Deanship of Graduate Studies

Al-Quds University

Impact of Family Planning Programs on the Quality of Women's Life in the Gaza Strip

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By

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DEDICATION

To my parents and my family for their support, to my daughters and my son who endured missing my care during my study, to my colleagues and my friends for their encouragement, to who are working in mother and child health centers.

I dedicated this job, to my wife, without her support, this work would not have been done.

Declaration:

I certify that this thesis submitted for degree of Master in the result of my own research, except where otherwise acknowledged, and that this thesis (or any part of the same) has not been submitted for a higher degree to any university or institution.

Signed.....

Hassan Abdalla Juda

Date : 20/4/2002

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Abstract

This case control study has been conducted to measure the impact of family planning programs on women's quality of life at reproductive age (15-49) years, in two family planning clinics own by MoH, one from Gaza City, and the second clinic from Rafah district. The sample size was 50 women from El-Remal Clinic and 25 women from Rafah Central Clinic as users, for each user their is a woman as a control (non-user). Standardized questionnaire is administered to collect the data by face to face interview.The mean age for starting family planning were 26.7 years, the mean number of children for users 5.14 child, for non-users the mean number of children 4.16%,. About 2.7% of the users started family planning when they have zero male, while 25.3% started family planning when they have zero female. The main reason for not practicing family planning for non-users was to have more children 60%. It is clear that family planning gives more time for women which may increases women's opportunities to participate in social activities, leisure, entertainment, education, opportunity to outside work, and help womens to avoid thje risk from frequent pregnancies and deliveries, which affect the living of the family, 44% of the users have desire to study, 75.8% of them have time for that, while 25.3% of non users have desire to study, all of them have no time for that. About 81.4% of the users have time to work, while 8% of the non-users have time to work, 73 (97.3%) of the users have time to participate in health awareness sessions, while 7 (9.3%) of the non-users have time, also 98.7% of the users have time to participate on social activities while 13.3% of the non users have time and 93.3% of the users have time for entertainment while 9.3% of the non-users have time. It is clear that our families started family planning

when they have satisfactory number of children mainly a male baby,and family planning gives more time for women which may increase women's opportunityies to improve the quality of life for women.

الخلاصـــــــــــــــــــة

برنامج خدمات تنظيم الأسرة أحد البرامج التي تحظى بدعم من الدول المانحة ومن وزارة الصحة ونتيجة لهذا الدعم القوي تأتى أهمية تقييم هذه الخدمات. لذلك تأتى هذه الدراسة وهي الدراسة الأولى في غزة حول تقييم اثر خدمات تنظيم الأسرة على المجالات المختلفة من حياة الأم.

هدف الدراسة:

تهدف هذه الدراسة إلى تقييم برنامج خدمات تنظيم الأسرة على مختلف مجالات حياة الأم التي تستخدم وسائل تنظيم الأسرة .

لذلك تعتبر هذه الدراسة تقويمية وصفية تحليلية قد تساعد المهنيين وصانعي القرار على اتخاذ الخطوات اللازمة لتطوير هذه الخدمة وتحسينها في وزارة الصحة.

طريقة البحث:

لقد تم اختيار نظام الحالة الضابطة (Case Control) وذلك من اجل الحصول على نتائج اكثر دقة واكثر واقعية. الدراسة شملت الأمهات اللاتي يستخدمن وسائل تنظيم الأسرة لفترة متواصلة ولمدة عام فاكثر

(Users) في عيادتين من العيادات الحكومية (عيادة الرمال في مدينة غزة والأخرى عيادة رفح المركزية) ولقد تم اختيار 150 حالة من العيادتين 75 أم تستخدم وسائل تنظيم الأسرة ولمدة عام فأكثر و 75 حالة لا تستخدم وسائل تنظيم الأسرة ولم تستخدمه من قبل.

ولقد تم جمع المعلومات بواسطة مقابلة شخصية وتعبئة الاستبيانات المعدة لذلك.

تم استخدام برنامج إحصائي خاص بالعلوم الإنسانية SPSS لإدخال البيانات ومعالجتها إحصائيا وكذلك تم استخدام اختبارات إحصائية مثل Chi Square and P value لتوضيح العلاقات الإحصائية بين المتغيرات.

عكست نتائج الدراسة أن برامج تنظيم الأسرة هي برامج نافعة ومفيدة للام حيث أنها توفر الفرصة للام للعمل والدراسة والمشاركات الاجتماعية ورعاية الزوج والأبناء كما إنها تحمي الأم من مخاطر الحمل والولادة المتتابعة والتي بدورها تؤثر بشكل عام على وضع الأسرة ككل وعلى الأم بشكل خاص.

التوصيات:

1- زيادة العمل على توعية الجمهور عن مخاطر الزواج المبكر والفوائد الصحية للمباعدة بين الأحمال من خلال البرامج الصحية في المراكز الصحية والمجتمع.

2- تأمين خدمات تنظيم الأسرة وذلك من خلال المحافظة على استمرارية تقديم خدمات تنظيم الأسرة.

3- العمل على إدخال خدمة (Counseling) من خلال خدمات تنظيم الأسرة للفتيات في السن المبكرة.

ABBREVIATIONS

CBR	Crude Birth Rate
EC	European Commission
FP	Family Planning
HMIS	Health Management Information System
GS	Gaza Strip
ICPD	International Conference on Population and Development
MCH	Mother /Child Health
MoH	Ministry of Health
NGOs	Non Governmental Organizations
NHP	National Health Plan
IPPF	International Planned Parenthood Federation
PCBS	Palestine Central Bureau of statistic
PHC	Primary Health Care
PNA	Palestine National Authority
RH	Reproductive Health
SPSS	Statistical Package for Social Sciences
TFR	Total Fertility Rate
UN	United Nation
UNFPA	United Nation Fund for Population Activities
UNRWA	United Nation Relief and Works Agency
US	United States
WB	West Bank
WHDD	Women's Health and Development Directorate
WHFPP	Women's Health and Family Planning Project
WHO	World Health Organization

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Chapter One

Introduction

This chapter focuses on the key elements of family planning practice worldwide. Chapter one concentrates on the measurement of the program impact, the focus of the study and the study objectives. Then the feasibility and justification of the study, constrains to contraceptive benefits and definition of terms. The final part of this chapter discusses the demographic context of the study area.

Family planning programs have an impact on fertility, fertility regulation, and health of women and infants in particular and family and community as a whole. Impact studies were considered necessary to convince policy-makers of the utility of family planning programs for socioeconomic and health progress in their respective countries.

Women's quality of life depends not only on good health status and physical well being, but on a variety of other circumstances, which include family stability and harmony, the welfare of children, and freedom to enjoy different activities including leisure, education, employment or community participation. Family planning can influence nearly all aspects of women's quality of life (Best, 1998).

It is well known that too early, and too late, and too, frequent and too close pregnancies imply poor reproductive health status, the improvements in health that early family planning programs strive for, were declining in maternal and infant morbidity and mortality. From the time when the first family planning programs were organized, pregnancies of very young and of older women, short intervals between births, unwanted pregnancies, and unsafe induced abortions were understood to be potential health hazards for women and the children they were

bearing. Then, family planning programs were designed and organized to amend these hazards (World Bank 1993).

So far, most research has focused on measuring program impact in terms of changes in fertility and contraceptive use as a result of widespread interest in lowering fertility in order to achieve slower population growth. Few operation research projects measure health improvement because continuos change in health status is difficult to be measured and also it needs long time to measure their impact.

In reviewing most of the projects of impact of family planning, all achieved a clear impact on fertility regulation by increasing contraceptive prevalence and by providing a wider choice of methods. Corresponding problems occurred in documenting impact on maternal or child health in other studies, although making an impact on health was likely to have been objective in all of the studies (Foreit & Frejka 1998).

Family planning program impact is measured by, decline in fertility, changes in the prevalence and composition of means of fertility regulation, and improvements in health (Foreit & Frejka 1998).

1.1: Focus of the study

Since family planning is a significant issue for effective health and development in the Gaza Strip (GS), evaluation of the impact of family planning programs on women's health is extremely important. Most research studies were conducted worldwide have focused on measuring impact in terms of changes in fertility and contraceptive use as a result of widespread interest in lowering fertility in order to achieve slower population growth. Up to date, there has been no research documented in Gaza Strip assessing the impact of family planning programs on women's quality of life at reproductive age (15-49 years old).

This study focuses on measuring the impact of family planning program on women with respect to health, education, employment and social aspects of women's life in the Gaza Strip.

1.2: Study objectives

1.2.1: Overall aim

Assessing the impact of family planning program on the quality of women's lives in the Gaza Strip who utilized family planning services.

1.2.2: Specific objectives

1. To identify benefits of birth spacing, such as decreasing the burden of care given to a large number of children.
2. To identify benefits gained in reducing exposure to high-risk effects in pregnancies and childbirth.
3. To a certain the impact of family planning program on women's work and continuing education.
4. To explore whether practicing family planning service has given the client users the opportunity of saving time for entertainment/rest.
5. To a certain the impact of family planning program on women's social aspects.

1.3: Feasibility of the study

This study was partially supported by the European Commission/Women's Health and Family Planning Project. In gaining the access and gatekeepers the researcher must know that without the access the research project can not be viable or may face several problems. In all stages of the project the researcher must prove the credibility and respect of confidentiality. Extensive negotiations and discussions took place with the project primary stakeholders in the Primary Health Care (PHC) at the Ministry of Health (MoH).

The health departments at the MoH were contacted for approval and ethical agreements were obtained. All logistics and facilities such as stationary, computer work, training, transportation, and photocopying were made available.

1.4: Justification for the study

Family planning service is an essential part of reproductive health care and have saved the lives and protected the health of millions of women, men and children. Over the past 30 years, the development of modern contraceptive methods has given people greater individual freedom and enhanced their ability to plan their family size at the time and place they wanted. The aim of family planning programs should enable couples and individuals to decide freely and responsibly the number of their children, the spacing time between births and to have the information and means to do so and to ensure informed choices and make available full range of safe and effective methods (Puri, and McLellan, 1996).

I.5: Constrains to contraceptive benefits

Social, political and economic problems which prevent women from benefiting from family planning, the benefits of family planning for women are decreased when contraceptive methods are ineffective, used incorrectly or inconsistently or discontinued early. For some, adolescents pregnancy is wanted because the family and the couples themselves wish to know their ability to be pregnant or not, family members-particularly husbands, mothers and mothers in-law–play a critical role in women's experiences with family planning. Family planning is often initiated late in reproductive life, men often have a dominant role in family decisions but tend to be marginalized by family planning programs, and women are generally satisfied with family planning services but want more female health care providers, more emotional support;

take care of side effects and more information about contraceptive methods to have the right decision.

1.6: Definition of terms

1.6.1: Reproductive Health (RH)

"*RH is a state of complete physical, mental, and social well being & not merely the absence of infirmity, in all matters relating to the reproductive system and to its functions and process*" (United Nations, 1995).

1.6.2: Family Planning

"*Practices that help the individuals or couples to obtain certain objectives, to avoid unwanted births, to bring about wanted birth, to regulate the intervals between pregnancies, to regulate the time at which births occur in number of children in the family*"

(WHO, 1994).

1.6.3: Case (Users)

A woman at the reproductive age (15-49 years) who is utilizing family planning services regularly for at least one year

1.6.4: Control (Non users)

A woman of the same age (within 5 years) as the case who lives in a neighboring household in which there are no known cases and who did not practice family planning services.

1.7: Context of the study

Any situation is best understood within its terms of reference; therefore, the researcher presents some background data and information about the Palestinian population, demography, socio-economic trends and development, fertility trends among Palestinian women, the

utilized family planning programs and the impact of these programs on the women's quality of life.

1.8: Demographic Context

1.8.1:Geographic Location

Palestine has an important geographic and strategic location; it is situated on the eastern coast of the Mediterranean Sea in the Middle East. Syria and Jordan border it on the east, by Lebanon on the north, the Gulf of Aqaba on the south and by Egypt and the Mediterranean Sea on the west. See Map of Palestine (Annex 1). According to the Palestinian Central Bureau of Statistic (PCBS) projection of population in 1999, the Palestinian National Authority (PNA) comprises the West Bank (WB) region and Gaza Strip (GS). WB is divided into ten districts with a population density of 342 square kilometers per person. Gaza Strip (GS) region is divided into five governorates: Gaza north, Gaza City, Mid- zone, Khan-Younis and Rafah, with a population density of 2923 square kilometers per person. The GS is a narrow Zone of land, bordered on the South by Egypt, Mediterranean Sea on the West and Israel on the North & East. It is 46 kilometers long and 5-12 Kilometers wide with an area of 362 square Kilometers. It has four towns, fourteen villages and eight refugee camps. A few thousand Israelis settlers live in isolated settlements, which occupied large distance of land about 20% in comparison to their number. See Map of Gaza Strip (Annex 2).

1.8.2 : Population

Population size

According to the census done by the PCBS in 1997, the midyear population size of the Gaza Strip at 2001 will be estimated at 1,196,591 people of whom 50.5% are males and 49.5% females. See Population Pyramid-Gaza (Annex 3).

Table (1): Distribution of population between GS. provinces

Province	North	Gaza City	Mid-zone	Khan-Younis	Rafah	Total
Population %	222,344 %18.58	424,509 %35.47	173,416 %14.49	233,202 19.48	143,120 %112	1,196,591 %100

Source: (MoH, 1999)

Population growth

It has been observed that the estimated natural increase dropped remarkably in Palestine. According to the reported figures from MoH in 1994, the population growth in Palestine was estimated at 4.5% and gradually dropped down to 3.7% in 1996. It declined in 1997 and 1998 to 3.1% and 3.0% in 1999. It is 2.9% in the WB and 3.2% in GS (MoH 1999). Although this is a very substantial decrease, it still compares high to global growth rate of 1.3% according to UNFPA estimation (UNFPA, 1999).

Births

Despite of the progressive decline over the years when the PNA took over the responsibility on the health services, the number of live births / 1000 population per year is still high compared with other countries. The crude birth rate (CBR) declined from 40.1/1000 in 1996 to 32.8/1000 in the 1999. The total number of births in the GS is 36,709 with an average CBR 33.8/1000.

Fertility

According to the MoH, Health Management Information System (HMIS) 2000, the total fertility rate (TFR) which is defined as the average number of children born to women at age of 15-49 years old estimated at 3.8 in WB while it was 5.4 in the GS and in Palestine was 4.3 (MoH, 2000). Women of childbearing age (15-54 year) comprise 22.7% of the total population. However, TFR in Palestine in general and in GS in particular is higher in comparison with neighborhood countries as shown in the table below:

Table (2): Fertility Rate in Comparison with Neighborhood Countries between 1990- 1995

Country	Egypt	Jordan	WB &Gs	Israel	Iraq	Lebanon	Syria
TFR	4.1	5.7	6.06	2.9	5.7	3.1	6.1

Source: (PCBS, 1998)

The researcher can infer from the above table that the fertility rate is considered high in comparison with the other countries of the region. Big efforts to reduce the fertility rate were implemented to improve and enhance the quality of women's life to, family and community as a whole.

1.9 : Family Planning Services in the Gaza Strip

Family planning is an essential part of reproductive health care and have saved the lives and protected the health of millions of men, women and children. Over the past 40 years, the development of modern contraceptive methods had given people greater individual freedom and enhanced their ability to plan their families (UNFPA, 1999).

Surveys from more than 60 developing countries indicate that more than 100 million women who are not currently using a contraceptive method want to delay the birth of their next child or to stop childbearing altogether (UNFPA, 1999). Palestinians have one of the highest total fertility rates (TFR) in the Middle East and through out the World (United Nation,1998). In 1965, UNRWA, introduced family planning as part of their health services delivery to refugees in the Gaza Strip and is currently providing family planning services at its clinics on a wide scale as an integral part of its maternal and child health program, at nine clinics (UNRWA, 1999). Consistent with WHO policy, the agency's family planning program offers a wide range of contraceptive methods including pills for breast feeders, pills for non-breast feeders, Intra-uterine Device (IUDs), condoms and spermicides.

In July 1995, the Palestinian National Authority took over the responsibility of health services. It became more concerned with meeting the social and welfare needs of its rapidly growing population and established the Women's Health & Development Directorate (WHDD). Since then, the WHDD took the responsibility of setting polices and strategies for the improvement of the Palestinian health status. To improve Women's health situation WHDD taking into consideration all the life cycle of women and the recommendation of the ICPD. In the late 1995, family planning program was integrated into the country's extensive primary health care system. The program has increased the access to safe and acceptable and promoted choice of contraceptive use. The European Commission (EC) has contributed a great help to the Palestinian people by providing financial assistance to reproductive health domain, which represents a key issue of concern among the Palestinian main priorities of health service delivery. RH services used to be available before the PNA took over responsibility for health in may 1994, as part of heath services provided by governmental and non-governmental organizations (NGO's) including private sector. Several components of the RH by then, were not accessible to the majority of the community because they were provided on limited basis either by the private sector or by the United Nations Relief and Works Agency (UNRWA) for Palestinian Refugees. Therefore, the strategy adopted by the MoH was to develop the already existed services and to introduce the unavailable forms of RH care particularly family planning services. So, the EC contribution was a response to the identified RH needs. The first phase of support was for a pilot program for one year 1995-1996. The EC support in the second phase was

translated into an agreement between the EC and MoH on a National Program for Women's Health and Family Planning in WB.&Gaza.

The main activities of the project were as follows

Recruiting staff, hiring places and providing the project's offices with all needed equipment and furniture, developing the management and procurement systems including the logistics, procedures of the project and information system, approaching the relevant government and NGO's who have participated and taken up activities, developing communication and relationships with media institutions, assessing the needs for equipment, supplies and clinics' renovation and refurbishment, preparing staff for family planning services in terms of orientation and training to develop the positive attitude and skills needed for the family planning services, and awareness and empowerment programs for women, youth and students in schools and universities.

Family planning facilities in the GS. owned by MoH started with three clinics and increased to five clinics in 1996 and eight new family planning centers were added in 1997. Training for 16 physicians & 13 nurses were done to meet the needs of an increasing demand for services, and some clinics owned by the NGO's were distributed between the districts. The number of new women who received services in the public family planning clinics in 2000 was 6864, and repeated cases was 35691 with total number of users is 42555 (WHFPP, 2001).

Table (3): Number of beneficiaries for the year 2000 according to the district

District	New	Repeated	Total
Gaza City	3274	16445	19719
North Gaza	1465	4435	05900
Middle Zone	0402	2672	03074
Khan-Younis	1357	9151	10508
Rafah	366	2988	3354
Total	6864	35691	42555

Source: (WHFPP, 2001).

The table (3) shows that the total number of beneficiaries from the family planning program is about 42555 at the year 2000, while this figure was 33562 and 27349 at the years 1999 and 1998 respectively which indicates that there is a sharp increase in the number of family planning users.

At the MoH family planning clinics, the utilization of family planning services by method at the year 2000 was oral contraceptive pills 39.1 percent, the IUD 33.8 percent, male condom 12.4 percent, counseling 12.0 percent, ovules 2.6 percent (WHFPP, 2000).

To summarize, in this chapter the researcher discussed the measurement of impact of family planning program, focus of the study, study objectives, feasibility of the study, justification, of the study, constrains to contraceptive benefits, detention of terms, demographic context, and family planning service in Gaza. Family planning is a significant issue for effective health and development in the Gaza Strip, so evaluation of family planning program on women's health is extremely important. The population growth in Gaza is 3.2% which is still high to global growth rate 1.3% (UNFPP 1999). Also CBR is still high compared with other countries, which is 33.8/ 1000 in Palestine, while at the neighbor countries is 6.06 / 1000, in spite of the availability of family planning services in most of Gaza provinces.

The next chapter will discuss the historical overview of family planning, the benefits of family planning for women, some literature related to the topic and family planning in Islam.

Chapter two

Literature Review

This chapter focuses on the key elements of family planning. This review demonstrates the definition and importance of family planning in relation to the impact of family planning on the women's quality of life, and discusses family planning in Islam.

2.1: Historical overview

The aim of family planning programs worldwide is to provide women & men with access to safe, effective, affordable and acceptable methods. In fact assertions on the need for free and informed choice of methods of fertility regulation has been made in the international declaration at 1968 human rights conference held in Tehran, Iran. The UN member states agreed that "Parents have a basic human right to determine freely and responsibly on the number and spacing of their children and a right to adequate education and information in this respect" (Hardon & Hayes 1997).

Assistance from western countries for programs of population control traced back as far as 1952, when the Ford Foundation gave support to the Indian Family Planning Association.

During the 1960, as mortality fell in response to better health and social conditions, Morocco's annual population growth rate went over 3 percent in certain years. During the time the first steps were taken by the King and the Government to set up family planning programs, and total fertility fell in response from 7.4 children per women in the early 1960s to under 6 children by 1980. Since then, it has fallen more quickly to under 4.5 in 1987, and the contraceptive prevalence rate is probably over 40 percent. But because of a further reduction in death rates, specially the infant mortality rate which has fallen to around 70, the population growth rate is still around 2.3 percent higher than the third world average (Hamand, 1991).

US government started to give support to family planning programs for the developing countries in 1965 (Caren & Finkle 1989). As a result the UN created international organizations as UNFPA and the World Bank became actively involved in giving aid and support to family planning programs worldwide.

Both sides (South & North) agreed that population is problem at the first official International Conference with respect to population in Bucharest Romania 1974. Also they rephrased the 1968 formulation of reproductive rights by addressing "couples and individuals" and not just parent (Hardon & Hayes 1997).

At the Mexico City Conference (1984), the plan of action shifted from population control and development to implementation of population policies.

The importance of the International Conference on Population and Development (ICPD) Cairo, 1994 as moving the debate from the demographic way of thinking about population programs towards the broader concept of sexual & reproductive health including family planning. Also, it emphasized the importance of women's interests, needs, and rights as essential components of development, which was argued in Puri & McClellan(1994), paper about ICPD and family planning associations. The aim of family planning programs as decided in the ICPD is to enable couples & individuals to decide freely & responsibly the number & sparing of their children, to have correct information & means to ensure informed choices, and make available wide range of safe & effective methods that are accessible and affordable. For the first time, a definition of reproductive health (RH) was adopted at the ICPD 1994 as:

"*RH is a state of complete physical, mental, and social well being & not merely the absence of infirmity, in all matters relating to the reproductive system and to its functions and process*" (United Nations, 1995).

Family planning was defined according to the World Health Organization (WHO) as "*practices that help the individuals or couples to obtain certain objectives, to avoid unwanted births, to bring about wanted birth, to regulate the intervals between pregnancies, to regulate the time at which births occur in number of children in the family*" (WHO, 1994).

According to (Estaugh & Wheatley 1990). the nature of family planning in its broad sense has been summarized as: "The term family planning is generally understood to mean planning families and includes where and when to have children, spacing of children, & timing their arrival, birth control, planning baby, timing conception, pre-pregnancy care as well as help and advice for fertility problems.

In the GS, family planning policies have been formulated to improve women and children health in addition to reduces the high population growth. The Palestinian MoH has adopted the policy of integrating women's health and family planning services in the PHC in 1994 as one of the national health strategies which aimed at giving women the necessary attention and focus which have long been ignored and underdeveloped. Prior to 1994, there were no family planning services in the health department, which were managed by the Israeli Civil Administration. Family planning services started with three clinics and increased to six in 1996 and seven clinics were added in 1998 in addition to one family planning clinic located at Shifa Hospital (MoH, 1998).

2.2: The meaning of family planning practice For women

Health benefits

Family planning programs offer women clear health benefits. In less developed countries in general, complications related to pregnancy and childbirth is the common cause leading to maternal death. Every minute of every day, a woman dies from causes related to pregnancy and childbirth most of which are preventable. The vast majorities 99% of these 550,000 deaths, which occur each year, take place in the developing countries (Senanayake, 1994).

The women who have too early, too late or too close, too many pregnancies are exhausted. But when women space their children she is in peace and have low sicknesses. In a study conducted by family health International an about 800 women in Lampurg & South Sumatra, Indonesia, showed that women with only one or two children feeling greeter vitality which defined as having no health problems and feeling good than those with more than two children. Women also reported that they feeling more attractive which means that due to many pregnancies, their body will shrink & gets skinnier fast and old fast (Best, 1998).

The researcher can conclude from above that practicing family planning can reduce the total number of pregnancies, thereby decreasing women's lifetime risk of dying from causes related to pregnancy & childbirth.

A study conducted among contraceptive users in Malaysia in 1997, showed they were significantly less likely than non-users to report marital disruption (Best, 1998).

Impact on education

One of the benefits of family planning is that users have more free time, which could be to devote more attention to education. Gaining better education is the goal of many children and their parents, but getting pregnant as a teen is one of the ways to cut short a girl's schooling.

Education is much more likely to delay getting married than those without schooling. Also they will probably postponed having their first pregnancy and childbirth.

A study was conducted in Mutare, Masvingo & Harare Zimbabwe, showed that many female students reported high academic study & vocational ambitions, but educational avenues often closed when young women become pregnant. Out of 27 girls in the study become pregnant in primary or secondary school, 67% dropped out and did not complete their study, of 36 young women who become pregnant in college 78% dropped out (Williamson, 1998). The researcher can conclude from the study above that education is one of the benefits of utilizing the leisure time offered by practicing family planning. Family planning users have more free time to spend in education, reading and training because of less time to spend in taking care with big family.

Expanded job opportunities

Expanded job opportunities with fewer children and more time between pregnancies, women find it easier to work outside the house, raise their incomes and provide for their families. It is well known that when women begin to utilize family planning services early in their reproductive lives will lead to reduction in fertility, so had fewer children than non users and these women were more likely to be currently working which improve the likelihood that women will work for pay. In a study conducted in South Korea in 1997 showed that fertility fell dramatically and married women's work participation began to increase. In 1960, Korean mothers with children under the age of six rarely worked outside home. By 1990, when most married women were used modern family planning methods which resulted in avoiding unplanned and unwanted pregnancies and having one or tow births, the result was 48% of mothers with young children were working outside home (Best, 1994).

The researcher can infer that using contraceptives not only tends to give women a chance to work but with small families are more likely to have higher total earnings than women with large families. Women with fewer pregnancies will have enough time for training to be as skillful worker to perform jobs that needs special skills.

Participation in the community and politics

Women with fewer children also have more time to participate in the religious, social and political life of their communities. Of 87 family planning users who were surveyed in a study conducted in central and Java, Indonesia 1997, approximately 86% of them said that using family planning methods resulted in more leisure time (Best, 1998). The researcher can conclude that utilizing family planning services save more free time for the users to participate in the social and political issues.

Relationships with their kids, husband, families and friends

A study conducted in Zimbabwe among couples utilizing family planning services showed that they described more peace and happiness in their homes than couples who were not using family planning services (Best, 1998). The researcher can conclude from this study that smaller families bring women greater harmony at home. With fewer children they have more time to spend and take care with each child and with their husbands as well. Communication over sexuality and family planning are lead to better communication on a variety of other matters.

Increasing their self-esteem

Women controlling over their reproduction give them a greater sense of control over other aspects of their lives like job and educational chances. This in turn increases the self-esteem

of girls and women. In facts, the introduction of the modern family planning methods has been cited as the number one reason, women have advanced in career and educational opportunities. Utilizing family planning services affects many aspects of women's lives, which include their roles as individuals, as family members and as participants in the larger community. Family planning affects various domains of women's lives – domestic, health, economic, employment, education, social and community participation. The vast majority of women are convinced that utilizing family planning services and having smaller family size provide many benefits.

The aim of family planning clinics controlled by the MoH is to provide advice and family planning methods to married couples who request it. Also, it provides programs to raise the public awareness on women's health and family planning. As well, change the attitude of health personnel and update their knowledge and skills.

2.3 : Importance of Family Planning

Planning of births is one of the most effectual and least expensive ways of improving the women's quality of life on earth now and in the future. Family planning could bring more benefits for mothers, babies, families and community as a whole at less cost than any other single technology now available to human race. Family planning could prevent unknown millions of disabilities, many of them painful, permanent, embarrassing and secret, which are the common consequence of high risk and unwanted pregnancies.

Family planning can dramatically improve the quality of women's lives in both short and long term, by reducing the physical, mental, social and economic burdens of having too many children. It can also increase the free time available for women's education, for vocational training, for earning incomes, for improving childcare, for community participation, for

personal development and for the rest and leisure which is virtually unknown to millions of women in the less developed countries today.

Family planning would prevent, predominantly, those births which are known to be high risk – the births which are less than two years interval, as mothers who are under the age of 18 years or over 35 years or who already have four or more pregnancies. Because the great majority of child deaths are associated with these risk factors, the well-informed timing and spacing of births would result in a far more than proportionate reduction in child deaths.

2.4 : Islam and Family planning

Researcher focuses on family planning practice and Islam. This is important because quality of services is closely linked with cultural appropriateness.

Family planning is a crucial issue debated by opponents and proponents, its seriousness comes from the fact that infanticide wa'd is a cardinal sin (kabirah) and not simply (haram)

(Omran 1992 pp.86).

Opponents

Virtually all opponents of family planning argue strenuously that al-azl or any practice that prevents pregnancy is infanticide, they invoke the following quotations:

"Kill not your children, on a plea of want. We provide substance for you and for them" (151) (al-An'am, Sura 6:151).

"Kill not your children for fear of want. We provide substance for them and for you, the killing of them is a great sin" (31) (Al-Isra', Sura 17:31).

"And they will not slay their children" (12) (al-Mumtahana, Sura 60:12).

opponents of family planning go further to consider the above quotations as indirect text

(nuss) of prohibition, they support their claim, by referring to a hadith narrated by Judama in which the Prophet is reported to have referred to al-azl as hidden wa'd.

(Omran 1992 pp.86)

Arguments against al-azl based on Judama's traditions

The strongest arguments concentrate heavily on the prophet's qualification of al-azl as hidden infanticide in Judama's tradition. The leading prohibitor of al-azl is Imam Ibn Hazm, he argued that the tradition reported by Judama confirms the prohibition of al-azl

"On the authority of Judama bint Wahb al-Asadiyya {sister of Ukkasha} who said ' I was among others in the Prophet's audience while he was saying "I almost prohibited al-ghayla but then I considered the Romans and Persians and found that they used to suckle their children by their pregnant mothers without ill effects." Then they asked him about ai-azl and he said "it is hidden infinticide (al-wa'd al-khafiyy)" (Omran 1992 pp.130).

Theologians who oppose family planning

They cite the Qur"an in support of their opposition as follows:

Multitude is highly recommended in Islam.

Children are the adornment of life.

Begetting children is the purpose of marriage.

Contraception is wa'd or murder.

Family planning contradicts the will of Allah (predestination) and doubts His ability to provide for children (risq) (Omran 1992 pp. 203).

Sheikh Abu Zahra

He began by referring to the verses in the Qur"an which deal with killing children out of poverty or fear of poverty.

"Kill not your children for fear of want. We provide substance for them and for you, the killing of them is a great sin" (31) Al-Isra', Sura 17:31).

(Abu Zahra 1962).

Also Maulana Moudoudi , in his book (The birth Control Movement) clarify augments against family planning. It makes the following claims:

The birth control movement is a plot against Islam.

To import birth control into developing countries would be tantamount to ushering in moral malaise ranging from breakdown of the family planning to sexual promiscuity and sexual transmitted diseases. Women would feel free to join the labor force and abandon their traditional roles (Omran 1992 pp.205).

Proponents

Family planning advocates take issue with those who equate contraception with infanticide or wa'd. to them wa'd occurs biologically when alive born child slain or buried alive or when a formed fetus is aborted, practices that they, as Muslims, detest and forbid. They maintain that contraception merely prevents pregnancy and involves no killing. They support their claim they cite Imam Ali who in the presence of Caliph Omar and other companions denied that al-azl is wa'd. Imam Ali maintained that wa'd could only apply once the fetus reached the seventh stage of creation (khalqan aakhar) he based his opinion on :" Man We did create from a quintessenceof clay; Then We made the sperm into a clot of congealed blood{alaqa}; Then of that clot We made a {fetus} lump {mudgha}; Then we made out of that lump bones; And cloted the bones with flesh; Then We developed of it 'another creature'{khalqan' aakhar}; 'Blessed be Allah, the best to create"(Al-Mu'minoun, Sura 23:12,13,14).

Caliph Omar agreed with Imam Ali and praised him for his interpretation. There is a similar tradition concerning Ibn Abbas who also denied that al-azl is infanticide and practiced it himself. He based his obenion on the same versus in Sura al-Mu'minon.

(Omran 1992 pp.87-88).

Islam permits contraception as long as it does not entail the radical separation of marriage from its procreative function. The evidence of permissibility of contraception in Islam is documented by the Prophet's traditions. Contraception must be practiced by the choice of the couples and not imposed by force of pressure. About 1000 years ago the great scholar Al-Ghazali listed a full spectrum of valid indications for contraception, ranging from health reasons where pregnancy can causes risk to the mother's health and financial causes (Bankowiski 1988).

Fatwas and opinions of twentieth century jurists

Fatwa Committee of Al-Azhar (1953)

They confirmed the permissibility of contraception, based this time on the Shafe'I school of jurisprudence. The committee disallowed permanent sterilization

Fatwa by Sheikh Hasan Ma'moun (Al-azhar, 1964)

He concluded, Islam is never against human welfare. Family planning in this sense without compulsion, is sanctioned and quality (Omran 1992 pp.225).

Fatwa by Sheikh Tantawi(1988)

The mufti sanctioned family planning liberally for economic, cultural or health reasons.

He actually approved contraception by a rich couple with three children who wanted to use contraception not because they can't afford more children but because they live in a country which needs family planning. He ruled that new methods are as lawful as al-azl and

contraception is not murder or contradiction of predestination or rizq. Abortion is disallowed (Omran 1992 pp.228).

Sheikh Yusuf al-Qaradwi (Qutar, 1980)

The preservation of the human species is unquestionably the primary objective of marriage, and such preservation of species requires continued reproduction. Accordingly, Islam encourages having many children and has blessed both male and female progeny. However, it allows the Muslim to plan his family due to valid reasons and recognized necessities. The common method of contraception at the time of Prophet (PBUH) was coitus interrupts, or withdrawal....the Companions of the Prophet (PBUH) engaged in this practice during the period when the Qur"an was being revealed to him (Al-Qaradawi 1980).

Common or jumhor position in Islam

Differences among schools of jurisprudence on the legality of al-azl as a family planning method exist but there is more agreement than disagreement.the majority of theologians (jumhour al-fuqaha' or 'aammatul ulama' or simply al-jumhour) from almost all schools of Islamic jurisprudence agree that al-azl is permissible with wife's consent. The strength of support (Omran 1992 pp.152).

Old Methods of Contraception:

Coitus interrupts

Coitus interrupts is the oldest method of birth control, widely used in Muslim and Christian communities, but not in the Oriental countries (Loudon is preferred to quantity.

(185 :1985Islam as a religion prefers healthy, powerful and strong believers. Family planning encourages small, healthy, and strong families with improved socio-economic status. Among the Prophet traditions, which approve of family planning through al-azl is a tradition was

reported by Jaber. The tradition, as reported say: *"we used to practice coitus interrupts during the time of the prophet while the Quran was being revealed"*. Muslim adds that, the Prophet came to know of this, but he did not forbid us (doing it)

(Omeran, 1992 pp.117).

Breast-feeding: natural way of spacing babies

If the mother is feeding her baby milk exclusively from her breast, it is quite likely that the ovulation will not return for about six months. After the baby reaches 6 months of age, and whenever the mother begins to give her baby supplementary food and decrease breast-feeding, its contraceptive effect diminishes, especially if menstruation return. Breast-feeding causes the augmented release of prolactin hormone, which prevents ovulation. The Quran mentions breast-feeding and emphasize its duration *"The mothers shall give suck to their offspring for two whole years for whomever desires to complete the term of lactation"*

(Al Bakara sura, 2: 233).

Breast-feeding has many advantages more than a nutritional process. It is effective in about 98% as a contraceptive for the first 6 months postpartum. Breast-milk is cheap, ready all the time, and contains antibodies that give the baby immunity against infection. It has also psychological effect which encourages bounding between the mother and her baby and physiological effect.

It is estimated that, if breast-feeding become the collective normal way of feeding babies in the first two years of life, the drop in reproductive rate and spacing out of pregnancies in community would exceed that produced by the modern methods of family planning.

This chapter demonstrated the definition and importance of family planning, the historical overview, and family planning in Islam, family planning is one of the most effectual and least

expensive way of improving women's quality of life, in both short and long term, by reducing the physical, mental, social and economic burdens of having too many children, and it also increase the free time available for women's life aspects. The next chapter will discuss the methodology of the study.

Chapter Three

Methodology

This chapter focuses on the methodology of the study, study design, place and time of study, sample and sampling, tool of data collection, data entry and analysis, and limitations of the study.

3.1: Study design

The design of this evaluation study was case-control, which conducted in order to measure the impact of family planning program on quality of women's life. Case-control study is an observational study in which characteristics of one group exposed to an agent of change (cases) compared with these of a selected sample have not exposed to the same agent of change (control), cases and controls share the same other demographic characteristics. The prime advantages of the case control study are practical; it is relatively simple, requires few subjects, logistics are easy and less expensive (Altman, 1999). In a case control study the researcher starts with a group of subjects who have already experienced an outcome and another one or more group who have not. There should be at least one control person for every case. This study allows us to compare between two similar groups except that cases utilize family planning service and controls do not use that service.

3.2: Place of the study

The study conducted in two localities of the Gaza Strip, first Gaza City represented by Remal Clinic and the second is Rafah district represented by Central Rafah Clinic.

3.3: Time table

The timeline for this study was from May 2001 through end of July 2002 for 75 cases and 75 controls randomly selected from the two family planning centers in Remal and Central Rafah. The study took one year from the inception.

3.4:Target population

The target population in this study included women at reproductive age (15-49 years) who received family planning services (cases) and controls were women at the same age and live in the same localities but they do not use family planning services. EpiInfo software was used to determine the sample as representing sample in this study.

3.5: Sampling

The researcher choose two family planning clinics run by the MoH, one from Gaza City as an Urban area of a high socio-economic class. The total number of new family planning users at the end of 1999 was 572 women. The second clinic from Rafah district, which considered as low socio-economic class with a total number of new family planning users at the end of 1999, was 279 women. The desired sample was taken from the records randomly in a systematic way every tenth case from the record. Then, the woman who was selected to be a control from the same locality and age group.

3.6: Sample size

Sample size is two groups of family planning users, 50 women from Remal Clinic and 25 women from Rafah Clinic. For each user as a case, there was a woman as a control ,which was chosen with the same criteria except that they did not practice family planning methods (non users). However, these controls were chosen among women who visiting the center for other purpose other than seeking family planning services.

3.7: Pilot study

A pilot study was conducted on a small sample to test recruitment, response rate, size of effect, validity and suitability of questionnaire as well as areas of ambiguity.

Before the long study, a sample of 5 cases and 5 controls were selected from both clinics El-Remal and Rafah, all of these cases and controls excluded from the study. Rewording and changing in the questionnaire was done according to the results of the pilot study.

3.8: Research methodology

Standardized questionnaire was administered to 150 subjects, 75cases and 75 controls from two different areas. The administered questionnaire was used as it saved time and limit interviewer effect, especially that a number of different interviewers were involved in the research. The analysis of data seems to be easier as answers can be found quickly. The researcher used interviewer to fill the questionnaire because some of family planning users are illiterate. Data was collected from files and records through auditing client medical records, which were available at the health centers.

3.9: Questionnaire design

In the interview, the researcher used self constructed a structured questionnaire relevant to the women group which had been designed for this purpose. Great care was taken to ensure confidentiality, the interviews were done in private, the interviewer gave the participants in the study enough time to answer the questions and encourage them to be open and virtuous in answering while assuring them that information given in the interview will remain confidentially and just will be used for the purpose of the study. The questionnaire is divided into three parts, the first, is about demographic or factual data, the second, about the obstetric

and gynecological information and the third, about the reproductive health and family planning data and its benefits. The questionnaire consisted from 35 questions. The questions were in close-ended form because they can be pre-code and can easily be put in the computer, saving time and money, and they are less time consuming for the respondent to be complete. The questions were answered by yes or no.

3.10: Ethical consideration

Ethical issue is very important and the researcher ensured the privacy and confidentiality, participants in the study received complete explanation about purpose of study including the time and how long interview will take. Written consent form was obtained from each participant in the study. Every woman participated in the study know that she has the right to share or not. The interviewer gave the participant sufficient time to answer the questions and encouraged them to be open and honest in answering while assuring them that information given in the interview will be confidentially. The Minister or the Director General of MoH was officially informed.

3.11: Data collection

Data was collected through face to face interviews with clients and controls in the clinic or at the home. Before starting, all questionnaire forms were prepared, organized and numbered with serial numbers to ensure the availability's of all forms to identify the subjects and the completion of the study sample without errors. Four trained interviewers were trained through intensive training program to learn how to complete the questionnaire correctly and to administer the informed consent procedure. The interviewer asked questions to the participants and recorded the answers directly on questionnaire form.

3.12: Data entry and analysis

Data was entered, cleaned and analyzed by using the SPSS program.

Cross tabulation was used to show the association between variables such as the association between time and family planning, P value, and Chi- square were used as statistical testing

3.13: Study limitations

The researcher abilities and position lend him the chance to face minimal limitations and difficulties, which included:

1- Time limitation

2- Selecting controls

3- Closure and Siege

4- Family planning is a sensitive issue and not easy to be discussed.

5- The tittle of the study is studied for the first time in the Gaza Strip and a few studies were conducted internationally.

3.14: Eligibility criteria

3.14.1: Inclusion criteria

Any client receiving family planning services at the two clinics controlled by MoH (EL-Remal and Central Rafah), agree to participate in the study, have used family planning method at least for one year and at reproductive age (15-49 years) included in the study.

3.14.2: Exclusion criteria

Clients refused to participate or newly practicing family planning for less than one years excluded from the study.

This chapter demonstrated case control study as a design for this study to compare users (cases) and non-users (control).

Chapter four

Results

The results of this study have been sorted out of the data collected from the study population by an organized structure interview questionnaire, which was the tool of this case control study. The following tables have been classified to show the results which answered the questions of the research in terms of the impact of family planning programs on the quality of women's life among women using family planning methods for at least one year.

The study population have been selected from women at reproductive age (15 – 49 years).

Tow localities were selected in this case control study, one in Gaza City which is EL-Remal clinic, and the second was Rafah Central Clinic in Rafah area.

The sample was selected randomly as described in chapter three; the size of the sample was (150 subjects) 100 subjects from Remal Clinic (50 users and 50 non users), and 50 subjects from Rafah Clinic (25 users and 25 non users).

4.1: Sociodemographic characteristics

Sociodemographic characteristics selected in this study were the age group (for users and non users), years of education for both wife and husband, the housing condition (its type and number of rooms), the household members and the monthly income.

The distribution of sociodemographic variables is shown in the following tables:

Table (4): Distribution of Participants by Their Age Groups

Age Group	Users		Non users	
	Number	Percent	Number	Percent
Less than 20	2	2.7 %	2	2.7 %
20 to 24	9	12.0 %	9	12.0 %
25 to 34	44	58.6 %	44	58.6 %
More than 35	20	26.7 %	20	26.7 %
Total	75	100 %	75	100 %

N.B. Users and Non-users were matched for age.

Table (4) shows that the majority 44 (58.6 %) of users were in the age group from 25 to 34 years old.

Table (5): Distribution of the Participants by Education of the Subjects

Years of Education	Users		Non users		P Value
	Number	Percent	Number	Percent	
9 years and below	26	34.6%	34	45..3 %	0.112
0 to 12	37	49.3%	33	44.0 %	
13 and more	12	16.0%	8	10.6 %	
Total	75	100 %	75	100 %	

Table (5) shows that, the non-users who studied 9 years and below were 34 (45.3%), which was higher than the users, 26 (34.6%), but from 10 to 12 years the users were 37 (49.3%) which was higher than the non-users 33 (44.0%), also 12 (16.0%) of the users obtained the first degree, which was higher than the non-users 8 (10.6%). However, this variation between users and non-users is not statistically significant (P value 0.112).

Table (6): Distribution of the Participants by Education of the Husband

Years of Education	Users		Non users		P Value
	Number	Percent	Number	Percent	
9 years and below	24	32.0%	39	52.0 %	0.007
10 to 12	26	34.7%	21	28.0 %	
13 and more	25	33.3%	15	20.0 %	
Total	75	100 %	75	100 %	

Table (8) shows that 10 (23.8%) of the users had not desire to study because of child care, which was lower than non-users 33 (59%). Of the users 5 (11.9%) had not desire because they had no time, which was lower than non-users 9 (16%). Of the users, 13 (30.9%) had no ability to complete education which was higher than the non-users 7 (12.5%), also of the users 5 (11.9%) had not desire because of husband's objection, which was lower than the non-users 7 (12.5%). The last two results about (have no ability, and husband's objection) were contrary to researcher's expectation.

Table (9): Distribution of Participants by Having Time to Work

Having Time to Work	Users		Non users		P Value
	Number	Percent	Number	Percent	
Yes	61	81.4%	6	8%	0.001
No	14	18.6 %	69	92%	
Total	75	100 %	75	100 %	

Table (9) shows that 61 (81.4%) of the users had time to work which was higher than the non-users 69 (92%) had no time to work. This variation is highly statistically significant (P value 0.001).

Table (10) : Distribution of Participants by Having Job Outside Home

Job Outside Home	Users		Non users		P Value
	Number	Percent	Number	Percent	
Yes	14	18.7 %	2	2.7 %	0.001
No	61	81.3 %	73	97.3 %	
Total	75	100 %	75	100 %	

Table (10) shows that 14 (18.7%) of the users had job outside home, while 2 (2.7%) of non-users which means that the users were higher in having job out side home than non-users, this variation is highly statistical significant (P value 0.001).

Table (11): Distribution Participants by the Job of Their Husbands

Husband's Job	Users		Non users	
	Number	Percent	Number	Percent
Professional	22	29.3%	22	29.3%
Skilled labour	31	41.3%	23	30.7%
Unskilled labour	10	13.4%	23	30.7%
Unemployed	12	16.0%	7	9.3%
Total	75	100%	75	100%

Table (11) shows that 22 (29.3%) of the husbands of the users were professional, which was the same as non-users, while the users who were skilled labour 31 (41.3%) which was higher than the non-users 23 (30.7%), but the unskilled labour of the users were 10 (13.4%) which was lower than the non-users 23 (30.7%) and 12 (16.0%) of the users were unemployed which was higher than the non-users 7 (9.3%).

Table (12): Distribution Participants by Their Monthly Income

Monthly Income	Users		Non users		Total		P value
	Number	Percent	Number	Percent	Number	Percent	
Less than 250$	36	48 %	39	52 %	75	50%	0.135
250 to 500$	24	32 %	31	41.3 %	55	36.7%	
More than 500$	15	20 %	5	6.7 %	20	13.3%	
Total	75	100%	75	100%	150	100%	

Table (12) shows that 36 (48%) of the users had monthly income less than 250$, which was lower than the non-users 39 (52%). Of the users, 24 (32%) had monthly income from 250$ to 500$, lower than the non-users 31 (41.3%), but 15 (20.0%) of the users had monthly income more than 500$, higher than the non-users 5 (6.7%), however these variations are not statistically significant (P value 0.135).

Table (13): Distribution of Participants' Home Condition by Their Kind of House

Kind of house	Users		Non users		Total	
	Number	Percent	Number	Percent	Number	Percent
Concrete	57	76.0%	57	76.0%	114	76.0%
Asbestos	18	24.0%	18	24.0%	36	24.0%
Total	75	100%	75	100%	150	100%

Table (13) shows that the distribution of the home condition as 57 (76.0%) of both users and non-users live in concrete house, while 18 (24.0 %) of both live in asbestos.

Table (14): Distribution of Participants' Home Condition by Number of Rooms

Number of Rooms	Users		Non users		Total	
	Number	Percent	Number	Percent	Number	Percent
From 1 to 3	45	60.0%	46	61.3%	91	60.7%
From 4 and more	30	40.0%	29	38.6%	59	39.3%
Total	75	100%	75	100%	150	100%

Table (14) shows that the distribution by number of rooms as 45 (60.0%) and 30 (40.0%) of the users had 1 to 3 and from 4 and more rooms at their house respectively, which were almost the same as non-users 46 (61.0%) and 29 (38.6%) respectively.

Table (15): Distribution the Participants by the Number of Children

Number of children	Users		Non users		Total		P value
	Number	Percent	Number	Percent	Number	Percent	
1 to 3	22	29.3 %	35	46.7 %	57	38.0%	0.009
4 to 6	36	48 %	28	37.3 %	64	42.7%	
7 and more	17	22.6 %	12	16.0 %	29	19.3%	
Total	75	100%	75	100%	150	100%	

Table (15) shows that 22 (29.3%) of the users had 1 to 3 children, which was lower than the non-users 35 (46.7%). Of the users, 36 (48.0%) had 4-6 children, which was higher than the

non-users 28 (37.3%), also 17 (22.6%) of users had 7 and more children, which was higher than the non-users 12 (16.0%), these variations are statistically significant (P value 0.009).

Table (16): Distribution the Participants by Using Crowding Index

Crowding Index	Users		Non users		Total		P value
	Number	Percent	Number	Percent	Number	Percent	
Less than 2	20	26.7 %	25	33.3 %	45	30.0%	0.264
From 2 to 4	47	62.7 %	41	54.7 %	88	58.7%	
More than 4	8	10.6 %	9	12.0 %	17	11.3%	
Total	75	100%	75	100%	150	100%	

Table (16) shows that 20 (26.7%) of the users had crowding index less than 2 which was lower than the non-users 25 (33.3%) and 47 (62.7%) for users with crowding index from 2 to 4 were slightly higher than the non-users 41(54.7%). However, these variations are not statistically significant (P value 0.264).

4.2: Results of the information about deliveries

Table (17): Distribution of the Participants by Age at Marriage

Age at Marriage	Users		Non users		Total		P value
	Number	Percent	Number	Percent	Number	Percent	
Less than 18	37	49.3%	26	34.7%	63	42.0%	0.0001
From 18 to 22	35	46.7%	16	21..3%	51	34.0%	
More than 23	3	4.0%	33	44.0%	36	24.0%	
Total	75	100%	75	100%	150	100%	

Table (17) shows that 63 (42.0%) and 51 (34.0%) from users and non-users married at less than 18 and from 18-22 years old respectively. The number of users married at less than 18 years was 37 (49.3%) which was higher than the non-users 26 (34.7%). Of users, 35 (46.7%) married at the age from 18 to 22 which was higher than the non-users 16 (21.3%). While at age more than 23 the number of users was 3 (4.0%) which was lesser than the number of non-users 33 (44.0), these variations are very high statistically significant (P value 0.0001)

Table (18): Distribution of the Participants by Age at First Pregnancy

Age at First Pregnancy	Users		Non users		Total		P value
	Number	Percent	Number	Percent	Number	Percent	
Less than 18	28	37.3%	12	16.0%	40	26.7%	0.0001
From 18 to 22	41	54.7%	29	38.7%	70	46.7%	
More than 23	6	8.0%	34	45.3%	40	26.7%	
Total	75	100%	75	100%	150	100%	

Table (18) shows that 28 (37.3%) of the users had the first pregnancy at age less than 18 years which was higher than the non-users 12 (16.0%). Also at age from 18 to 22 the users' number was 41 (54.7%) which was higher than the non-users 29 (38.7%) and at age more than 23 years the users' number was 6 (8.0%) which was less than the non-users 34 (45.3%). These variations are very high statistically significant (P value 0.0001).

Table (19): Distribution of the Participants by Age at First Delivery

Age of First Delivery	Users		Non users		Total		P value
	Number	Percent	Number	Percent	Number	Percent	
Less than 18	16	21.3%	6	8.0%	22	14.7%	0.0001
From 18 to 22	47	62.7%	32	42.7%	79	52.7%	
More than 23	12	16.0%	37	49.3%	49	32.6%	
Total	75	100%	75	100%	150	100%	

Table (19) shows that 16 (21.3%) of the users had the first delivery at age less than 18 years which was higher than the non-users 6 (8.0%), also at age from 18 to 22 the users' number was 47 (62.7%) which was higher than the non-users 32 (42.7%), while at age more than 23 years the users' number was 12 (16.0%) which was less than the non-users 37 (49.3%). These variations are very high statistically significant (P value 0.0001).

Table (20): Distribution of the Participants by the Number of Pregnancies

Number of Pregnancies	Users		Non users		Total		P value
	Number	Percent	Number	Percent	Number	Percent	
From 1 to 3	16	21..3 %	21	28.0 %	37	24.7%	0.129
From 4 to 6	34	45..3 %	35	46.7 %	69	46.0%	
From 7 and more	25	33.4 %	19	25..3 %	44	29..3%	
Total	75	100%	75	100%	150	100%	

Table (20) shows that 16 (21.3%) of the users had 1to 3 pregnancies, which was lower than the non-users 21 (28.0%), while 25 (33.4%) of the users had 7 and more pregnancies, which was higher than the non-users 19 (25.3%). However, these variations are not statistically significant (P value 0.129).

Table (21): Distribution of the Participants by the Number of Live Births

Number of Live Births	Users		Non users		Total		P value
	Number	Percent	Number	Percent	Number	Percent	
From 1 to 3	22	29.3 %	31	41.3 %	53	35.4%	0.007
From 4 to 6	36	48 %	32	42.7 %	68	45.3%	
From 7 and more	17	22.7 %	12	16 %	29	19.3%	
Total	75	100%	75	100%	150	100%	

Table (21) shows that 22 (29.3%) had 1 to 3 children, which was lower than non-users 31 (41.3%), while 36 (48.0%) and 17 (22.7%) of the users had 4-6 live babies and 7 and more respectively, which was higher than the non-users 32 (42.6%) and 12 (16.2%) respectively, these variations are statistically significant (P value 0.007).

Table (22): Distribution of the Participants by Number of Deaths of Children

Number of Deaths	Users		Non users		Total		P Value
	Number	Percent	Number	Percent	Number	Percent	
0	61	81.3%	65	86.7%	126	84%	0.439
1	12	16.0%	6	8.0%	18	12.0%	
2 and more	2	2.7%	4	5.3%	6	4.0%	
Total	75	100%	75	100%	150	100%	

Table (22) shows that 12 (16.0%) of the users had one death which was higher than the non-users 6 (8.0%), while 2 (2.7%) of the users had 2 and more deaths which was lower than the non-users 4 (5.3%). However, these variations are not statistical significant (P value 0.439, Fisher test 0.024).

Table (23): Distribution of the Participants by Number of Abortions

Number of Abortions	Users		Non users		Total		P value
	Number	Percent	Number	Percent	Number	Percent	
0	48	64.0%	51	68.0%	99	66.0%	0.625
1 – 2	21	28.0%	20	26.7%	41	27..3%	
3 and more	6	8.0%	4	5.3%	10	6.7%	
Total	75	100%	75	100%	150	100%	

Table (23) shows that 21(28%) of the users had from 1-2 abortions, which was similar or slightly higher than the non-users, which was 20 (26.7), also 6 (8.0%) of the users had three and more abortions which was slightly higher than the non-users 4 (5.3%), these variations are contrary to researcher expectations, and are not statistically significant (P value 0.625).

4.3: Results of Family Planning practice and birth spacing

Table (24): Distribution of User's Age at Time when they Use Method for First Time

Age Group	Users	
	Frequency	Percent
From 20 to 24	22	29.3%
From 25 to 29	28	37.3%
From 30 to 34	17	22.7%
More than 34	8	10.7%
Total	75	100%

Table (24) shows that 22 (29.3%) of the users had used family planning method for the first time at the time when their age was from 20 to 24 years old, 28 (37.3%) was at the age group from 25 to 29 years old and 17 (22.7%) was at the age group from 30 to 34 years old.

Table (25): Distribution of Number of Children (Males and Females) by the Initiation of Using Contraception Methods by Users

Number of Children	Males		Females	
	Number of Users	Percent	Number of Users	Percent
Zero	2	2.7%	19	25.3%
One	22	29.3%	9	12.0%
Two	24	32.0%	24	32.0%
Three and more	27	36.1%	23	30.3%

Table (25) shows that 2 (2.7%) of the users had zero number of male at the time when use family planning method for the first time, while 19 (25.3%) had zero number of female. Of the users, 22 (29.3%) had one male at the time when use family planning method for the first time, while 9 (12.0%) had one female. Male preference was demonstrated by the study population through practicing family planning methods when women have male children and may not use family planning method unless they have male children.

Table (26): Distribution of Decision-Makers with Respect to Using of Family Planning Method

Decision-Makers	Users	
	Frequency	Percent
Both Husband and Wife	60	80.0%
Husband	8	10.7%
Wife	7	9.3%
Total	75	100%

Table (26) shows that 60 (80.0%) of the users made the decision with respect to practicing family planning method by both.

Table (27): Distribution of Participants by the Reasons for Practicing Family Planning Methods

Reasons for Practicing Family Planning Methods	Number	Percent
Keeping Health	45	60.0%
Economic and Financial Difficulties	41	54.7%
Birth Spacing	31	41.3%
Other Reasons	2	2.7%

Table (27) shows that 45 (60.0%) practicing family planning in order to keep their health free from problems, 41 (54.7%) for economic and financial difficulties and finally 31 (41.3%) in order to make birth spacing.

N.B: most of the users chose more than one reason.

Table (28): Distribution of Participants by the Reasons for Not Practicing Family Planning Methods

Reasons for Not Practicing Family Planning Methods	Number	Percent
Desire to Have More Children	45	60 %
Husband's Objection	20	26.7 %
Religion	4	5.3 %
Others	3	4 %
Side Effects	2	2.7 %
Cost Expenses	1	1.3 %

Table (28) shows that 45 (60.0%) not practicing family planning methods because they had the desire to have more children and 20 (26.7%) have husband's objection.

The result of the question number 29 (what are the effects of practicing family planning in your relationship with your husband, positive or negative?) shows that all users 75 (100%) said that practicing family planning had positive impact and had no fear in the sexual relationship.

Table (29) Distribution of Participants by Positive Impact of Family Planning

Positive Impact of Family Planning	Number	Percent
Offer more Time	63	84.0 %
Meet Husband and Children Needs	50	66.6 %
Avoid Pregnancy and Delivery Risk	50	66.6 %
Economic	50	66.6 %

Table (29) shows the result of the question number 35 (while you were practicing family planning, do you have any positive effects on your social and economical life ?) if yes mention) shows that all users said that family planning had positive effects.

The positive effects of using family planning as shown in the above table were offer more time 63 (84.0%), economic effects 50 (66.6%), meet their husband's and children needs 50 (66.6%) and avoid the risk of pregnancy and delivery 50 (66.6%).

N.B: most of the subjects said more than one option.

Table (30) Distribution of Participants by Negative Impact of Family Planning

Negative Impact of Family Planning	Number	Percent
Prolonged Bleeding	4	5.3 %
Irregularity of Menstruation	3	4.0 %
Back Pain	3	4.0 %
Headache and Dizziness	2	2.6 %
Discomfort from Husband (from condom)	1	1.3 %

Table (30) shows that number of the users said that practicing family planning had negative impact which include prolonged bleeding 4 (5.3%), irregularity of menstruation 3 (4.0%), back pain 3 (4.0%), headache and dizziness 2 (2.6%) and discomfort from husband from condom 1 (1.3%).

N.B: most of the subjects said more than one option.

4.4: Results of women's quality of life

Table (31): Distribution of Participants by Their Desire to Participate in Health Awareness Sessions

Having Time to Participate in Health Awareness Sessions	Users		Non users		P value
	Number	Percent	Number	Percent	
Yes	73	97.3%	6	8%	0.001
No	2	2.7%	69	92%	
Total	75	100 %	75	100 %	

Table (31) shows that 73 (97.3%) of the users had time to participate in health awareness sessions in the community, which was higher than the non-users, which was 6 (8%), while 2 (2.7%) of the users had no time for participation, which was lower than the non-users, which was 69 (92%), these variations are very highly statistically significant (P value 0.001) Fisher test (593.189)

Table (32): Distribution of Participants by their Desire to Participate in the Social Activities

Having Time to Participate in Social Activities	Users		Non users		P value
	Number	Percent	Number	Percent	
Yes	74	98.7%	13	17.3%	0.001
No	1	1.3%	62	82.7%	
Total	75	100 %	75	100 %	

Table (32) shows that 74 (98.7) of users had time to participate in social activities, which was higher than the non-users which was 13 (17.3%) had time for that, one of the users had no time for participation, while 62 (82.7%) of the non-users had no time, these variations are very highly statistically significant (P value 0.001) Fisher test (312.902).

Table (33): Distribution of Participants by Having Time for Entertainment

Having Time for Entertainment	Users		Non users		P value
	Number	Percent	Number	Percent	
Yes	70	93.3%	7	9.3%	0.001
No	5	6.7%	68	90.7%	
Total	75	100 %	75	100 %	

Table (33) shows that 70 (93.3%) of the users had time for entertainment (reading magazines and stories and watching TV), which was higher than the non-users, which was 7 (9.3%), while 5 (6.75) of the users had no time for participation, which was lower than the non-users which was 68 (90.7%), these variations are very highly statistically significant (P value 0.001) Fisher test (355.576).

Chapter Five

Discussion

As a component of reproductive health, family planning involves more than distribution and use of contraceptives. It also encompasses many aspects of programs aimed at improving maternal and child health. Family planning services can help women reduce the health risks from mistimed and unwanted pregnancies (World Bank, 1993).

The data gathered in this research provides a descriptive information about the impact of family planning services on the quality of women's life in two locations in the Gaza Strip. This chapter discusses the results of the study in view of the relevant literature and interpretation of results inferred by the researcher. To the best of the researcher's knowledge, this study is the first study that shows the impact of family planning programs on the women's quality of life conducted in the Gaza Strip.

The presented information of this study is based on data obtained from 150 subjects distributed as 75 cases (family planning users) and 75 controls (family planning non-users). Interviewed structured questionnaire was the instrument of data collection in this study to explore the impact of family planning programs on the women's quality of life. The response rate on the study was found to be high. The study population seemed satisfied and appreciate the importance of birth spacing and its impact on their own life.

Family planning programs contributed to organize the pregnancies of the very young and older women, short intervals between births, unwanted pregnancies and unsafe induced abortions of which were understood to be potential health hazards for women and their children, then family planning programs were designed and organized to meliorate these hazards.

Characteristics of the study population used had its impact on the nature of the study results, the largest age group was from 25 - 34 years (58.6%), and the second age group was more than 35 years (26.7%). This study revealed that approximately 49.3% of the study population got married at age less than 18 years old. A study conducted by Kariri, (1999) showed that 60.2 % of the study population married at age less than 18 years. According to WHO the period of childhood extends to 18 years, this means that most of the study population got married before completing childhood. It is a common belief between Palestinians that girls should marry at early age to avoid missing the possible opportunities of marriage if they become over than the age of 20 years. Young girls are not developed enough to carry out the responsibilities of home, pregnancy, child birth, and child care. In fact they may in need to be cared of. So, in researcher's opinion recommendations for policy makers to adopt programs of health education directed to adolescents in order to increase their awareness about the risk of early marriage and benefits of spacing for their health through community and clinic based programs.

This study illustrates that one fifth of the study population had their first pregnancy at age less than 18 years. Women who become pregnant while they are very young (less than 18 years) have higher risk of complications during the period of pregnancy and childbirth. The same is true of women who become pregnant near the end of reproductive years (after the age of 35). Aghabekian (1998), referred that Haj and others stated that 30 – 39 percent of married women conceive prior to 18 years old. Also the risk of maternal mortality among those aged 15 – 19 years is three times as those aged 20 – 24 years, and five times for those aged over 35 years (Kassas, 1994). WHO recommends that postponing first birth until women exceeds 18 years of age decreases the risk of death for the first born by 20 percent (

WHO 2001).

Family planning offers women clear health benefits. In less developed countries complications related to pregnancy and childbirth are the common cause of women's death. By allowing adequate spacing between pregnancies, preventing the occurrence of pregnancy very early or late in women's reproductive lives when risks are greater, and avoiding unintended pregnancies that may lead to illegal and dangerous abortions, family planning can improve the outcome of women's health.

The study revealed that the mean age for starting family planning for the users was 26.72 years, 60.0% of the users started family planning at age from 25-34 years. The researcher attributes practicing family planning in the age above 25 years to the cultural and political context of the Palestinian families. Also, Palestinian families like children and most of the couples decide to practice family planning after they have satisfied number of children. The study revealed that the mean number of children in the study population 5.14 child, while the mean number of children for non-users, 4.16 children the number of users who had 1-3 children was 22 (29.3%), which was lower than the number of non-users, which was 35 (46.7%), while 53 (70.6%) of the users had more than 7 children which was higher than the non-users, which had 40 (53.3%) Also in the study 25.3% started family planning when they had a male child and zero females, while 2.7% started family planning when they had zero male. These findings supported the results in the study conducted by MoH, (1997) which showed that 40.6% have 4 - 9 children. The researcher can infer that the Palestinian families like to have more children to support them and they considered them as a social support when they become older.

Also by asking the non-users about the reasons for not practicing family planning , 60.0% of

them said because of their desire to have more children. All of these results are in line with the Palestinian culture and in reaction to the political context, and supported that our Palestinian families like children mainly male preference.

The results of the study revealed that 80% of the users decided to use family planning by the agreement of both husband and wife. Also a study conducted by Mousa, (2000) revealed that 82.6% of subjects both the husband and wife decided to practice family planning. In Cebu, the Philippines, more than two-thirds of 2200 women surveyed about household decision making said they would consult their husbands about contraception used (Adair, et al 1997). In Indonesia, when family planning has been widely promoted by the government since the 1970s, women in west Java and north Sumatra said that couples jointly made decisions about family planning although husbands were regarded as heads of the household (http://reproline.jhu. Network Summer 1998, vol. 18, No. 4).

This means that most of family planning decisions were taken by both husband and wife.

In this study, 60 percent of the users said that they practice family planning because they wanted to maintain or restore their health because too early or too late and too close or too short pregnancies is real cause of risk on women's health. It also revealed that 54.7 percent practice family planning for economic and financial benefits which reflects the effects on health. The study also concluded that 41.3 percent used family planning method for birth spacing , 66.6 percent of the users said that family planning had a positive impact in avoiding pregnancy and delivery risk which let them enjoy their sexual life without fearing from pregnancy, and maintain their health. Also 73 (97.3%) of the users said that they had time to participate in health awareness sessions, and 69 (92%) of the non-users said that they had no time to it, which was highly statistically significant. The researcher can conclude that

practicing family planning provides women a better status free from problems and also serves them more time to participate in the sessions held in the community with respect to health awareness.

In Mali, new users of modern contraception in Bamako said they chose to use contraceptive because they wanted to restore or maintain their health . Also in a women's studies project, study of 55 contraceptive users, women revealed that close pregnancies is exhausted. But when they space their children they are in peace and avoid sickness (Knote, et al, (1998) Also in focus group discussions with more than 130 women and men from Mashonaland East Province, it was seen that relief from the burden of childbearing and rearing having psychological and health benefits (http://reproline.jhu. Network Summer 1998, vol. 18, No. 4). Also the study revealed that the number of users who had more than one death child was 14 (18.7%), which was higher the number of non-users who had the same number of death child, which was 10 (13.3%), which was contrary to the researcher expectations, and need more investigation to know if these deaths occurred, before, during or after practicing family planning. Although impact of family planning on health status of users documented in literature in Palestine still needs further investigations to identify its impact on health status of users.

The study revealed that, the users studied 9 years and below were 26 (34.7%), which was less than the non-users, which was 34 (45.3%), while around half of the users (49.3 %) have a level of education from 10 - 12 years, which was higher than the non-users, which was 33 (44%). However these variations were not statistically significant, but the researcher induce that the educated women are likely to practice family planning more than the non-users. Also the study showed that 44% of the users have desire to complete their education, 75.8% of

them have time to complete their studying, while 25.3% of the non-users have desire to complete their study but all of them have no time for that which was statistically significant. The researcher attributes this result may be from practicing family planning, and not being busy all time in caring for small children.

The study revealed that the main reason, 34 (60.7%) of the non-users who have no desire to complete their education was child care, while the main reason, 13 (30.9%) of the users who have no desire to complete their education was no ability.

Also in the study which was conducted by MoH, (1997) showed that 64.7% of the mothers had studied 7 - 12 years, also in Mousa, (2000) the majority of the population 66.25% from 7 - 12 years. Also studies in South Korea, Japan, Taiwan, Singapore, Thailand and Indonesia showed that women enrollment in secondary school increased markedly between 1960, when women had on average 6 children, and 1990 when women had on average 2 children or lower (Westley, et al (1998).

This means that contraceptive use is associated with gains in women's education and supported what Taylor (1993) said that uneducated women tend to marry younger and are less likely to use family planning while the educated women marry later and practice family planning method early, consequently the women have time to spend in study. The researcher can conclude that the educated women married in a later age or after completed their study, that means she will be pregnant later. With this regard, the researcher recommends that the decision maker should a mandate a low for the education years for girls to be at least 12 years of education. Therefore, the girl becomes developed enough with respect to the health, social and psychological status and can be responsible for herself and her family.

The study revealed that, 24 (32%) of the user's husbands studied 9 years and below, which was lower than the non-user's husbands which was 39 (52%), while 26 (34.7%) the user's husbands studied from 10-12 years, which was higher than the non-users, which was 21 (28%), also at level above 13 years of education the user's husbands was 25 (33.3%), which was higher than the non-users 15 (20%). The researcher induce that the wife of educated husband likes to practice family planning more than uneducated one, these variations were statistically significant.

The study revealed that 81.4 percent of the users have time to work in compression with non-users 69 (92%) have no time to work which was very highly statistically significant. Also , the results of this study illustrate that 18.7 percent of the users have job outside home, while 2.7 percent of the non-users have work out side home which was highly statistically significant. According to PCBS labor force survey conducted during 1995 to 1997, the rate of employment have been in average of 11 – 12 % among women in Palestine, the rate in Gaza Strip 7% which is lower than West Bank up to 17% (PCBS 1997).

Also in Mousa (2000) 90.3 percent of the study population were unemployed (housewives). The result of this research was higher than the Palestinian percent of employed women, this is may be because of small sample.

In Zimbabwe women who use contraceptive were more likely to be currently working than non-users (Mhloyi, et al 1998).

In South Korea, the married women's work participation began to increase in 1960 Korea mother mothers with children under age of 6 rarely worked out side the home, by 1990 when most married women were rearing only 1 to 2 child 48% of mother curve working out side home (http://reproline.jhu. Network Summer 1998, vol. 18, No. 4).

The researcher can induce that the users have high opportunities of work out side home and consequently will participate in improving the economic level of the family as a whole. All of these results supported that practicing family planning provides time for women for working and study.

The result revealed that there was similarity between users and non-users, when the husband's job was professional, but with skilled labour users were 31 (41.3%), which was higher than the non-users, which was 23 (30.7%), also with unemployed users were 12 (16%), which was higher than the non-users which was 7 (9.3%), but with unskilled labour users were 10 (13.3%), which was less than the non-users, which was 23 (30.7%), these results were contrary to the researcher' expectation, and may be due to political and economical context at this period.

The study showed that 98.7 percent of the users said that by using family planning the women have time to participate in social activities, but 82.6 percent of non users said that they have not time for participating in social activities which was very highly statistically significant. Also 97.3 percent of the users have time for entertainment, comparing with non-users 90.7 percent have not time for that which was very highly statistically significant. Also when asking the users about the positive impact of family planning, 84% of them said that it offers more time, 66.6% said that we can meet the needs of the husbands and children From all of these results, it is clear that family planning gives more time for women which may increase women's opportunities to participate in social activities, leisure, entertainment, education, and opportunity to work outside home.

Women's studies project showed that even when women perceive contraceptive use as a way to improve the quality of their lives, family planning, and the resulting smaller family size, is

seldom viewed as an end in itself. Instead, controlling family size is simply one step on a long continuum of social and economic factors that may improve the quality of life for all family members.

Also contraceptive users in Malaysia were significantly less likely than non-users to report marital disruption, perhaps due to better communication between spouses.

In study conducted in zimbabwe, contracepting couples described more peace and happiness in their homes than couples who were not using contraception.

Also in our study , 5.3 percent of users complained of prolonged bleeding, 4 percent complained of irregularity menstruation, 4 percent complained of back pain, and 2.6 percent complained from headache.

Even women who recognize the health benefits of family planning complain of some side effects of contraception, in FHI's Lampung and south Sumatra, Indonesia, study, 31 percent of contracepting women reported experiencing a major problem related to their method. A frequent complaint was headaches, menstrual irregularities, which may reduced quality of life for Moslem women whose religion teaches that a menstruating women should not fast, pray, have sex or touch holy book (http://reproline.jhu. Network Summer 1998, vol. 18, No. 4).

Chapter Six

Conclusion and Recommendations

6.1: Conclusion

For women around the world, family planning is about more than just health-although their health and that of their children is a primary concern. Family planning is about improving the quality of women's life in all it's many facets. So far most research has focused on measuring program impact in term of changes in fertility and contraception use as a result of widespread interest lowering fertility in order to achieve slower population growth. Since family planning is significant issue for effective health and development in the Gaza Strip, evaluation of impact of family planning programs on women's quality of life is extremely important.

Up to date there has been no research documented in Gaza Strip assessing the impact of family planning programs on women's quality of life at reproductive age (15 – 49) years. This case control study has been conducted to measure the impact of family planning programs on women's quality of life in two family planning clinics own by MoH, one from Gaza city as an urban area of a high socio-economic class, and the second clinic from Rafah district which considered as a low socio-economic class, the sample size was 50 women from El-Remal clinic and 25 women from Rafah central clinic as users, for each user their will be a women as a control (non-user).

The mean age of the studied population when they starting to practice family planning was 26.72 years old. Slightly 60.0 percent of women started to use family planning services at age from 25 - 34 years old. The study illustrates that half of participant women get married at age less than 18 years old. The users of family planning services get married earlier than

non-users and consequently delivered their first baby also earlier. Users of family planning have significant more children than non-users. This means that women practice family planning late or family planning services are coming late after the mother have already get satisfied number of children and it will be fruitful to concentrate in the awareness activities on younger age group. The study revealed that approximately half of the users in the study population studied from 10 to 12 years and only 16 percent of them studied more that 13 years. This reflects the drop out from the school and the girls leaving the school so early to get married.

The present study shows that less than one quarter of the users and only 2.7 percent of the non-users have work out side home. We need to pay attention to empower women and find an employment for them. The study illustrate that 37.3 percent of users become pregnant at age less than 18 years and one fifth of them have their first delivery at the same age. This means that they conceive and delivered while they are children according to the new definition of children by the WHO.

It was clear that family planning provide opportunity for women for studying, working, participating in health awareness sessions, and social activities, and having time for entertainment. The study revealed that the majority 97.3 percent of users have time to participate in the health awareness sessions, 98.7 percent have time to participate in the social activities and 93.3 percent have time for entertainment, which include reading books and magazines, reading stories and watching TV. In the other side non-users only 8 percent of them have time to participate in the health awareness sessions, 17.4 percent have time to participate in the social activities, and 9.3 percent have time for entertainment.

it is clear that family planning gives more time for women which may increase women's opportunities to participate in social activities, leisure, entertainment, education, and opportunity to outside work.

Family planning, and the resulting smaller family size, is seldom viewed as an end itself. Instead, controlling family size is simply one step on a long continuum of social and economic factors that may improve the quality of life for all family members.

6.2: Recommendations

1- Raising awareness of women about the risk of early marriage and benefits of spacing for their health through community and clinic based programs.

2- To sustain the service so that, availability of the service is secured.

3- Introduce the counseling service on family planning to women at early age.

Chapter Seven

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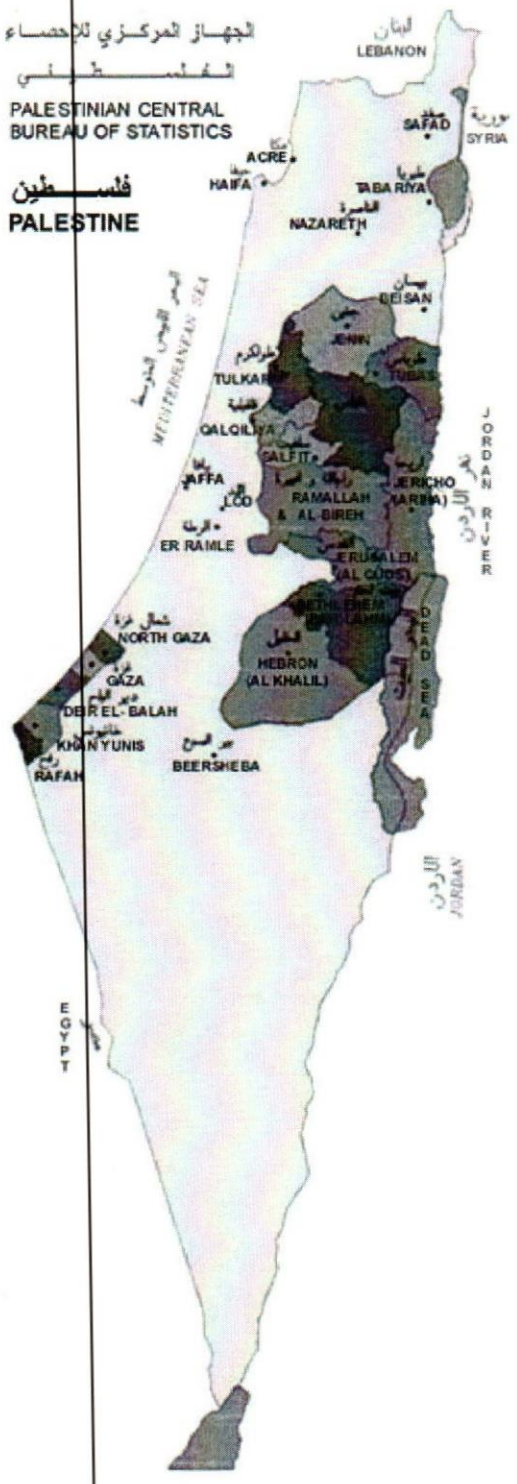
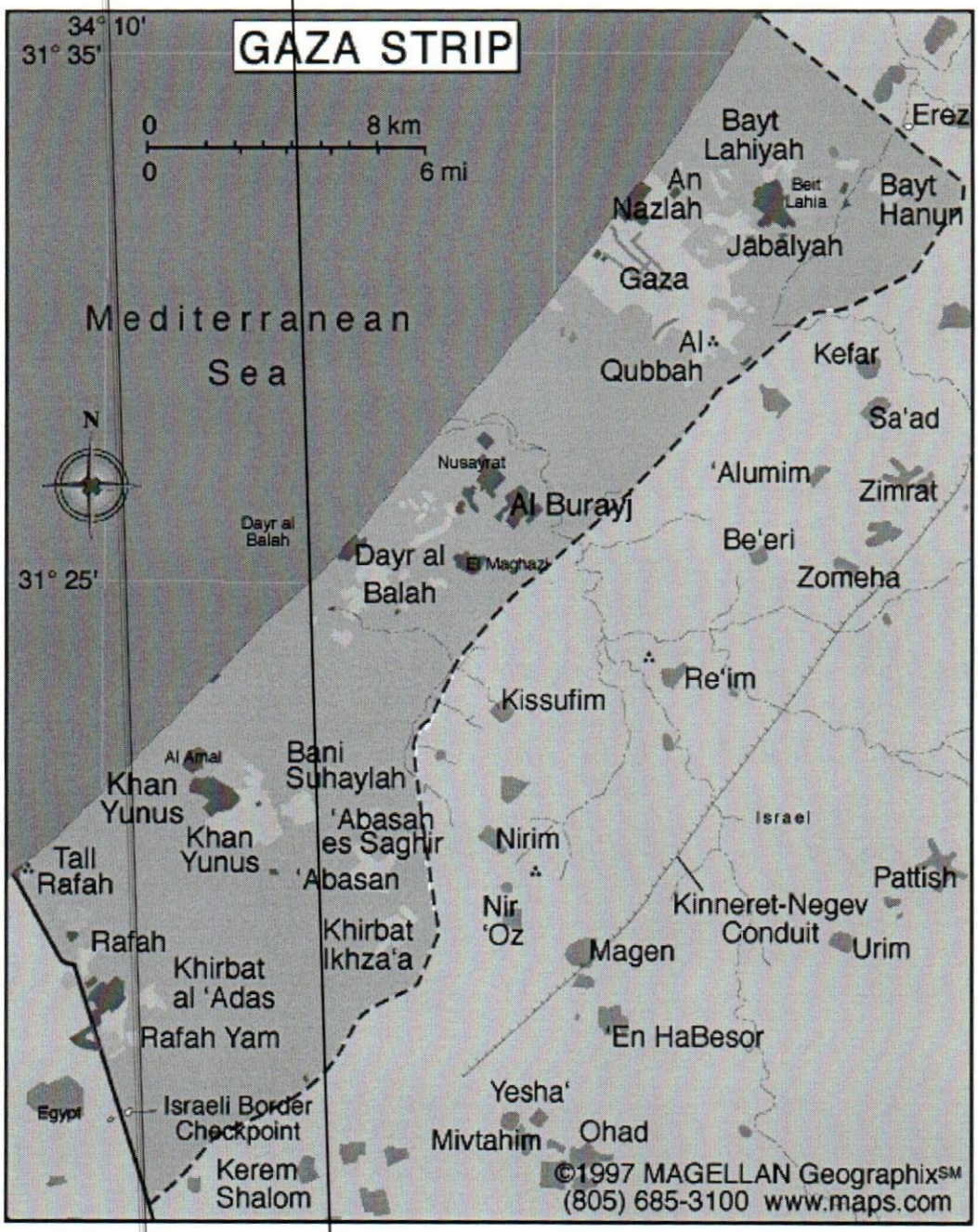
Annex 1 (Map of palestine, MoH, 2000)



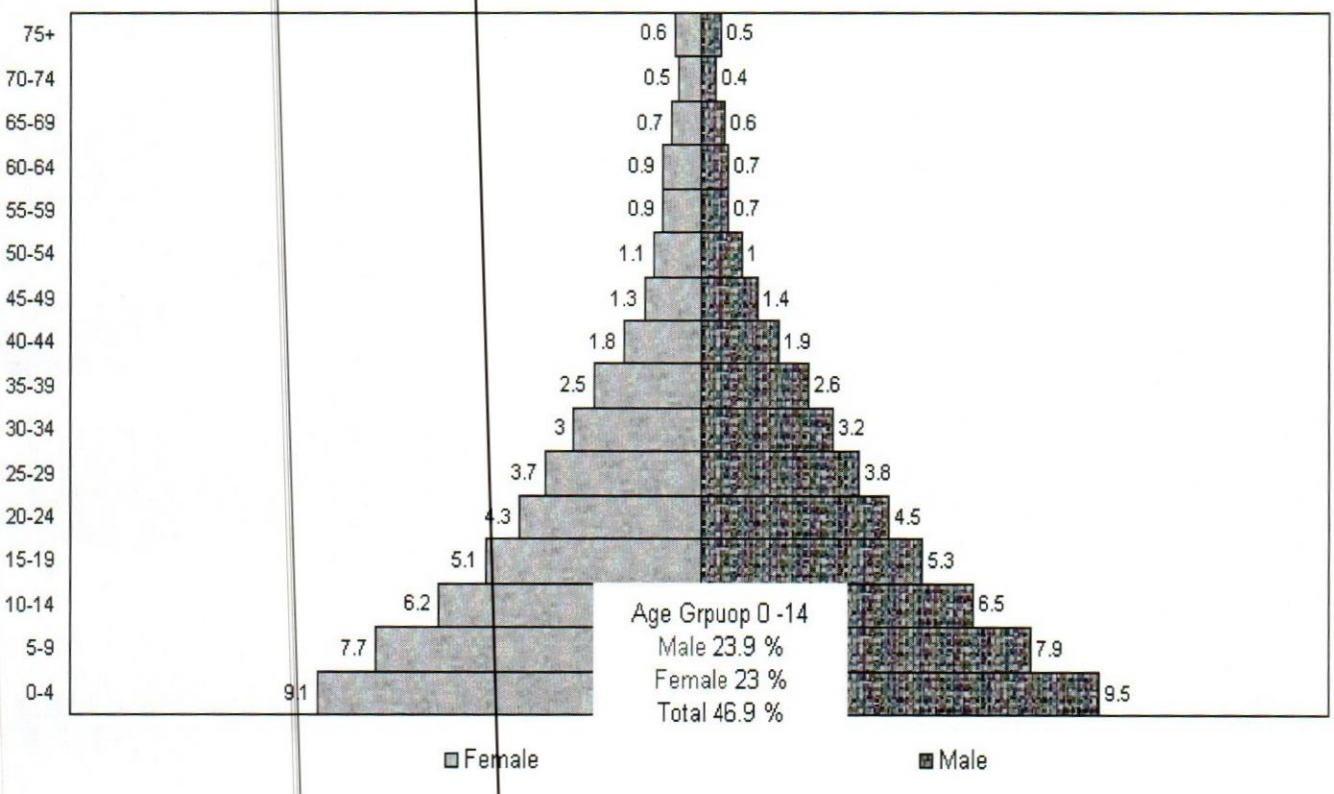
(MoH, 2000)

Annex 2 Map of Gaza Strip (MoH, 2000)



(MoH, 2000)

Annex 3 Population Pyramid-Gaza Provinces 1999 (MOH, 2000)



(MoH, 2000)

Annex 4

Structured Interview questionnaire

Serial No..... date.....

Clinic ..... Interviewer.....

Do you receive family planning services?

1- Yes 2- No

Personal information:

!- How old are you?

1- Less than 20 years 2- From 20 – 24 years.

3- From 25 – 29 years 4- From 30 – 34 years

5- More than 35 years.

2- How many years has you studied?

1- Less than 6 years 2- From 6 – 9 years.

3- From 10 – 12 years 4- From 13 – 16 years.

5- First university degree or above

3- How many years your husband studied?

1- Less than 6 years 2- From 6 – 9 years.

3- From 10 – 12 years 4- From 13 – 16 years.

5- First university degree or above

4- Do you have work out side home?

1- Yes 2- No

5- What is yours husband's work?

6- Site of residence?

1- City 2- Village

3- Camp 4- Other

7- Type of dwelling?

1- Concrete 2- Aspastose

3-Others.....

8- Number of rooms without the kitchen and bath?.....

9- Number of children?.....

10- Number of household?.....

11- Average monthly income?.....

Delivery information:

12- Age at marriage .....years.

13- Age at first pregnancy.....years.

14- Age at first delivery.....years.

15- Total number of pregnancies.....years.

16- Number of delivered living children....., dead.....

17- Number of miscarriage.....

Birth spacing and family planning information:

18- did you use family planning method previously?

1- Yes 2- No

If no go to question No. 23.

19- Age at first time of using family planning method.....years.

20- Number of children when you used family planning for the first time,

male....., female....., total.....

21- Who are decide to use family planning?

1- Husband..... 2- Wife.....

3- Both..... 4- Others, specify.....

22- What are the factors encouraged you to practice family planning?

1- Birth spacing 2- Regulating pregnancies and deliveries

3- Economic and financial difficulties 4- Restore my health

5-others, specify.....

23- What are the factors discouraged you to practice family planning methods?

1- Religious factors 2- Needs more children

3-Social security 4- husband and family objection

5- High expensive 6- Lack of knowledge

7- Side effects 8- Others, specify.....

24- Do you complain from chronic diseases?

1- Yes 2- No

25- If yes , which diseases .....

26- Do you have desire to complete your study?

1- Yes 2- No

27- If yes? Do you have enough time for that?

1- Yes 2- No

28- If no ? why?.....

29- what is the effect of contraceptive methods on your sexual relationship, and your role as a wife?

Positive effect.....

Negative effect.....

30 – How many hours you spend for ?

1- Teaching children..... hours

2- Talking with children..... hours

3- Living services.....hours.

31- Do you have enough time to work out side home?

1- Yes 2- No

32- Do you have enough time to participate in health promotion sessions?

1- yes 2- No

33- Do you have enough time to participate in social activities?

1- Yes 2- No

34 – Do you have enough time for entertainment as reading and watching TV.?

1- Yes 2- No

35- During your practicing contraception methods, was their positive effect on your social and economical life?

1- Yes 2- No

If yes ? what are the positive effects?.....

If no ? why ?.....

Annex 5 (Informed Concent)

الرقم المسلسل :---------

طلب موافقة

أخي العزيز / أختي العزيزة

أرجـــو التكرم بالإجابة على أسئلة الاستبيان الذي تم إعداده لجمع المعلومات اللازمة لتقويم خدمات تنظيم الأسرة في مراكز الرعاية الأولية الحكومية بقطاع غزة .

يـــتم هـــذا البحـــث بالتنسيق مع وزارة الصحة وجامعة القدس ، وذلك كمتطلب تخرج لإنهاء درجة الماجستير في صحة الأم والطفل .

إن تعاونكم وموافقتكم على المشاركة والإجابة على أسئلة الاستبيان سيكون له أهمية بالغة لإنجاز هذا البحث، وكذلك للارتقاء بخدمات تنظيم الأسرة في مراكز الرعاية الأولية الحكومية .

كما أن المعلومات الخاصة بكم وبنتائج البحث ستكون في سرية تامة ولكم مطلق الحرية في المشاركة أو عدم المشاركة دون أن يكون هناك أي ضرر يلحق بكم في حال عدم المشاركة أو أي عائد مادي للمشاركة .

شاكرين تعاونكم

الباحثة : حسن جودة

.....

الرقم الرمزي :--------

إقرار شهادة

أشهد بأنني سأشارك في الإجابة على أسئلة هذا الاستبيان بمحض إرادتي بعد أن علمت بأن المعلومات ستكون سرية وأنه لن يلحق بي أي ضرر ناتج عن إجراء هذا البحث.

توقيع المشارك/ة : --------

بسم الله الرحمن الرحيم

التاريخ: 2001/9/3

السيد / مدير عام وزارة الصحة

د. عماد طراوية المحترم

تحية طيبة وبعد

Annex 6 (approval of MoH Director General)

بسم الله الرحمن الرحيم

التاريخ: 2001/9/3

السيد / مدير عام وزارة الصحة

د. عماد طراوية المحترم

تحية طيبة وبعد

الموضوع / الموافقة على إجراء بحث حول مدى تأثير خدمات تنظيم الأسرة على الحياة المعيشية للأم في قطاع غزة.

ضمن مشروع دراستي في كلية الصحة العامة بجامعة القدس للحصول على درجة الماجستير في تمريض الأمومة والطفولة أنوي القيام بدراسة حول خدمات تنظيم الأسرة بمراكز الرعاية الأولية الحكومية (عيادة رفح المركزية + مركز شهداء الرمال غزة).

The impact of family planning on woman's quality of life.

ستشمل الدراسة زيارات للمراكز المختارة وتعبئة استبيانات خلال الزيارة مع المنتفعات من الخدمة.

يرجى التكرم بالموافقة نحو ذلك واجراء توجيهاتكم اللازمة

وزارة الصحة
مكتب الوزير العام
الصادر ٢٨٠٢
التاريخ ٢٠٠١-٩-٤

الباحث

حسن جودة

وزارة الصحة
مكتب الوزير العام
الوارد ٢٠٠٢
التاريخ ٢٠٠١/٩/٤