditional, cultural, and moral barriers towards family planning because while the Government of Pakistan has made efforts to promote the benefits of family planning, its success largely depends on people's attitude towards its use (Asif et al., 2021).

In a patriarchal society like Pakistan, the only ones making decisions for all the households are the men of the family without women's involvement or consideration (Ahmed et al., 2024d). So, to achieve any meaningful progress regarding reducing maternal and child mortality rates, it's important to actively involve and educate men regarding contraceptive use and its advantages to help control population growth (Asif et al., 2021). Many Pakistani women fear that using contraceptives would go against their husbands' wishes and could cause a conflict with prevailing cultural and social norms (Jamali & Simon, 2024b).

Under the Bhutto regime, the family planning program was disturbed, and for the next twenty years (M. Sultan et al., 2002f), the political support gradually declined in 1965 after the war with India, mainly because it had been launched by its political rival, General Zia ul Haq. General Zia ul Haq's main focus was on Islamization, causing further abandonment of family planning and bringing the program to a halt (Jamali & Simon, 2024b).

The government of Pakistan introduced a community-based approach in 1993 by training literate married women to provide door-to-door counseling and contraceptive supplies to improve access to contraceptive services within their own and neighboring communities (M. Sultan et al., 2002f). This initiative led to the formal launch of the Lady Health Worker (LHW) Program in 1994, under the Ministry of Health. LHWs are trained to deliver essential health education, maternal and child healthcare, and family planning services under this program to serve

particularly in rural and underserved areas where access to healthcare is limited (Ahmed et al., 2024d). The program plays an important role in bridging the gap between communities and the healthcare system, making reproductive health services more accessible and attainable at the grassroots level (Sultan et al., 2002). approximately 5,500 village-based family planning workers and around 30,000 Lady Health Workers had been trained and were actively serving their communities by the end of 1996 (Sultan et al., 2002c).

Abortion, under Pakistani law, is permitted during the first trimester of pregnancy (Ahsan and Jafarey 2008; Sathar et al. 2014). The original 1860 colonial Penal Code permitted abortion only to save a woman's life. In 1997, the amendment was made to align with Islamic teachings so that, in the first three months, an abortion may be performed to save the mother's life or for "necessary treatment." But after the first trimester and once the fetus's organs have developed, abortion is permitted only to preserve the woman's life (M. Sultan et al., 2002f).

1.1 Problem statement

Family planning is crucial for reproductive health in women of reproductive age, and their education plays a critical role in allowing women to make informed decisions regarding childbirth and spacing during pregnancies, ultimately reducing maternal and child mortality rates. It also plays an important role in empowering women with the knowledge and confidence required to utilize family planning services effectively. Studies show that higher educational attainment leads to better awareness, positive attitude, and acceptance among people of different contraceptive methods.

However, this area remains unexplored in regions like Islamabad,

1.2 Research objectives

1. To assess the current level of family planning knowledge among married women in Islamabad, Pakistan.
2. To examine the relationship between education level and family planning knowledge among married women in Islamabad, Pakistan.
3. To identify the factors influencing attitudes towards family planning among married women in Islamabad, Pakistan.

1.3 Research Questions

To guide this investigation, the following research questions have been formulated:

- What is the relationship between education level and family planning knowledge among married women in Islamabad?
- How does education level influence attitudes toward the use of contraceptive methods among married women in Islamabad?

1.4 Significance of the study

This study is important because it presents the present level of knowledge on family planning, attitudes, and practices among married women in Islamabad. The findings show that women do not have accurate and detailed information about modern contraceptive methods, especially long-acting methods, although family planning awareness was high. The gap shows the necessity of greater access to credible information and improved health communication. The significance of the variables that the study identified, such as the level of education, cultural attitudes, influence by the partners, and information sources that women use, makes it noteworthy.

The attributes need to be understood so as to design effective interventions that have the potential to reinforce informed contraception and healthy reproductive outcomes. The conclusions are also key tidings to the policy makers and medical practitioners. To bring about awareness, extend service delivery, and help women make decisions that benefit their families and health, identifying challenges that women face, including the misconception, lack of counseling by health professionals, and using unofficial sources, can help develop programs to address the problem. Altogether, this research can fill the local gap in the research in Islamabad and contribute to further efforts aimed at improving maternal health, reducing the rates of unwanted births, and improving the well-being of families by means of more effective family planning methods.

1.5 Conceptual Framework

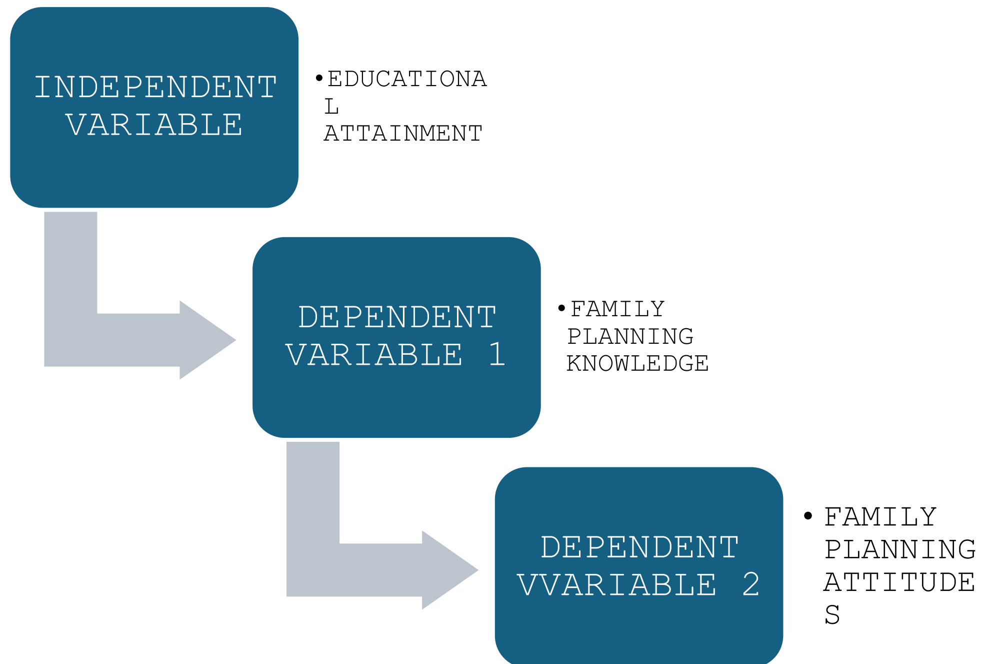

Figure 1: Conceptual Framework

CHAPTER TWO

LITERATURE REVIEW

Family Planning helps partners as well as non-partners to have proper planning for their children. This can be made possible through various contraceptive methods and infertility treatments (World Health Organization: WHO, 2019a). Access to family planning services and awareness regarding contraceptive options are fundamental to personal health and are recognized as basic human rights (Ahmed et al., 2024d).To prevent unintended pregnancies, the use of contraceptives can play a major and effective role; it will help reduce maternal health complications and lower the incidence of pregnancy-related deaths (World Health Organization: WHO, 2023d).

Due to the high maternal mortality ratio of 600 deaths per 100,000 live births and numerous pregnancies, which raise the risk of maternal death, over 30,000 women die each year from complications related to pregnancy, childbirth, or botched abortion. A Pakistani woman has a 1 in 23 probability of dying from maternal causes over her lifetime, compared to 1 in 5,000 in the developed world (Mahsud-Dornan, 2007b). In many low- and middle-income countries (LMICs), pregnancy and childbirth are the main causes of death for girls and women between the ages of 15 and 49(Meherali et al., 2021). Family planning will help minimize these risks to young women, who are at greater risk of health-related issues due to early childbearing, while older women may also face complications related to age during pregnancy and childbirth by offering safer reproductive choices (M. Sultan et al., 2002f).

To this extent, family planning and availability of contraceptives are necessary in reducing the morbidity and mortality related to pregnancy, improving the health of young girl children and women, and reducing the social and economic expenses of early pregnancy (Meherali et al., 2021). In traditionally patriarchal countries such as Pakistan, gender disparities and the low position of women are rooted in the culture, and this aspect denies not only women the opportunity to utilize health services but also makes health-related choices. This difference is further aggravated by the fact that women do not have autonomy or income access. Besides, the education, employment, and fertility concerns of women are strong predictors of their FP knowledge and practice. It has

also been found that education is an important determinant that influences the attitudes of women towards FP (Yameen et al., 2021).

In addition, the possibility of access to contraceptives by couples has an advantage in decreasing unsafe abortion as well as reducing the chances of mother-to-child HIV infection (Ahmed et al., 2024b). There are also broader social benefits: it allows girls to continue their education and places women more pertinent in the labor force and active in the political life (Ahmed et al., 2024d).

However, approximately 257 million women of reproductive age still have an unmet need for contraception according to 2023 estimates. This is due to limited access, insufficient variety of methods, and fear of side effects, cultural and religious opposition, poor service quality, and gender-based barriers (World Health Organization [WHO], 2019b Even while family planning services are now more widely available globally (Cahill et al., 2018; MacQuarrie, 2014), there is still a big gap in terms of successfully addressing contraceptive needs and family planning objectives in LMICs (Chandra-Mouli et al., 2017).

2.1 Historical Context of Family Planning in Pakistan

Pakistan was among the earliest developing countries to introduce a national family planning program in the 1960s (Jamali & Simon, 2024c). In 1947, at the time of independence, Pakistan's population was 31 million. By 1995, it had escalated to 140 million. Family planning programmes were started in the 1950s and 1960s by private and government institutions. Donors such as the World Bank and the UN, along with the government of Pakistan, funded the programmes for family planning (FP). For years, these institutions focused only on women, as it was thought that FP was the preserve of women; therefore, the audience was 100% female. (Mahsud-Dornan, 2007). However, no visible improvements were made due to political instability. After the 1965 war with India, a lack of sustained political support led to a decline in program momentum (M. Sultan et al., 2002f).

During Prime Minister Zulfikar Ali Bhutto's regime, Family planning initiatives were deprioritized and further marginalized under General Zia ul Haq's regime, which emphasized Islamization (Jamali & Simon, 2024b). The Lady Health Worker (LHW) Program under the Ministry of Health was launched in 1994, which was a renewed effort to revive family planning and to make

contraceptives accessible and available especially in rural and underserved regions by giving training to literate women from the same regions, this program played a significant role in the addressing the gaps in service delivery in Pakistan's primary healthcare system (Sultan et al., 2002). The practice of purdah (public view through veiling) makes it more difficult for women to obtain social services, including family planning. In 1991, only a quarter of women could go unaccompanied to a clinic. Poor programme outreach exacerbates the problems facing women who observe purdah (Mahsud-Dornan, 2007b). Over half a century has gone by, millions of dollars have been spent, many resources have been depleted, and Pakistan continues to grow by four million people annually (Mahsud-Dornan, 2007).

Pakistan is facing an enormous obstacle. With 140 million citizens, it is already the seventh largest nation in the world and will rank third in terms of population growth. By 2050, Pakistan's population is expected to reach over 380 million, exceeding that of the US, Indonesia, Brazil, and Russia, making it the third largest country in the world after China and India (Mahsud-Dornan, 2007). Pakistan's population is expected to reach 260 million by 2035 (UNFPA, Pakistan).

Furthermore, education and family planning knowledge have an impact on home dynamics and decision-making in addition to individual awareness. The more educated women are, the more probable they are to negotiate with their spouses the use of contraceptives and gain more autonomy in decisions concerning reproduction (Ahmad et-al. 2024b). The family planning also fosters gender equality: women are allowed to gain education and employment, which leads to empowerment that will enhance the well-being of the family and economic stability (Ahmad et-al., 2024d). Women who are capable of scheduling their pregnancies are in a better position to remain healthy, experience fewer challenges, and provide quality care and nutrition to their children (Mahammed et-al., 2012).

2.2 Global Trends in Modern Contraceptives

The availability of modern contraceptive methods has been on the rise throughout the world, yet the development remains on an unequal footing. Sixty-seven percent (67) was increased to 77.5 percent from 1990 to 2022 because the need of women aged 18-49 to have family planning was addressed with modern contraceptive methods (WHO, 2023). Such a slight rise by 10 percentage points in the past 30 years indicates that there are still problems like the lack of contraceptive

options, unequal access, especially in youth, the low-income, and those who are unmarried, and fears of side effects (World-Health-Organization: WHO, 2023d). The effective use of family planning programs is still plagued by cultural and religious opposition, low-quality service provision, and discrimination due to gender factors (World-Health-Organization: WHO, 2019c).

Nevertheless, in those areas that reported positive efforts to overcome those challenges, usage of modern contraceptives has risen significantly, which is why policy interventions are highly needed (World Health Organization: WHO, 2023d). One of the requirements that is significant in increasing CPR is the knowledge of FP. Although there is universal awareness of modern contraceptives among both men (98.6) and women (98.1) in Pakistan, a quarter of married women of reproductive age (MWRA) are using modern contraceptives, and therefore, there is a disconnect between knowledge and practice. The gap between contraceptive knowledge and behavior has been named as the know-do gap (Yameen et al., 2021).

The current unmet need among MWRA in Pakistan is 17%, including 33% MWRA who are not using contraception but intend to use it in the future. Other factors influencing a woman's access to FP information and services include her desire to use contraception, age, education, occupation, socio-economic status, region of residence, number of living children, underlying medical conditions, and exposure to mass media. However, less is known about the reasons for discordance between knowledge and behavior (World Health Organization: WHO, 2023d).

2.3 Contraceptives

There are many types of contraceptives, each suited to different needs and personal preferences depending on a person's age, health status, sexual activity, desire for future children, and family medical history (World Health Organization: WHO, 2019a). Having Access to preferred contraceptive options upholds several human rights, including the right to life, freedom of choice, and the right to education and employment. In addition to empowering individuals, the proper use of contraceptives delivers major public health and socioeconomic benefits (World Health Organization: WHO, 2023e).

Individuals differ in the advantages and significance of using family planning techniques. The use of family planning techniques is helpful and produces favorable results since it lowers child

mortality and raises the birth gap. When the fatality rate from unsafe abortions is high, using contraceptives effectively can enhance the health of both mother and child. The past 20 years have seen a rise in the usage of family planning techniques. Family planning has improved both mother and child health in several ways (Khan et al., 2023). In my view, as a student in the university, contraceptives are not just their biological role but are indeed social empowerment devices. Getting access to these tools allows individuals and women, in particular, to organize their families according to their personal goals in life, to get an education, and enter the labor market (UNFPA, 2023). I have heard that reduced cases of teen pregnancy, unsafe abortion, and maternal mortality are associated with increased rates of contraceptive use (Guttmacher Institute, 2023).

The consent and informed choice continue to emerge in the contraception debate as well. Nurse practitioners will be urged to counsel in an evidence-based manner that will inform the consumers on the advantages, restrictions, and side effects of every available choice. Nevertheless, we should address the myths and misunderstandings, especially in more conservative contexts, to enhance adherence and persistence (Ahmed et al., 2024). To add to it, there are still very few young married women and teens who receive reproductive care that is youth-friendly. Only less than 10% of females under 15-24 years consider any modern contraception, mostly due to social taboos and apprehension toward being judged by medical personnel (Sathar and Zaidi, 2021).

Education affects attitudes towards fertility choices, marital negotiation, and faith in medical professionals, in addition to increasing knowledge of various options. On the other hand, women from low socioeconomic backgrounds often encounter more obstacles, such as restricted access to healthcare, false information on side effects, and a lack of communication between spouses (Hussain et al., 2023).

2.4 Contraceptive Methods

There are various kinds of Contraceptive methods and their effectiveness. The term "contraceptive methods" refers to a wide variety of alternatives that differ in terms of mechanism, duration, and efficacy. There are always four general types of contraceptives, which are behavioral, permanent, reversible, long-acting, and short-acting. So, to aid all of us in making smart, long-term decisions, knowing the advantages and disadvantages of either is of key importance (WHO, 2023).

The common ones are oral contraceptive pills, implants, injectables, patches, vaginal rings, intrauterine contraceptive devices (IUDs), condoms, sterilization (both male and female), locational amenorrhea, withdrawal, and fertility awareness-based approaches (World Health Organization: WHO, 2023d). These techniques operate differently; some of them prevent ovulation, others prevent sperm, and some modify the uterine lining. Their efficacy is normally indicated by the number of pregnancies per 100 women with the use of the method within a duration of one year. This is useful to get people to make informed choices and can achieve better reproductive health results (WHO, 2023).

In the recent past, the research environment has been oriented in terms of innovation, independence, and inclusion. Researchers are developing the next-generation contraceptives that reduce side effects as well as expand the options for men and women. The excitement arises with male contraceptive hormonal gels created by the micro-needle patches, biodegradable implants, all geared towards ensuring that family planning is as safe and convenient to all (WHO, 2022).

Shots, patches, and oral pills that come in short-acting are good ware since they are extremely easy to pick up and you can always quit taking them as you wish. However, the latter actually requires staying with them regularly to achieve anything out of it, as the former ones are the primary offenders when it comes to making people give up on them and accuse them of side effects or misleading information. Condoms are a win-win; they prevent pregnancy as well as STIs (WHO, 2023). Long-acting reversible contraceptives (LARC) such as IUDs and mini-implants have emerged as a real hot topic in a large number of low-income settings since they are also effective and have a long-term lifetime effect. These techniques rely on the ability and availability of the supplier, and they need little user maintenance (Makki et al., 2023).

For those who have finished having families, permanent procedures like vasectomy for males and tubal ligation for women are appropriate. Due to cultural taboos and misunderstandings about reversibility, uptake is still limited in Pakistan despite its efficacy (Imran et al., 2023).

They are typically classified into four categories based on effectiveness:

1. Very Effective (0–0.9 pregnancies per 100 women/year)

2. Effective (1–9 pregnancies per 100 women/year)

3. Moderately Effective (10–19 pregnancies per 100 women/year)

4. Less Effective (20 or more pregnancies per 100 women/year)

2.5 Pakistan's Context of Family Planning

Pakistan's population stood at 207.7 million, with a high annual growth rate of 2.4% according to the 2017 national census (Jamali & Simon, 2024c). In this way, Pakistan will be one of the top five biggest countries by the year 2050, so long as things continue as they are. Its family planning picture is yet to develop due to a blend of culture, the health system staff, and population pressures. All the government and donor programs have not yet succeeded in getting the contraceptive use above the regional average (Family Planning, t).

It is evident that since people are aware of birth control, there exist several challenges that prevent them from continuing to use it regularly. Pakistan was among the signatories of FP2020 and was committed to increasing its rates of contraceptives to 55 percent in the country, yet the recent survey (2017 18) records 34 percent only (Sultan et al., 2002).

The gap between the policy statement and the reality is due to a ton of obstacles: lack of knowledge, low motivation, the limited role of women, delivery difficulties, and social backlash (WHO, 2019c). All that is indicative of the fact that we sorely require health programs that educate individuals, transform behavior, and provide easy access to family planning. The solution is community-based interventions and addressing cultural hiccups in order to ensure that more people use birth control and population targets are achieved (WHO, 2023e).

Education remains the largest factor in family planning in Pakistan. A Punjab survey carried out in 2024 indicated that secondary school or higher-educated women were three times as likely as women who had never attended school to use modern contraception (Kayani et al., 2025). The technology of mHealth is also a paradigm changer among health workers, in particular, community nurses. Digital job aids will provide checklists, counseling tips, and referral tools, which can help

Lady Health Workers increase the quality of service they provide. The tech-enhanced approach to counseling makes people happier and prefer to use long-acting approaches, which happened in Pakistan, Ethiopia, and Nepal (Labrique et al., 2021).

Social media sites, Facebook, YouTube, Instagram, etc., are beginning to play a significant part in disseminating birth-control information. Digital advertising aimed at young people can dispel myths, reduce the stigma, and achieve the goal of making people visit the clinic (Shelton & Kortz, 2020). According to researchers, the verified and research-based posting is required; however, they also warn that when it comes to social media, fake material may indeed harm (Rehman et- al., 2021).

2.6 Family Planning and Women's Empowerment

The empowerment of women is closely connected to education- it has a direct relation to the level of knowledge found among the women, their emotional condition, and their behavior in regards to family planning. Prata et al. (2017) state that more educated women are far more informed about the birth-control methods and their possible side effects, and they have a more positive perception of family planning services (Upadhyay et al., 2014). Such cognitive advantage reduces resistance linked to fear and makes smarter choices. More educated women contribute to decision-making within the confines of the home, particularly when it comes to choosing methods and space. Research in South Asia and largely Pakistan indicates that secondary-educated women are relatively more autonomous in their reproduction and can also negotiate the use of contraceptives with their spouses (Do & Kurimoto, 2012).

The resulting empowerment increases frequent utilization and makes them feel comfortable requesting FP information from doctors. Economic empowerment and education are closely related, and their access increases their power to make decisions regarding reproduction (Bloom et, 2019). Women who are educated have higher chances of working and earning, which makes them financially independent and gives them the authority to get contraceptives when they feel the need to get them. The less they are forced to depend on their husbands' or in-laws' approval and financial support, the better, especially in patriarchal areas such as Islamabad (Starbird et al., 2016).

Education also influences the perception of contemporary methods of contraception. Higher-educated women are less likely to accept falsehoods about cancer, infertility, or the long-term negative effects of contraceptives. Additionally, they report higher levels of trust in healthcare personnel and more favorable opinions of health services (Cleland et al., 2018). These elements lower the 'know-do' gap that is frequently seen in Pakistan and increase method continuation rates (Bloom et al., 2019).

Women's health empowerment is also facilitated by education; educated women are more aware of the health dangers associated with unsafe abortions, short birth intervals, and recurrent pregnancies (Starbird et al., 2016). This encourages them to employ family planning for home stability, child welfare, and health preservation. Due to their powerful position in the family, marriage, the first child, and the ideal number of children are frequently postponed (Do & Kurimoto, 2012).

To put it briefly, education improves each of the three areas that affect family planning,

Knowledge (knowledge of procedures, advantages, and dangers)

Attitudes (openness, less fear, and optimistic beliefs)

Decision-making (autonomy, bargaining with spouse)

This means that among married women in Pakistan, education is one of the best indicators of the adoption of contraceptives and positive attitudes toward family planning.

2.7 Digital and Mobile-Health (mHealth) Interventions:

Particularly in low- and middle-income nations, digital health interventions have become effective instruments for increasing family planning knowledge, access, and continuance. Reproductive health programs are increasingly relying on mHealth tactics as mobile phone adoption rises

worldwide, including in South Asia (WHO, 2022). These technologies aid in removing obstacles based on gender, geography, and culture that keep women from using health facilities for family planning services.

The most popular trick is the use of SMS messages in which a fire triggers a reminder concerning the time to take medication, get a shot, receive instructions on side effects, etc. Studies indicate that they reduced the number of injections and pill dropouts by a considerable margin (Lund et al., 2018). This comes in handy, particularly among young and busy gals who rarely visit a doctor. Among the teens and recently married women, apps that specialize in reproductive health are the hot spots. Many of them monitor menstruation, provide fertility data, and offer bespoke birth-control consultations. Research indicates that app learning enhances knowledge and brings more confidence to women to communicate with their partners and clinicians (Ippoliti and L'Engle, 2017). Young people are fond of receiving confidential and secretive information through an app instead of discussing reproductive health in the open (Biswas et al., 2022).

Besides, mHealth makes an actual game-changer for health professionals, particularly community health workers. Digital job-aid applications will provide the Lady Health Workers with checklists, counseling guidelines, and referrals, which will enhance the quality and precision of their work. In fact, digital job aids increase happiness in clients and uptake of long-acting reversible contraceptives, as evidenced by research on Tech-enhanced counseling in digital settings in Pakistan, Ethiopia, and Nepal (Labrique et al., 2021).

Moreover, social networks such as Facebook, YouTube, or Instagram are also starting to have a significant influence on disseminating contraception information. Myth-busting, stigma reduction, and drawing in individuals to clinics are achieved by youth-oriented advertisements (Shelton & Kortz, 2020). Scientists note that we require material that is verified, evidence-based, but also, they argue that false information within social media platforms can harm a company in both significant and actual ways (Rahman et al., 2021).

In sum, research indicates that mHealth interventions enhance awareness, positive attitudes, and sustain the use of contraceptives. They perform optimally when they are culturally and linguistically oriented, portals to available health systems, and supported by actual human

resources (WHO, 2022). mHealth tactics have a great deal of promise to improve family planning programs and target underprivileged groups, as digital literacy in Pakistan keeps rising (Rahman et al., 2021).

2.8 Myths, Misconceptions, and Fear of Side Effects:

One of the most enduring obstacles to the use of contraceptives in low- and middle-income nations, especially in South Asia, is fear of negative effects (Chandra-Mouli et al., 2014). Women's decisions, continuing rates, and willingness to talk about family planning are greatly influenced by false assumptions and inflated anxieties, even when they show awareness of contemporary methods of contraception (Sedgh et al., 2016).

Most communities believe that contraceptives, especially hormonal contraceptives, may cause irregular menstrual cycles in the long run, cancer, and developmental abnormalities in the fetus, infertility, and irreversible weight gain (Guttmacher Institute, 2023). Such misconceptions are often due to the lack of scientific knowledge, the stories that people share in their families, and the fact that they tend to rely on unofficial sources rather than on qualified medical professionals. Indeed, rumors that intrauterine devices (IUDs) can travel in or get lost in the body or cause serious infections are widely circulated in qualitative studies in South Asia and Africa. Such fears usually prevent women from utilizing long-acting reversible contraceptives (LARCs), despite claiming that they do not want to get pregnant in the near future (Castle and Askew, 2015).

Another level of fake information is the cultural and religious interpretations. Other individuals believe that the use of contraceptives will be contravening the will of God, undermine the body, and prevent the natural reproductive processes. These ideas restrict the reproductive freedom of women and the gender conventions that discourage them from independently deciding on fertility (Ali et al., 2012). Understanding that in most patriarchal cultures, women who use contraceptives secretly or who have their negative impact disrupt the normal household routine are afraid of reprisals on their part by husbands or in-laws (Chandra-Mouli et al., 2014).

Another level of false information is cultural and religious interpretations. Some individuals believe that contraceptive use will be against the will of God, weaken the body, or obstruct the natural reproduction cycle. These ideas restrict the reproductive freedom of women and enforce the gender roles that discourage them from acting independently on fertility matters. Women are

afraid of being reprimanded by their husbands or in-laws in most patriarchal environments that either use contraceptives secretly or whose perceived side effects disrupt normal home functions (Castle & Askew, 2015). The fear of infertility is the most misperceived in research. Many women believe that hormonal methods are a way of burning the eggs, drying the womb, or permanently preventing pregnancy. This is a major concern for newlywed women who are supposed to conceive a baby soon after getting married. They therefore do not use birth control at an early age, and this leads them to have closely spaced pregnancies with severe health implications (Gyan et al., 2019).

There are also myths about side effects that influence the rate of discontinuation significantly. Some minor and temporary side effects that are mistaken to be signs of long-term damage include spotting, weight changes, and headaches. Most women stop using all forms of contraception altogether instead of therapy or technique switching (Sathar et al., 2016). Research has always indicated that poor counseling and follow-up contribute to anxiety; women who have never heard about any negative effects are prone to discontinue a medication too early (Ali et al., 2012). More importantly, studies have shown that such beliefs are closely linked to poor literacy, limited access to quality information, and limited interaction with competent medical workers. The barriers related to fear are also significantly minimized when Lady Health Workers or midwives provide systematic counseling, discuss myths in a publicly available place, and help women to make their choice (Sathar et al., 2016).

The current studies also focus on the increasing issue of social media misinformation. Viral messages, bad health information, and conspiracy theories have been proven to deter hormonal contraceptive method adoption among young women, especially in urban areas with high smartphone adoption (Gyan et al., 2019). Intervention strategies that have been employed to dispel myths have been effective in the form of community discussions, male partner education, interactive counseling, as well as experience-sharing by satisfied users. Evidence-based reassurance, culturally acceptable communication, and open communication programs show a statistically significant increase in the use of modern birth control (Ali et al., 2012).

2.9 Economic Costs and Financial Incentives

Economic hardship has been revealed to be one of the greatest obstacles to the uptake or the sustenance of modern contraception. When they theoretically access services, low-income women

get demotivated by the true expenses, which include transport, fees, lost wages, and childcare (Ahmed et al., 2019). More hidden costs affect rural and peri-urban women, as transportation is less reliable and the health facilities are more distant.

In addition to that, direct expenses on contraceptives, including small fees on pills, injections, or insertion of an IUD, can discourage the use among poor households (Cleland et al., 2018). In matters of prevention of health care, it usually plays second fiddle to necessities such as food and utilities, particularly to families who are below the poverty line. Due to this reason, although they do not desire pregnancy, many women delay family-planning services or avoid them altogether (FP2020, 2021).

A lot of studies have shown that the removal of the user fees leads to the widespread use of birth control. Subsidized clinic visits, transportation vouchers, free contraception, or conditional financial transfers have programs whose increases in adoption and continuation are quantifiable (Hamal and others, 2022).

The financial benefits of family planning extend beyond the domestic frontiers. More birth control will reduce dependency rates, make population easier to manage, and provide a demographic dividend on the national scale, allowing authorities to invest in economic growth, healthcare, and education (Bloom et al., 2014). Economic benefits were achieved in the long term due to early Family planning investments, as it not only enhanced maternal health but also boosted the workforce participation of females, and reduced the stress on available services (Sathar and Zaidi, 2019).

Financial incentives are the other important element in empowering women. There are a lot of women who cannot cover medical costs independently, as they lack a source of income due to a low-resource setting and rely on spouses or in-laws. Programs that provide incentives to women to have greater reproductive agency because of reduced prices of contraceptives (Blackstone, 2017). In some cases, it has been observed that vouchers and subsidies increase access to marginalized groups such as women who work in informal labor markets, migrants, and teenagers (Ganle et al., 2021).

Also, studies indicate that the rise in the cost-effectiveness of long-acting reversible contraceptives (LARCs) notably affects uptake. Free or reduced-cost insertion of an IUD or

implants is very useful in boosting the use of these types of birth control devices by low-income earners, even though they are cost-efficient in the long run (Hubacher et al., 2015). Though the short-acting methods have lower success rates, the majority of the women will use them where such methods are not funded by others, since they require smaller and frequent payments.

Having been taken into consideration, the evidence clearly indicates that the economic variables influence the family planning behavior in all its variations, i.e., in terms of awareness, availability, adoption, method choice, as well as sustained usage. Enhanced policymaking in contraceptive prevalence and overall reproductive health is strongly correlated with the reduced cost barrier, either achieved by devoting funds from the state or by providing insurance or distributing contraceptives at the community level (Morgan et al., 2020).

2.10 National Health Vision (NHV) 2016–2025 & Family Planning

The NHV acknowledges the contribution that family planning makes towards being one of the most cost-effective interventions to curtail maternal and newborn mortality (Publisher, -b). The document indicates that there is a need to incorporate family planning services in other health programs, like maternal among others (WHO-EMRO, 2022). Health programs, newborn and child health (MNCH) programs, nutrition, and immunization programs. This combined strategy is supposed to support the operation that has long been isolated between the Ministries of Health and Population Welfare, ensuring that there is a joint effort to achieve better outcomes on reproductive health (WHO, 2025).

Notably, the NHV focuses on education and community involvement as a measure to enhance the take-up of contraceptives. It acknowledges that the success of family planning measures requires not just clinical access alone but also covers social determinants of health, which include literacy, equality of the sexes, and cultural permission. Therefore, the NHV promotes the use of digital health information systems, such as the District Health Information System (DHIS-2) and Contraceptive Logistics Management Information System (cLMIS), to facilitate planning, management of the contraceptive stock, and monitoring of contraceptive supply at provincial and district levels with the use of data (WHO-EMRO, 2022). These technological advances have ensured that the availability of family planning supplies is tracked, as well as reducing stock-outs

in the public health institutions. It is with the purpose of an intentional population policy shift in Pakistan, no longer deeming family planning as a demographic policy tool but appreciating it as a public health and human rights priority, that the National Health Vision is named. Nevertheless, their success requires further political commitment, adequate investments, and provincial commitments in the actualization of integrated service delivery patterns in the country (UNFPA Pakistan, 2023).

Family planning, according to the NHV, is one of the most cost-effective and life-saving interventions that have a direct influence on reducing maternal and newborn mortality. Vision facilitates an integrated service delivery model in which one primary healthcare platform is adopted to accommodate immunizations, nutrition, maternal care, and contraception. This approach aims at reducing cases of duplication of resources between federal and provincial programs, enhancing accessibility, and ensuring continuity of service (WHO, 2025).

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Research design:

This study uses a quantitative, cross-sectional design to assess the relationship between education level and family planning knowledge and attitudes among married women in Islamabad, Pakistan.

3.2 Sampling and data collection method

A convenience sample strategy was employed to collect the data from the married women in Islamabad. This non-probability sampling method is chosen due to the time and accessibility constraints. Additionally, the primary data was collected by paper-based questionnaires, and by filling out forms in person by the women in Islamabad.

3.3 Universe

The universe for this study constitutes married women of reproductive age (18-49) currently living in Islamabad, Pakistan.

3.4 Population Frame

The study's population frame consists of married women from different educational backgrounds living in both urban and peri-urban areas of Islamabad.

3.4.1 Inclusion Criteria

- Married women aged 18–49 years
- Women’s living in Islamabad
- Willing to participate

3.4.2 Exclusion Criteria

- Unmarried, widowed, or divorced women
- Women unwilling to participate

3.5 Instrument for data collection

The data for this research was collected using a structured questionnaire specially designed for this study, consisting of four sections which included demographic information, knowledge about family planning methods, their attitude towards contraceptive use, and their basic practice patterns. Age, education level, number of children, and their socioeconomic background all the details were all gathered in the demographic section. The knowledge section measured benefits, side effects, and awareness towards several types of contraceptive methods. In the attitude section, the perception shaped by religion, culture, and personal beliefs was explored. Some questions also inquired about the current and previous use for better understanding. The questionnaire was closed-ended, and Likert scale questions to allow easy quantification of responses, and the questions was translated into Urdu to make sure it's easily understandable and accessible. A small pilot test (n=20) was conducted to make modifications in the questionnaire based on the feedback provided by the participants during data collection to ensure reliable responses.

3.6 Sample size calculation

To determine the necessary sample size for this study, Slovin's formula (n = N / (1 + Ne2)) is used to calculate the sample size for the study. For a population (N) of 384,000, a sample size (n) of roughly 400 will be required with a 95% confidence level and a 5% margin of error. This sample size is deemed appropriate to provide statistically meaningful insights about the population.

3.7 Data analysis type and technique

This study uses a descriptive design to assess the knowledge of married women about the use of contraceptives about their demographic characteristics, and knowledge levels. The collected data will be analyzed using SPSS, descriptive analysis to help evaluate data in the form of visual statistics, and to summarize the knowledge levels of the respondents in descriptive statistics.

3.8 Ethical considerations

This study will adhere to strict ethical research standards. The confidentiality and anonymity of participants will be maintained by removing identifying information to ensure that the participants' data is safe. Moreover, before participation, the participants will be offered a thorough explanation of the study's purpose, potential risks, and benefits.

CHAPTER FOUR

DATA ANALYSIS / RESULTS

4.1 Descriptive Analysis

The descriptive analysis of the data gathered from 300 married women in Islamabad. It provides an overview of their socio-demographic characteristics and family planning knowledge, attitudes, and behaviors. This study aims to give a concise summary of the sample and identify broad trends in the data. The results provide preliminary insights into the relationship between awareness and use of family planning methods and factors such as age, education, domicile, and marital status.

Table 1: Correlation of attitude and education

	Attitude			
Education	Unfavorable	favorable	Chi square	pValue
no formal education	15	10	13.492	.004
higher	105	32		
secondary	60	43		
primary	29	6		

Table 1 shows that attitude and education level are significantly correlated (p =.004). Compared to respondents with secondary, primary, or no formal education, those with higher education demonstrated a more positive outlook. Unfavorable sentiments were more prevalent among those without formal education. Overall, the findings suggest that people tend to adopt more optimistic viewpoints as their knowledge increases.

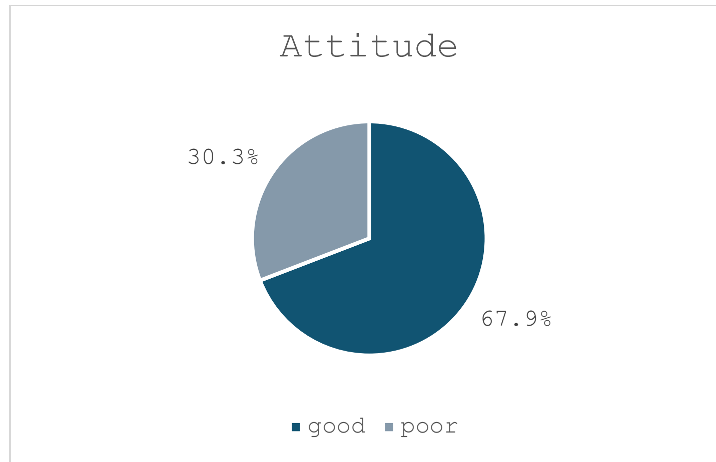

Figure 2: Attitudes

The distribution of respondents' opinions is depicted in the pie chart. While 30.3% of individuals had a negative attitude, the majority (67.9%) had a positive attitude. This suggests a generally positive outlook within the group, as more than two-thirds of the respondents have a favorable attitude. The lower percentage of unfavorable attitudes indicates that negative opinions exist but are not prevalent.

Table 2: Correlation of knowledge and education

	Knowledge			
Education	good	poor	Chi square	pValue
no formal education	22	3	11.908	.008
higher	136	1		
secondary	101	2		

Knowledge and education are significantly correlated (p =.008) in Table 2. Very few people reported having inadequate knowledge, while those with secondary and higher education showed very good knowledge. Compared with those with formal schooling, those without formal schooling knew less. Higher education is highly associated with higher levels of knowledge, according to this pattern.

Table 3: Socio-Demographic Characteristics of Married Women in ISB (N=300)

Characteristics	Categories	Frequency (n)	Percent (%)
Age (Years) (Grouped)	18–24	120	40.0
	25–31	55	18.3
	32–45	125	41.7
	Total	300	100.0
Education Level	No formal education	25	8.3
	Primary	35	11.7
	Secondary	103	34.3
	Higher	137	45.7
	Total	300	100.0
Residence	Urban	245	81.7
	Rural	55	18.3
	Total	300	100.0
Duration of Marriage (Years)	0–5 years	130	43.3
	6–10 years	80	26.7
	11–25 years	90	30.0
	Total	300	100.0
Occupation	Housewife	163	54.3
	Teaching/Govt/Health worker	54	18.0
	Private sector/Small business	65	21.6
	Unemployed/Student	18	6.0
	Total	300	100.0
Number of Children	0–3	246	82.0
	4–6	47	15.7
	7+	7	2.3
	Total	300	100.0

The age distribution indicates that the majority of the surveyed respondents are young women between the age of 18 to 20 and the participation levels decline with age, meaning that younger married women are more active in reproductive-health surveys. This is significant since young women are normally at the initial stages of marriage, where education has a strong impact in terms of the knowledge and attitudes of family planning. Almost 50 percent of the respondents (45.7) have a higher education level, with only 8.3 percent having no formal education, which shows the close relationship between education, reproductive-health knowledge, autonomy, and making informed choices. The most recent survey population represents a housewife (54.3 per cent) but there is some occupational variety with the other respondents either being employed in teaching or in a specific personal job or in health care, and the working women tend to have more health information available and the housewife perhaps more influenced by family issues, so education is a dominant factor in family-planning decisions. The vast majority of the respondents (81.7% of the women reside in urban regions) with access to health services, education, and family-planning in greater numbers than rural women, who might have difficulties with cultural and informational access; joined with education, residence becomes a significant predictor of reproductive practices. The most significant percentage (43.3) has married 0-5 years (when the couples make early decisions regarding childbirth and childbirth spacing), thus family-planning knowledge is the most specific and education is a stronger contributor to such knowledge. The majority (82) of the respondents have 0-3 children, indicating that they were in the early childbearing stage, and they were mostly interested in pregnancy spacing and contraceptive knowledge most, and education has continued to affect the reproductive goals, so more educated women preferred smaller families, had delayed early childbearing, and used family-planning methods more regularly, which signifies a generalized shift in the favor of smaller families.

Table 4: Knowledge of Family Planning (FP)

Knowledge of family planning	Categories	Frequency (n)	Percent (%)
Ever Heard of FP	Yes	293	97.7
	No	7	2.3
	Total	300	100
Main Source of Information	Friends	157	52.3
	Media	88	29.3
	None	23	7.7
	Spouse / Health worker / Other	32	10.7
	Total	300	100
Awareness of Traditional Method	Yes	162	54
	No	138	46
	Total	300	100
Knowledge of Service Availability	Yes	196	65.3
	No	104	34.7
	Total	300	100
Knowledge of Side Effects	Yes	169	56.3
	No	131	43.7
	Total	300	100

The statistics indicate almost universal understanding of family planning (97.7%), which proves the fact that the concept is popular among the Islamabad people. The knowledge distribution is, however, skewed and heavily influenced by the educational attainment. The general level of awareness is good, but informal sources such as friends (52.3%), the media (29.3%), and less reliance on formal ones such as medical professionals or school institutions are the primary informational sources. This unofficial dependence is linked to an increased reported use of conventional procedures (54) and uninformed awareness on some long-acting medications. Condoms usage was most prevalent (72.3%), and the use of long-acting options was named very rarely. Also, although over half of the women (56.3) knew about the side effects, such understanding is often coupled with fears or misunderstandings as opposed to clinical information. It is always observed that higher education is very essential in enabling women to receive and

analyze more reliable information, which helps them better understand the service provision (65.3%), and also expands their understanding of the benefits and the barriers of modern family planning. This underlines the importance of a targeted, institutionalized educational outreach to ensure that every woman is no longer in the rudimentary awareness level but is well and comprehensively informed with trust.

Table 5: Attitudes towards Family Planning (FP)

Characteristic	Category	Frequency (n)	Percent (%)
FP Benefits for MCH	Favorable (Strongly Agree/Agree)	282	94.0
	Neutral	14	4.7
	Unfavorable (Disagree/Strongly Disagree)	4	1.3
	Total	**300**	**100.0**
Contraceptives Improve Welfare	Favorable (Strongly Agree/Agree)	265	88.3
	Neutral	17	5.7
	Unfavorable (Disagree/Strongly Disagree)	18	6.0
	Total	**300**	**100.0**
FP Against Religious/Cultural	Favorable (Strongly Agree/Agree)	121	40.4
	Neutral	67	22.3
	Unfavorable (Disagree/Strongly Disagree)	112	37.4
	Total	**300**	**100.0**

Characteristic	Category	Frequency (n)	Percent (%)
Belief: Contraceptive Use Increases Promiscuity	Favorable (Strongly Agree/Agree)	107	35.7
	Neutral	114	38.0
	Unfavorable (Disagree/Strongly Disagree)	79	26.3
	Total	**300**	**100.0**
Both Partners Should Decide	Favorable (Strongly Agree/Agree)	269	89.7
	Neutral	21	7.0
	Unfavorable (Disagree/Strongly Disagree)	10	3.3
	Total	**300**	**100.0**
Encourage Others to Use FP	Favorable (Strongly Agree/Agree)	247	82.4
	Neutral	20	6.7
	Unfavorable (Disagree/Strongly Disagree)	33	11.0
	Total	**300**	**100.0**
Comfort Discussing FP with Spouse	Favorable (Strongly Agree/Agree)	262	87.3
	Neutral	19	6.3
	Unfavorable (Disagree/Strongly Disagree)	19	6.3
	Total	**300**	**100.0**

Characteristic	Category	Frequency (n)	Percent (%)
Cost Makes FP Inaccessible	Favorable (Strongly Agree/Agree)	171	57.0
	Neutral	63	21.0
	Unfavorable (Disagree/Strongly Disagree)	66	22.0
	Total	**300**	**100.0**

Assessments of views generally have a positive view of family planning (FP) yet there has been sociocultural opposition and financial issues. There is a wide consensus in the benefits of FP to maternal and child health (94.0% strongly agree/agree) and the role of FP in improving the overall family welfare (88.3%). The increased level of education is always associated with this positive attitude, indicating that literacy makes it easier to realize the long-term health, social, and economic gains. Reservations, however, have a basis in perceived socio-cultural impediments: 35.7% think that using contraceptives would promote promiscuity and 40.4% think that using FP would be against religious or cultural beliefs. These negative feelings were also present much more frequently in women with lower education, which means that cultural beliefs and misinformation can be perpetuated because of insufficient reproductive education. Speaking of interpersonal relationships, the majority of the respondents (a significant number of which is 89.7 out of 100) said they share their modern views on the issue and support collaborative decision-making (89.7%) and are comfortable discussing FP with their partner (87.3%). This transparency reflects a trend of fair reproductive health decisions, and is usually linked with a higher level of education. Finally, cost was the last factor listed by over 57.0 percent of respondents. This is an important conclusion because women who are less educated are found to be disproportionately impacted by financial concerns. It demonstrates that even positive intentions are not able to break the barriers of accessibility and the government should take some steps to provide easy access to FP services.

Table 6: Practice and Barriers

Characteristic	Category	Frequency (n)	Percent (%)
Currently Using FP Methods	Yes	124	41.3
	No	176	58.7
	Total	**300**	**100.0**
Ever Heard of FP Method	Yes	176	58.7
	No	124	41.3
	Total	**300**	**100.0**
Decision Maker	Joint decision	162	54.0
	Self/Husband/Others	138	46.0
	Total	**300**	**100.0**
Visit Frequency	Once in 6–12 months / Once in last 3 months	137	45.7
	Never / Rarely	163	54.3
	Total	**300**	**100.0**
Ever Discontinued FP Method	Yes	43	14.3
	No	257	85.7
	Total	**300**	**100.0**
Main Reason for Discontinuation	Side effects	21	7.0
	Wanted Pregnancy/Missing	3	1.0
	None	276	92.0

Characteristic	Category	Frequency (n)	Percent (%)
	Total	**300**	**100.0**

The study of Family Planning (FP) practices demonstrates a large reduction (14.3) or inconsistent use (method) of the practices which represented a significant difference between ever-use and current use. The process of decision-making is largely contemporary and participative with more than half of the respondents indicating a joint decision-making process, despite the general use (current use at 41.3) indicating mediocre use. This outcome is characterized by the higher level of education and increased female independence in reproductive issues and enhanced communication between the spouses. Nevertheless, some evident barriers to continued practice still exist. Quite a high proportion of the women do not use FP services at all, a tendency that is often brought about by the low health literacy and poor health-seeking tendencies among less-educated women. The major cause of technique discontinuation was side effects (7.0% of all respondents). Although this is an average rate, the situation is urgent: the fear or misunderstanding of negative effects, which is more common with women with low education, is certainly the primary cause of such discontinuity. This proves that practice is not merely in the availability but also in the long-term consistency which is always impaired by ignorance and fear-based practice particularly among vulnerable groups, which is significantly reduced by 14.3% or lack of consistent family planning (FP) practices. The decision-making is mainly recent and cooperative with 54 percent of the respondents saying that family planning decisions are made jointly. Regardless of this, the total rate of utilization, which is currently at 41.3, implies moderate acceptance of such methods. The results indicate that a rise in female autonomy in matters concerning reproductive decisions and a rise in communication between the partners is correlated with high levels of education. Nevertheless, there exist certain obstacles to the regular utilization of FP services. Quite a significant proportion of women do not even use such services, sometimes the reason being low health literacy and less proactive health-seeking behavior, especially in less educated women. The most dominant cause of discontinuation of methods is side effects being reported by 7.0% respondents. This percentage may be considered as a moderate one, but the setting matters. This discontinuation is largely caused by fear or lack of understanding of the negative effects, especially among women with low education levels. This shows that accessibility is not the only requirement

in effective family planning but also a long-term compliance that can be compromised by the lack of knowledge and decisions based on fear especially among the vulnerable groups of the population.

Table 7 :Desired Outcomes and Major Barriers

Characteristic	Category	Frequency (n)	Percent (%)
Ideal No. of Children	1–3	214	71.3
	4+	86	28.7
	Total	**300**	**100.0**
Preferred Birth Interval	3–4 years	185	61.7
	1–2 years / 5–6 years	115	38.3
	Total	**300**	**100.0**
Spouse Approval of FP	Yes	208	69.3
	No	92	30.7
	Total	**300**	**100.0**
Major Community Barrier	None significant	135	45.0
	Fear of side effects	71	23.7
	Husband opposition	51	17.0
	Cost / Taboo	43	14.3
	Total	**300**	**100.0**

The fertility objectives conform to the current, health-aware family planning. Two to three children was the desire of the vast majority of the respondents (71.3), which is in accordance with the trend among the educated women and the appreciation of smaller and more manageable family sizes to have better planning and resource distribution. This wish to have small families is logically supported by the preference of 34 34-year birth interval (61.7%), which demonstrates high

awareness of the need to have optimum spacing between children to ensure that they will have better health outcomes of both mother and child. Spousal approval (69.3) is high which also indicates the intention to practice FP, arguing that family planning is mostly a co-operative and accepted process in the household. This observation is often associated with better communication and joint decision-making that is common in better-educated couples. There are still major perceived and external barriers, however. Husband resistance (17.0%) and fear of side effects (23.7) were discovered to be the largest impediments in the community. These obstacles are essential, as they highlight the systematic nature of misinformation and conventional patriarchal ideals, within which the issues are often better established within the community of less educated people and reduced access to trustworthy and objective health data. Breaking these barriers should not just be a question of enhancing availability, but should be accompanied by the inclusion of males and the active effort to confront the community-based misconceptions about FP procedures.

CHAPTER 5:

DISCUSSION AND CONCLUSION

5.1 DISCUSSION

The current study was intended to evaluate the knowledge, attitude, and practices of married women regarding family planning living within the boundaries of Islamabad. The results show that the sample is distinguished by a sufficient level of family planning awareness; however, the number of discrepancies remains rather high in regard to the level of knowledge, the methods used, and the frequency of their utilization. The overall findings are that women do understand the significance of planning their family, and the social norms, education, as well as availability of information, spouse pressure, and non-official sources still influence the decision-making.

The conclusion that 97.7 percent of the respondents had heard about family planning may be stated among the most important findings of the work, which helps to conclude that the level of awareness of the general population is high. This kind of general awareness is realized through exposure to the media, residing in an urban area, and engaging in broader social discussion on the subject of reproductive health. However, the majority of respondents in the research were introduced to family planning by friends and the media, with a reasonably low number indicating medical professionals and other learning resources. Such awareness does not necessarily find its way into a profound comprehension. This reliance on informal networks may be the reason behind the relatively small scope and quality of family planning information, particularly among the less educated women. These tendencies indicate that information sources influence perceptions and decision-making. The study found that education was a very crucial determinant. The more educated women were assured more in long-term methods, as well as were more educated on contraception methods, and more so on current methods. Conversely, less educated females were more dependent on short-term and socially acceptable solutions and less conscious of the long-term strategies. This knowledge and education correlation is also consistent with other studies that have been carried out on the same in Pakistan, where formal education increases the exposure to the correct information on reproductive health and the ability to assess various contraceptives.

Findings of Islamabad confirm the idea that the improvement of accessibility of the female population to education can have a positive impact on the reproductive health of the population, such as by using informed contraceptives. According to the findings of the research, the most prevalent method in using long-acting reversible methods like IUCDs and implants, which had relatively low levels of knowledge, was condoms (72.3%). The cause of this gap lies in the general misconceptions and the poor communication of birth control by the healthcare organization in the long term. Further, the use of male-dominated channels, i.e., condoms and withdrawal, implies that there are usually debates on fertilizing in marriages. Female patients could feel freer to talk or practice methods that do not pose so many clinical intervention or privacy challenges. The other reason behind low awareness of long-acting techniques is that the community health workers, who are considered to play a crucial role in the provision of evidence-based ideas, were rarely cited by the research subjects. The answers of the sample on family planning were even. Though several women confirmed that family planning is healthy for the mother and child, others raised concerns regarding the misinformation about side effects, cultural forces, and coercion to bear more children. Some of the respondents were not very common; however, some of them believed that family planning was against religious or family values. These are the findings as per the more general socioeconomic trends in Pakistan, whereby community norms, spouse communication, and family influence have a significant impact on reproductive behavior. What is more important, women who have positive attitudes and frequently use contraception have higher chances of doing so when they have positive husbands or those who have open marital relations. In the research, it is indicated that there is a massive disparity between awareness and actual family planning. The respondents who used modern contraception regularly were lower, but the majority of the respondents appreciated the need to space their births and the need to take care of their mothers. The condom and the withdrawal method were the most preferred, which have low efficacy and high inconsistency in the utilization of these methods. Small adoption of long-term treatments is observed to be linked with fear of side effects, lack of trust in medical practice, inexperienced counseling, and the impact of the local gossip regarding the dangers or safety of permanence and dangerousness. Such a tendency shows that there is a need to have more high-quality counseling services, awareness campaigns to be done within the community, and better therapeutic communication. The survey results also reveal the degree to which medical practitioners fail to provide knowledge about family planning. Only a small fraction of the respondents responded that

they had been counselled by medical practitioners, LHWs, or qualified health educators. This is especially of concern to the city of Islamabad, where it is more likely that health facilities are more accessible in comparison with rural regions. Unstructured therapy results in a lack of understanding, technique failure, and abandonment. Through the media and the workmates, such women might not get all or sound information and thus, it becomes difficult to make sound decisions. Overall, the findings of the current research suggest that the disparity between the high level of awareness and the lack of comprehensive knowledge and practice is rather significant. The majority of women have been found to have found the need to plan a family, although the lack of expert advice, false information, and socio-cultural influence are some of the challenges to the good use of contraceptives. The results show that there is a need to improve the application of couple-based communication, increase the role of health care practitioners in counseling, and improve reproductive health education. The interventions should be aimed at raising awareness of long-acting practices, demystifying, and making sure the correct information is readily spread to ensure more is done. This is a promise and fight presented by Islamabad. Even though health infrastructure will act as a framework, the community should be engaged more actively and have a particular educational program to fill existing gaps and apply family planning more frequently.

5.2 CONCLUSION

This paper concludes that despite the fact that married women in Islamabad possess an extremely high degree of overall awareness of family planning, the gap in terms of the quality of knowledge, the variety of techniques to use is still significant, and its practical implementation continues to be widely lacking. Since women mostly depend on unofficial sources such as friends and the media, their awareness about the existence of alternative contraceptives is usually incomplete or misguided. Education is important in that highly educated women are better informed and are more at home with modern contraception. The findings also indicate that marital communication, societal expectations, and perceived side effects are all important in influencing family planning opinions. Although most women agree that family planning is better to enhance the health of both mothers and children, the social restrictions and myths do not allow them to use it regularly. Both male pressures and ignorance about more efficient long-acting methods are shown through the obvious choice of condoms and withdrawal. Low involvement of healthcare professionals in delivering credible information on family planning is one of the major issues. Without professional

guidance and advice, women might use incorrect or substandard information, resulting in inconsistent or inefficient behaviors. Special initiatives to reduce such differences, especially those involving community education, the role of males, fortification of counselling services, and ensuring long-term decisions are a common issue, are required. The study is, in essence, an attempt to attract attention to a gap between awareness and behavior. Enhancing health education, empowering women through the enhancement of access to the right information, and the active involvement of the healthcare workers are all essential to better health outcomes in the field of reproductive health in Islamabad. By enhancing these spheres, the making of informed decisions will be made easier, the efficient use of contraceptives will be promoted, and, after a certain period, the health outcomes of mothers and children will improve.

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Questionnaire:

Family Planning Knowledge, Attitude, and Practice (KAP) Study

Section 1: Socio-Demographic Information

1. Age of respondent (in years): ______

2. Educational level: ( ) No formal education ( ) Primary ( ) Secondary ( ) Higher

3. Occupation: ______________________

4. Residence: ( ) Urban ( ) Rural

5. Duration of marriage (years): ______

6. Number of children: ______

7. Average household monthly income: ______

Section 2: Knowledge on Family Planning

1. Have you ever heard of family planning methods?

( ) Yes

( ) No

2. Sources of information (tick all that apply):

( ) Health worker

( ) Media

( ) Friends/Relatives

( ) Spouse

( ) Community meetings

( ) Others: ______

3. Which *modern* family planning methods do you know? (tick all that apply):
( ) Pills

( ) Injections

( ) Implants

( ) IUD

( ) Condoms

( ) Female sterilization

( ) Male sterilization

( ) Other: ______

3. Are you aware of *traditional* family planning methods?

( ) Yes

If yes, specify: ______

( ) No.

4. Do you know where family planning services are available in your community?

( ) Yes

( ) No

5. Do you know any possible side effects of modern family planning methods?

( ) Yes

If yes, specify: ______

( ) No.

Section 3: Attitudes Toward Family Planning

Instruction: Please indicate your opinion on the following statements

(Strongly Agree, Agree, Neutral, Disagree, Strongly Disagree).

1. Family planning is beneficial for maternal and child health.

2. Using contraceptives improves family welfare.

3. Family planning is against religious or cultural values.

4. Contraceptive use encourages promiscuity.

5. Both husband and wife should decide together on family planning.

6. I would encourage others to use family planning methods.

7. I feel comfortable discussing family planning with my spouse.

8. The cost of contraceptives makes them inaccessible to many in my community.

Section 4: Practice of Family Planning

1. Have you or your spouse ever used any family planning method?

( ) Yes

( ) No

2. Are you currently using any family planning method?

( ) Yes

( ) No

3. If yes, which method are you currently using? ______________________

4. If not currently using, what are the main reasons? (tick all that apply):

( ) Want more children

( ) Fear of side effects

( ) Religious/cultural objections

( ) Lack of access

( ) Husband's opposition

( ) Cost

( ) Lack of knowledge

( ) Other: ______

5. Who usually decides on family planning use in your household?

( ) Self

( ) Husband

( ) Joint decision

( ) Others: ______

6. How often do you (or your spouse) visit a health facility for family planning services?

( )Often (≥ once in last 3 months)

( ) Occasionally (once in 6–12 months)

( ) Rarely ( ) Never

7. Have you ever discontinued a family planning method?

( ) Yes

If yes, what was the reason for discontinuation? ______________________

( ) No

If yes, what was the reason for discontinuation? ______________________

Section 5: Additional/Contextual Questions

1. What is your ideal number of children? ______

2. What is your preferred interval between births? ______ years

3. Does your spouse approve of family planning?

( ) Yes

( ) No

( ) Don’t know

4. What are the major barriers in your community to accessing family planning services?

____

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This is to certify that the research work entitled "A Quantitative Study on the relationship between education level and family planning knowledge and attitudes among married women in Islamabad, Pakistan" submitted by Misbah Jehan, in partial fulfillment of the requirements for the degree of Bachelor of Science in Public Health, is an original piece of work carried out by the student.

I further declare that this research has not been submitted previously to any other university or institution for the award of any degree or diploma. All sources of information used in this research have been properly acknowledged and cited. The similar index of this research work is within the acceptable limit as per university policies

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