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Are Status of Women and Contraceptive Prevalence Correlated in Pakistan?

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1. BACKGROUND

Pakistan with an estimated population of around 142.5 million in mid 2001 is the seventh most populous country in the world and fourth in Asia and Pacific countries. The historical trends indicate a continuously increasing growth in population (Table 1). The population of the area now constituting Pakistan was 16.6 million in 1901. Since then the population has increased over eight-fold. Annual growth rates have risen from 1 percent in the first three decades of the century to around 2 percent in the next three decades and after peaking at little over 3 percent in the 1960s, has started showing a declining trend. Currently it is estimated that Pakistan's population is growing at around 2.1 percent, still a very high rate of annual growth in population.

Major contributing factor to the fast growth in population of Pakistan has been high fertility which has remained high for a very long period. It is evident that nearly 100 million population has been added to the population of Pakistan since 1961, that is, during the last four decades. Such rapid growth in population has several adverse implications for the socio-economic development of the country which has been offsetting the gains in social and economic development.

Positive government policy towards family planning in Pakistan goes back as far as economic planning itself [Robinson (1978)]. A realisation of the hazards of the population explosion and the necessity to keep it under control has existed in Pakistan since early 1950s. Successive five-year plans have expressed concern about rapid population growth and proposed measures to deal with it. A number of family planning strategies have been experimented and the programme in Pakistan has passed through various phases of development almost coinciding with successive development plans for the country and has been referred to under various titles during these periods. In this process each phase has been subsumed by the preceding phase rather than replacing it [Population Welfare Division (1983)].

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Table 1

Population Size and Rate of Population Growth, Pakistan, 1901-2001

Year	Population (Thousand)	Annual Growth (Percent)
1901	16576	–
1911	19382	0.6
1921	21109	0.8
1931	23542	1.1
1941	28282	1.9
1947	32500	1.8
1951	33740	1.8
1961	42880	2.4
1982	65309	3.6
1981	84254	3.1
1998	130600	2.6
2001	142500	2.1

Source: Census from 1901 to 1998 except population for 1947 and 2001 which is estimated.

As viewed by some experts, the failure of each model, combined with fluctuating government commitment, led to its replacement by another, with negative consequences for staff morale and for the orderly development of skills and careers. This contributed to problems of management, which have been increasingly serious throughout the life of the programme. Moreover, the models themselves were seriously flawed, notably in their failure to provide outreach to a population characterised by limited demand and mobility; in retrospect only the Continuous Motivation System, given time and suitable modification, might have succeeded [Hakim and Miller (1996)].

Although having old history, the family planning programme in Pakistan could not achieve the same success as programmes in other countries of the Asian region have achieved. The Pakistan Fertility and Family Planning Survey 1996-97 indicates that among currently married women age 15–49 years, still only a small group 24 percent (including seven percent traditional methods) are current users of contraception (Table 2). The unmet need for family planning is around 38 percent. Fertility norms are still high in the society with ideal family size of 4.3 children. Infant and child mortality are also high (around 90 per 1000 live births). There are inadequate services and supplies for both health and family planning in the country and full coverage have not yet been achieved [Hakim *et al.* (1998)]. Several factors are responsible not achieving wide spread use of contraceptives and an early reduction of fertility by the programme but low status of women, in particular their education and employment are considered important factors.

Table 2

Trends in Current Use of Specific Methods, among Currently Married Women

Method	PCPS 1984-85	PDHS 1990-91	PCPS 1994-95	PFFPS 1996-97
Any Method	9.1	11.8	17.8	23.9
Any Modern Method	7.6	9.0	12.6	16.9
Pill	1.4	0.7	0.7	1.6
IUD	0.8	1.3	2.1	3.1
Injectables	0.6	0.8	1.0	1.4
Vaginal Methods	0.1	0.0	0.0	0.1
Condom	2.1	2.7	3.7	4.2
Female Sterilisation	2.6	3.5	5.0	6.0
Male Sterilisation	0.0	0.0	0.0	0.0
Any Traditional Method	1.5	2.8	5.2	7.0
Periodic Abstinence	0.1	1.3	0.0	1.9
Withdrawal	0.9	1.2	4.2	4.6
Others	0.5	0.3	–	0.5
N	7405	6364	7922	7584

2. THE STATUS OF WOMEN

Being a complex phenomenon, the status of women in each society is interpreted differently. Despite increased attention to the concept of status of women in demography, the meaning of this concept has remained unclear [Mason (1986)]. To denote the status of women, various scholars have used different concepts in literature such as female autonomy by Dyson and Moore (1983), patriarchy by Cain *et al.* (1979), women's rights by Dixon (1975) and men's situational advantage by Caldwell and McDonald (1981). The aspects of women's status and roles that are of interest to social policy-makers are the ability of women to plan their reproductive behaviour and their capacity to limit their fertility to a desired number of children [Syed (1987)].

On the basis of discussions by Oppong (1980) and Dixon (1978); Shah (1986) defines the term "status" in the Pakistani context to denote, first, an access to resources such as education, gainful employment, and health services and, second, the position (power, prestige, authority) that a woman has in various situations. Since many forces determine the overall status of women in a society, a woman's status cannot be defined by a single indicator but has to be viewed as a combination of multiple types of status, some of which are high while others are low.

Syed (1978) and Sathar *et al.* (1988) used conventional measures of education and employment of women to denote their status. An historical appreciation of the current role and status of Pakistani women is possible only when their lives are analysed in their entirety, including such aspects as their cultural values in the family, community, and nation, as well as their demographic and economic roles. Furthermore, it is essential to understand the religious, political and legal prescriptions and rules relating to an adversely affecting the status of women [Hakim and Aziz (1998)].

Table 3

Quantitative Indicators of Status of Women in Pakistan, 1998

Education Female Population 5 Years and Above (%)	
No Formal Education	47.7
Primary/Middle	37.2
Secondary and Above	15.1
Marital Status and Age at Marriage	
Single Woman in Age 20–24 (%)	40.0
Single Woman in Age 25–29 (%)	13.0
Single Woman in Age 34–34 (%)	3.2
Divorced(%)	0.9
Marriage between Relations(%)	62.8
Mean Age at Marriage	18.2
Singulate Mean Age at Marriage	
Males	26.54
Females	22.01
Fertility and Fertility Control	
Wanted Fertility	4.0
Total Fertility Rate (TFR)	5.36
Total Marital Fertility Rate (TMFR)	7.55
Knowledge and Use of Family Planning (%)	
Knowledge	94.3
Ever User	36.4
Current Use	23.9
Health and Mortality	
Expectation of Life at Birth	62.0
Maternal Mortality Rate (Per 100,000 Births)	350
Deliveries at Home (%)	83
Birth Interval (Median Months Since Previous Birth)	26.0
Median Age at First Birth	21.25
Mobility	
Have Gone Outside Village/Mohallah Alone (%)	18.1
Perceived Ability to Go to Hospital Alone (%)	24.4

Source: Hakim *et al.* (1998).

The quantitative indicators of the status of women are presented in Table 3. It is evident that still majority of women in Pakistan have lower socio-economic, demographic and reproductive health indicators. Nearly half of female population (5 years and above) have no formal education. Age at marriage of women is still low and their marriages are arranged mostly within relatives. The level of fertility is still high and contraceptive prevalence is low. Similarly the health indicators of women are not favourable. Most importantly, the mobility of women for going outside their locality alone is limited.

3. VARIATIONS IN CONTRACEPTIVE PREVALENCE

During 1996-97, the Pakistan Fertility and Family Planning Survey (PFFPS) was undertaken to measure the level of contraceptive use and related aspects. The findings of PFFPS 1996-97 indicate a 24 percent level of contraceptive prevalence. Many factors contribute to the use and non-use of contraception in the country. In this article, using data from PFFPS 1996-97 [Hakim *et al*. (1998)], variations in contraceptive use have been examined. The analysis identifies effects of women's demographic and socio-economic factors on contraceptive use.

Demographic Factors and Contraceptive Use

In many societies, age and number of living children, particularly living sons, are considered important factors indicating variations in contraceptive use [Conception (1981)]. Most of the women in Pakistan are married off relatively at an early age and after marriage women want to have children as soon as possible. Therefore, a woman's current age and number of living children are important to explain variations in contraceptive use.

The analysis of the PFFPS 1996-97 data indicates that both age and number of living children indicate differentials in contraceptive use (Table 4). However, number of living children appears to be comparatively more significant. Women in younger age groups, particularly 15–19 and 20–24 have a very low level of current use (except for aged 20–24 with four or more living children). In higher age groups the use contraceptive tends to increase with increasing parity.

The number of living sons is another important factors influencing the use of contraception [Bairagi and Langsten (1986)]. As the numbers of living children and living sons are interdependent, the proportion of current users, controlling for these two factors simultaneously, is presented in Table 5. The current use rate in each category of women by number of surviving children tends to increase with the increasing number of sons. Although the number of living children is an essential consideration in Pakistan before a woman can think about the use of contraception, nevertheless, to have a son is of paramount importance to make this decision. Compared to the number of living children, the number of living sons is a stronger indication of use of contraception.

Table 4

Percent of Currently Married Women who are Current Contraceptive Users by Age and Number of Living Children, Pakistan, 1996-97

Age Distribution	Number of Living Children						Total
	0	1	2	3	4	5+	
15–19	1.5	11.1	14.8	31.8	–	–	6.2
20–24	0.3	6.2	17.0	17.1	21.6	15.0	9.9
25–29	0.0	14.3	27.3	19.9	27.3	23.9	21.0
30–34	0.0	7.1	10.1	26.8	34.3	40.1	30.7
35–39	0.0	3.3	25.0	45.0	39.1	36.6	33.8
40–44	0.0	0.0	4.5	43.9	43.7	38.1	35.4
45–49	0.0	0.0	0.0	24.1	34.7	29.8	27.5
Total	0.6	8.9	19.8	25.6	33.3	35.1	23.9
Number	965	932	1046	996	907	2738	7584

Table 5

Percent of Currently Married Women who are Current Contraceptive Users by Number of Living Sons and Living Children, Pakistan, 1996-97

Number of Living Sons	Number of Living Children						Total
	0	1	2	3	4	5+	
0	0.6	5.7	18.8	14.9	14.4	14.8	5.5
1	–	11.8	19.8	23.4	28.2	21.5	19.5
2	–	–	20.6	30.4	36.6	32.5	30.7
3	–	–	–	24.3	32.9	37.6	35.2
4+	–	–	–	–	42.2	37.9	38.1
Total	0.6	8.9	19.8	25.6	33.3	35.1	23.9
Number	965	932	1046	996	907	2738	7584

The findings also suggest that women in Pakistan rarely use contraception for spacing; rather, most of them use contraception for limiting family size after they have completed their desired family size. The demand for children, particularly sons, is still very high among families, for economic, social and lineage reasons.

Socio-economic Factors and Contraceptive Use

Literacy and educational attainment alter parents perceptions of the advantages of small families, bring changes in the status of women, change the social and economic aspirations which children would have, and affect both attitude towards contraception and ability to understand and make use of particular methods [Cassen (1981)]. Education has positive effects on attitudes towards contraception,

knowledge of contraception, communication between husband and wife, and through these and other variables, contraceptive usage which ultimately affects fertility. Various studies contain empirical evidence of the relationship between education and contraceptive use in Pakistan and other developing countries [Hakim (1993)].

The education level of women appears to be a better determinant of contraceptive use, particularly in the least developed countries [United Nations (1983)]. The study of the 1968 National Impact Survey and the 1975 Pakistan Fertility Survey data also found that education was markedly higher for users than for nonusers, indicating comparatively higher use by educated females than educated males [Shah and Shah (1984)]. This implies that better educated women are either more able to regulate or more motivated towards regulating fertility, compared to educated men in Pakistan. This also reflects, at least in part, that the family planning programme is generally oriented towards women rather than men, but it is the men who are still the decision markers in Pakistan, as in many parts of the developing world.

In this analysis sharp differentials in contraceptive use by education level of women can be seen (Table 6). Women who have attained some education (primary) are two times more likely to use contraception than are those who have no education. In comparison to women's education, their husband's education indicates less striking differentials in contraceptive use between different educational levels. In fact, there is not much difference in contraceptive use between those women whose husbands have attained primary education and those who have no education. It is only with attainment of at least secondary level education by the husband that differentials in contraceptive use become clear.

Table 6

Percent of Currently Married Women who are Current Contraceptive Users by Education of Women and their Husbands, Pakistan 1996-97

Education Level of Women	Education Level of Husband						
	No Education	Only Informal or Quranic	Upto Primary	Upto Middle	Upto Secondary	Above Secondary	Total
No Education	14.8	20.2	20.2	21.7	21.2	15.1	17.3
Only Informal or Quranic	21.1	18.4	13.2	26.1	34.2	26.5	23.3
Upto Primary	24.7	17.8	31.7	50.4	32.3	34.4	35.1
Upto Middle	23.6	0.0	52.0	31.5	37.8	41.4	36.8
Upto Secondary	43.1	0.0	59.5	30.8	44.0	52.3	46.6
Above Secondary	30.2	0.0	0.0	8.2	27.9	43.4	40.3
Total	16.5	18.8	21.9	29.4	30.1	35.8	23.9
Number	2842	304	1173	929	1352	984	7584

Although contraceptive use rates also vary according to a husband's education level, differentials in the proportion of current users are comparatively more pronounced if a woman's own education level is considered. Table 6 also represents current use of contraceptive controlling both for the education levels of women and their husbands. Women's education level clearly show stronger effects on current use of contraception than their husbands' education level. Husband's primary education has no effect on current use of contraception. It is interesting to note that women's education has a positive effect on contraceptive use even when her husband has no education. In this category when husbands have no education and women have primary education, the current use is 25 percent and it is 43 percent if she has secondary education. Presumably women having some education and living with uneducated husbands enjoy somewhat higher status in the family and are able to have access to contraception.

Occupation of women is another factor that affects contraceptive use. Style of living is generally associated with the type of work women do. It is noted that professional women are more likely to use contraceptive than their counterparts who are either working for other different jobs or not working for any job (Table 7). This is even upheld when education level of women is controlled. The data show that women working as professional employees have a higher level of current use (49 percent) than those who are employed against other jobs or performing home duties.

Women's education level and participation in the labour force increase contraceptive use. It is generally the case that occupation is related to education. If a woman is engaged in employment outside home, it is more likely that she had some schooling. However, in Pakistan even working women mostly have no education. The analysis of this study shows that women's employment, if combined with educational attainment is an important factor leading to the use of contraception. Women who are employed and have attained some education have the highest current use (Table 7).

Region of Residence and Contraceptive Use

The percentage distribution of currently married women aged 15–49 years who are current users of contraception by region of residence according to level of education is presented in Table 8. The level of current use is high in Punjab (27 percent), followed in Sindh (23 percent), NWFP (19 percent) and Balochistan (7 percent).

Women's education represents current use in the expected direction; that is, there is a positive relationship between current use and level of education in all regions.

Table 7

Percent of Currently Married Women who are Current Contraceptive Users by Work Status and Education Level, Pakistan, 1996-97

Work Status of Women	Education Level of Husband						Total
	No Education	Only Informal or Quranic	Upto Primary	Upto Middle	Upto Secondary	Above Secondary	
Professional	19.6	40.2	0.0	59.5	78.3	42.0	48.8
Administrative	0.0	0.0	–	100.0	–	–	12.7
Clerical	0.0	–	–	100.0	–	9.8	12.9
Sales	17.0	37.8	33.3	–	–	–	20.9
Service	13.8	13.4	21.9	0.0	–	–	14.2
Agriculture	9.6	6.3	0.0	43.3	0.0	–	9.4
Production	21.3	24.5	44.1	44.9	63.1	0.0	27.5
Other	25.3	26.2	0.0	–	–	–	24.5
Housewife	18.0	24.2	35.3	35.4	43.3	40.5	24.7
Total	17.3	23.3	35.1	36.8	46.6	40.3	23.9
Number	4085	1587	810	327	350	425	7584

Table 8

Percent of Currently Married Women who are Current Contraceptive Users by Education Level and Region of Residence, Pakistan 1996-97

	Region of Residence				Total
	Punjab	Sindh	NWFP	Balochistan	
No Education	20.6	16.0	16.4	5.4	17.3
Only Informal or Quranic	23.6	20.0	24.9	12.2	23.3
Upto Primary	36.8	31.7	28.7	35.0	35.1
Upto Middle	36.4	37.1	41.6	34.9	36.8
Upto Secondary	48.9	43.3	44.8	26.5	46.6
Above Secondary	42.3	38.7	32.3	66.2	40.3
Total	26.8	23.4	18.7	7.1	23.9
Number	4429	1680	1102	372	7584

Place of Residence and Contraceptive Use

Although the family planning programme in Pakistan started at the same time both in urban and rural areas, still there are better facilities for family planning services in urban than in rural areas. Most of the family welfare centres, health clinics, and hospitals which provide family planning services are located in urban nearby areas. In addition, condoms can be bought from local pharmacists and some general stores in urban areas. Because of easy access to modern health care and hospital facilities in urban areas, infant mortality is also lower in urban than in rural areas, which also leads to the greater use of contraception in urban areas.

The findings of this study show that there are distinct differentials in the levels of contraceptive use between rural and urban women. The current use is 40 percent in major urban, while it is 32 percent in other urban and only 19 percent in rural areas (Table 9).

Table 9

Percent of Currently Married Women who are Current Contraceptive Users by Education Level and Place of Residence, Pakistan 1996-97

Education Level	Region of Residence			Total
	Major Urban	Other Urban	Rural	
No Education	33.4	23.0	15.1	17.3
Only Informal or Quranic	38.0	31.6	19.9	23.3
Upto Primary	56.5	34.9	28.7	35.1
Upto Middle	30.6	50.1	36.7	36.8
Upto Secondary	47.2	52.5	39.8	46.6
Above Secondary	39.8	42.5	41.0	40.3
Total	39.9	32.3	18.6	23.9
Number	1235	1009	5339	7584

Even at least a primary level of education has a significant effect on the use of contraception for women in rural areas where it is 15 percent with no education, 29 percent with primary level and 40 percent with secondary level of education. However, if women have secondary level education or above, current use increases substantially both in rural and urban areas.

Since differentials in current use have been striking by level of women's education, age, and urban or rural residence, the use of contraception has been analysed by controlling for these three factors (Table 10). Even allowing for cohort and educational effects, the proportion of current users is still higher among urban than rural women except in the younger age group, 15–24 years, where there are negligible differentials among urban or rural users with primary level education. In the older age groups, 25–34 and 35–49 years, differences between urban and rural women are quite substantial, even controlling for education.

The rural-urban differentials have also been noted in current use while controlling for women's education and number of living children (Table 11). The rural urban differentials are less pronounced among women having no education compared to those who have primary education even controlling for the number of living children. It is also notable that contraceptive use is reasonably high (above 20 percent) both in rural and urban areas, if women have secondary education or above with at least two living children. In urban areas, the proportion of women using contraception is higher among educated women having at least one child.

Table 10

Percent of Currently Married Women who are Current Contraceptive Users by Place of Residence, Age and Education Level, Pakistan 1996-97

Place of Residence	Education of Women			Total
	No Education	Primary	Secondary +	
All Ages				
Major Urban	35.0	43.8	42.2	39.9
Other Urban	25.9	39.8	48.7	32.3
Rural	16.3	30.1	40.2	18.6
15–24 Years				
Major Urban	9.9	3.9	18.3	12.0
Other Urban	9.3	11.4	27.8	12.7
Rural	6.2	14.9	14.6	7.6
25–34 Years				
Major Urban	33.2	46.1	40.3	39.1
Other Urban	23.3	41.4	47.2	31.6
Rural	16.5	38.2	39.5	20.2
35–49 Years				
Major Urban	41.9	58.7	58.9	51.3
Other Urban	31.6	52.9	55.7	38.4
Rural	21.9	32.0	76.0	23.6

Table 11

Percent of Currently Married Women who are Current Contraceptive Users by Place of Residence and Number of Living Children Controlling for Education, Pakistan 1996-97

Place of Residence	Education of Women						Total
	0	1	2	3	4	5 +	
All Women							
Major Urban	2.2	12.0	39.1	46.9	58.3	55.7	39.9
Other Urban	0.7	12.3	20.3	37.7	43.6	43.8	32.3
Rural	0.3	7.2	15.1	17.8	25.3	28.8	18.6
No Education							
Major Urban	0.0	3.5	14.4	42.6	23.8	48.1	33.6
Other Urban	0.0	6.9	12.0	22.2	30.9	35.1	24.7
Rural	0.3	4.6	11.4	9.0	19.8	26.6	15.8
Primary							
Major Urban	0.0	1.3	39.9	30.4	72.5	68.2	41.9
Other Urban	2.5	8.8	21.2	38.7	45.7	66.6	38.2
Rural	0.0	11.8	31.2	35.4	63.9	41.7	29.7
Secondary and Above							
Major Urban	5.4	18.9	50.5	49.9	75.3	50.1	41.1
Other Urban	0.0	27.1	35.2	71.7	77.1	50.3	46.6
Rural	0.0	27.2	8.4	85.0	49.3	94.2	39.5

Conclusion and Policy Implications

In this paper differentials in contraceptive use by women's demographic and socio-economic status have been analysed. The analysis indicates that current use of contraception increases with an increase in age and number of living children. Although the number of living children is an essential consideration in Pakistan before a woman can think about the use of contraception, nevertheless, to have a son is of paramount importance in adopting this behaviour.

The most important among the socio-economic variables influencing contraceptive use is women's education. Women who have attained some formal education are likely to use contraception more frequently compared to those who have no education. If women have attained secondary or higher education, they are much more likely to use contraception than are those who have no education. In comparison to women's education, their husband's education indicates less striking differentials in contraceptive use.

While controlling both for the education levels of women and their husbands, women's education clearly shows stronger effects on current use of contraception than does their husband's education. It is noted that women's education indicates its positive effect on contraceptive use even when her husband has no education. In this category (no education of husbands) current use is 25 percent with women's primary education and 43 percent with women's secondary education. Presumably women having some education and living with uneducated husbands enjoy somewhat higher status in the family and are able to have access to contraceptive use. Nevertheless the combination of higher education of both husband and wife leads to much higher use of contraceptives.

The current use of contraception by work status of women shows that women working as professional employees have a higher level of contraceptive use than do those who are otherwise employed or performing home duties. It is also observed that women's employment, if combined with educational attainment is an important factor leading to the use of contraception. Women who are employed and have secondary education have a very high rate of contraceptive use (over 60 percent). However, the number of women employed and having some education is small.

There are not many differentials in contraceptive use by region of residence, except for Balochistan, where current use of contraception is very low (7 percent). Compared to other regions of Pakistan, women in Balochistan are less educated and facilities for family planning are also inadequate. However, there exist large differentials between rural and urban women in the use of contraception in all four provinces. The study shows that there are distinct differentials in the level of contraceptive use between rural and urban women even controlling for education. The current users are 40 percent among major urban women, compared to 32 percent for other urban and 19 percent for rural women. Among demographic factors, number of living children and living sons appear to be more crucial in the use of

contraception. Similarly, women's education, although important in both urban and rural areas, appear to have more impact in rural areas.

It is evident from this study that a wide gap in contraceptive use between urban and rural women persists even when controlling for demographic or socio-economic variable. However, women's education can reduce this gap to some extent. Women's education has a more significant effect on contraceptive use in rural areas. Although the family planning programme in Pakistan started at the same time both in rural and urban areas, there are better facilities for family planning services in urban than in rural areas. Most of the family welfare centres, health clinics, and hospitals which provide family planning services are located in urban or nearby urban areas. In addition, condoms can be bought from local pharmacists and some general stores in urban areas. Because of easy access to modern health care and hospital facilities in urban areas, infant mortality is also lower in urban than in rural areas, which also leads to the greater use of contraception in urban areas. The higher cost of raising a large number of children may also play an important role in the decisions by urban women to adopt contraception.

Combined with provision of reproductive health including family planning services, education, in particular, education for females and their gainful employment are the most important factors which require serious attention. This will increase social and economic value of females in the society and at the household level. A very high young age population which is likely to sustain for several decades if fertility remains high, needs special focus. Investment in terms of education and skills to this young group in general and females in particular, will lead to adoption of small family norms and also boasting economic development in near future.

REFERENCES

Bairagi, R., and Ray L. Langsten (1986) Sex Preference for Children and Its Implication for Fertility in Rural Bangladesh. Studies In *Family Planning* 17: 6/Part I.

Conception, M. B. (1981) Family Planning and Contraception in Selected Developing Countries: Policy Implications of WFS Findings. In *World Fertility Survey Conference 1980*, held at London, *Record of Proceedings*, Vol. I. Voorburg, Netherlands: International Statistical Institute.

Cain, M., Syeda Rokeya Khanam, and Shamsun Nahar (1979) Class, Patriarchy, and Women's Work in Bangladesh. *Population and Development Review* 5:40, 5–438.

Cassen, R. H. (1981) Population and Development: A Survey. *World Development*, Vol. 2. Voorburg, Netherlands: International Statistical Institute. In J. C. Caldwell and F. Peter McDonald *Influence of Maternal Education on Infant and Child Mortality: Levels and Causes*. In Proceedings of the International Population

Conference 1981, held at Manila. Liege: International Union for Scientific Study of Population.

Dixon, Ruth B. (1975) Women's Rights and Fertility.) Reports on Population/Family Planning, No. 7.)

Dixon, Ruth B. (1978) *Rural Women at Work: Strategies for Development in South Asia*. Baltimore: Johns Hopkins University Press.

Dyson, T., and M. Moore (1983) On Kinship Structure, and Demographic Behaviour in India. *Population and Development Review* 9:1, 35–60.

Hakim, Abdul (1993) Contraceptive Use in Pakistan: Variations and Determinants. *Pakistan Population Review* 4:1. Islamabad: National Institute of Population Studies.

Hakim, Abdul, John Cleland, and Mansoor-ul-Hassan Bhatti (1998) *Pakistan Fertility and Family Planning Survey 1996-97*. National Institute of Population Studies and London School of Hygiene and Tropical Medicine.

Hakim, Abdul, and Azra Aziz (1998) Socio-cultural, Religious, and Political Aspects of the Status of Women in Pakistan. *The Pakistan Development Review* 37:4, 727–746.

Hakim, Abdul, and Peter C. Miller (1996) Family Planning in Pakistan: Have we Reached a Turning Point? IUSSP Conference Proceedings, Rawalpindi.

Mason, Karen Oppenheim (1986) The Status of Women: Conceptual and Methodological Issues in Demographic Studies. *Sociological Forum* 1:2, 284–300.

Ministry of Population Welfare and Population Council (1985) *Pakistan Contraceptive Prevalence Survey 1994-95: Basic Findings*. Islamabad: The Population Council.

National Institute of Population Studies and IRD/Macro International, Inc. (1992) *Pakistan Demographic and Health Survey 1990-91*. Columbia, Md.: IRD/Macro International, Inc.

Oppong, Christine M. (1980) A Synopsis of Seven Roles and Status of Women: An Outline of a Conceptual and Methodological Approach. International Labour Organisation, Geneva. (World Employment Programme Working Paper No. 94.)

Population Welfare Division (1986) *Pakistan Contraceptive Prevalence Survey 1984-85*. Government of Pakistan.

Population Welfare Division (1983) *Population Welfare Programme: A Document on Sixth Five Year Population Welfare Plan 1983-88.* Population Welfare Division, Islamabad.

Robinson, W. C. (1978) Family Planning in Pakistan, 1955–77: A Review. *The Pakistan Development Review* 17:2, 233–247.

Syed, Sabiha Hassan (1978) Female Status and Fertility in Pakistan. *The Pakistan Development Review* 17:4.

Sathar, Zeba A., N. Crook, C. Callum, and S. Kazi (1988) Women's Status and Fertility Changes in Pakistan. *Population and Development Review* 14:3, 415–422.

Shah, Nasra M. (1986) Contraceptive Knowledge, Attitude and Practice. In Nasra M. Shah (ed.) *Pakistani Women: A Socio-economic and Demographic Profile.* Islamabad: Pakistan Institute of Development Economics.

Shah, Nasra M., and Makhdoom A. Shah (1984) From Non-Use to Use: Prospects of Contraceptive Adoption. In Iqbal Alam and Betzy Dinesen (eds.) *Fertility in Pakistan: A Review of Findings from the Pakistan Fertility Survey*. Voorburg, Netherlands: International Statistical Institute.

United Nations (1983) *Relationship between Fertility and Education: A Comparative Analysis of WFS Data for Twenty Two Developing Countries.* New York: United Nations.

Comments

The title of the paper clearly indicates that in every society the status of women is correlated with contraceptive use. There is no denying this relationship. The higher the status of women, the higher is the contraceptive use rate. However, there are some exception to this in Bangladesh; even women of low status have a high contraceptive use rate which, among other things, is associated with governments policy, strategy logistics, and availability and acceptability of services. This has helped women of poor families and lower socioeconomic strata to accept family planning on a voluntary basis.

The paper is quite clear and interesting in bringing about this relationship. However, I have some other comments as follows.

— The reference [Syed (1987)] may be checked as on the references page the year given is 1978. This could be checked from *The Pakistan Development Review*.

— Table 3 shows quantitative indicators of the status of women in Pakistan. It does not show the reference period. It is obtained from *Pakistan Fertility and Family Planning Survey, 1996-97*. It will be appreciated that the title of the table should be made more clear and should be mentioned as "Quantitative Indicators of the Status of Women in Pakistan", (*Pakistan Fertility and Family Planning Survey, 1996-97*). If only the year has to be mentioned, then in the source under the table, full reference be given of the survey. Page 7, 3rd line from bottom [of the text distributed in the conference] the spelling of "conception" is "concepcion", which is correctly given on the references page. There are some other typographical errors which may please be checked also while discussing socioeconomic factors and contraceptive use. It would have been more appropriate if the author had compared his findings with other data and studies in Pakistan which give similar findings. It would have strengthened his findings further. The most important studies are *Pakistan Demographic Health Survey* and *Pakistan Contraceptive Prevalence Survey*. While interpreting the educational attainment, particularly secondary and above, and also work status of women (professionals and administrative workers), one should be very conscious about the number of women (N) in these cells of the tables. For example women with professional work having no education or only informal/Quranic education puts one in doubt about how professional workers are defined. It is interesting to note (Table 10, page 16) that women with 15–24 years of age with primary education are the

highest (15 percent) contraceptive users in the rural areas as compared to 4 percent in major urban and 11 percent in other urban areas. Such deviant findings one should try to compare with the data obtained in other surveys. When the data is further classified by the number of living children, place of residence, and education, one has to be very careful in interpreting the results when the number becomes too small. For example, the number of the rural women with secondary and more education would be quite small. The findings that rural educated women have more than 85 percent contraceptive use, which is higher than their urban counterparts of the corresponding characteristics, make one wonder about whether the situation is true or an artifact of the data. So the conclusion that women's education, although important in both urban and rural areas, appears to have more impact in rural areas and needs more investigation from other sources of data to substantiate this conclusion. The study has found that mobility of women is very small (Table 3). This may be particularly true in the rural and outreach areas, where the accessibility and availability of family planning services are scanty.

One the whole, the paper is very interesting, giving directions that the education and employment and income-generation activities among women are the crucial factors affecting contraceptive use in Pakistan.

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