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Deanship of Graduate Studies
Al-Quds University

Knowledge, Attitudes and Practices regarding Family Planning among Palestinian couples in Gaza-Strip, Palestine

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M.P.H Thesis

Jeruselem- Palestine

April - 2006

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A thesis Submitted in Partial fulfillment of requirements for the degree of Master of Public Health
Al-Quds Univesity

April 2006

Al-Quds University
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Thesis Approval

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Jerusalem- Palestine

April / 2006

Dedication

To those people who have never stopped believing in me…
Those who are always supporting me…
I dedicated this work to

My mother
My husband
My son and daughters

Those who gave me every opportunity of success

Ghada Abou Nahla

Declaration

I certify that all this thesis submitted for the degree of Master is 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 other university or institution.

Signed

Ghada Yousef Abu Nahla

Date: April -2006

Acknowledgement

I would like to express my gratitude to people who assisted me during my research, without their support this work would not have been done:

Dr. Yehia Abed, Associated Professor, Al Quds University, my academic supervisor, for his continuous support, unbelievable tolerance and approach in dealing with this topic, useful guidance, and help.

Dr. Ayoub El Alem, Chief Field Health Program of UNRWA, for his encouragement, assistance, facilitation and support to conduct the study, his support is highly appreciated.

Dr. Amna Shurbasi, Deputy Chief Field Health Program of UNRWA, for her endless support, help, facilitation and assistance, her support is highly appreciated.

Dr. Suzanne Shasha'a, the assistant dean of the school of public health, for her continuous support and encouragement.

Dr. Bassam Abu Hamad, for his useful suggestions and support.

My thanks expanded to all those who provided helpful suggestions and useful recommendations during the preparation of research instrument especially, Dr. Yousef Mousa, Dr. Ali El Jeesh and Dr. Jameel Fannona

I wish to extend my thanks to the school of Public Health staff and personnel, especially Mr. Shaban Mortaja, for his support, Miss Suzan Abed, Miss Labiqa El- Wally and Mr. Sadi Awwad for their generous kind and assistance.

My thanks go to data collection team for their commitment and to the Palestinian women and men for their co-operation, and participation in this study.

Abstract

The importance of family planning in promoting maternal and child health is widely recognized all over the world. Family planning has the potential to be a part of economic development process. The aim of the study is to assess Knowledge, Attitude *and Practice towards family planning among Palestinian women and their husbands in Gaza Strip and to identify factors affecting them in order to provide information about susceptible actions.*

A community based cross sectional study was conducted among women in reproductive age from 15 to 49 years old and their husbands who lived in Gaza Strip districts. In order to ensure that the sample was geographically representative, A proportional stratified multistage and clustering sampling was used, and a random sample was selected. Sums of 380 interviewed women and 352 respondent husbands, with response rate equals to 95% among women 88% among their husbands.

Knowledge of family planning among participated women was high. About 75% of women participated in the study had a knowledge of family planning, while about 64% of interviewed men did have this knowledge. Participants were aware of most family planning methods, but lacked in-depth knowledge. There was high percentage of approval of family planning among Palestinian women as about 90% of women approved the use of family planning compared to 72% of men approved the use of family planning, The percentage of women currently using family planning was about 35%, while the percentage of women who had ever used family planning was 66.5%. Intra uterine device was the most prevalent method followed by pills. This study revealed the importance of men in family decision as results indicated that husbands have the main role in decision of family size and the final decision in using family planning. There was a statistical significant positive relationship between women educational level, marital age and women knowledge, practice and attitudes towards FP. Families who are financially below poverty line are practicing FP less than those above poverty line; they were also like to have more children than those above poverty line. Child mortality was more among women who have large family size, short birth interval and young marital age.

A good FP program must work in the context of changing social environment that encourages couples to have fewer children and discourages them from having large families. Empowering women is an important aspect to be discussed when talking about family planning practice. Male involvement in family planning program is essential. Design effective information, education and communication strategies to reach men, will encourage them to actively participate and allow their wives to use contraceptives. All these factors are important besides the fact that the quality of care is the most critical factor which will enable the primary health care/family planning programs to attract more clients and improve the reproductive health among Gaza Strip population.

ملخص الدراسة

إن تنظيم الأسرة وأهميته في تطوير و رقى صحة الأم والطفل متعارف عليه في العالم أجمع. ويلعب تنظيم الأسرة دورا هاما في عملية التطوير الاقتصادية.

الهدف من هذه الدراسة هو تقييم معرفة واعتقادات وممارسة النساء الفلسطينيات وأزواجهم لتنظيم الأسرة في قطاع غزة، والتعرف على العوامل التي تؤثر عليها، وذلك حتى نتمكن من تزويد المعلومات الكافية التي تمكن من اتخاذ الإجراءات اللازمة.

إن هذه الدراسة هي دراسة وصفية تحليلية قطعية على السيدات في المرحلة الإنجابية اللواتي تتراوح أعمارهم من 15–49سنة، وأزواجهم الذين يعيشون في محافظات قطاع غزة.

تم اختيار طريقة العينة بحيث تكون ممثلة لجميع فئات وشرائح المجتمع الفلسطيني والتوزيع الديموغرافى في قطاع غزة لذلك تم اعتماد الطريقة الطبقية النسبية المتكررة والعنقودية لاختيار أفراد الدراسة. تم تحديد عينة الدراسة لتكون 400إمرأة وزوجها.ولقد تم مقابلة 380إمرأة منها 352من أزواجهم حيث كان معدل الاستجابة بين النساء 95%و88% بين أزواجهن.

لقد كان معرفة نسبة النساء المشاركات في الدراسة لوسائل تنظيم الأسرة عالية حيث أنه حوالي 75%منهن كن على معرفة بوسائل تنظيم الأسرة وحوالي 64% فقط من الرجال المشاركين كانوا على معرفة بوسائل تنظيم الأسرة

لقد أظهرت الدراسة أن النساء المشاركات في الدراسة كان لديهم الوعي تجاه وسائل تنظيم الأسرة ولكن كان تنقصهن المعرفة العميقة لهذه الوسائل. وقد أظهرت الدراسة أيضا أن نسبة المؤيدين لتنظيم الأسرة سواء من السيدات أم أزواجهم كانت مرتفعة حيث أن 95% من النساء كن يؤيدن تنظيم الأسرة مقارنة ب72%فقط من الرجال. نسبة النساء اللواتي يستعملن وسائل تنظيم الأسرة في خلال فترة الدراسة كانت 35%، ولكن نسبة النساء اللواتي استعملن من وسائل تنظيم الأسرة خلال حياتهم الإنجابية كانت 66.5%.

ولقد أظهرت الدراسة أيضا أن أكثر وسيلة من وسائل تنظيم الأسرة انتشارا بين السيدات هي اللولب يليها حبوب تنظيم الأسرة.

لقد أظهرت الدراسة أهمية الرجل في اتخاذ القرار في العائلة حيث أن النتائج أشارت إلى أن الزوج له الدور الأساسي في اتخاذ القرار النهائي بالنسبة لحجم الأسرة وتحديد عدد الأطفال في الأسرة وأيضا لإتحاد القرار في استعمال وسيلة تنظيم الأسرة أم لا.

ولقد كان هناك علاقة ذو دلالة إحصائية موجبة بين مستوى التعليم للمرأة وسن الزواج على معرفة المرأة واعتقاداتها وممارستها لتنظيم الأسرة وأيضا على دورها في اتخاذ القرارات الخاصة في حياة الأسرة وزيادة إمكانية المشاركة والتحدث بين الأزواج عن الأسرة.
أظهرت الدراسة أن الأسر التي تعيش تحت خط الفقر يمارسون تنظيم الأسرة أقل من هؤلاء الذين يعيشون فوق خط الفقر، حيث أن الأسرة الفقيرة كانوا يفضلون أن ينجبوا أطفالا أكثر من الأسرة الغير فقيرة. من نتائج هذه الدراسة أيضا أن نسبة الوفيات بين الأطفال الذين يعيشون في أسر كبيرة الحجم، أو الذين كانت الفترات بين الولادة قصيرة أو لأمهات تزوجوا في سن مبكرة كانت أكثر.

لذلك فإن برنامج تنظيم الأسرة الجيد يجب أن يعمل على تغيير السلوك والبيئة الاجتماعية وليس فقط على الجانب الطبي حيث تم تشجيع وتحفيز الأزواج ليكون لديهم أطفال أقل وأسر أقل حجما.
تطوير المرأة وتفعيل دورها في المجتمع حيث أن المرأة المتعلمة والمثقفة والعاملة لن يكون دورها الوحيد في المجتمع هو الحمل والإنجاب فقط بل سيكون لديها القدرة على العمل والإنتاج.
إشراك الرجل في برامج تنظيم الأسرة، وعدم اقتصار برامج تنظيم الأسرة للسيدات فقط له دور كبير حيث تصل المعلومة الصحية للرجل الذي له الدور الأساسي في تحديد حجم الأسرة.كل هذه العوامل مهمة بالإضافة إلى حقيقة تواجد رعاية جيدة لخدمات تنظيم الأسرة ذو جودة عالية حيث أن هذا هو العامل الأساسي الذي يمكن الرعاية الصحية الأولية وبرامج تنظيم الأسرة لجذب عدد أكبر من المنتفعين وبالتالي تحسين الصحة الإنجابية في قطاع غزة.

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Definitions of terms

Age Specific Fertility Rate: One of the most precise ways of measuring fertility. It is calculated by the number of births occurring annually per 1,000 women of specific age (usually given in 5-years age group) (Weeks, 2003).

Antenatal Care (4+ visits): Percentage of women who receive four or more antenatal care visits during pregnancy (United States Census Bureau, 2003).

Attitude: In the context of maximum cultural development denotes a state of mind, mood, viewpoint, outlook, or belief. Attitudes are primarily shaped by information. A person then can have faulty attitudes based on misinformation (Wikipedia, the free encyclopedia, 2006).

Contraceptive Prevalence Rate, Modern Methods: Percentage of all women ages 15-49 currently using a modern method of contraception. Modern methods include oral contraceptives, IUDs, injectables, female and male sterilization, all emergency contraception, and barrier methods (National Population Council, 1996).

Contraceptive Prevalence: It is the percentage of women of reproductive age (15-49) who are using a method of contraception (Weeks, 2003).

Crude Birth Rate: It is the number of live births in a year divided by the midyear population. It is usually multiplied by 1,000 (Weeks, 2003).

Crude Death Rate: It is the total number of deaths in a year divided by the average total population. It is usually multiplied by 1,000 (Weeks, 2003).

Crude Death Rate: The number of deaths per thousand of the population. The product of the number of deaths divided by the midpoint population, multiplied by 1,000 (National Population Council, 1996).

Family Planning: "It is 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 planning" (WHO, 1994).

Fertility: refers to the number of children born to women. It is composed of two parts; one biological and one social. The biological component refers to the physical ability to reproduce. The social component refers to opportunities and motivations for childbearing (Weeks, 2003).

Infant Mortality Rate: The estimated annual number of deaths of infants under 12 months in a given year per 1,000 live births in that same year (United States Census Bureau (BUCEN), 2004).

Knowledge: is information of which someone is aware. *Knowledge* is also used to mean the confident understanding of a subject, potentially with the ability to use it for a specific purpose (Wikipedia, the free encyclopedia, 2006).

Maternal Mortality Ratio: It is the death of woman while pregnant or within 42 days of termination of pregnancy, irrespective to the duration or place of pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes (Hill, Abou Zahr and Wardlaw, 2004).

Population Growth Rate: The average annual growth rate is the rate of natural increase in a population plus the net migration rate. The rate of natural increase is the difference between the birth rate and the death rate, but it is conventionally measured in percentage terms (per hundred rather than per thousand) (United States Census Bureau, 2004).

Practice: the process of carrying out an idea, plan, or theory especially one that has developed through experience and knowledge (Encarta, World English Dictionary, 2005).

Total Fertility Rate: The number of children a woman between ages 15-49 would have during her reproductive life, if, for all of her childbearing years she were to experience the age-specific birth rates for that given year (United States Census Bureau, 2004).

Abbreviations:

Epi-info	Epidemiological Information
FP	Family Planning
GNP	Gross National Product
GOI	Governmental of Israel
GS	Gaza Strip
ICPD	International Conference for Population and Development
IUD	Intra Uterine Device
MCH	Maternal and Child Health
MMWR	Morbidity and Mortality Weekly Report
MOH	Ministry Of Health
NGOs	Non Governmental Organizations
NIS	New Israeli Sheqal
PCBS	Palestinian Central Bureau of Statistics
PHC	Primary Health Care
PNA	Palestinian National Authority
SD	Standard Deviation
SPSS	Statistical package of Social Sciences
STDs	Sexual Transmitted Diseases
TFR	Total Fertility Rate
UN	United Nation
UNFPA	United Nation Fund for Population Activities
UNRWA	United Nations Relief and Work Agencies

Chapter 1

Introduction

The role of family planning in promoting maternal health and improving child survival has been proved through studies all over the world. Family planning has the potential to save lives and reduce morbidity by enabling women to plan their pregnancies at the right age and time and to have the desired family size with minimal risks.

The fertility rate in Palestine is high compared to those dominant in other countries, which may be explained by early marriage especially among females, the desire to have many children, and the prevailing traditions of the Palestinian society. This high fertility leads to high dependency rate, and also leads to high growth rate (MOH, 2004).

Limiting fertility is the best way to slow down the population growth, but it is also the most complex, because it must act through two approaches, biological and social ones. Most national policies have been aimed only at the biological aspect, enhancing the ability of couples to control their fertility. That is why family planning programs not always work or succeed to decline fertility, so a decline in fertility is as dependent on motivation as it on technology, the UN noted that "the important lesson to be learned from Japanese experience is that the desire for fewer children spreads quickly if a strong motivation exists, but without this, FP programs are not likely to achieve their aims (United Nations, 1988). A good FP program must work in the context of a changing social environment that encourages couples to have fewer children and discourages them from having large families. Davis, 1992 stated that "The leaders of current policies escape the necessity of asking why women or men desire so many children and how this desire can be influenced".

Empowering Women is an important aspect to be discussed when talking about family planning practice. Change in the gender roles taught to boys and girls, giving equal treatment to the sexes in the educational and occupational spheres, have an important role in empowering women. If the woman's adulthood and femininity are expressed in other ways besides childbearing, then the pressures lessen to bear children as a means of forcing social recognition. Likewise, if a man's role is viewed as less domineering then the establishment of family may be less essential to him as a means of forcing social recognition (Davis, 1992). Any policy aimed at affecting motivation will have to alter the way people perceive the social world and how they deal with their environment on an everyday basis. It will have to involve a restructuring of power relationships within the family, a reordering of priorities with respect to gender roles, a reorganization of the economic structure to enhance the participation of women (Weeks, 2003).

Declining fertility is one of the demographic conditions that have helped increase the economic independence of women. When an advanced education, a prestigious career, and a good income were not generally available to women, then the lack of such things was not perceived as a cost of having children. But when those things are available, reducing them for the sake of raising a family may be perceived as a sacrifice. As fertility has gone down, more time has become available for women to pursue alternate life style, and as the alternatives grow in number and attractiveness, the costs of having children have gone up (Scanzoni, 1976). Scanzonis analysis that those women who are employed are more likely to have a modern gender role orientation than those not employed, and among the employed, job prestige and earnings are also related positively to gender role modernity. It seems apparent, therefore, that freedom from the traditional women's role leads to lower fertility (Scanzoni, 1976). One way in which lower fertility can promote socioeconomic

development is by reducing the proportion of dependent children in the population. A lower ratio of children to adults can create a "demographic bonus" with fewer children, families have more disposable income to save or invest. Furthermore, a smaller proportion of children mean that a greater percentage of the population is in the working age groups.

1.1 Demographic context

Gaza Strip comprises a narrow zone of land, located on the south of Palestine, constituting the coastal zone of Palestinian territory stretches along the Mediterranean Sea 50 kilometers long and 5 to 12 kilometers wide with a surface area about 362 square kilometers and attitude of 0-40 meters above sea level. Gaza Strip is divided into five provinces which are, North Gaza, Gaza, Mid-Zone, Khanyounis and Rafah. There are three different environmental areas urban, rural and camps; there are four towns, eight refugee camps and fourteen villages. Further the population density rate in Gaza Strip is considered to be one of the highest worldwide; it is estimated at 3,806 inhabitants per one square kilometer (PCBS, 1998).

The total number of population in Palestine was estimated at 3,637,529 in 2004 according to 1997 census (PCBS). In Gaza Strip, the population size is estimated at 1,337,236, about 36.8% of the total population in Palestine, and about 2,300,293 residing in West Bank which represents 63.2% of Palestinian population. About 19% of Gaza population resides in the north of Gaza, 36% in Gaza city, 14% in the central area and about 31% in the southern area. About 66.1% of the total number of population live in Gaza Strip are refugees (PCBS, 1998). By the end of 2004 the total number of Palestinian refugees registered with UNRWA was 4.2 million, 1.6 million (38.6%) were in the occupied Palestinian territory of GS and WB, while the remaining 2.6 million were registered in

Jordan, Lebanon and the Syria Arabic Republic. The refugee population living in GS are about 952,295, and about 682,657 in WB. In GS 49.2 of the refugees living in GS live in camps and the other 50.8% of them live outside camps in towns and villages. In WB 26.3% of the refugee live in camps and 73.7 live outside camps (UNRWA, 2004).

Regarding gender, female population is estimated at 49.4% of the whole population. The sex ratio was 102.6 males per 100 females (102.7 and 102.6). The percentage of population under 15 years old was 46.3%, 49.4% in GS and 44.4%in WB. The percentage of population above 65 years was 2% (GS 1.6and 2.2% in WB). The CBR was 28.6 (33.6 in GS and 25.6 in WB) per 1000 population. The median age of population was 16.7 years, 15.4 years in GS and 17.7 years in WB (MOH, 2005).

1.2 Socio-economic context

Palestine has been under-going the new experience of autonomy since the Palestinian Liberation Organization (PLO) and the Government of Israel signed the declaration of principles of peace in 1993. Due to many political and economic difficulties Alaqsa Intifada occurred in September 2000, Intifada witnessed a further steep decline in all Palestinian economic indicators. Gross National Income (GNI) 1 in 2002 mounted to 40 percent less than in 2000. With a 9 percent growth in the population of the West Bank and Gaza over two years from 2000 to 2002, real per capita incomes are now only half of their September 2000 level. Unemployment stands at 53 percent of the workforce (World Bank, 2003).

Overall GNI losses reached US$5.4 billion after 27 months of the Intifada. The opportunity cost of the crisis is now equivalent to one full year of Palestinian wealth creation.

The proximate cause of Palestinian economic crisis is closure by the Government of Israel (GOI). The closure affects the movement of Palestinian goods and people across borders and within the West Bank and Gaza. The restrictions take two major forms, internal restrictions reinforced by curfews, and external closure of the border between Israel and the Palestinian territories, including limitations on the entry of Palestinian workers.

In September 2000, an estimated 128,000 Palestinians worked in Israel and the Israeli settlements. With the outbreak of the Intifada, internal closures make it hard for many workers to move though the West Bank and Gaza to the designated workplace.

Despite violence, economic hardship and the daily frustrations of living under curfew and closure, lending and sharing are widespread and families for the most part remain functional. Even with high dependency ratio in Gaza and a dearth of formal safety nets, outright destitution is still limited; those who have income generally share it with those who do not. The West Bank and Gaza has absorbed levels of unemployment that would have torn the social fabric in many other societies.

Even though the rate of economic decline is slowing down, it would be a mistake to think that a stable equilibrium has been reached. The combination of political insecurity and closure continues to choke the economy, and each passing month makes ultimate recovery more difficult.

The economic crisis has seriously compromised household welfare. Many families have endured long periods without work or incomes, and despite the various employment generation efforts of the PA, donors and NGOs, many now depend on food aid for their daily survival. Coping with the situation has meant selling assets, borrowing from families, neighbors and shopkeepers and cutting consumption, including food.

Using a poverty line of US$2 per day, the World Bank estimated that 21 percent of the

Palestinian population were poor on the beginning of the Intifada, a number that increased to about 60 percent by December 2002. Accounting for population growth, the numbers of the poor have tripled, from 637,000 to just less than 2 million. The poor are also getting poorer. In 1998, the average daily consumption of a poor person was equivalent to US$1.47 per day. This has slipped to US$1.32. More than 75 percent of the populations of the Gaza Strip are now poor. The high rate of Palestinian population growth (4.35 percent per annum) is fuelling the growth in poverty.

The health status of the Palestinian population has deteriorated measurably. Real per capita food consumption has dropped by up to 30 percent since September 2000. A recent survey indicated that 13.3 percent of the population of Gaza suffer from acute malnutrition, similar to levels found in Zimbabwe 13 percent and Congo 13.9 percent (World Bank, 2003).

Teachers are reporting an increase in violent behavior at school, many adolescents see no sense in continuing their education, and drop-out rates in this age group have risen markedly during the Intifada although teenagers have a very limited chance of finding employment in the formal labor market. Many of these adolescents may find themselves locked into a life-long poverty trap, with poor prospects of escaping it even if the economy recovers. International research shows how devastating protracted unemployment can be in patriarchal societies, and how this can translate into domestic violence. A range of social and human rights organizations working at the household level in the West Bank and Gaza have noted an increase in violence against women as the crisis has lengthened. Declining health and educational standards are eroding the skills base of Palestinian youth (World Bank, 2003).

1.3 Health context

The Palestinian Health Authority represented by Ministry of health (MOH), United Nation Relief and Work Agency (UNRWA), Non Governmental Organizations (NGOs), and the Private sector were considered the four major health providers of health care services in Palestine. There are 77 hospitals, 22 hospitals in GS furnished with 1,989 beds, with population/hospital ratio is 60,783 and bed/population ratio is 14.8 beds/10,000 (a bed for 700 persons) , and 55 hospitals in WB furnished with 2,835 beds with population/hospital ratio is 41,824 and bed/population ratio is 12,32 beds/10,000 (a bed for 800 persons) . The total number of primary health care (PHC) centers in Palestine was 731, the average person per center was 4,976 (MOH, 2005).

UNRWA health services are focused on primary health care with very selective use of secondary and tertiary medical care services. According to UNRWA clinic records, refugee population who have access to UNRWA primary health care services both preventive and curative, were 77.6 percent of the total registered population of the total registered population (UNRWA, 2004).

1.4 Women health

The average of women at childbearing age from total population was 22.1%, and the maternal mortality ratio per 100,000 live births among women aged 15-49 years was 10.6, 20 in GS and 3.4 in WB. The total fertility rate in Palestine is still one of the highest rates; it was calculated at 4.19, 5.5 in GS and 3.7 in WB. The majority of deliveries took place in hospitals with percentage of 87.5%. The governmental hospitals have the highest contribution of the total deliveries with a percentage of 56.2% (MOH, 2005).

The number of visits paid per pregnant women for MCH- MOH was 6.3 visits in Gaza and 5 visits in WB (MOH, 2005). In UNRWA clinics the percentage of pregnant women who paid 4 visits or more to UNRWA maternal health services, was 92.6 per cent in GS, and 75.6 per cent in WB (UNRWA, 2004).

The total number of family planning clinics in the year 2004 is 45 clinics in GS and 183 in WB, 17 MOH clinics, 18 UNRWA clinics and 10 NGOs clinics. According to the Demographic and Health Survey conducted by the PCBS in 2004, the percentage of married women currently using family planning method was 47.9 % in the year 2004. The most popular method which has been used by new clients in Palestine was IUDs, followed by Pills (MOH, 2005).

1.5 Justification for the study

There has been important progress since 1994 towards the International conference of population development goal of universal access to reproductive health services. Greater attention has been given to reproductive rights in laws and policies. But millions of people, particularly the poor, still lack access to quality services, including modern family planning methods, emergency obstetric services, and prevention and management of sexual transmitted diseases (United Nations Population Fund, 2004).

Palestinian MOH works towards the improvement of health and quality of the women's life during all stages of their life span, so it takes into consideration the indicators of women's well being, like total fertility rate which is high when it is compared with other countries. The total fertility rate in Palestine by region was 4.7 in Gaza Strip and 3.4 in West Bank. Regional distribution of family planning visits shows that it increased in West Bank from 26,671 visits in 2002 to 29,665 visits in 2003, with an increasing percentage of 10%. In

Gaza Strip, it decreased from 46,725 visits in 2002 to 45,419 visits in 2003, with a decreasing percentage of 2.8% (MOH, 2004). Population density rate in Gaza Strip is considered to be one of the highest worldwide; it is estimated at 3,806 inhabitants per one square kilometer (PCBS, 1998).

Meeting the existing demand for family planning services would reduce pregnancies in developing countries by 20 per cent and maternal deaths and injuries by a similar degree or more (UNPF 2004). About 201 million couples do not have access to contraception and if they could practice family planning, 22 million abortions, 142,000 pregnancy-related deaths, and 1.4 million infant deaths each year could be prevented (Haub, 2004).

Family planning can improve health and quality of life; it can reduce the risk of mortality associated with child-birth. Death in childbirth is almost 20 times as likely for each birth in developing countries as in developed countries. Many successive pregnancies magnify this risk. Reducing fertility by half would also reduce this risk by about half. Effective use of contraception can also reduce maternal mortality by enabling women to delay first births until age 20 or later, space births at least two years apart, and reduce the number of unwanted pregnancies that might otherwise end in abortion (Ahmed, Rahman, and Ginneken, 1998).

Low fertility reduces the proportion of school-age children reduces the burden on schools. Reducing child dependency also allows families and nations to invest more in education, improving the quality of the future labor force.

Lower fertility can also reduce pressures on the environment and provide a grace period for dealing with other kinds of pressures, such as the needs for housing and employment, for public services such as health care, and for managing typically limited resources such as water (Achievement in public health, family planning, 1999).

Population size, growth and distribution are closely linked to prospects for economic and social development, by 1994, most developing countries saw a need to address population concerns in order to promote economic growth and improve people's well-being. No poor country can increase its standard of living and raise its per capita income while wrestling with the problems of trying to feed and care for a rapidly expanding population. Thus, poor and developing countries should invest in family planning programs as part of their economic development process (United Nations Population Fund, 2004).

Through their greater access to resources and power, men often determine the family size and access to health care, Reproductive health programs are increasingly being designed to counter the ways that gender inequality limits women's and sometimes men's access to health care (Malhotra,, and Mehra. 1999). The population field tended to focus almost exclusively on the fertility behavior of women, paying little attention to men's roles in its study of the macro dimensions and implications of population growth and fertility rates (Greene, and Biddlecom 2000). As a consequence, basic family planning programs served women almost exclusively, research has long shown that men want to know more about reproductive health and want to support their partners more actively, men's desire to limit their family size often makes it possible for women who want to use contraception to do so (Ezeh, Seroussi, and Raggers 1996).

All these factors can impose cost burdens, and impede opportunities for economic development, increase health risk for women and children, affect badly on the quality of life by reducing access to education, nutrition, and scarce resources. So such rapid population growth is leading social unrest and environmental degradation. Because all of these factors, Family planning context, knowledge, attitude and practice among women and also men are worthwhile to be investigated.

1.6 Objectives of the study

General objective:

To assess Knowledge, Attitudes and Practices towards family Planning among Palestinian women and their husbands.

Specific objectives:

1. To examine the relationship between maternal factors and family planning practice.
2. To highlight the relationship between cultural and socio demographic factors and family planning practice.
3. To compare between women and men in their knowledge, attitudes and practices towards family planning.
4. To explore the nature of gender roles in family life including family planning decision making.
5. To recommend strategies that aiming to increase awareness of people towards family planning.

Chapter 2

Literature review

2.1 Public health importance of family planning

A United Nations report says poverty perpetuates and is exacerbated by poor maternal health, gender discrimination, and lack of access to birth control. This holistic view has helped slow the increase in world population. The world's population is expected to grow by 39% over the next 45 years and births in the 50 poorest nations are estimated to rise by 228%. Education and improved health for women and access to contraception are vital. Smaller families are healthier families and improve the prospects of each generation. 201 million couples do not have access to contraception and if they could practice family planning, 22 million abortions, 142,000 pregnancy-related deaths, and 1.4 million infant deaths each year could be prevented. Since 1994 more women have access to education and other rights, and more early-marriage traditions are being opposed (UN, 2004).

MMWR, 1999 reported that, during the 20th century, the hallmark of family planning in the United States has been the ability to achieve desired birth spacing and family size. Fertility decreased as couples chose to have fewer children and so child mortality declined, people moved from farms to cities, and the age at marriage increased. Smaller families and longer birth intervals have contributed to the better health of infants, children, and women, and have improved the social and economic role of women. Despite high failure rates, traditional methods of fertility control contributed to the decline in family size. Modern contraception and reproductive health-care systems that became available later in the century further improved couples' ability to plan their families. Publicly supported family

planning services prevent an estimated 1.3 million unintended pregnancies annually. This report reviews the history of family planning during the past century; summarizes social, legal, and technologic developments and the impact of family planning services; and discusses the need to ensure continued technologic improvements and access to care. Family size declined between 1800 and 1900 from 7.0 to 3.5 children. In 1900, six to nine of every 1000 women died in childbirth, and one in five children died during the first 5 years of life. Distributing information and counseling patients about contraception and contraceptive devices was illegal under federal and state laws, the timing of ovulation, the length of the fertile period, and other reproductive facts were unknown (Achievement in public health, family planning, 1999). Family planning can improve health and quality of life; it can reduce the risk of mortality associated with child-birth. Death in childbirth is almost 20 times as likely for each birth in developing countries as in developed countries. Many successive pregnancies magnify this risk. At the total fertility rate in sub-Saharan Africa of about 6.0 children, the average woman has a 1 in 18 lifetime risk of dying in childbirth. Reducing fertility by half would also reduce this risk by about half. Effective use of contraception can also reduce maternal mortality by enabling women to delay first births until age 20 or later, space births at least two years apart, and reduce the number of unwanted pregnancies that might otherwise end in abortion (Ahmed, Rahman, and Ginneken, 1998).

Lower fertility also produces healthier children. Closely spaced children (less than two years apart), children with many siblings, and children born to younger and older mothers are all more common at higher levels of fertility, and all face higher mortality risks. For example, data show that children born less than two years apart are twice as likely to die in the first year of life as those born after an interval of at least two years. Furthermore,

closely spaced pregnancies are more likely to result in low-birth weight babies. Close spacing also interferes with breast-feeding, which has a vital role in child nutrition and in building the child's resistance against infectious disease. Family planning can help women achieve optimum spacing between births (Population Reference Bureau, 1997). Family planning Improves Life options for Women allowing women more control over their fertility can enhance their status and choices in settings where educational and economic opportunities are expanding. High levels of fertility generally mean that women become pregnant in their teen years. In some developing countries, this pattern of early pregnancy is associated with more than a quarter of female school dropouts, beginning as early as primary school. Furthermore, over their lifetimes, women in these countries may spend the equivalent of 6 continuous years being pregnant and 23 years caring for children younger than six years old (Population Reference Bureau, 1997).

Low fertility reduces the proportion of school-age children reduces the burden on schools. Reducing child dependency also allows families and nations to invest more in education, improving the quality of the future labor force.

The most important determinant of declining fertility in developing countries is contraceptive use, which explains 92% of the variation in fertility among 50 countries. Overall fertility declined by approximately one third from the 1960s through the 1980s, from an average of six to four children per woman, with dramatic decreases occurring in some parts of the world (e.g., 24% decline in fertility in Asia and Latin America, approximately 50% in Thailand, and approximately 35% in Colombia, Jamaica, and Mexico. As fertility declined in developing countries, Maternal deaths decreased and also the infant mortality rate decreased from approximately 150 deaths per 1000 live births in the 1950s to approximately 80 per 1000 in the early 1990 (Royston and Armstrong, 1992)

Despite advances in family planning, population growth remains a worldwide concern. In 1999, world population reached six billion, an increase of 4.4 billion births since year 1900. World population reached six billion, an increase of 4.4 billion births since 1900. In 1994, an international conference on population and development in Cairo focused international attention on the full scope of family planning that can be addressed during delivery of family planning services, including reproductive and primary-care concerns. For example, the introduction of cervical screening has led to a 20%-60% reduction in cervical cancer death rates. Screening programs for Chlamydia, the leading cause of preventable infertility, can lower the prevalence of Chlamydia and reduce complications such as pelvic inflammatory disease. The sexual transmitted diseases STDs prevention benefits of family planning may be enhanced by new female-controlled barrier methods such as vaginal micro biocides and the female condom (Achievement in public health, family planning, 1999).

Managed care is rapidly changing patterns of health-care delivery and creating new challenges for primary and reproductive health-care providers. Managed-care plans often offer more comprehensive coverage of such services than traditional insurance plans. In the late 1990s, legislatures in 19 states mandated partial or comprehensive insurance coverage for reversible methods of contraception. Access to high quality contraceptive services will continue to be an important factor in promoting healthy pregnancies and preventing unintended pregnancy in this country (Achievement in public health, family planning, 1999).

During the 20th century, restrictive policies and laws affecting family planning were largely replaced by legislative and funding support for family planning services by physicians and specialized reproductive health-care providers. Marshaling public support for efforts needed to reduce the high rate of unintended pregnancy and to provide the full

array of reproductive health-care services remains a challenge. Reported by: Division of Reproductive Health, National Center for Chronic Disease Prevention (Achievement in public health, family planning, 1999).

The UN calculates that developing countries can increase their economic growth by reducing population through lower fertility. In many East-Asian countries, lower fertility led to a lower dependency that fostered savings and investments for economic growth. The key factors are investments in health, education and gender equality. As fertility declines, the working-age adult population increases and with a lower dependency and investments in health and education, families were able to move out of poverty, which led to economic growth. Though countries have only one chance to take advantage of this effect, many developing countries have yet to reach that stage. Investments in health and education in developing countries take on more importance since their effect on economic growth may be larger than previously thought. For countries to take advantage of this, a better understanding of the effects of investments on economic growth is needed. Studies have established that higher education, awareness of reproductive health services and opening labor market opportunities, lead to lower fertility. Increased education for women does not always lead to greater participation in the labor market, thereby reducing fertility, but allows for more investment in their children in the form of more schooling and better health. This higher investment increases the cost of having an additional child and may lead to a fall in the demand for children (UN, 2003).

Reduced fertility has helped create favorable conditions for socioeconomic development in some countries. A prime example of this connection has been the so-called Asian Economic Miracle. From 1960 to 1990, the five fastest-growing economies in the world were in East Asia: South Korea, Singapore, Hong Kong, Taiwan, and Japan. Two other

Southeast Asian nations, Indonesia and Thailand, were not far behind. During this 30-year span, women in East Asia reduced their childbearing from an average of six children or more to two or fewer in the span of a single generation. Analysis of the experience of East Asian countries suggests that the reductions in fertility in the past decades relieved not only dependency burdens but also dependence on foreign capital by contributing to high saving rates.

One way in which lower fertility can promote socioeconomic development is by reducing the proportion of dependent children in the population. A lower ratio of children to adults can create a "demographic bonus". Furthermore, a smaller proportion of children mean that a greater percentage of the population is in the working age groups. If good jobs are available, this situation can contribute to economic growth (National Research Council, 1989).

2.2 The magnitude of the problem

2.2.1 Globally

The rate of growth in the world has declined since 1960, dropping from high of 2.0 percent to the current rate of approximately 1.5 percent. At present, it translates into 90 million more humans next year. During the next 12 months, approximately 140 million babies will be born in the world while 50 million of all ages will die, resulting in the net addition of 90 million people. Nearly all of this growth is concentrated in the developing nations of the world, where there are low levels of mortality but retain high levels of fertility, this rapid growth constantly hampers even the most important strategies for economic growth and development (Weeks, 2003).

World fertility is expected to decline and the world population will stabilize in 40 years. Over the last 50 years, the world has slowed population growth, raised life expectancy, lowered mortality and improved quality of life. The last century, had seen the total population more than triple, to 6.1 billion in 2000, growing annually at 1.2%, lower than the 2% in the late 1960s. The number of children per woman came down from 5 in the 1950s to less than 3 currently, and the annual increase of the population fell to 77 million in 2004 from 87 million in 1987. The increase has been falling since the 1980s and is expected to fall to 29 million by 2050, when there will be stabilization, attributed to lower fertility. When fertility decreases to the replacement level of 2, the birth rate and the death rate will be in harmony. There are 60 countries below that level, but population growth is not yet over and is expected to last 25 to 40 years. Six developing countries, India, China, Pakistan, Nigeria, Indonesia and Bangladesh account for half of the annual increments of the world population, with India making up 21%. South Asia and Africa are the two fastest-growing areas (Davis, 1992).

The first International Population Conference was held in 1974, followed by the second in Mexico City in 1984, and the third in Cairo in 1994. The attention and funding given to international family planning programs are credited with helping to bring a decrease in population growth in developing countries from about 2.4% per year in the 1960s to about 1.8% in the 1990s. Fertility rates have fallen in the developing world from 6.2 children per woman in 1950 to just below 3 in 1998. Nevertheless, while global population growth has slowed, it reached 6 billion in 1999 and is expected to rise to 8.9 billion by 2050, with most all of the growth occurring in developing nations. In 1960, 70% of the world's population lived in developing countries; today the level is 80%, and these countries now account for 95% of world-wide population growth (UNFPA, 2004).

Judithi, Helzer in his studies in family planning revealed that, The 1994 International Conference on Population and Development held in Cairo has generated widespread commitment to changing family planning programs from categorical and medically focused service organizations to reproductive health initiatives that embrace a wide range of social and human services. His article about the experience of nine family planning association projects in the Latin American and Caribbean region that have made a successful organizational transition from services focused on family planning to a gender-based and sexual health approach. Factors that can promote a pilot intervention's becoming fully institutionalized include: the need for commitment from high-level staff and members of the board of directors, the creation of partnerships with other agencies, and an emphasis on monitoring and evaluation (Helzner, 2002).

There are still some 123 million women around the world, mostly in developing countries, who are not using contraception in spite of an expressed desire to space or limit the numbers of their births (Ross and Winfrey 2002).

An estimated 38% of all pregnancies occurring around the world every year are unintended, and around 6 out of 10 such unplanned pregnancies result in an induced abortion (The Alan Guttmacher Institute, 2003).

The reasons why family planning needs are often not met are varied, but include: poor access to quality services, a limited choice of methods, and lack of information, concerns about safety or side-effects and partner disapproval.

World Health Organization is currently addressing some of these needs in working to help Department of Reproductive Health and Research.

More recently, groups supporting strategies to limit rapid population growth are supporting a broader agenda of initiatives that include the promotion of gender equality, increasing

adolescent education on sexuality and reproductive health, and ensuring the universal right of health care, including reproductive health. Although endorsed at the July 1999 UN meeting of 179 nations to assess progress of the Cairo population conference recommendations, the issues of child education and government responsibilities for ensuring access to safe abortions in countries where the practice is legal were particularly controversial. Some governments opposed the broadening of the Cairo mandate and some, including Argentina, Nicaragua, and the Vatican, filed reservations to the recommendations reached by consensus (UNFPA, 2004).

Haub, (2004) stated that " It took the US 200 years to go from 7 babies per family to two, and Iran has more than halved its fertility rate in a decade."

Huab also mentioned that, according to the United Nations report which says poverty perpetuates and is exacerbated by poor maternal health, gender discrimination, and lack of access to birth control. The average family has declined from six children in 1960 to around three today.

Haub stated that when people feel threatened by a hand-to-mouth existence, they are more likely to look towards less-than democratic ways to reduce population, especially if they have the foresight to realize that population growth is like a run-away train, very difficult to slow and stop (Haub, 2004).

A study of family planning conducted by John Caldwell and Pat Caldwell by Health Transition Centre, National Centre for Epidemiology and Population Health, they concluded that, Sub-Saharan Africa will be the family planning frontier of the twenty-first century. Fertility levels and population growth rates are still high, and family planning programs suited to the region are still being developed. Nevertheless, by the end of the twentieth century, fertility transition was under way in Southern Africa and a few countries

elsewhere. Successful regional family planning in the twenty-first century will depend upon stronger political leadership, assistance to the market, and recognition of the central importance of hormonal methods, especially injectables. Problems include stagnation in economic growth and in child mortality decline, as well as the persistence of the AIDS epidemic (Caldwell, and Caldwell, 2002). Gavin Jones and Richard Leete (2002) studied Asia's family planning programs, as low fertility is attained, and therefore the dramatic demographic changes in Asia during the three decades from 1970 to the end of the twentieth century were attributed to major changes in government population policies and programs. Fertility declines occurred in widely different economic, socio-cultural, and political settings. Over time, programs generally have moved to a simpler approach. As increasing numbers of countries reach replacement-level fertility, and as policies are formed against the background of the 1994 International Conference on Population and Development held in Cairo, the role of family planning programs is increasingly debated and questioned (Jones and Leete, 2002).

African Population Studies about The Role of Men in Family Planning conducted by Alfred Adewuyi and Peter Ogunjuylgbe, this study examines the role of men in family planning with particular emphasis on men's sexuality, knowledge and attitude to contraceptive use among the Yorubas, who are living in South Western Nigeria. The region is largely inhabited by the Yoruba speaking people; however, there are tribes from other parts of Nigeria and neighboring countries in the region. The Yorubas constitute more than 80% of the resident population in this region. The South western region is highly urbanized. It has the largest number of urban centers with 100,000 or more inhabitants. The crude birth rate of the region compares with the national rate of 45 live births per 1000 population while the total fertility rate is 5.7 live births per woman.

Data for the study were obtained from a survey conducted in three states of South Western region of Nigeria in 1998. The study shows, that men play important roles in decisions pertaining to reproductive matters among the Yorubas, the knowledge of contraceptive use is high among men in the areas, however, usage is generally low. More than 90% of male population and 86.2% of female population had received formal education, where about 80% of the respondents were Christians while only 18% professed to be Muslims. About 63% of men compared to just 35.7% of women would approve the use of family planning. At least 50% of women and 38.1% of men indicated that they had talked about family planning matters with their spouses on three or more occasions. About 36% of the respondents gave an indication that their spouses would not stop them from using family planning methods. The role of men's knowledge and practice in influencing contraceptive use were ascertained. It has been shown that men in this area have considerable knowledge of family planning. They also indicate considerable control over the decision making process. Education, attitude and children ever born are also found to be significant socioeconomic and demographic factors that influence husband's knowledge and use of contraceptive. The study shows that couple's communication was high and male dominance seems to have been institutionalized. Thus men strongly appear to control important decisions, including fertility and contraceptive use decision in the family (Adewuyi and Ogunjuyigbe, 2003).

The study has some policy implications. The first is the need for health education programs to bring to the consciousness of men the impact of small family size. The second policy implication brings about the need to design effective information, education and communication strategies to reach men in every part of the federation on the need to

actively participate and allow their wives to use contraceptives (Adewuyi and Ogunjuyigbe, 2003).

2.2.2 Regionally:

In the last decade, the Egyptian state in collaboration with international donor agencies has embarked on an ambitious population control program. According to this program, Egypt's rapid population growth is the prime obstacle to the development goals set by Egyptian authorities. Between 1980 and 1992, the program increased current contraceptive use among couples, from 24 percent to 47 percent. At the same time, it reduced the total fertility rate from above five to 3.9 percent (National Population Council, 1992).

A study of “Modernization and Family Planning Programs in Egypt” by Ali Kamran, (1997), revealed that association of reproduction and fertility with femaleness, perpetuates a private/public dichotomy and splits social analysis into female/male spheres. Such characterizations continue despite the expanded participation of women in the labor force and advances in female education that have changed the organization of the household and redefined female space and boundaries (Kamran, 1997). Historically, the Egyptian Family Planning Program has concentrated on women as recipients of its services. Specific surveys of women assessed the total fertility rate, the contraceptive prevalence rate, the age at marriage, the social status of women, and knowledge, attitude and practice of fertility control. This information helped policy planners assist women to make "independent choices" on the available contraceptive methods. The relative invisibility of men in the debates on fertility control and contraceptive methods was perpetuated by this focus on women (Watkins, 1993).

The study conducted by Ali Kamran found that to promote the acceptance and use of contraceptive methods by women, internationally sponsored family planning programs have begun to focus on male partners. To enhance male involvement in family planning decisions in Egypt by the state and international development agencies continues historical efforts to "modernize" the Egyptian poor. Thus, the family planning program is linked to constructions of gender, domestic life and the emergence of a responsible citizenry in Egypt (Kamran, 1997). Kamran took about male involvement in family planning in Egypt, mentioned that attention in international family planning circles to how different cultures organize fertility decisions has induced planners to study male views on fertility control. Surveys conducted in developing countries have helped to explain male behavior in fertility regulation and to identify trends affecting future family planning policies. International family planning efforts have successfully integrated male methods, such as condoms and vasectomy, into their various programs. In Egypt, however, user rates for these methods are extremely low. This failure is explained partly by evoking traditional culture, patriarchal norms, and native notions of maleness. Planners have attempted to overcome the perceived resistance to family planning through a concerted media campaign to educate men on the importance of family planning (Kamran, 1997).

In 1991, Macro International and the Cairo Demographic Center conducted a survey funded by USAID of male attitudes and behaviors in Upper Egypt and Cairo with respect to family planning, Egyptian Male Survey, the rationale for the survey was that available data from the 1988 Egyptian Demographic and Health Survey indicated that the percentage of currently married women who had ever used contraception in rural Upper Egypt was almost half (26 percent) that of rural Lower Egypt (58 percent). Similarly, the current contraceptive use among women was three times higher in rural Lower Egypt (36 percent)

compared to rural Upper Egypt (12 percent). The 1988 survey also showed that a higher percentage of women in rural Upper Egypt believed that their husbands disapproved of family planning. The survey was based on the premise that the low current use in Upper Egypt was due to the persistence of traditional norms and the dominance of Upper Egyptian males in decision making within the household. The 1991 survey was set up as a comparison of the knowledge, practice and attitude of men from Cairo, considered more modern, and those of the more traditional of Upper Egypt and especially rural Upper Egypt. The first report of the USAID survey showed that the percentage of men in Cairo who have ever used or are currently using modern contraceptives with their spouses (81 percent) was twice as high as that for men in rural Upper Egypt (44 percent). The survey reported that men in Upper Egypt were more likely than men in Cairo to cite fatalistic reasons (e.g., 'there is nothing one can do,' 'I accept what God gives me) for not intending to use contraceptives. These justifications for non-use of contraception fit, according to the survey, with a view of more traditional men in Upper Egypt (Sayed, El-Zanaty and Cross, 1991).

A higher percentage of Upper Egyptian men (47.3 percent) than in Cairo (40.3 percent) had discussed fertility issues their wives. Similarly, contrary to belief in family planning circles that Islam is a major hindrance to contraception, religion did not seem to stop the respondents from using family planning methods. In fact, rural Upper Egyptian men were less likely (8.9 percent) than men in Cairo (14.3 percent) to cite "religion as the main reason for not intending to use" contraception. Thus, the results challenged the predictions of the analysts. The survey found that the percentage of men in Upper Egypt who reported that using family planning methods for the first time was mainly their wife's idea was higher in Upper Egypt (39 percent, 43 percent in rural Upper Egypt) than in Cairo (31

percent). The survey analysts acknowledged that the results were "contrary to expectations," and undermined the conservatism thesis. They interpreted the findings in a way, however, that obscured this conclusion, asserting that the "wife's role was negatively related to the level of modernization" (Sayed, El-Zanaty and Cross, 1991). Finally, Kamran Ali in a study of modernization of family planning concluded that, as the Egyptian state and international agencies link future economic growth of Egypt to the population question, they combine high-pressure appeals for contraception with the deeper impact of socioeconomic coercion. Demographic transition may occur in Egypt. But it will be less for the classical reasons usually linked to better standards of living than to the majority of Egyptians' diminishing opportunities to make a living (Kamran ,1997).

In Jordan, although Jordan established its National Population Commission in 1973, family planning services only became available from the government in 1980. By 1997, the contraceptive prevalence rate was 53%. Jordan's current maternal mortality ratio is relatively low 44 deaths per 100,000 live births (Department of Statistics, 1998).

A study about the Reproductive health policies and programs in eight countries: progress since Cairo" one of them was Jordan, according to some respondents, service providers need continuing education and training in reproductive health and family planning, and some still need to be convinced of the benefits of family planning and reproductive health. A few respondents underscored the problem of the lack of female physicians, especially in rural areas, which prevents many women from seeking reproductive health services out of embarrassment over being examined by a man (Hardee, etal 1999).

A qualitative research with married men and women to understand Jordanians' attitudes and practices concerning family planning conducted by, the Jordan National Population Commission (JNPC), the findings of this research emphasize that while traditional values

on family size, family planning and birth spacing predominate, there is evidence that Jordanian attitudes and beliefs about contraceptive practice are changing. The research findings indicate recognition among most respondents that closely spaced births often result in health risks to mother and child and that broad economic changes have altered the costs of children. Many respondents believe that contraception is acceptable for economic as well as health reasons. This indicates a change in social norms from the older generation and, in turn, presages behavioral changes with significant demographic implications for the near future. Information, education, and communication programs can facilitate and support these normative and behavioral changes. Knowledge about family planning methods, participants were aware of most family planning methods, but lacked in-depth knowledge. Participants were more familiar with what they referred to as "natural" methods than with modern methods. Specific findings include: the oral pills, intrauterine device (IUD), condoms, vaginal tablets , and sterilization were recognized by most participants. Injectables and Norplant implants were mentioned by only a few participants (Farsoun, Khoury, and Underwood, 1996).

Two nationally representative surveys, one of 1000 married women aged 15-49 and the other of 1000 men married to women aged 15-49, and a census of all Muslim religious leaders in Jordan collected information on knowledge, attitudes and beliefs regarding family planning, and sources of information about it. The survey results show that 80% of men, 86% of women, 82% of male religious leaders and 98% of female religious leaders believe that family planning is in keeping with the tenets of Islam. Among religious leaders, 36% reported that they had preached about family planning in the year preceding the survey. In the general public 75% of women and 62% of men in the general public said that they had spoken about family planning with their spouse, and 9% and 17%,

respectively, reported having spoken with a religious leader. On a scale of 0-10 measuring agreement with statements regarding the benefits of family planning (with 10 being in complete agreement), women averaged 9.4 and men 8.8, while male religious leaders averaged 6.5 and female religious leaders 7.2. Among the general public, 74% of women and 58% of men said that deciding to practice contraception is a joint decision between husband and wife. About 90% of religious leaders agreed or agreed strongly with the statement that contraceptive decisions should be made jointly by husband and wife. Women were significantly more likely than men to believe that specific contraceptive methods are permitted under Islam, and male religious leaders were more likely than were men in the general population to find specific methods acceptable. Only 26% of men cited interpersonal communication as a source of family planning information, compared with 66% of women, 73% of male religious leaders and 89% of female religious leaders. Almost three-quarters of men and women said they want to know more about family planning. Although Islamic religious leaders in Jordan cite different reasons than the general public to justify the use of contraceptives, they are as likely as others in the population to approve of family planning (Underwood, 2000).

2.2.3 Locally:

In Palestine, the total number of Family Planning clinics has increased from 102 FP clinics in 1997 to 197 FP clinics in 2003 (44 in GS and 153 in WB). MOH is responsible for about 49.7% of total FP clinics in Palestine. The increase in number of Family planning clinics is accompanied with a significant increase in the use of contraceptive methods and the number of women who have been utilizing these services in Palestine over the last year. The current use rate of contraceptive methods is 51.4% of currently married women in

Palestine. It is higher in West Bank (54.3%) than in Gaza Strip (46.1%). The number of all beneficiaries visits (new and repeated visits) from FP services in MOH was 64,338 in 2000, 77,984 in 2001, 73,396 in 2002 and 75,084 in 2003. Regional distribution of family planning visits shows that it increased in West Bank from 26,671 visits in 2002 to 29,665 visits in 2003, with an increasing percentage of 10%. In Gaza Strip, it decreased from 46,725 visits in 2002 to 45,419 visits in 2003, with a decreasing percentage of 2.8%.

The number of new clients benefited from FP services in MOH was 12,559 and constitutes 16.7% of total beneficiaries.

In UNRWA, about 5,338 new clients in Gaza Strip benefited from FP services in 2003 which constitute about 5.7% of total visits (92,985 visits). There is one new client per 5-repeated clients in MOH and one new client per 16.4 repeated clients in UNRWA.

The most popular method which has used by new clients in Palestine was IUDs, followed by Pills. In governmental FP clinics, IUDs constituted about 34.8% (22.6% in GS and 41.6 in WB) then followed by Pills with percentage of 34.3% (32.9% in GS and 35.2% in WB), Male condoms with percentage of 21.7% (31.7% in GS and 16.2% in WB) out of total FP devices. IUDs was the first method used for FP in governmental clinics in West Bank, while Pills was the first method and IUDs the second method in Gaza Strip. In UNRWA clinics IUDs also was the second choice for new acceptors in Gaza Strip.

In Gaza Strip, in governmental FP clinics for each 100 new women benefited of inserting IUDs, only other 2 new women benefited by extracting it. Only 11 visits of women who had pregnancy on loop were reported, with a failure rate of 5 per 1000 women benefited from IUDs insertion. The number of women who received consultations was also increased significantly from 8,968 women in 2002 to 11,078 in 2003, with an increasing percentage of 23.5% (MOH, 2004).

Total fertility rate (TFR) in Palestine is high when it is compared with other countries. It was calculated to be 3.89 according to the data on number of women and live births. The TFR in Palestine by region was 4.7 in Gaza Strip and 3.4 in West Bank (MOH, 2004). TFR rate has been decreased progressively over the past 5year from 4.39 in the year 1999 to 4.34 in 2000 and decreased gradually to 3.89 in 2003. This indicates the great efforts which are possibly done in the domain of family planning and reproductive health in general. The fertility peak is among the age group of 25-29 years, then by increasing the age it steady decrease. Also, it shows that ASFR for all age groups in 2003 is less than that in 1999. This indicates that, there is a progressive improvement in controlling fertility rate in Palestine. However, the TFR and age specific fertility rate in Gaza Strip is higher than in West Bank, 4.7 in GS and 3.4 in WB (MOH, 2004).

Maternal Mortality Ratio is one of the most important indicators to determine the health status for women. Globally, most maternal deaths are the result of hemorrhage, complications of unsafe abortion, pregnancy-induced hypertension, sepsis and obstructed delivery. A number of factors have increased the risk of maternal mortality in refugee settings. During the exodus and emergency phase, pregnant women may become malnourished and anemic and they are at higher risk of infectious disease. They are exposed to physical and psychological violence. They are often alone and may have to give birth under hazardous conditions. In Palestine, although institutionalized deliveries are improved but many risk factors including unrest of the political situation and repeated curfews, frequent closures and separation of Palestinian areas are determinant factors that increase the risk of maternal mortality. Many pregnant women were imposed to deliver at Israeli Army chick points that exposed their life for danger due to unsafe delivery (MOH, 2004).

A study conducted by Dr. Haifa H. Madi Chief, Family Health UNRWA HQ, Amman, in the five fields of UNRWA's area of operations namely; Jordan, West Bank, Gaza, Lebanon and Syria. The findings were compared with the results of the baseline study conducted in 1995.

Among Palestinians served by UNRWA the overall prevalence of modern contraceptive use Agency-wide increased from 32.1% to 49.9% with the highest prevalence of 65.4% in Syria followed by Lebanon 64.7%, Jordan 48.7 %, the West Bank 41.9% and the lowest in Gaza 36.5%. Although Gaza Field is still having the lowest prevalence, nevertheless, a marked improvement has been attained as evidenced by the increase in the prevalence of modern contraceptive use from 23.7% in 1995 to 36.5% in 2000.

These results indicated that there was an increase in the percentage of women who are using family planning methods from 42.9% (32.1% modern + 10.8% natural) to 60.4% (49.9% modern + 10.8% natural) during the last five years.

The percentage of mothers who were lactating and not using any other method due to their belief that they are protected by lactation dropped from 25.9% in 1995 to 16.5% in 2000.

There has been a significant increase in the mean birth intervals in all UNRWA Fields from 29.8 months to 34.3 with an increase of almost 5 months.

Comparisons between the Fields in respect to birth intervals reveal that the proportion of women who have a birth interval of less than 12 months was almost the same in all Fields with the highest drop in Gaza from 5.5% in 1995 to 2.6% in 2000. While the proportion of women who have a birth interval more than 36 months was highest in Syria 42.7%.

The marital age ranged from 12 to 42 years in the follow-up study while it ranged from 10 to 40 years in the baseline study. There was an increase in the mean martial age Agency-wide from 19.2 years in the baseline study to 19.7 years. All Fields contributed to this

increase with the lowest mean marital age of 18.9 years in Gaza and the highest of 20.5 years in Syria (Madi, 2001).

Dr. Hmaid Abu Mousa, field preventive medical officer in UNRWA- Gaza conducted a prject about family planning knowledge, attitude and practices and focus group survey of Palestinian refugee community in 1994, he found that the fertility of Gaza population is very high. This is despite overwhelming support for the idea of family planning among refugee women with a third of the sampled population currently using contraceptive means and about half of the others indicating they intend to use contraception within the next 12 months. The factors leading to high fertility like Marriage at young age where 64.5% of women in the sample were married at age < 19 years old, the desire of family for a pregnancy immediately after marriage, child bearing at young age; 65% of women become pregnant at less than 20 years, short birth interval; 57.6% of women had birth intervals of less than 2 years, and the high parity rate; 26.2% of women had parity order > =7.

Data for women over 40 years indicate that complete families average 7.1 live children. Most of the interviewed women expressed preference for family size 5 children. Only 15.5 % of all interviewed women preferred 7 or more children (Abu mousa, 1994).

2.3 Methodology used in Family Planning studies

Different approaches were used by investigators to explore the status of the family planning programs and the factors affecting these programs. Alfred Adewuyl and Peter Ogunjuylgbe conducted a study to examine the role of men in family planning with particular emphasis on men's sexuality, knowledge and attitude to contraceptive use among the Yorubas who are living in South Western Nigeria witch is largely inhabited by the Yoruba speaking people. The data needed for this study were collected at the individual level. On the whole

1,396 respondents were interviewed. After data cleaning, they found only 1,168 of the returned questionnaires useful and these were made use of in the analysis. For the study to be truly representative of the towns, each of the study locations in the capital cities was divided into four strata: the traditional area, the migrant area, the mixed area (traditional and migrant) and the elite area. Within a stratum, five major streets were randomly selected from the listing of all major streets. They selected 50 houses among the five streets i.e. 10 houses from each street. The 10 houses in each street were systematically selected. From each house, a household was selected using lottery method. In each household, the husband and all the wives in the age group 15-49 were interviewed. In the rural areas, the selection of the 100 houses was by simple random sampling technique. However, the random selection was made in such a way that all the different parts of the locations were represented. A household was selected from each house also using lottery method. In each household, one currently married man aged 59 or younger and his wives were interviewed. Generally, the data collected were analyzed at three levels. The first level involved an examination of the distribution of the respondents according to each of the selected characteristics. Therefore, to know the structure of the population, data summarizing procedures such as frequency distributions and associated statistics were adopted. The second level involved the examination of the patterns of association between the dependent and independent variables (Adewuyi and Ogunjuyigbe, 2003).

Hoodfar, and Assadpour, study the politics of population policy in the Islamic Republic of Iran. This case study examines the different phases of population policy in Iran, especially after the 1979 revolution, based on informal interviews with officials, medical personnel, family planning clients, and religious leaders. It focuses on the formal and informal strategies adopted by political experts, the media, religious authorities, and the government

to bring about a reversal in policy toward family planning in what seemed to be an unfavorable environment (Hoodfar and Assadpour, 2000).

A study by Sidney Ruth Schuler, Lisa M. Bates and Md. Khairul Islam, used a combination of interviews and observations were to investigate how clients, communities, and program staff were adapting to a shift from door-to-door contraceptive distribution in Bangladesh to clinic-based delivery of a broader package of health services. To examine client and community reactions to the program changes, qualitative data were collected at three rural and two urban sites through in-depth semi structured individual interviews with clients, their husbands, other community members and service providers; group interviews; and observations in clinics and satellite clinics. The researchers use this information to examine responses to the new model of health care provision in the light of health-seeking strategies commonly used by the poor, and analyze continuing barriers to access and constraints to cost recovery, including gender and poverty (Schuler, Bates and Islam, 2001).

In a study about Knowledge and attitudes about reproductive health among fmily planning clients in Alexandria conducted by Ali Abdel Megeid, Sawsan El Sheikh, Mervat El Ginedy and Mohammed El Araby, a questionnaire was designed for data collection and it was developed in three main sections: HIV/AIDS-related issues (14 questions); reproductive health-related issues (5 questions); and family planning-related issues (8 questions). In addition, there were four questions about the main characteristics of the women interviewed. The sample size of this study was 4000 women drawn from all women who visited four Clinical Service Improvement centers in Alexandria over the three-month period from October to December 1994. Four teams were assigned to collect data during the three-month study period. Each team consisted of two members, most of

whom were social workers, and each was assigned to one of the centers. All teams received training and participated in the pre-testing of the questionnaire. The teams were supervised during the field work by the supervisor who had trained them. Descriptive analysis of the results of the study was carried out using dbase IV and Lotus 123. Analysis was based on three specific indicators reflecting the main characteristics of the population studied. These indicators were: age, education, and occupational status. Each of the indicators was cross-tabulated with data collected on different issues of HIV/AIDS, reproductive health, and family planning (Abdel Megeid, El Sheikh, El Ginedy, and El Araby, 1996).

The Jordan National Population Commission (JNPC) conducted a qualitative research with married men and women to understand Jordanians' attitudes and practices concerning family planning. In November and December 1995, 24 focus-group discussions were held in the central, northern, and southern regions. With encouragement from discussion leaders, participants expressed their concerns and introduced related issues during the discussions (Farsoun, Khoury and Underwood, 1996).

A study on Current Contraceptive practices among mothers of children 0-3 Years attending UNRWA MCH Clinics conducted by Dr. Haifa H. Madi Chief, Family Health UNRWA HQ, Amman, The study was conducted in the five Fields of UNRWA's area of operations namely; Jordan, West Bank, Gaza, Lebanon and Syria. The study population included mothers of registered children between 0-3 years of age, who came with their children for UNRWA's well-baby clinics during the study period. The total sample size was (5,565) mothers from UNRWA's five Fields of operation as follows: (954) in Jordan, (925) in the West Bank, (1660) in Gaza, (992) in Lebanon and (1034) mothers in Syria. The sample size was calculated according to the Field-specific prevalence rate of modern contraceptives as obtained from the baseline study, the number of registered children 0-3 years of age in each

Field with a confidence level of 95% and margins of error of 2% in Gaza and 3% in the other Fields. The sample can be considered as representative of the target population (mothers of children 0-3 years of age) because utilization of UNRWA's MCH services is high as evidenced by the complete immunization coverage against vaccine-preventable diseases which exceeded 99% among children registered at MCH clinics Agency-wide.

The study instruments comprised of the child health records which contain the basic data regarding mothers and children and a standard questionnaire completed through direct interviews with mothers (Madi, 2001).

2.4 Men involvement in Family Planning

In the past, family planning programs have focused attention primarily on women, because of the need to free women from excessive child bearing, and to reduce maternal and infant mortality through the use of modern methods of contraception. Most of the family-planning services were offered within maternal and child health (MCH) centers, most research and information campaigns focused on women. This focus on women has reinforced the belief that family planning is largely a woman's business, with the man playing a very peripheral role.

Involving men and obtaining their support and commitment to family planning is of crucial importance in the Africa region, given their elevated position in the African society. Most decisions that affect family life are made by men. Most decisions that affect political life are made by men. Men hold positions of leadership and influence from the family unit right through the national level (IPPF, 1984).

Male involvement in family planning means more than increasing the number of men using condoms and having vasectomies, male involvement also includes the number of men who

encourage and support their partner and their peers to use FP and who influence the policy environment to be more conducive to developing male-related programs. In this context "male involvement" should be understood in a much broader sense than male contraception, and should refer to all organizational activities aimed at men as a discrete group which have the objective of increasing the acceptability and prevalence of family-planning practice of either sex (Roudi and Ashford, 1996).

There are some examples of experience and initiatives in various forms which illustrate a genuine concern and creative approach toward achieving greater male involvement in family planning.

Programs to encourage men's involvement in family planning are expanding, especially through interventions to increase knowledge and interest of men, such as information, education, and communication campaigns using mass media, and interventions to increase access and use of FP services by men such as community-based distribution, condom sales and promotion, workplace programs, and a few male clinics and vasectomy services. Some of the field experiences have shown that well-targeted, focused male-involvement programs can have an impact on both male and female behaviors related to reproductive health (Kim, Marangwanda, Kols, 1996).

Only recently have family-planning associations recognized the importance of men's role and motivation in fertility decision making, particularly in Africa. Recently this issue has been recognized, the question is "what can family-planning and reproductive-health programs do to encourage men's cooperation?" (Hawkins, 1991, unpublished).

Some programs have developed campaigns aimed at increasing the awareness and knowledge of men. However, one of the crucial questions now facing these programs is how to move beyond increasing knowledge to changing attitudes and practice. How to

address the needs of men through different service-delivery strategies is also an important question (Hawkins, 1991, unpublished).

Various service-delivery strategies to meet those needs can be provided in a variety of ways, including primary health care facilities, special hours for men in MCH/FP clinics, male-only clinics, STDs clinics, integration of FP promotion in AIDS prevention programs, mobile units, organized groups, income generating schemes, employment-based programs, youth programs and peer counseling, male-to-male community-based distribution of condoms, social marketing, involvement of private agencies and medical practitioners. The husband's support is found to be a good predictor of future practice and continued use. There are studies done in the Philippines which indicate that the continuation rate among women whose husbands support their contraceptive practice is much higher than those whose husbands do not give support to their wives (IPPF, 1984).

In South Korea researchers found that 71 percent of women whose husbands approved family planning had used contraception at some time, compared with 23 percent of women whose husbands did not approve (Piotrow, Kincaid and Hindin, 1992). Wambui, 1995 mentioned that men's lack of access to services has been a barrier to family-planning use. Men cannot share responsibility for reproductive health and family planning if services and information do not reach them (Wambui, 1995).

Programs to encourage men's involvement in family planning are expanding, especially through interventions to increase knowledge and interest of men, such as information, education, and communication campaigns using mass media, and interventions to increase access and use of FP services by men such as community-based distribution, condom sales and promotion, workplace programs, and a few male clinics. Some of the field experiences have shown that well-targeted, focused male-involvement programs can have an impact on

both male and female behaviors related to reproductive health (Kim, Opia and Phyllis, 1992).

In September 1987, the Health Education Division of Ghana's Ministry of Health (MOH/HED) began a systematic family-planning project with funding from USAID. The goals of the first phase of the project were to increase knowledge of, and improve attitudes toward, family planning and promote contraceptive use among men and women of reproductive age, enhance family-planning counseling skills among MOH service providers, and strengthen the MOH's ability to develop, implement, monitor, and evaluate communication programs in health. The project used situational analysis, service provider training, and material development and mobilization for two campaigns in three regions before expanding the campaign to remaining areas. The project used a wide variety of material, media, and activities, including leaflets and booklets, motivational posters, national radio and television broadcasts, drama, a theme song, community audiovisual material, and community activities (Kim, Opia and Phyllis, 1992).

The second phase of the project highlighted male involvement in family planning. November 1991 study of the project found that almost all males surveyed in six regions had seen or heard at least one family planning campaign medium. In the Ashanti, Brong-Ahafo, and Central Regions where more intensive campaigns were run, more men were reached than in other regions. Findings indicate a significant increase in men's family planning knowledge and practice, and improvement in attitude with the increasing length of the project. Also, among those men exposed to the intensive campaign, 47 percent had discussed family planning with their partners, and 26 percent stated that they or their partners were using a more modern contraceptive method (Kim, Opia and Phyllis, 1992).

Men's lack of access to services has been a barrier to family-planning use. Men cannot share responsibility for reproductive health and family planning if services and information do not reach them. Most FP clinics cater to women, so men are uncomfortable about going to these clinics. Men must be reached in other ways (Salaway, 1994).

This testimony from a Kenyan man is a good illustration of that need: "After having three children, my wife went on the pill for her contraception because we could no longer afford an accident with the natural methods we were using. Her blood pressure immediately shot up, and she was advised to discontinue. She tried other methods, but they had complications too. I felt I was unfair and it was my duty, too, to take part in family planning. One morning we went together to our local family-planning clinic. I will never forget how embarrassed I felt. There was not even a single man there, just queues of women and their babies. This was a woman's world and I felt totally lost." (Wambui, 1995). This confirms the assumption that no matter how many men want to know about and utilize contraception, most family-planning programs have not yet given adequate attention to serving them.

2.5 Family Planning Intervention

Many strategies are implemented in different countries to enhance F.P program and to improve the reproductive health.

The government of Bangladesh is currently testing and implementing strategies to change its family planning program from a reliance on field-workers who conduct home visits to a conventional fixed-site delivery system. Researchers have made two suggestions: First, the program should encourage women to switch from non clinical methods delivered by family planning workers to more cost-effective clinical methods such as sterilization, and second,

field-workers should not be re-supplying non clinical methods, but should focus their attention on motivating nonusers to practice contraception. Longitudinal data from the Maternal and Child Health-Family Planning Extension Project of the International Centre for Diarrhoeal Disease Research, Bangladesh, are analyzed to show that a better strategy might be to target visits to women according to their educational level and area of residence. For uneducated women living far from clinics, access to contraceptives is likely to be a problem, and home visits for re-supply might have a larger impact on the contraceptive prevalence rate than would field-workers' visits to motivate nonusers.

Following new government and donor mandates, nongovernmental organizations in Bangladesh have changed their strategy for providing family planning and other basic health services. The new service delivery model relies on clinics and satellite clinics, and provides contraceptives through village depots instead of doorstep distribution. The new model expands the range of services and emphasizes quality (Schuler, Bates, and Islam, 2002).

The article by Attane provides a broad overview of China's family planning policy during the last three decades, highlighting key trends and goals of the program at national and provincial levels. It focuses on the administrative, economic, cultural, and other factors that have helped or hindered the family planning effort and reviews the impact of the program on the provincial population (Attane, 2002).

The dramatic demographic changes in Asia during the three decades from 1970 to the end of the twentieth century were matched by major changes in government population policies and programs. Fertility declines occurred in widely different economic, socio-cultural, and political settings. The extent to which they were attributable to family planning programs, established in most countries of the region by 1970, is hotly debated. The 1970s were the

heyday of family planning programs, which were created in a climate of urgency because of concerns over the "population explosion." Issues faced by programs at that time are discussed. Over time, programs generally have moved to a simpler service approach (Jones, and Leete, 2002).

Finkle and Mcintosh review the population conferences sponsored by the UN, beginning in Rome in 1954, and show how their priorities have shifted from scientific to political considerations. At the same time, participants have changed. First, independent experts were replaced by national delegations selected by and representing their governments. More recently, nongovernmental organizations representing civil society have begun to play an active role at the conferences. Because of the broader range of participants, the population field has grown in scope and complexity and is in danger of losing its focus. Increasingly, population issues are linked with broader questions of poverty, the environment, human rights, economic development, globalization and the like. They suggested that smaller regional or thematic meetings may be a good way to rationalize the conference process in the years to come (Finkle and Mcintosh, 2002).

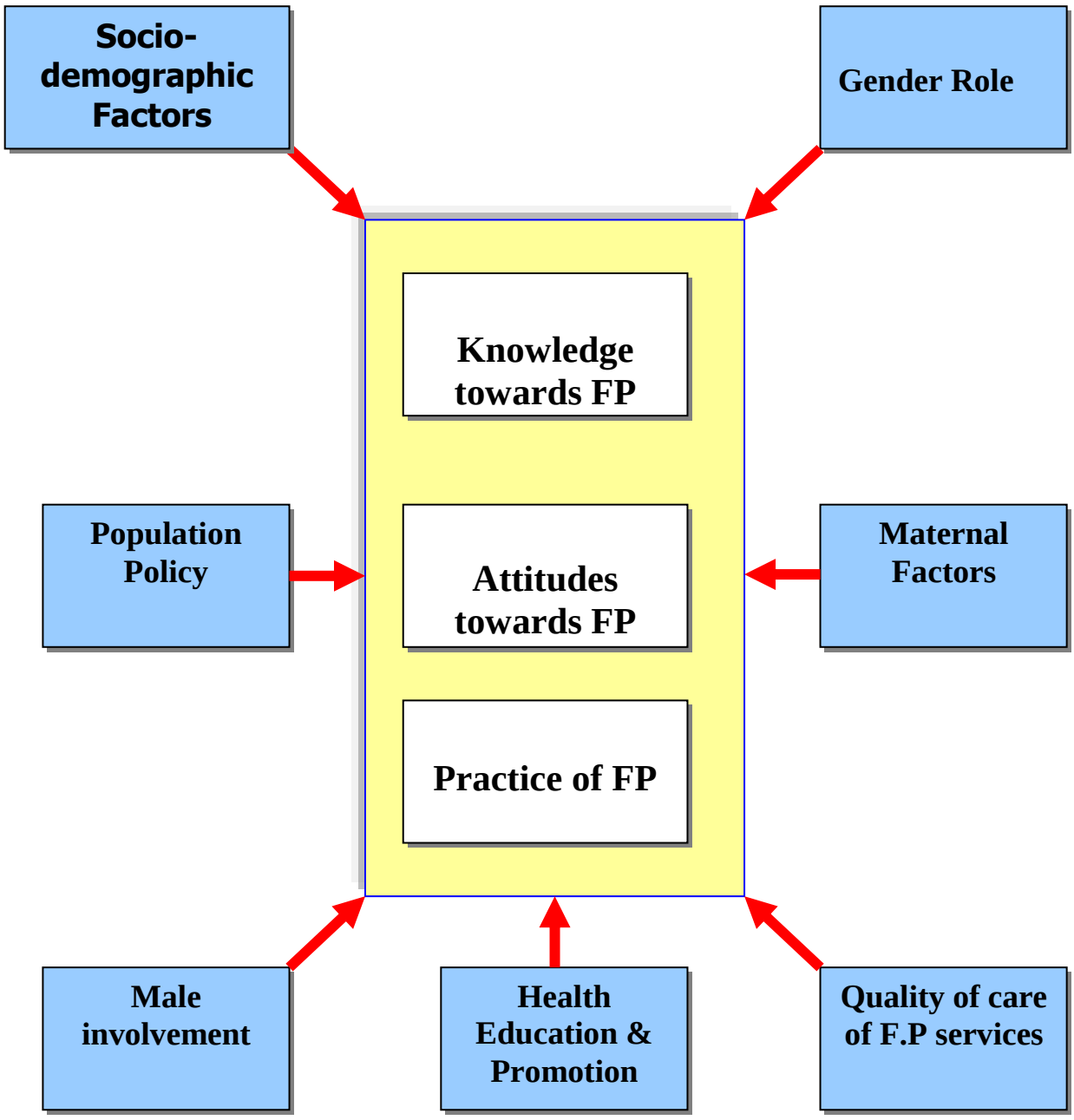
To examine progress in implementing the ICPD Program of Action, stakeholders were interviewed in eight countries Bangladesh, India, Nepal, Jordan, Ghana, Senegal, Jamaica, and Peru. While all of the countries have begun formulating policies to reflect the new emphasis on reproductive health care, program implementation has only just begun. Moving from policy to programs faces several challenges, including disseminating the message of Cairo to a wider base of stakeholders, planning for the complexity of integrated services, increasing human and financial resources, improving the quality of care, and viewing Cairo as a long-term process. The authors concluded that setting priorities and phasing in interventions are the key to progress (Hardee, etal 1999).

New approaches to family planning and reproductive health call for the application of human rights as well as public health principles, but these are not easily reconciled. The reproductive rights agenda focuses on the process as well as the outcome of program activities; addresses the gender dynamics of sex, which are rooted in cultural and social norms; addresses sexual coercion and infection as well as unwanted pregnancy; and seeks to instill a sense of entitlement among clients and a rights-based ethos among programs. Obstacles to change include: social, economic, and political conditions, such as poverty, that undermine rights and entitlement; weak support for the rights agenda at the national level; continuing program focus on reduced fertility; vague definitions of key concepts; rapid health care reforms; and limited capacity in the women's movement at the local level (Jacobson, 2000).

To ensure that international declarations on women's reproductive rights are meaningful, women must work toward the adoption and enforcement of national laws and policies reflecting their principles (Center for Reproductive Law and Policy, 2000).

Chapter 3

Conceptual Framework of Knowledge, Attitudes and Practice towards family planning among Palestinian couples in Gaza Strip



3.1 Introduction

In this chapter we described factors that can affect FP knowledge, attitudes and practice, which are the variables of our concern in the study. Those factors were identified after we had conducted literature review about this subject. The factors to be described were socio-demographic factors, maternal factors, population policy, gender role, quality of care, men involvement, and health education mainly mass media.

3.2 Socio-demographic Factors

Socio-demographic factors like education, employment status and income can affect knowledge, attitudes and also practice of family planning.

UN, (2003) reported that increased education for women lead to reducing fertility by increasing investment in their children in the form of more schooling and better health. This higher investment increases the cost of having an additional child and may lead to a fall in the demand for children and so less family size (UN, 2003). Since 1994 more women have access to education and other rights, and more early-marriage traditions are being opposed which affect positively family planning practice (Haub, 2004).

Women who are employed are more likely to have a modern gender role orientation than those not employed, and among the employed, job prestige and earnings are also related positively to gender role modernity. It seems apparent, therefore, that freedom from the traditional women's role leads to lower fertility (Scanzoni, 1976). According to the United Nations report which says poverty perpetuates and is exacerbated by poor maternal health, gender discrimination, and lack of access to birth control (Haub, 2004).

Declining fertility is one of the demographic conditions that have helped increase the economic independence of women. When an advanced education, a prestigious career, and a good income were not generally available to women, then the lack of such things was not perceived as a cost of having children. But when those things are available, reducing them for the sake of raising a family may be perceived as a sacrifice. As fertility has gone down, more time has become available for women to pursue alternate life style, and as the alternatives grow in number and attractiveness, the costs of having children have gone up (Scanzoni, 1976).

Aggressive population planning programs have held that high fertility rates and rapid population growth are serious impediments to a country's development. No poor country can increase its standard of living and raise its per capita income while wrestling with the problems of trying to feed and care for a rapidly expanding population. Thus, poor and developing countries should invest in family planning programs as part of their economic development process (UNFPA, 2004).

3.3 Maternal factors

Improved health for women and access to contraception are vital. Smaller families are healthier families and improve the prospects of each generation. More than 201 million couples do not have access to contraception and if they could practice family planning, 22 million abortions, 142,000 pregnancy-related deaths, and 1.4 million infant deaths each year could be prevented. Since 1994 more women have access to education and other rights, and more early-marriage traditions are being opposed (UN, 2004).

MMWR, 1999 reported that, during the 20th century, the hallmark of family planning in the

United States has been the ability to achieve desired birth spacing and family size. Smaller families and longer birth intervals have contributed to the better health of infants, children, and women, and have improved the social and economic role of women. Publicly supported family planning services prevent an estimated 1.3 million unintended pregnancies annually. In 1900, six to nine of every 1000 women died in childbirth, and one in five children died during the first 5 years of life (Achievement in public health, family planning, 1999).

In some developing countries, early pregnancy is associated with more than a quarter of female school dropouts, beginning as early as primary school. Furthermore, over their lifetimes, women in these countries may spend the equivalent of 6 continuous years being pregnant and 23 years caring for children younger than six years old (Population Reference Bureau, 1997).

3.4 Population policy

Dramatic demographic changes in Asia during the three decades from 1970 to the end of the twentieth century were attributed to major changes in government population policies and programs (Jones and Leete, 2002).

China's family planning policy during the last three decades, highlighting key trends and goals of the program at national and provincial levels. It focuses on the administrative, economic, cultural, and other factors that have helped or hindered the family planning effort and reviews the impact of the program on the provincial population (Attane, 2002).

To ensure that international declarations on women's reproductive rights are meaningful, women must work toward the adoption and enforcement of national laws and policies reflecting their principles (Center for Reproductive Law and Policy, 2000).

3.5 Gender role

Empowering women is an important aspect to be discussed when talking about family planning practice. Change in the gender roles taught to boys and girls, giving equal treatment to the sexes in the educational and occupational spheres, have an important role in empowering women. Likewise, if a man's role is viewed as less domineering then the establishment of family may be less essential to him as a means of forcing social recognition. Any policy aimed at affecting motivation will have to alter the way people perceive the social world and how they deal with their environment on an everyday basis. It will have to involve a restructuring of power relationships within the family, a reordering of priorities with respect to gender roles, a reorganization of the economic structure to enhance the participation of women (Weeks, 2003).

As a general role, when fertility has gone down, more time has become available for women to pursue alternate life style, and as the alternatives grow in number and attractiveness, the costs of having children have gone up (Scanzoni, 1976).

3.6 Quality of care

Managed care is rapidly changing patterns of health-care delivery and creating new challenges for primary and reproductive health-care providers. Managed-care plans often offer more comprehensive coverage of such services than traditional insurance plans.

Access to high quality contraceptive services will continue to be an important factor in promoting healthy pregnancies and preventing unintended pregnancy in this country (Achievement in public health, family planning, 1999).

It is clear that there are trends to improve the quality of family planning services all over the world. During the 20th century, restrictive policies and laws affecting family planning were largely replaced by legislative and funding support for family planning services by physicians and specialized reproductive health-care providers. Marshaling public support for efforts needed to reduce the high rate of unintended pregnancy and to provide the full array of reproductive health-care services remains a challenge ((Achievement in public health, family planning, 1999).

3.7 Men involvement

basic family planning programs served women almost exclusively, research has long shown that men want to know more about reproductive health and want to support their partners more actively, men's desire to limit their family size often makes it possible for women who want to use contraception to do so (Ezeh, Seroussi and Raggers, 1996). Only recently have family-planning associations recognized the importance of men's role and motivation in fertility decision making. But now that this has been recognized, the question is "what can family-planning and reproductive-health programs do to encourage men's cooperation?" (Hawkins, 1991, unpublished).

The husband's support is very important in future practice and continued use of family planning. There are studies done in the Philippines which indicate that the continuation rate among women whose husbands support their contraceptive practice is much higher than those whose husbands do not give support to their wives (IPPF, 1984). In South

Korea researchers found that 71 percent of women whose husbands approved family planning had used contraception at some time, compared with 23 percent of women whose husbands did not approve (Piotrow, Kincaid and Hindin, 1992).

Lack of male access to services has been a barrier to family-planning use. Men cannot share responsibility for reproductive health and family planning if services and information do not reach them. Most FP clinics cater to women, so men are uncomfortable about going to these clinics (Wambui, 1995).

3.8 Health education mainly mass media

The goals which can be achieved by health education of FP are to increase knowledge, and improve attitudes toward family planning and promote contraceptive use among men and women of reproductive age, enhance family-planning counseling skills among service providers, and strengthen the ability to develop, implement, monitor, and evaluate communication programs in health. Health education service provider training, material development, media, and activities, including leaflets and booklets, motivational posters, national radio and television broadcasts, drama, a theme song, community audiovisual material, and community activities (Kim, Opia and Phyllis, 1992).

In our study we are intended to examine the relationship between the previous described factors and our variables of concern, which are knowledge, attitude and practice.

Chapter 4

Methodology

4.1 Study design

This is a descriptive and analytical cross sectional study. It has been chosen because they are economical and cheap and in the same time it can describe the nature of the study objectives. Additionally, cross sectional studies examine exposure and effect in the same time, and they can give some indicators about the association among different exposures and the outcome under investigation. A community based cross sectional study is the most suitable study design to achieve the study objectives, since it can be used descriptively, to describe differences in prevalence rates among those with varying levels of exposure (Brownson and Petitti, 1998)

In this research cross sectional study allow to measure the prevalence of current use of FP and those who have ever use FP, and to compare the differences among the study variable groups.

4.2 Study Population

This study is targeting married women in reproductive age (15-49) as defined by WHO and their husbands, who live in Gaza Strip. The total number of women in reproductive age is about 305,587 represent 22.3% of the total population in Gaza Strip (MOH, 2004).

4.3 Eligibility criteria

4.3.1 Inclusion criteria:

1. Married women and their husbands.
2. Women aged (15-49years) old.

4.3.2 Exclusion criteria:

1. Widow or divorced women in reproductive age.
2. More than one married woman in reproductive age in the same household.
3. Women younger than 15 years or older than 49 years
4. Couple stayed in Gaza strip less than one year

4.4 Setting of the study

The study is a community based; the data were collected from sampled households distributed through GS governorates, using interviewed questionnaire of the women in reproductive age and their husbands.

4.5 Sample size

Considering statistical estimation, using Epi-info 6 program (Epidemiological Information statistical program, version 6), at confidence interval 95%, the sample size was 380 eligible couples, randomly selected from the study population. The researcher tended to increase the sample size to be 400 couples to overcome non respondents during the field work.

4.6 Sampling process

The sampling scheme of household and respondents is considered as a multistage combination of stratification, and clustering. In order to ensure that the sample was geographically representative, the study covered five governorates in Gaza Strip. These are North Gaza, Gaza, Deir al Balah, Khan Younis and Rafah, Gaza Strip; each governorate was included in the study. The percentage of each governorate population of the total Gaza Strip population was computed as it is shown in table (4.1) according to population distribution by Palestinian Central Bureau of Statistics classification, (1997), represented the total computed percent into the sample size give the total sampled households in each govern as shown in table (4.2). Each govern was divided into three strata: the rural area, the urban area, and the camp according to Palestinian Central Bureau of Statistics classification, (1997). Within the stratum, households selected according to the percent of each stratum from the total govern population. Units were selected using clustering from each randomly selected stratum.

Table 4.1: Distribution population through G.S governorates

Governorate	Population in each governorate		Population living outside camps		Population living inside camps	
	No	%	No	%	No	%
North Gaza	179,690	19	119,323	66.4	60,367	33.6
Gaza	359,941	36	297,905	82.8	62036	17.2
Deir al Balah	144,890	14	49,797	34.4	95,093	65.6
Khan Younis	196,662	19	162,115	82.4	34,547	17.6
Rafah	120,386	12	61,093	50.7	59,293	49.3

The sample size distributed proportionally in Gaza Strip governorates as follow:

Table 4.2: Distribution of the study population through G.S governorates

Govern	Couples needed to include		Living outside camps		Living in camps	
	%	No	%	No	%	No
North Gaza	19%	76	66.4%	50	33.6%	26
Gaza	36%	144	82.8%	119	17.2%	25
Mid-zone	14%	56	34.4%	19	65.6%	37
Khan-younis	19%	76	82.4%	63	17.6%	13
Rafah	12%	48	50.7%	24	49.3%	24

The sample size is distributed through G.S governorates according to the proportional distribution of population by PCBS, Population census, 1997.

4.7 Ethical considerations

An official approval was obtained from the Helsinki committee "Ethical committee in Gaza Strip" (annex 3). Every participant in the study received a complete explanation about the research purpose, full disclosure about the nature of the study, length of investigation, the investigation agency, and the subject's right to refuse participation risks and benefits, how they have been selected, confidentiality and sponsorship. An informed consent was attached to each questionnaire, was obtained from each participant in the study, (annex 4). All the ethical concepts were taken in consideration, respect of people and confidentiality.

4.8 Research instrument

Structure questionnaires were completed by twelve trained interviewers. The researcher elected using interviewed questionnaires because it is easy for the participants, which is a gold standard method of data collection. Quantitative approach provides wide coverage and characterized by high validity and reliability.

4.8.1 Questionnaire design

The questionnaire for the study was specially designed and prepared to compile information relating to the objectives of the study. In this regard, the questionnaire was constructed using questions formulated by a common Arabic popular language

to avoid language difficulties and misunderstanding or different interpretation of the questions by the interviewers or by the participants and to elicit information on the background characteristics of household members, socio-economic characteristics, fertility attitudes, husband/wife relationship, spouse reproductive history, spousal communication, value of children, family size preference, knowledge of, attitude toward and practice of family planning, family decision making.

4.8.2 Validity of the questionnaire:

The questionnaire used for data collection in this study is professionally prepared with high face validity. The researcher depends on two types of validity; the first is content related validity as the instrument designed after reviewing related literature. The second is content validity, where expert committee formed of public health specialists and MCH specialists were discussed questionnaire validity content. The researcher provided those experts the

objectives of the study. As a result of their comments some items were added, modified or neglected.

4.8.3 Reliability of the questionnaire:

To minimize inter-observer variations and intra-observer variations the researcher conducted a training sessions for the entire field workers participated in data collection. There were twelve interviewers who participated in data collection. Pilot study revealed common mistakes that could be avoided. All the collected questionnaires were reviewed daily to ensure that all the field workers are following the same method in data collection.

4.9 Pilot study

A pilot study was conducted before starting the long expensive study. The piloting process was very important and useful to test recruitment, response rate, validity, reliability, sensitivity of the questionnaire and also areas of difficulties and ambiguity. Piloting was performed on 15 subjects was selected randomly as cluster sample from two UNRWA, MCH clinics in Gaza. After piloting process some modifications and changes in the questions were done. The pilot subjects were excluded from the study sample.

4.10 Data Collection

The data were collected from sampled household by interview to complete a structure questionnaire with the eligible women and their husbands. The data collected by well trained interviewers who were involved in the research. The trained interviewers attended intensive training course to learn how to complete the questionnaire correctly and to administer the informed consent procedures.

4.11 Response rate

The response rate was high as 95% among women and 88% among their husbands, which confirmed the importance of community involvement in research projects.

4.12 Statistical Analysis

The collected data was introduced to the computer using SPSS (Statistical Package for Social Science version 8.0) program. Data were checked for entry errors using a frequencies and logical checks on all variables. Data analysis was carried as follows:

Descriptive analysis was performed to examine the distribution of different factors among the study population. The dependent variables in the study were Knowledge, attitudes and practice of FP among participant, the independent variables were socio-demographic factors, maternal factors, gender role, information access and health education including mass media and men involvement. The relationship between the dependent variables and the independent variables were tested by using different methods, Chi Square used for categorical variables and T-test was used for continuous variables, Epi-info. 6 program was also used to calculate odds ratio for different variables and the level of significance by using P-value. Manual calculation was also used to examine the significance of the difference between women and men FP knowledge as it is shown in annex (5).

Chapter 5

Results

This chapter represents the core results of the study including socio-demographic characteristics of the subjects of the study population, maternal factors and gender role that affecting knowledge, attitudes and practices of the study population towards family planning. The data collected in this study provide information related to these variables.

Then the researcher examined factors that may affect FP knowledge, attitudes and practice of respondents. The researcher also compared between women and men in some concerned factors.

5.1 characteristics of the study population

The study population was 400 Palestinian couples living in Gaza Strip. The number of women who had participated in the study was 380 with response rate high as it was 95% while the response rate of their husbands was 88%. The study showed obvious variations in socio-demographic factors and socioeconomic status.

5.1.1 Distribution of the study population by Governorate and locality:

The study was conducted to be representative to the five geographical districts of Gaza Strip. Table (5.1) shows the total 380 subjects were distributed within the provinces. North Gaza represents 18.9% of the study population; Gaza City represents 35.5%, Midzone 14.2%, Khan-younis 19.5% and Rafah 11.8% (figure 5.1).

This percentage distribution for the study sample is similar to the population distribution conducted by the Palestinian Central Bureau of statistics (PCBS, 1997).

Table 5.1: Distribution of the study population by province and locality

Variable	No	Percentage (%)
Governorate		
• **North Gaza**	72	18.9
• **Gaza**	135	35.5
• **Midzone**	54	14.2
• **Khan younis**	74	19.5
• **Rafah**	45	11.8
Locality		
• **Living outside camp**	263	69.2
• **Living in camp**	117	30.8

Distribution of the study population by living area shown that 69.2% of the study population were living outside camps and 30.8% are living in camps

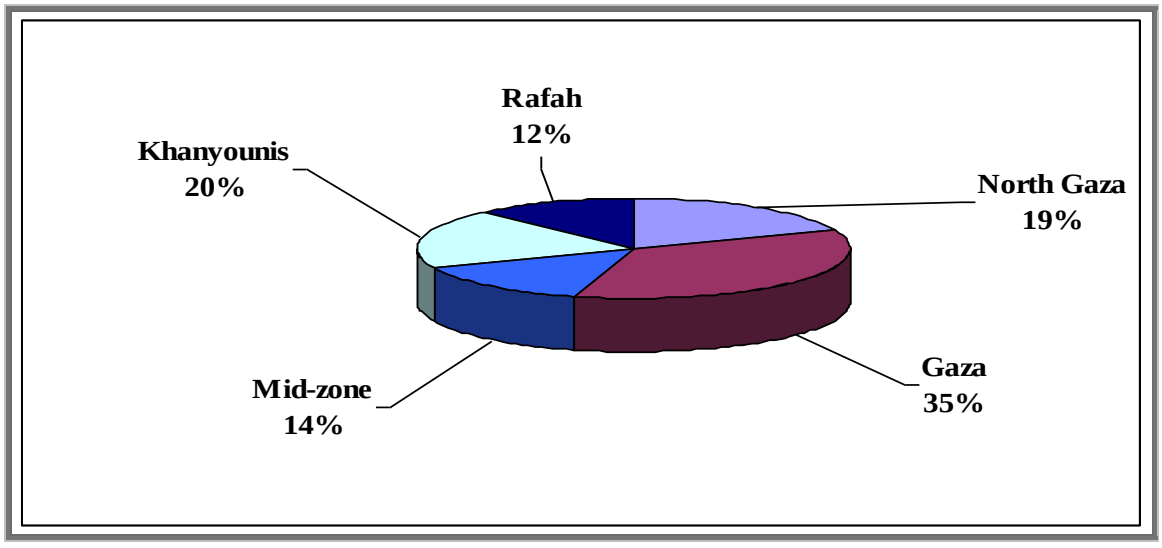


Figure 5.1: Distribution of the study population by Governorate

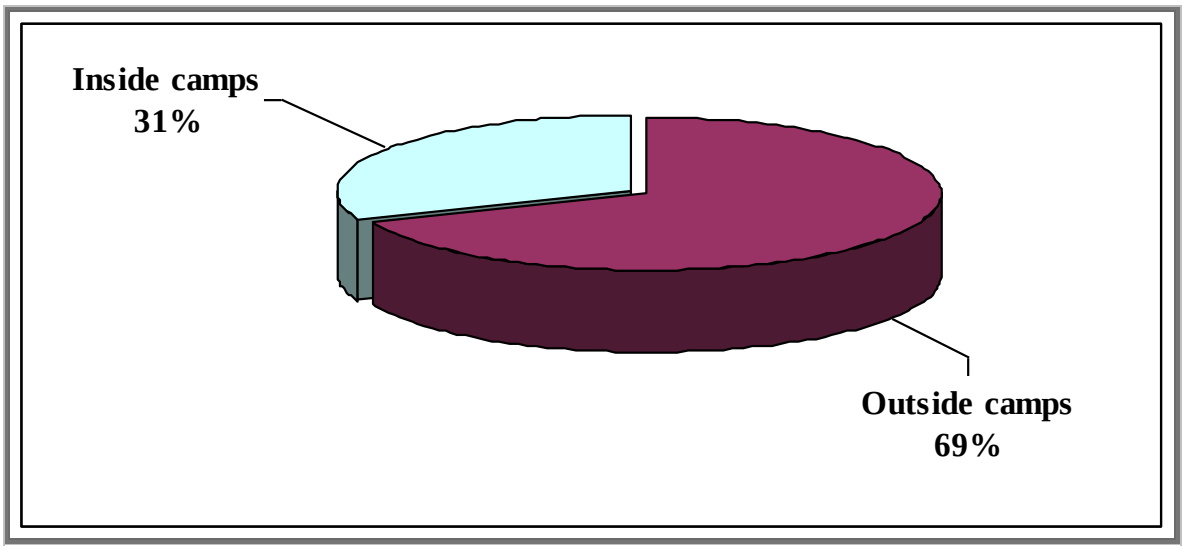


Figure 5.2: Distribution of the study population by locality

5.1.2 Socio-demographic characteristics and socioeconomic status:

The study showed variations in socio-demographic characteristics of the participated women and their husbands. Table (5.2) summaries the main characteristics like age distribution among women and men participated in the study, educational level of the study population, as the researcher recoded the data collected and categorized these data as demonstrated in the table below, another factor was working status of both women and men, if they are employed or not and then he examined the occupations of the employed respondents.

Table 5.2: Distribution of the study population by socio-demographic characteristics of participants

Socio-demographic Variables	woman		Husband	
	No	%	No	%
1. Age group				
- 15-24 years	85	22.4	20	5.3
- 25-34 years	173	45.5	145	38.2
- ≥35 years	122	32.1	215	56.6
Total	380	100	380	100
2. Education level				
- Low (0-6 years)	33	8.7	50	13.2
- Medium (7-12 years)	250	65.8	185	48.7
- High (>12 years)	380	25.5	145	38.2
Total	380	100	380	100
3. Working status				
-Working	60	15.8	261	68.7
- Not working	320	84.2	119	31.3
Total	380	100	380	100
4. Occupation				
- Skilled	0	0	8	2.1
- Professional	42	11	76	20
- Merchant	0	0	12	3.2
- Policeman	0	0	63	16.6
- Unskilled	14	3.7	98	25.8
- Pocket money Employee	4	1.1	4	1.1
- Unemployed	320	84.2	119	31.3
Total	380	100	380	100

5.1.2.1 Age of respondents:

The mean age of women participated in the study was 31.1 years with standard deviation (SD) 7.72, median 30 years and range from 16 to 49 years old. The highest age category

was among women aged 25 to 34 years old (45.5%) followed by women aged 35 years and older with percentage 32.1% and 22.4% of women aged 24 years and below.

The mean age of husbands was 36.2 years, (SD) 7.92, median 35 years and range from 20 to 66 years old, with highest percentage (56.6) among men aged 35 years old and above followed by those aged 25 to 34 years old with percentage (38.2), and only 5.3 % of husbands aged 24 years and below.

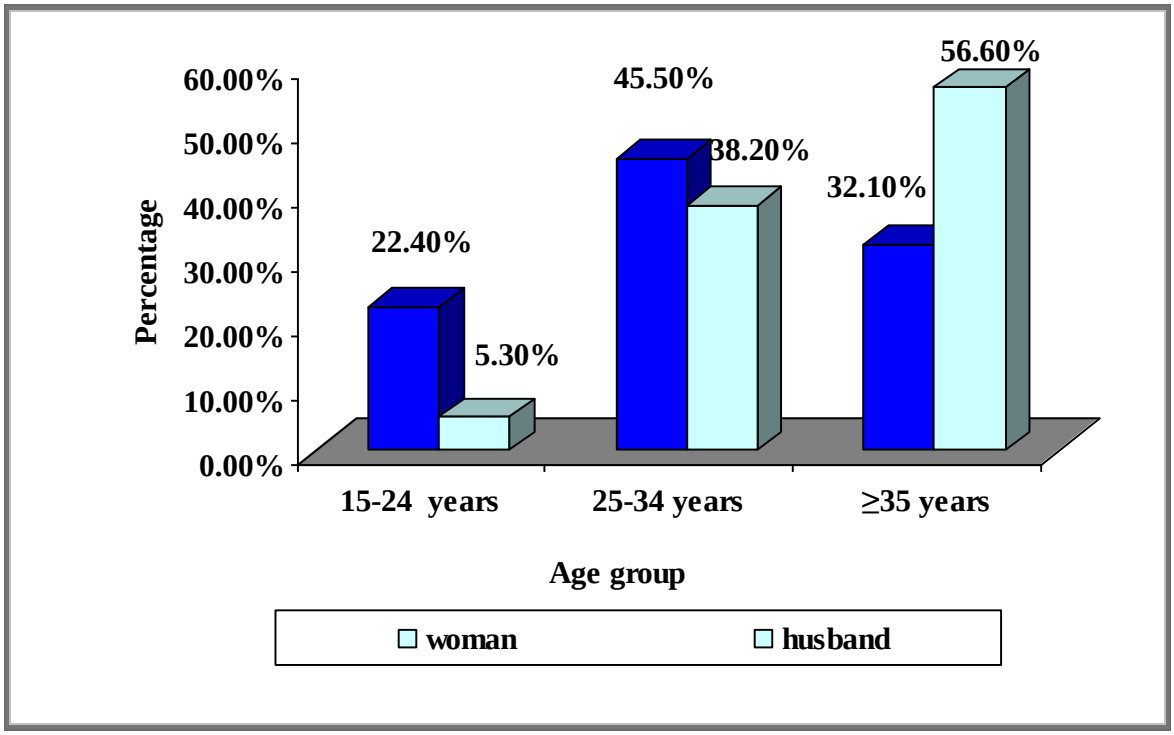


Figure 5.3: Percentage distribution of women and their husbands by age groups

5.1.2.2 Education level of respondents:

Regarding the education levels of participated women and the respondents of their husbands, the researcher categorized and re-codes the years of education into three categories. The first was low level of 6 years of education and less which represented 8.7%

among women and 13.2% among husbands. Second group which is the median level from 7 to 12 years, which represented the majority of the study population 65.8% among women and 48.7% among husbands, the third group, high level with more than 12 years of education represented 25.5% of women and 38.2% of husbands as shown in figure (5.4). The mean of women years of education was 11.5 years, the median was 12 years, (SD) was 3.26, range from 0 to 18, and for husbands the mean was 12 years, the median 12, (SD) 4.13 and range from 0 to 25 years.

A study conducted by Planning & Research Center (PRC) in the West Bank in 1996, revealed that the median year of women's education was 9 years and for their husbands it was 10 years. Nearly about 63.9% of surveyed women had less than 12 years of education (Ismail and Sahin, 1996). In our study there was 65.8% of women had educational level from 7-12 years or less. 42% of women had educational level less than 12 years.

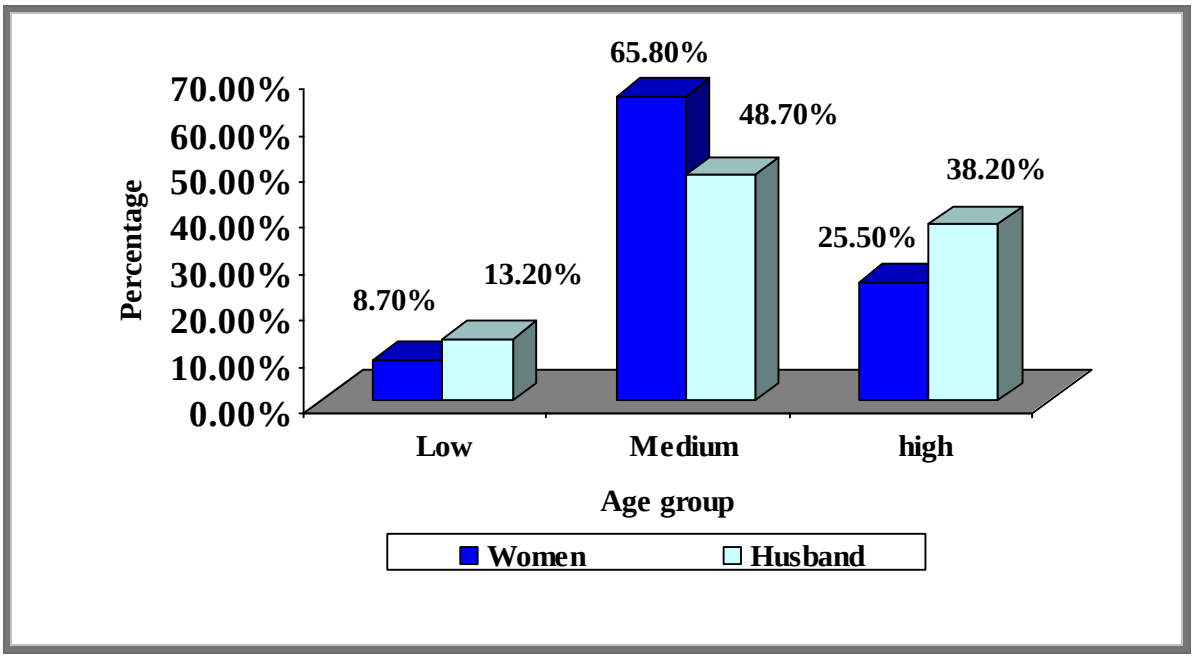


Figure 5.4: Percentage distribution of women and husbands by educational level

5.1.2.3 Working status of respondents:

As shown in table (5.2) there was high rate of unemployment among women. Congruently, 320 out of 380 women were unemployed and represented 84.2% of the participated women, and 60 of the women were workers and represented only 15.8% of the participated women. For women, 11.8% of women involved in the study had professional jobs, 3.7% unskilled jobs and 1.1% worked as pocket money employee as shown in figure (5.5). The percentage of working husbands was 68.7%, while 31.3% of husbands were unemployed. Among husbands, unskilled workers represented the highest percentage which was 25.85 of the study population, followed by professionals who represent 20%, while policeman represent 16.6% of husbands in the study, merchants represent 12% which equal to those worked as skilled added to those husbands worked as pocket money employee as shown in figure (5.6).

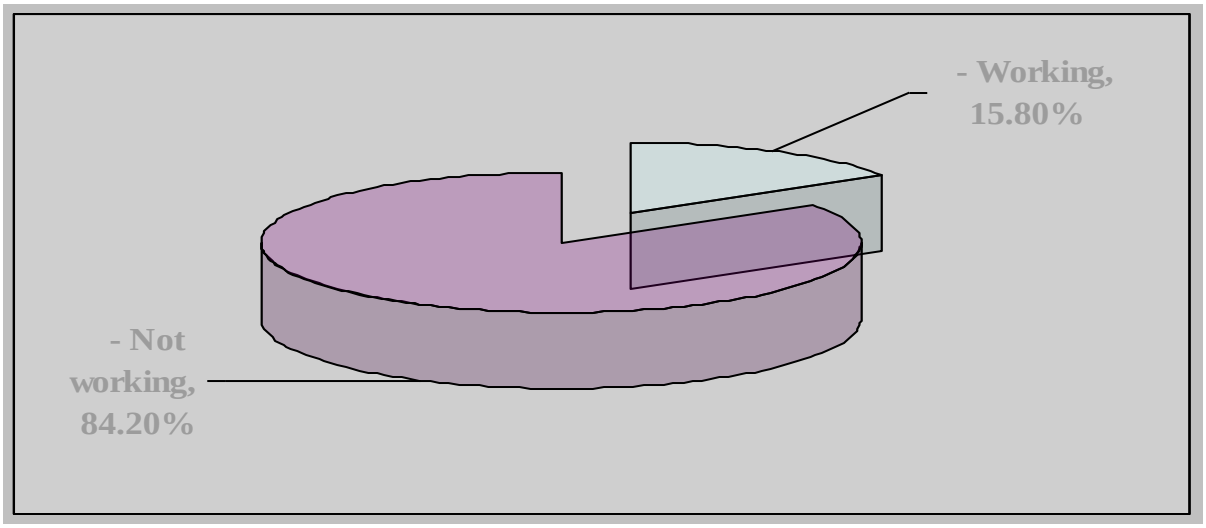


Figure 5.5: Percentage of distribution of women by working status

Theses findings are approximately consistent with PCBS survey (2005), which revealed that the unemployment rate in Gaza Strip decreased from 30.2% in the 2nd quarter to 29.0% in the 3rd quarter 2005, which is still high.

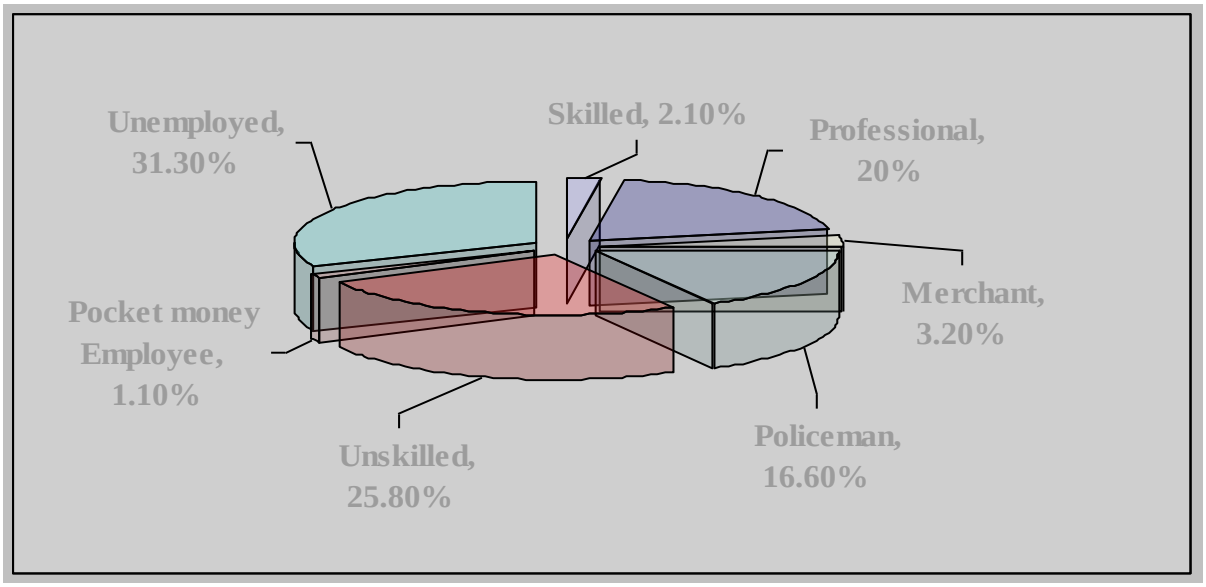


Figure 5.6: Percentage distribution of husbands by occupational groups

5.1.2.4 Financial status of the family:

Regarding financial status of the families involved in the study, the researcher classified family income according to PCBS definition of poverty into two levels, under poverty line those families with monthly income less than or equal 1,642 NIS, and above poverty line those with income more than 1,642 NIS. About 95 participants (25%) of the study population refused to answer or didn't know the monthly income of the family. Among the remainder 285 participants (75%) of the study population, 79.3% were under poverty line and 20.7% of them were above poverty line figure (5.7). The mean of their monthly family income was 998.5 NIS; the median income was 500 NIS with (SD) 1264.9 and range from 0 to 8500 NIS.

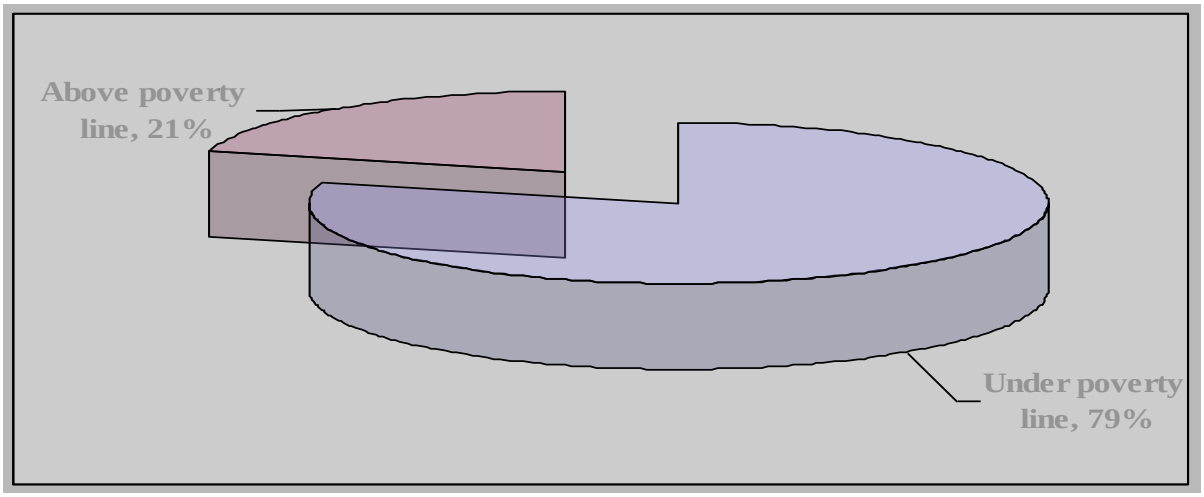


Figure 5.7: Percentage distribution of the study population by according to financial status

5.1.2.5 Type of home:

From the study population 56.6% of the families were live in nuclear family, 26.8% of them live in apartments inside family house and 16.6% were live in multifamily homes.

So about 83% of the study population live in nuclear families, according to Palestinian Central Bureau of Statistics, about 73% of Palestinians live in nuclear families (PCBS, 1998). This may minimize the role of the extended family and its effect on social status and individual life. So women and their husbands could take their own decisions of FP as it will be seen in the following results.

5.2 Maternal factors

Maternal factors which had been examined in the study were marital age of participated women, family size or Number of live children and birth intervals, the researcher described the distribution of these factors among respondents as it is shown in Table (5.3).

Table 5.3: Distribution of the study population by maternal factors:

Variable	No	Percentage%
1. Marital age		
<18 years	134	35.3
≥18 years	264	64.7
Total	380	100
2. Number of live children		
<6 children	234	61.6
≥6 children	146	38.4
Total	380	100
3. Birth interval		
≤2 Years	231	70.9
>2 Years	95	29.1
Total	326	100

5.2.1 Marital age:

Marital age among respondents ranged from 14 to 35 years old, the mean marital age was 18.9 years old; the median was 18, with (SD) 2.96. The researcher classified marital age into two groups, about 35% of the study population were married at age less than 18 years, and about 65% of women in the study population their marital age was equal to or more than 18 years old as depicted in figure (5.8).

In a study conducted in West Bank by Planning and Research Center, 1996. The average age of marriage for women participated in the study was 19 years which is similar to the result in this study, approximately 3% of women married at age less 15 years, 51% married at age 15-19 years, while 26% of women married at age of 20-24 years old and about 7% at age 25 years old or more (Ismail and Shahin, 1996).

In our study approximately 2% of women married at age less 15 years, 59% married at age 15-19 years, while 19% of women married at age of 20-24 years old and only about 3% at age 25 years old or more.

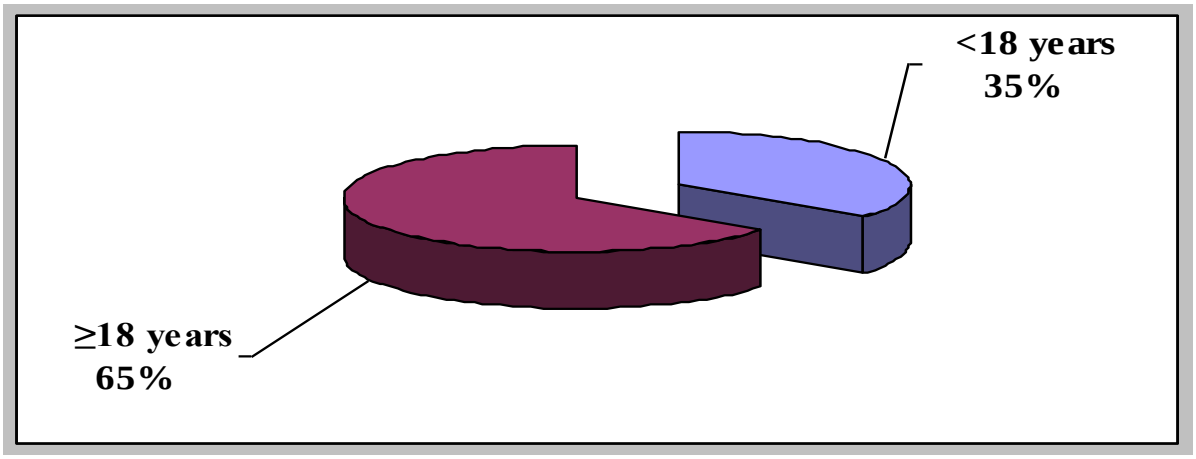


Figure 5.8: Distribution of the study population by marital age

A study conducted by Dr. Haifa H. Madi, among Palestinian refugees in UNRWA five fields which are Jordan, Lebanon, Syrian Arab Republic, Gaza and the West Bank. This study resulted in that the mean marital age among Palestinian refugee women in Gaza was 18.9 years in year 2000, which is the same result in our study as it was also 18.9 years old. The percentage of women married before the age of 18 years was 30.2% of Palestinian refugee women in all fields of UNRWA, which is expected to be higher in Gaza because the mean marital age in Gaza is less than it in other fields, which is close to our results as it was about 35% (Madi, 2001).

5.2.2 Number of live children:

Number of live children ranged from 0 to 14 children, the mean was 4.7, and the median was 5 children, with (SD) 2.83. Women who have less than 6 children represented 61.6% of the study population, and women who have ≥ 6 children represented 38.4% of the study population. There is another factor must be taken in consideration which is the period of marriage, as there was a considerable percentage of young couples in the study population who were married for short period, which may be a cofounder that can affect the results, when we selected couples who were married for a period more than 10 years, there was 65% of them were have 6 children or more and the other 35% of them were have less than 6 children. This reflects the desire to have many children in Palestinian population.

5.2.3 Birth interval:

Birth intervals provide one of the useful tools to examine the pace of childbearing. Short birth intervals adversely affect the health of mothers and the survival chances of their children. Information on the length of birth intervals among the target group as can be seen in table (5.3) above, the percentage of women who have birth interval ≤ 2 was about71% of the study population and those who have birth interval > 2 years represents about 29% of the study population.

This result indicates that birth spacing among Palestinian women is low as the large percentage of the study population were have birth interval between the last two deliveries less than or equals two years. MMWR, 1999 reported that, during the 20th century, the hallmark of family planning in the United States has been the ability to achieve desired birth spacing and family size, so birth spacing is a good indicator of practicing FP, and the achievement of FP programs.

5.3 Gender roles in family life including family planning decision making

The researcher examined the gender roles in family life of respondents by describing some variables like husbands participation in house work, discussion of respondents with their spouses about family planning and if they had been ever talking about the desired number of children and use of contraceptives. Family planning decision making in the family, who to decide the number of children, who decide to do family planning or not, all these questions are answered in table (5.4) below.

Table 5.4: Distribution of variables related to gender roles in family life in the study population

Variable	Frequency	Percentage%
1- Helping of husbands in house work	114	29.7
2- Talking with husband about the desired no. of children	217	58.0
3- Decision of family size		
- Husband	219	57.6
- Husband and wife	112	29.5
- Wife	20	5.3
- Husband family	16	4.3
- No body	13	3.3
4- Decision to use contraceptives		
- Husband	233	61.2
- Husband and wife	133	35.1
- Wife	10	2.6
- Husband family	4	1.1

Women who mentioned that their husbands were helping them in house work constitute about 30% of the study population and 70% revealed that their husbands were not helping in this work , the main reason was that, it is a work of women which was the answer for about 34% of those who mentioned the causes of why they didn't help their wives, some of

them mentioned that, they didn't like this job (18), the other (9%) because of their habits and culture, and about 30% refused to do this work because they are busy in their jobs.

Whether the participants and their husbands had been ever talking about family planning, 58% of them indicated that they were had talked with their spouses about family planning matters and about the desired number of children they want, while 42% of them had never talked about this.

About 58% of the study population mentioned that men who were decided the family size and, about 30% of them the decision was by both the women and their husbands, while women who could decide the family size represents only 5% of the study population as depicted in figure (5.9).

Among married women of reproductive age in developing countries, 53% plan the size of their families, 90% of these women report using modern birth-control methods.

About 91% of participants revealed that they should have a permission to use family planning, about 95% of them were take the permission from their husbands and about 5% from their husband's family, so a firm decision to use family planning should be approved by husbands in most of the study population.

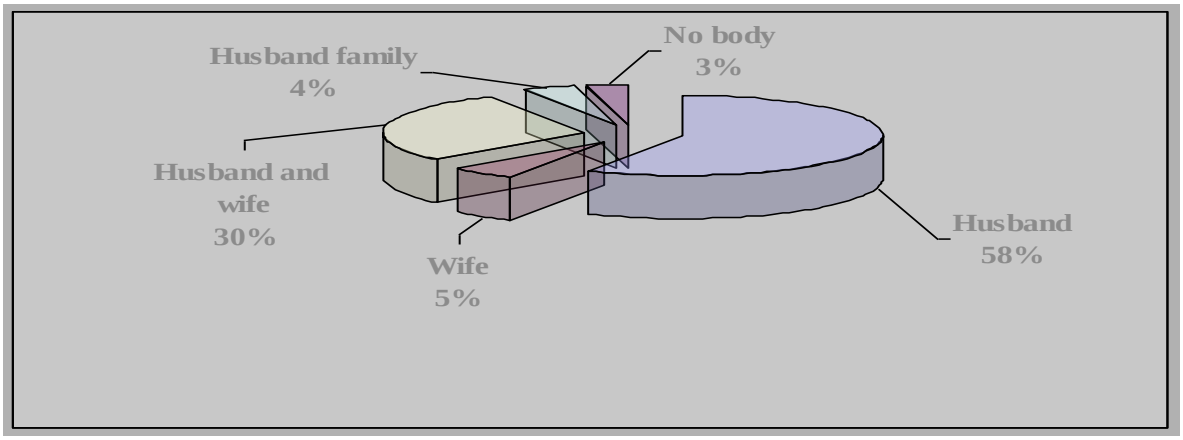


Figure 5.9: Decision of family size in the study population

5.4 Knowledge of Contraceptive

A pre-requisite for the use of contraceptives is adequate knowledge about methods. For a high rate of use to be attained, the population has to be very familiar with at least one of the modern methods of contraception. Respondents were asked about their knowledge of some methods of fertility control. The respondents' claim of any method was only confirmed if they could describe how it is used. They were later asked if they had ever used the method.

Table 5.5: Knowledge of Family Planning among study population

Variable	Percentage in women %	Percentage in men %
Knowledge of F.P		
- Have a knowledge	74.7	64
- Don't have a knowledge	25.3	36
t= 4.77	P-value<0.001	
No. of known contraceptive tools		
- 3 tools and more	59.7	36.8
- 2 tools	18.9	34.5
- one tool	21.4	28.7
Knowledge about		
- IUD	90.1	70.1
- Pills	88.4	60.2
- Condoms	80.3	69.1
- Other modern F.P. methods	5.3	1.2
- Traditional methods	62.1	35.7

Table (5.5) shows the percentage distribution of respondents by knowledge of contraception. The table shows that knowledge of contraceptive is high among respondents in the area. About 75% of women participated in the study were have a knowledge of FP and the remaining 25% were not have this knowledge, while about 64% of interviewed men

were have knowledge of FP and the other 36% were not have enough knowledge. The significance of difference between FP women knowledge and FP men knowledge was tested by using statistical calculation as it is demonstrated in annex (5). The finding of these calculation are highly statistically significant with P-value <0.001. This means that women knowledge of FP is significantly more than it of men.

About 60% of women and 37% of men interviewed were know three methods or more and about 19% of women and 35% were know 2 FP methods, while 21% of women and 29% of men were know only one contraceptive method.

Among women and men who mentioned that they had knowledge of FP methods, IUD was the most widely known method with 90% of these women, and 70% of these men claiming knowledge of it respectively. This is followed by pills with almost 88% of women and 60% of men claiming knowledge of it, and about 69% of men mentioned their knowledge of condoms. The least known among the modern contraceptives are other modern contraceptives like injections, suppositories and sterilization, with a proportion of only 5.3% women and 1.2% men. Knowledge of some traditional methods like lactation, abstinence and withdrawal was about 62.1% of women and 35.7% of men. Generally, a high proportion of both female and male populations (75% and 64% respectively) have knowledge about family planning methods, but only a small proportion of them are practicing contraception. There was a high percentage of knowledge of FP methods, which was general knowledge because when we went in our questions to ask about if these women were know how to use these methods which were known to them, about 25% of them mentioned that they didn't know how to use them, and about 75% of them claimed that they know how to use them.

Table 5.6: women knowledge of how to use the known family planning methods

Women know how to use known FP methods	Frequency	Percent
Yes	284	74.7
No	96	25.3
Total	380	100.0

There was 35% of study population as shown below were currently practicing F.P, this proportion of currently using contraception among couples was low comparing to high percentage of knowledge.

A qualitative study about knowledge, attitude and practice of family planning in Jordan (1996), studied knowledge about family planning methods, participants were aware of most family planning methods, but lacked in-depth knowledge. Participants were more familiar with what they referred to as "natural" methods than with modern methods. Specific findings include (Farsoun, Khoury and Underwood, 1996).

5.5 Practice of Family planning

The analysis of practice of family planning depends largely on the categories of `ever used' and `currently using'. Therefore, for the purpose of this study, contraceptive use will be examined by "ever use" and "current use" among different categories of men and women in the study area. Table (5.7) demonstrates family planning practicing variables and their distribution among respondents.

As it is shown in table (5.7), the percentage of women who had unwanted pregnancy in the previous pregnancy was about 36% of the study population. The main cause of occurrence of unwanted pregnancy among participants was husband desire which represents about

43% of the causes, followed by pregnancy on the top of contraceptive use, and a considerable percentage 12% due to insufficient knowledge about family planning.

Table 5.7: Distribution of family planning practices in the study population

Variable	Frequency	Percentage%
1. Women using F.P. methods	130	34.9
2. Women who ever used F.P. methods	225	66.5
3. F.P methods used by the respondents		
Intrauterine device	117	49.9
Pills	44	18.7
Condom	38	16.2
Traditional methods	24	10.2
Injection	6	2.6
Sterilization	6	2.6
4. Health providers		
UNRWA health center	115	57.7
Governmental health center	33	16.5
Private doctor	27	13.7
Pharmacy	12	5.8
Non governmental health center	5	2.7
Others	7	3.5
5. Percentage of unwanted pregnancy	133	35.9
6. Causes of unwanted pregnancy		
Husband desire	65	43.9
Pregnant while using contraception	28	18.9
Pregnant while she was lactating	20	13.5
Don’t have sufficient knowledge about FP	18	12.2
Husband family desire	17	11.5

5.5.1 Percentage of currently using Family Planning methods:

As it is shown in the table (5.7), percentage of women currently using family planning was about 35%, while the percentage of women who had ever used family planning was 66.5%. Madi,, (2001) in her study about current contraceptive practices among mothers of children 0-3 years attending UNRWA MCH clinics revealed that the prevalence of modern contraceptive use among refugee women in Gaza Strip was 36.5%, and it was 41.9% in West Bank. The prevalence of contraceptive use in Gaza Strip was the lowest among Palestinian refugee women in the five fields of UNRWA (Madi, 2001).

5.5.2 Distribution of the population according to the contraceptive use by method:

The study revealed that the majority of the study population, about 50% were using intrauterine device (loop), 19% were using contraceptive pills, 16% were using condoms, 10% were using traditional methods (like safe period and withdrawal method), and about 5% were using other methods (vaginal suppositories, hormonal injection, sterilization). It could be concluded that Loop and contraceptive pills were the preferred methods by family planning acceptors in Gaza Provinces as shown in figure (5.10).

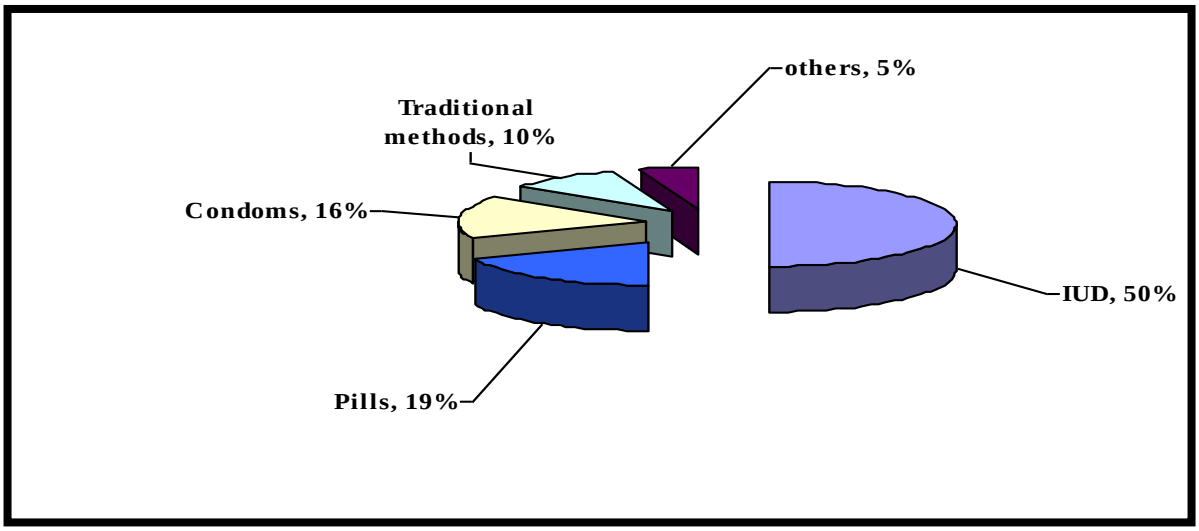


Figure 5.10: contraceptive use by method

A qualitative study of family planning in Jordan (1996), revealed that the oral pill, intrauterine device (IUD), condoms, vaginal tablets, and sterilization were recognized by most participants, injectables and Norplant implants were mentioned by only a few participants (Farsoun., Khoury and Underwood, 1996).

5.5.3 Distribution of the population according to the contraceptive use by source:

The two major health providers in Gaza Strip, are UNRWA and MOH, about 58% of respondents who were using family planning , received the service from UNRWA, about 17% of them were attended MOH clinics, 14% received the service from private clinics, and about 12% from other places.

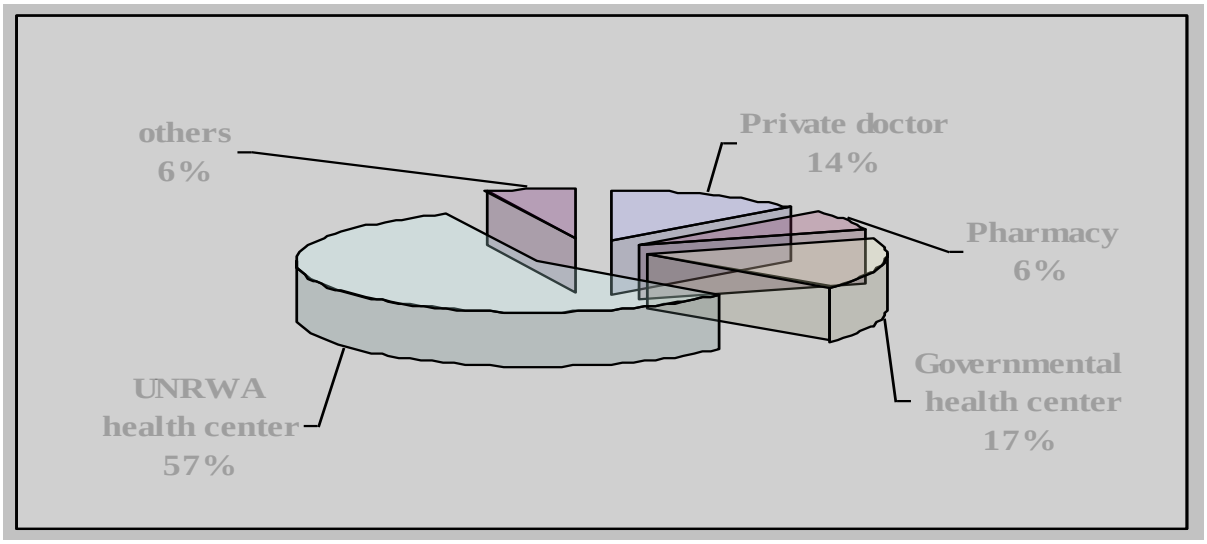


Figure 5.11: Contraceptive use by source

5.5.4 Access to health services:

The average time required to reach health facility was 19 minutes, the median was 15 minutes, ranged from 5 to 60 minutes, about 63% of participants required 15 minutes or less to reach the health facility.

5.5.5 Unwanted pregnancy among the study population:

Percentage of unwanted pregnancy among participated women, which is pregnancy which occurred against women desire, it was about 36%, which is a high percentage, we asked those women about cause \s that lead to unwanted pregnancy, about 44% of them were due to husband desire, about 19% they were pregnant while using contraceptives, about 14% of them were pregnant while they were lactating as the used lactation as a contraceptive method, about 12% of them were haven't enough knowledge about family planning and so didn't know how to use contraceptives to prevent unwanted pregnancy, and about 12% were due to husband family desire.

5.5.6 Reasons of non use contraceptives:

Reasons of not use family planning methods are many, as shown in Table (5.8) about 46.7% of women who didn't use family planning was because their desire to have more children, 20% of them was due to husband and family opposition, 14% was due to lactation, this is mainly due to that mother thought they are protecting from pregnancy by lactation, or due to their fear that contraceptives might interfere with breast feeding, 13.3% of them were pregnant and 4.7% of them didn't approve the use of contraceptives.

Table 5.8: Reasons of not use contraceptives

Reason	Frequency	Percentage%
Women want more children	70	46.7
Husband and family opposition	30	20
Lactation	21	14
Currently pregnant	20	13.3
Don't approve F.P	7	4.7
Others	2	1.3

Madi, (2001), revealed that the most common reason for non-use of contraceptives among mothers of children 0-3 Years Attending UNRWA MCH Clinics, was lactation which represents 41.7%, and it is dropped as a reason for non-use from 56% in the first year of child life to 26% in the second year, in our study lactation was the third reason of non use contraceptives as in our study the study population were women in reproductive age and not only mothers of children 0-3 years old. The second reason for non-use of contraceptives was pregnancy which represents 21.5% among participating women in the study, comparing to our study it represents 20% which is close to that result. The third reason was the desire to have more children, which represents 21.5% (Madi, 2001). In our

study this was the first reason of non use of contraceptives it represents 47% from one point of view indicating that more women are planning their pregnancies but from other point of view it indicates that there is a desire of many women in Palestinian community to have more children

5.6 Attitudes of family planning

Table (5.9) shows distribution of the study population according to their attitudes towards family planning. Variables related to FP attitudes which had been studied, were meaning of FP approval for FP, the desired family size, desired birth interval, their point of view about religion and political situation with FP.

5.6.1 Meaning and approval of family planning among respondents:

Respondents were asked if they approve or disapprove the use of family planning, as it is shown in table (5.9), about 90% of women approved the use of family planning compared to 72% of men would approve the use of family planning, and this is according to their understanding of the meaning of family planning as there was about 73% of women mentioned that family planning means birth spacing and 66% of men mentioned that while 14% of women and 12% of men believed in that FP means limitation of fertility, only 9% of participated women and 14% of interviewed men were believe in that FP means to have children when they want them. Men who believed that The FP means limitation of fertility were more than women, and women were believe that FP means birth spacing were more than men but this difference in meaning of FP between men and women was not significance as P-value equals (0.139). Women approval of FP was more than it for men, as women approval of FP was two times than men approval of FP, OR=2.13, CI=(1.3-

1.22). The difference between women and men in their approval of FP was highly significant as P-value was <0.001.

Table 5.9: Attitudes of family planning among study population

Variable	Women		Men	
	No.	%	No.	%
1- Meaning of family planning				
Birth spacing	278	73.2	250	65.8
To have children when they want	34	8.9	46	13.6
Limiting of fertility	53	13.9	39	11.5
Others	15	4	4	1.2
X^2 = 3.95		**P- value=0.139**		
2- Approve F.P				
Yes	340	89.7	274	80.4
No	39	10.3	67	19.6
OR=2.13 C.I=(1.36-3.34)		**X^2 = 12.5**		**P-value=0.000**
3- Desired family size				
≤6 children	236	77.6	130	52.4
>6 children	68	22.4	118	47.6
OR=3.15 C.I=(2.15-4.63)		**X^2 = 38.860**		**P-value=0.000**
4- Desired birth interval				
≤2 years	221	62.4	233	72.1
>2 years	133	37.6	90	27.9
OR=1.56 C.I=(1.11-2.18)		**X^2 = 7.20**		**P-value=0.007**
5- Religion				
Against F.P	49	12.9%	56	16.4
Not against F.P	278	73.1%	247	72.4
Don't know	53	14	38	11.1
X^2 = 2.44		**P- value= 0.294**		
6- Political situation				
FP not serve political situation	146	38.9	140	41.4
FP serves political situation	198	52.8	179	53.0
Don't know	3.1	8.3	19	5.6
X^2 = 2.05		**P-value= 0.359**		

5.6.2 Desired family size among respondents:

As it is shown in table (5.9) about 78% of women in the study population were like to have ≤ 6 children and the other 22% were like to have > 6 children while 52% of participated men were like to have ≤ 6 children and about 48% of participated men were like to have > 6 children. The mean number of children women were like to have was 5.8 and for men it was 7.3. There was a difference between women and men in their desired family size, as men who were like to have bigger family size "family size > 6 children" were about three times than women who were like to have family size > 6 children, the difference was highly statistically significant as P-value was < 0.001.

5.6.3 Desired birth interval among respondents:

The desired birth interval among respondents was categorized into two groups ≤ 2 years and > 2 years, about 62% of participated women were like to have birth interval ≤ 2 years and about 38% of them were like their birth interval to be > 2 years, while about 72% of participated men were prefer birth intervals to be ≤ 2 years and about 28% of them were like it to be > 2 years. The difference between women and men in their desired birth interval was statistically significant, as women were like to have longer birth intervals than men, women who were like to have birth interval > 2 years were about 1.6 times than men who were like to have birth interval > 2 years, OR=1.56 with CI = (1.11-2.18), P-value= 0.007. These results indicate that men have less awareness towards the benefits of birth spacing than women and this may be due to lack of knowledge about maternal and also child health.

5.6.4 Believes about religion and Palestinian political situation with family planning:

About 13% of participated women and about 16% of participated men believed that religion is against FP, while 73% of women and 72% of men believed that religion is not against FP, the others didn't know if religion against or with FP.

Two nationally representative surveys, one of 1000 married women aged 15-49 and the other of 1000 men married to women aged 15-49, and a census of all Muslim religious leaders in Jordan collected information on knowledge, attitudes and beliefs regarding family planning, and sources of information about it. Eighty percent of men, 86% of women, 82% of male religious leaders and 98% of female religious leaders believed that family planning is in keeping with the tenets of Islam. Among religious leaders, 36% reported that they had preached about family planning in the year preceding the survey

Respondents were asked about their point of view in that if FP serves Palestinian political situation or not, about 53% of participated women and also about 53% of participated men were believe in that FP serves political situation while 39% of women and 41% of men were see that FP doesn't serve Palestinian political situation. The others were having no idea about that issue. Men believed in that religious and political factors against FP more than women, but the difference was not statistically significant.

5.7 Men involvement in family planning

As we mentioned before men have the main role in decision of family size and the final decision in using family planning. So involvement of men in family planning services is important to be studied and to examine how we can encourage men. The involvement of men in family planning would therefore not only ease the responsibility borne by women in terms of decision-making for family-planning matters, but would also accelerate the

understanding and practice of family planning in general. Variables related to men involvement in family planning, from where they can get knowledge of family planning, is it acceptable for them to visit family planning clinics, if not why it is not acceptable and their opinion of mass media as a way to provide the required information about family planning and if they support their wives in using contraceptives.

Table 5.10: Men involvement in the study population

Variable	Frequency	Percentage
1. Source of information of F.P.		
Wife	117	37.3
Mass media	97	20.0
Health centers	35	11.2
Friends	35	11.2
Don't know	46	14.7
Others	18	5.8
2. Visit F.P. clinics		
Yes	120	35.6
No	217	64.4
3. Reasons of inability to visit F.P. clinics		
Embarrassment	78	44.6
Women work	74	42.3
Others	23	13.1
4. Husband approved mass media to provide information of F.P.		
Yes	248	72.7
No	55	16.1
Don't	38	11.1

As it is shown in table (5.10) the main source of information of family planning for men were from their wives with about 37% of respondents, then through mass media constitutes about 20% of all sources, 15% of respondents didn't know from where they can get information of family planning and about 11% of them mentioned that they got the

information from health centers, and also about 11% of them got the information from friends ,so these results indicates men's lack of access to services which has been a barrier to family-planning use.

Men cannot share responsibility for reproductive health and family planning if services and information do not reach them. The percentage of men who mentioned that they can visit family planning clinics represents about 36% of respondents, the other 64% of them revealed that they couldn't visit family planning clinics mainly because most FP clinics cater to women, so men are uncomfortable and feel with embarrassment about going to these clinics. Men must be reached in other ways.

Men who approved that mass media is a good way to provide FP knowledge for them constitutes about 73% of participated men, about 16 % did not agree with that, and about 11% of them did not know if it can be a good method or not.

So we concluded that involving men and obtaining their support and commitment to family planning is very important in Palestinian society. IPPF concluded the same in African region, as men given their elevated position in the African society. Most decisions that affect family life are made by men. Most decisions that affect political life are made by men. Men hold positions of leadership and influence from the family unit right through the national level (IPPF, 1984).

Jordanian study of family planning also mentioned that programs to encourage men's involvement in family planning should be expanded and also interventions to increase knowledge and interest of men, such as information, education, and communication campaigns using mass media, and interventions to increase access and use of FP services by men such as community-based distribution, workplace programs a few male clinics and

focused male-involvement programs can have an impact on both male and female behaviors related to reproductive health (Jordan National Population Commission, 1995).

5.8 Family planning knowledge by socio-demographic characteristics of respondents

Table (5.11) and (5.12) represent the relationship between women and men knowledge with selected socio-demographic characteristics, which are age of women and men and educational level of them.

5.8.1 Relationship of women knowledge of family planning with women age and educational level:

Table (5.11) represents the relationship between women knowledge and selected socio-demographic characteristics, which are women's age and educational level.

Table 5.11: Distribution of women family planning knowledge by socio-demographic characteristics

Variable	Women Knowledge of FP				X^2	P-value
	Yes		No			
	No.	%	No.	%		
Women age						
15-24 years	69	81.2	16	188		
25-34 years	166	96.5	7	4	24.900	0.000
35-49 years	119	97.5	3	2.5		
Educational level of women						
Low	21	63.6	12	36.4		
Medium	186	74.4	64	25.6	7.001	0.030
High	82	84.5	15	15.5		

The women FP knowledge significantly increased from 81.2% of young women with age group from 15 years to 24 years had FP knowledge, to 96.5% among the second age group,

and 97.5% among ages from 35 to 49 years old. So FP knowledge increased with age. The difference between the two age groups reached a statistical significant level as (P<0.001).

The knowledge of women among high- educated women with percentage 84.5% was higher than knowledge among medium and low- educated women with percentages 74.4% and 63.6% respectively, which is statistically significant (P=0.03).

So we concluded from the results of this study that as educational level of women increases knowledge of family planning.

UN, (2003) reported that increased education for women does not always lead to reducing fertility, but allows for more investment in their children in the form of more schooling and better health. This higher investment increases the cost of having an additional child and may lead to a fall in the demand for children (UN 2003).

5.8.2 Relationship of men knowledge of family planning with men's age and educational level:

Table (5.12) represents the relationship between men knowledge and selected socio-demographic characteristics, which are men age and educational level. There was significant difference in FP knowledge among men with respect to their ages. The men FP knowledge significantly increased from 33.3% among young men with age group less than 24 years, to 65.7% among the second age group, and 65.6% among ages more than 35 years old (P=0.021).

The knowledge of men among high- educated men with percentage 63.8% was higher than knowledge among medium and low- educated men with percentages 65.5% and 58.5% respectively, but was not statistically significant (P=0.710).

Table 5.12: Distribution of men family planning knowledge by socio-demographic characteristics

Variable	Men Knowledge of FP				X^2	P-value
	Yes		No			
	No.	%	No.	%		
Husband age						
≤ 24 years	6	33.3	12	66.7	7.7	0.021
25-34 years	88	65.7	46	34.3		
≥35 years	126	65.6	66	34.4		
Educational level of husbands						
Low	24	58.5	17	41.5	0.68	0.710
Medium	108	65.5	57	34.5		
High	88	63.8	50	36.2		
Women knowledge of FP					64.228	0.000
Yes	200	75.2	66	24.8		
No	20	25.6	58	74.4		

5.9 Distribution of family planning practice by socio-demographic characteristics

Regarding socio-demographic status, the researcher identified which women had ever used FP more frequent within the variations of socio-demographic indicators. Selected variables were chosen to study the relationship between them and FP practice, which are women age, women educational level, husband educational level, working status of women and financial status of families, as demonstrated in table (5.13).

5.9.1 Family planning practice according to women age:

The researcher intended to study if women age affect the percentage of contraceptive use, as it is shown in table (5.13) there was strongly statistically significant difference of FP ever used with respect to women age (P<0.001), as the age of women increases the percentage of use FP increases significantly, it was 97.3% in women with age group from

35 to 49 years old, and decrease to 72.3% in age group from 25 to 34 years old and dramatically decrease in women aged 15 to 24 years old despite that the mean marital age among respondent was 18.9.

Table 5.13: The relationship between family planning practice and selected socio-demographic characteristics

Variable	Ever use FP				X^2	P-value
	Yes		No			
	No.	%	No.	%		
Women age group						
15-24 years	31	36.5	54	63.5	45.92	0.000
25-34 years	125	72.3	48	27.7		
35-49 years	96	97.3	25	20.7		
Women educational level						
Low	16	48.5	17	51.5	7.451	0.024
Medium	164	65.9	85	34.1		
High	72	74.2	25	25.8		
Husbands educational level						
Low	30	61.2	19	38.8	7.869	0.020
Medium	115	62.2	70	37.8		
High	110	75.9	35	24.1		
Women working status						
Working	53	88.3	7	11.7	14.350	0.000
Not working	202	63.3	117	36.7		
Financial status of family						
Under poverty line	141	62.7	84	37.3	15.933	0.000
Above poverty line	53	89.8	6	10.2		

5.9.2 Family planning practice according to educational level of women and their husbands:

Respondents were categorized into three categories according to the level of education. The first category with a level of education 6 years and less, second group from 7 to 12 years and the third group was more than 12 years of education. Family planning practice was increasing significantly with increasing the level of education either of women or

husbands. Percentage of FP practice was 74.2 % among highly educated women, while it was 65.9% and 48.5% among medium and low level of education respectively (P=0.024). The difference in the percentage of women FP use with respect to men educational level was also statically significant, as it increase from 61.2% to 62.2% and 75.9% among low, medium and high educational level respectively (P=0.020).

5.9.3 Family planning practice according to working status of women:

The population studied showed a high rate of unemployment, around 84.2% of respondents were unemployed and 15.8% of them were unemployed. These findings are approximately consistent with high unemployment rate among Palestinian women in Gaza provinces. The relationship between FP use and women working status is demonstrated in table (5.13) which was strongly statistically significant, as the percentage of women who ever used FP among not working women was 63.3% which increased to 88.3% among not working women (P<0.001).

5.9.4 Family planning practice according to financial status of families:

Regarding financial status of the families involved in the study, the researcher classified family income according to PCBS definition of poverty into two levels, under poverty line those families with monthly income less than or equal 1,642 NIS, and above poverty line those with income more than 1,642 NIS. The relationship between Financial status of Palestinian families and FP practice among respondents was demonstrated in table (5.13), where it was strongly significant, as poor families whose their monthly income is below poverty line were practicing FP less than families who are classified above the poverty line, with percentages 62.7% and 89.8% respectively (P<0.001).

These results can be explained by that low economic status of families leads to decrease other factors like educational, social levels and decrease the investment of the child and as we mentioned before these factors are associated with low percentage of knowledge and practice of family planning.

5.10 Desired family size of participated women according to socio-demographic characteristics

The relationship between the desired family size (desired number of children in the family) by women in the study population, and selected socio-demographic factors, women age**,** educational level "low, medium and high", working status, occupation and financial status of their families shown in table (5.14).

5.10.1 Distribution of women's desired family size by women age:

As shown In this study young women who categorized in age group from 15 to 24 years old, were found to be more likely to have less family size than other older ages, the percentage of women in age group from 15 to 45 years old who desired to have children ≤ 6 children is 90.5% and who desired to have >6 children is 9.5%, the percentage of women who did like to have ≤6 children among women aged from 25 to 34 years is 79.2% and who did like to have > 6 children is 20.6%, among women aged from 35 to 49 years old, women who did like to have > 6 children represented 36% of them, so there were significant difference between women age groups according to their desired family size ($P<0.001$).

Table 5.14: Distribution of women's desired family size by socio-demographic characteristics

Variable	Desired no. of children				X^2	P-value
	≤6		>6			
	No.	%	No.	%		
Women age group						
15-24 years	67	90.5	7	9.5	16.826	0.000
25-34 years	112	79.2	29	20.6		
35-49 years	57	64.0	32	36.0		
Women educational level						
Low	16	64	9	36	5.190	0.023
Medium	148	76.3	46	23.7		
High	72	84.7	13	15.3		
Women working status						
Working	41	83.7	8	16.3	1.228	0.268
Not working	195	76.5	60	23.5		
Women occupation						
Professional	34	94.4	2	5.6	14.760	0.002
Non skilled	6	60	4	40		
Pocket money	0	0	2	100		
Unemployed	196	76.6	60	23.4		
Family Financial status						
Under poverty line	132	72.9	49	27.1	10.27	0.001
Above poverty line	48	94.1	3	5.9		

5.10.2 Distribution of women's desired family size by women educational level:

Also there were a significant difference of desired family size by women according to their educational level (P=0.023), where the percentage of women who were like to have > 6 children were 36% among low educational level, decreases to 23.7% and then it decreases to 15.3% among medium and high educational level respectively as it is shown in table (5.14). Highly educated women, educational years more than 12 years, were found to be more likely to have less family size than other women with lower educational level, medium and low levels, from 0 to 6 years and from 7 to 12 years respectively.

5.10.3 Distribution of desired family size by women according to working status and occupation of women:

The percentage of women who preferred to have > 6 children among working women were 16.3%, which is less than it among not working women where it was 23.5%, but this difference was not significant where P-value was 0.268.

But the difference of percentages of women who preferred to have > 6 children among different occupations were significant, the percentage of women who preferred to have > 6 children among professional working women was 5.6%, while it was 40% among non skilled working women.

5.10.4 Distribution of desired family size by women according to financial status of their families:

The percentage of women who preferred to have > 6 children among poor families was 27%, which is more than it among families above poverty line as it was 6%, this difference was statistically significant, P-value =0.001.

5.11 Desired family size of men according to socio-demographic characteristics

The researcher examined the relationship between the desired family size or desired number of children in the family by men, and selected socio-demographic factors like educational level of men " low, medium and high", their working status "employed or not", occupation and financial status of their families, as shown in table (5.15).

5.11.1 Distribution of desired family size by men according to their educational level:

The percentage of men who preferred to have > 6 children among men with low educational level was 71.4%, decreases to 52.6% and 35.6% among men with medium and high educational level respectively, this difference was significant, as P-value (0.001) as it is shown in table (5.15). So highly educated men whose years of education is more than 12 years, were found to be more likely to have less family size than other men with lower educational level, low and medium levels, from 0 to 6 years and from 7 to 12 years respectively.

Table 5.15: Distribution of men desired number of children by socio-demographic characteristics

Variable	Desired no. of children				X^2	P-value
	≤6		>6			
	No.	%	No.	%		
Men educational level						
Low	8	28.6	20	71.4	13.40	0.001
Medium	54	47.4	60	52.6		
High	68	64.2	38	35.8		
Men work status						
Working	103	56.9	78	43.1	5.407	0.02
Not working	27	40.3	40	59.7		
Men occupation						
Skilled and professional	45	68.2	21	31.8	13.7	0.003
Non skilled and merchants	35	43.2	46	56.8		
Police men	20	64.5	11	35.5		
Unemployed and pocket money	30	42.9	40	57.1		
Men knowledge of FP						
Yes	97	66	50	34	26.638	0.000
No	33	327	68	67.3		
Family Financial status						
Under poverty line	70	45.8	83	54.2	9.733	0.002
Above poverty line	30	73.2	11	26.8		

5.11.2 Distribution of desired family size by men according to their working status and occupation:

The percentage of men who preferred to have > 6 children among employed men were 43.1%, which is less than it among not employed men where it was 59.7%, this difference is statistically significant where P-value was (0.02).

The percentage of men who preferred to have >6 children among skilled and professional men was 31.8%,and it was 35.5% among policemen while it was 56.8% among non skilled men and merchants and 57.1% among unemployed and pocket money employed men. The findings are highly statistically significant with P-value equals to (0.003).

To explore this difference of desired family size among different occupational categories, and the significance of this difference the researcher conducted further statistical tests, the results are shown in table (5.16).

Table 5.16: The relationship between desired family sizes by men among different occupations

Variable	O.R of family size ≤6	Confident interval	X^2	P-value
Skilled and professional	2.86	(1.34 - 6.14)	8.81	0.002
Policemen	2.42	(0.93 - 6.39)	4.03	0.045
No skilled and merchants	1.01	(0.51 - 2.04)	0.00	0.965
Unemployed and Pocket money	1	(0.48 - 2.06)	0	1

As it is shown in table (5.16), men who are in skilled and professional occupations preferred to have smaller family size "family size ≤6", about 3 times than those men who are unemployed or pocket money employees with P-value equals 0.002 which is highly statistically significant, so men in highly prestige occupations preferred to have smaller

family size. Policemen also were found to like smaller families than unemployed men; they preferred to have smaller family size "≤6 children" 2.4 times than unemployed men, with P-value equals 0.045. The desired family size by non skilled employed men and merchants were not different from that for unemployed men (OR=1.01, P-value=0.965), so both groups were the same in their desired family size.

5.11.3 Distribution of desired family size by men according to their knowledge of family planning:

As it is shown in table (5.15), men who have knowledge about FP are more likely to have less family size than those who don't have FP knowledge. As the percentage of men who preferred to have >6 children among men who have sufficient knowledge about FP was 34%, and it was 67.3% among those who haven't such knowledge. The difference is highly significant with P-value equals to 0.000. So knowledge of FP can affect the attitudes of men towards family planning and family size.

5.11.4 Distribution of desired family size by men according to financial status of their families:

The percentage of men who preferred to have more than 6 children among poor families (less than poverty cut of point) and families who are classified above poverty line, were 54.2% and 26.8% respectively. So men in families with monthly income less than the poverty cut of point were found to be more likely to have larger family size than those above poverty line, this difference was statistically significant as P-value equals 0.002.

5.12 Relationship between marital age and family size:

The researcher found that it will be worthy to examine the relationship between marital age of women in the study population and family size (number of children the woman has).

Table 5.17: Independent t-test for women marital age by family size and child mortality

variables	Mean	Standard deviation	t-test	p-value
Women marital age			4.647	0.000
Family size ≤6	19.22	2.85		
Family size >6	17.66	2.96		

The mean marital age of women who were having ≤6 was 19.22 which is more than it for women who were having > 6 children which was 17.66, which means that women who married early (with low marital age), had larger family size, the difference is highly statistically significant as it is shown in table (5.17) as P<0.001.

5.13 Child mortality according to family size and birth interval

MMWR, 1999 mentioned that as fertility decreased as couples chose to have fewer children child mortality declined. Smaller families and longer birth intervals have contributed to the better health of infants, children, and women.

Our study examined this relationship between family size and presence of child mortality, and the results was corresponding to what is mentioned by MMWR.

As it is shown in table (5.18) there was a significant relationship between increasing family size and having child death, as family size increased the percentage of having child death increased too, the percentage of having child deaths among families who were have family

size ≥ 6 children is 28.3% while it was 17.8% among families who were have family size < 6 children, so families who have family size ≥ 6 children are 1.8 times or about two times are more likely to have child death than families with birth interval < 6 children. The findings are significant as P-value=0.017.

Table 5.18: Child mortality according to family size, birth interval and marital age

Variable	Child mortality				X^2	P-value
	Yes		No			
	No	%	No	%		
Family size						
Family size <6 children	41	17.8	189	82.2	5.684	0.017
Family size ≥ 6 children	41	28.3	104	71.7		
O.R=1.82 C.I = (1.08-3.07)						
Birth interval						
Birth interval < 2	34	36.2	60	63.8	8.64	0.003
Birth interval ≥ 2	48	20.6	185	79.4		
O.R=2.18 C.I=(1.25-3.83)						
Marital age						
Marital age <18 years	43	32.6	89	67.4	13.67	0.000
Marital age ≥18 years	39	16.0	204	84.0		
O.R=2.53 C.I=(1.49-4.30)						

Our study also revealed that there was a strong significant relationship between short birth interval and increasing child mortality, as it is shown in table (5.18), among women who had birth interval less than two years the percentage of child mortality (36.3%) was higher than it among those with birth interval two years or more where it was (20.6%), so death of children among women with birth intervals less than two years was about two times more

than it among women with birth intervals two years or more (O.R=2.18), this result is highly significant where P-value=0.003.

As it is shown in table (5.18), the relationship between marital age of women and having died children was also strongly significant, so early marriage was associated with increase the incidence of child mortality, as our study revealed that the percentage of child mortality among early marriage which is <18 years old, was 32.6% while it was 16% among those with marital age ≥ 18 years old, OR was (2.53) which means that child mortality was two times more among early married women than those women with marital age at least 18 years old, the relationship was highly significant as P-value<0.001.

Findings from the Population Reference Bureau in US, 1997 show the same results of our study as it mentioned that, lower fertility produces healthier children. The findings shows also that closely spaced children (less than two years apart), children with many siblings, and children born to younger and older mothers are all more common at higher levels of fertility, and all face higher child mortality risks. USA data show that children born less than two years apart are twice as likely to die in the first year of life as those born after an interval of at least two years; the findings are in accordance with our study findings (Population Reference Bureau, 1997). Scientifically, closely spaced pregnancies are more likely to result in low-birth weight babies. Close spacing also interferes with breast-feeding, which has a vital role in child nutrition and in building the child's resistance against infectious disease. Family planning can help women achieve optimum spacing between births.

5.14 Relationship between family size decision making and selected socio-demographic factors

This study revealed that, decision of family size was mainly taken by husbands and small percentage was taken by women, so the researcher was interested to examine some factors that they might affect family size decision making, these factors were years of education of women and men and women marital age. To study the relationship between family size decision making and these factors, a t-test was conducted and the findings are presented in table (5.19).

Table 5.19: Relationship between family size decision and selected socio-demographic factors

Variable	Decision of family size	mean	Standard deviation	t-test	P-value
Women years of education	**-Husband**	10.43	2.91	-8.642	0.000
	-wife	16.25	2.57		
Men years of education	**-Husband**	11.22	3.83	-5.011	0.000
	-Wife	15.85	5.16		
Marital age of women	**-Husband**	17.87	2.62	-7.582	0.000
	-wife	22.55	2.91		

5.14.1 Relationship between family size decision making and years of education of women:

As it is shown in table (5.19), as the years of education of women increased they became more likely to take the decision of size of their family. The mean years of education of women among families whose family size decision making was taken by husbands, was 10.43 years, and it was 16.25 years for those families where decision was taken by women, the difference is highly significant, P-value < 0.001. This means that there is significant

positive relationship between woman years of education and her ability to take a decision in her family size.

5.14.2 Relationship between family size decision making and years of education of husbands:

The mean years of education of husbands among families in which family size decision making was taken by husbands, was 11.22 years, which is much less than it among families in which family size decision making was taken by women where it was 15.85 years, as it is shown in table (5.19). The relationship between both factors was highly significant with P-value equals < 0.001.

5.14.3 Relationship between family size decision making and women marital age:

As marital age of women increased, they became more likely to have their decision in family size. The mean marital age of women among families in which family size decision making was taken by husbands, was 17.87 years, which is much less than it among families in which family size decision making was taken by women where it was 22.55 years, as it is shown in table (5.19). The findings are highly significant with P-value is < 0.001.

Chapter 6

Conclusion and Recommendations

Conclusion

This study assesses family planning knowledge, attitudes and practice of Palestinian couples in Gaza Strip. In order to ensure that the sample was geographically representative, a proportional stratified, multistage and clustering sample was used and randomly selected. The response rate was high as 95% among women while it was 88% among their husbands. There was a high percentage of knowledge of FP methods among respondents, FP knowledge among women was significantly more than it among men, participants were aware of most family planning methods, but lacked in-depth knowledge.

Comparing to this high percentage of knowledge the percentage of currently practicing FP among participating women was low.

Findings of this study showed that there is a high percentage of approval of family planning among Palestinian women where there was about 90% of women approved the use of family planning compared to 72% of men approved the use of family planning, and due to that the percentage of women who had ever used contraceptives was 66.5%. But that approval of family planning did not mean to have small number of children because 22% of participated women preferred to have more than 6 children and about 48% of participated men preferred to have > 6 children, the mean number of children that women preferred to have was about six children and for men it was about 7 children. And also approval of FP among respondents did not increase the desired birth interval among respondents as there

was high percentage of women and men were like short birth interval as about 62% of participant women were like to have birth interval ≤ 2 years while about 72% of participant men preferred birth intervals to be ≤ 2 years, and we mentioned before in the study the negative impact of short birth interval on women and child health.

So despite of high percentage of FP approval among respondents the desired family size is still high, many women and men preferred to have more children. But the desired family size by men was significantly more than women.

This study revealed the importance of men in family decision as results indicated that husbands have the main role in decision of family size and the final decision in using family planning. So husband's support is found to be a good predictor of future practice and continued use of family planning. And as men in this study preferred to have more children than women, the result will be larger families as they have the final decision, so men involvement in family planning means more than increasing the number of men using male contraceptives, men involvement also includes the number of men who encourage and support their partner and their peers to use FP and who influence the policy environment to be more conducive to developing male-related programs. In this context "male involvement" should be understood in a much broader sense than male contraception, and should refer to all organizational activities aimed at men as a discrete group which have the objective of increasing the acceptability and prevalence of family planning practice of either sex.

As the desired family size by both women and men in Palestinian population is still high there is a question always be asked why women or men desire so many children and how

this desire can be influenced", this is the most complex, because it must act through two approaches, biological and social ones. Most national policies have been aimed only at the biological aspect, enhancing the ability of couples to control their fertility. That is why family planning programs not always work or succeed to decline fertility, so in order to decline fertility we must work on motivation as it on technology, that the desire for fewer children spreads quickly if a strong motivation exists, but without this, FP program are not likely to achieve their aims. A good FP program must work in the context of a changing social environment that encourages couples to have fewer children and discourages them from having large families.

The study results in that FP knowledge among women was significantly more than it among men. Men in the study revealed that it was difficult for them to visit FP clinics because most or even all the clients there were women, so men must be reached in other ways.

Mass media as a source of information of FP was considered a good way for many men participant in the study as about 73% of them accept that FP information can be useful through mass media as Television programs.

As it was shown in the study there was a significant positive relationship between women educational level, marital age and women knowledge, practice and attitudes towards FP and also in her role in decision making in family life and to increase the possibility of participation and talking with their spouses about family life. So empowering Women is an important aspect to be discussed when talking about family planning practice, change in the gender roles taught to boys and girls, giving equal treatment to the sexes in the

educational and occupational spheres. If the woman's femininity should be expressed in other ways besides childbearing, any policy aimed at affecting motivation will have to alter the way people perceive the social world and how they deal with their environment on an everyday basis.

The findings from this study have demonstrated that three principal variables - education, fertility decisions and communication- have significant impact on the likelihood of bringing fertility to a much reduced level. These findings have major policy implications.

Finding of this study showed that families who are financially below poverty line were practicing FP less than those above poverty line; they preferred to have more children than those above poverty line. So we concluded that poverty is linked to low social, low educational levels younger marital age and less investment for the child, and all these factors were found to increase family size and less practicing FP.

Child mortality was found in this study to be positively and significantly related to large family size, short birth interval and young marital age. The findings show that closely spaced children (less than two years apart), children with many siblings, and children born to younger mothers are all facing higher child mortality risks.

Recommendations

Efforts to be done according to the following recommendations can have a positive impact to improve women lives either in health and social aspects and also their families and thereby the whole community. Policy makers and programs managers can take the following recommendations in order to achieve that:

- The fact that the quality of care is the most critical factor which will enable the primary health care/family planning programs to attract more clients and improve the reproductive health of women should be widely disseminated.
- More efforts must be made to enhance quality of care of family planning programs, provide training and supervision, training in interpersonal communication and counseling skills. Contraceptives should be freely available for the less advantaged population.
- There is a need for health education programs to bring to the consciousness of men and women the impact of small family size. Using mass media to disseminate this information will be useful to carry a message for each Palestinian family, men and women, especially men due to poor access of information for them.
- Working on the social level, try to encourage a motivation by women and men to have smaller families, this can be achieved by certain activities made by social organizations and programs. Reference to the economic conditions and demands of modern society should be effectively used in increasing population awareness including family size regulation through the acceptance and adoption of family planning in the country.

- Male involvement in FP program, to design effective information, education and communication strategies to reach men. Various service-delivery strategies to meet these needs can be provided in a variety of ways, including primary health care facilities like special hours for men in FP clinics, male-only clinics, FP campaign and educational programs to students in the high schools and universities.
- Activities to increase awareness about the disadvantages of early marriage should be included in primary health care/family planning centers.
- Activation and strict implementation of the rule that prevents marriage below 18 years old.
- Women empowerment, women organizations need to work more in order to improve women situations, gender role in family life and society and try to solve the problem of young marital marriage. Equal treatment of both males and females in education and working situations.
- More investment in family planning programs should be encouraged as a part of economic development process.
- Health professionals and research agencies need to support research and evaluation of family planning program.
- The same study is needed to be conducted in West Bank to generate the results in Palestine.
- Further studies about family planning perception by couples with special emphasis on men; qualitative studies are advised in order to take in depth information from people and try to reach to the real social and cultural factors that affect Palestinian family life.

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Annexes

Annex 1
Map of Palestine

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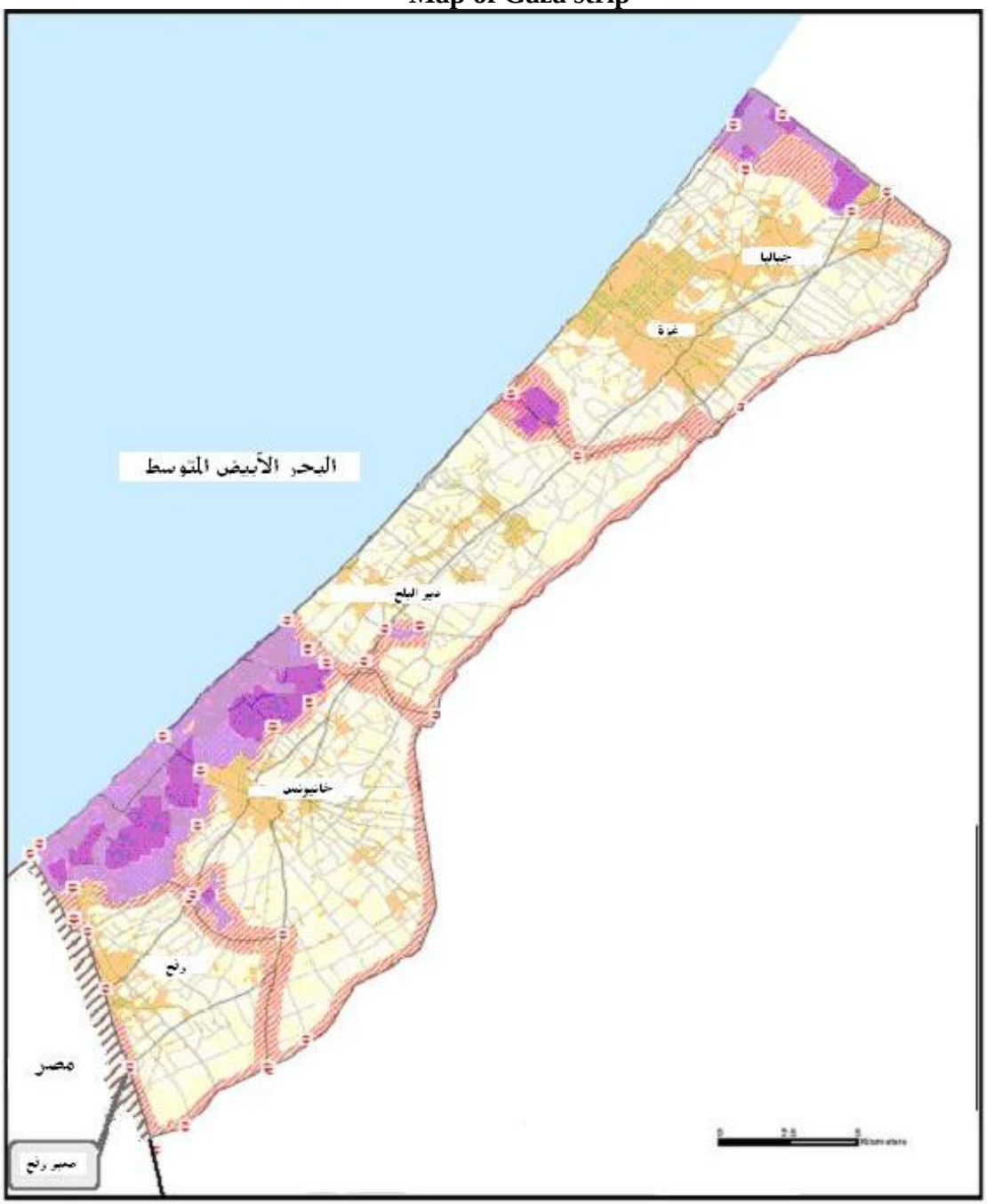
Annex 2

Map of Gaza strip



Ref/UNRWA annual report 2003

Annex (3)

بسم الله الرحمن الرحيم

إلى منسق لجنة هلسينكي : د: سوزان شعشاعة حفظها الله.

الموضوع: الموافقة على إجراء بحث بعنوان:

"Knowledge, attitudes, and practice of family planning among Palestinian couples"

"المعرفة, التوجهات و الممارسة لتنظيم الأسرة بين الأزواج الفلسطينيين"

و شكرا لتعاونكم

مقدم الطلب :

الطالبة : غادة يوسف أبو نحلة

Ghada Yousif Abu Nahla

Annex (4)

موافقة على إجراء استبيان حول دراسة " المعرفة, التوجهات و الممارسة لتنظيم الأسرة بين الأزواج الفلسطينيين في قطاع غزة".

أنا الطالبة غادة يوسف أبو نحلة أدرس في برنامج ماجستير الصحة العامة التابع لجامعة القدس– أبو ديس وفي إطار البرنامج المذكور يجب تنفيذ بحث لتقديمه كأطروحة التخرج ولهذا الغرض فقد وافقت الجامعة على دراسة " **المعرفة, التوجهات و الممارسة لتنظيم الأسرة بين الأزواج الفلسطينيين في قطاع غزة**" ومن المتوقع أن تساعد المعلومات المزمع جمعها في هذه الدراسة مقدمي الخدمات في دوائر عديدة سواء كانت وزارة الصحة أو وكالة الغوث لتخطيط الخدمات ذات العلاقة بشكل أكثر جدوى ومنفعة للمجتمع الفلسطيني بصفة عامة و المراة الفلسطينية بصفة خاصة.

. سأقدر جدا اشتراككم في الدراسة

تتطلب تعبئة الاستبيان بين 15–20 دقيقة لإتمامه، علما بأن كافة المعلومات التي سيتم جمعها ستستعمل لأغراض البحث العلمي فقط وستبقى سرية ولن تكشف هوية أصحابها لأي شخص كان .

الاشتراك في هذا الاستبيان طوعي وللمجيبة و المجيب الخيار في عدم إجابة أية سؤال أو أسئلة. على أية حال بما أن رأيك مهم فنحن نأمل أن تشاركي في هذه الدراسة .

الجهات المعنية. الدراسة ممولة من الباحث فقط وقد حصل الباحث على الموافقة من

و لكم مني كل الشكر

التاريخ:_____ توقيع جامع المعلومات _____

☐ المجيب يوافق على إجراء اللقاء ☐1– المجيبة توافق على إجراء اللقاء

☐ المجيب لا يوافق على إجراء اللقاء☐2– المجيبة لا توافق على إجراء اللقاء

استبيان

"لدراسة المعرفة, التوجهات و الممارسة لتنظيم الأسرة بين الأزواج الفلسطينيين في قطاع غزة"

رقم الاستبانة ☐☐☐

العنوان:

1. الشمال 2. غزة 3. المنطقة الوسطى 4. خانيونس 5. رفح

المنطقة:

1. حضر 2. ريف 3. مخيم

العنوان بدقة : _____

رقم الهاتف : _____

تاريخ إجراء المقابلة: ___/___/____

القسم الأول : خلفية المستجيبة

1. الاسم:.....

2. الرقم المسلسل:.....

3. تاريخ الميلاد؟
..... سنة..... شهر ..... يوم

4. أكم سنة عمرك؟ ..... سنة

5.أكم سنة خلصت دراسة ؟..... سنة

6.هل بتشتغلي شغل ثاني غير شغل البيت؟
1. نعم (استمري)
2. لا (انتقلي الى سؤال 8)

7. ايش بتشتغلي؟
----

8 . قديش كان عمرك أول ما تزوجتي؟ ..... سنة

7. قديش كان عمر زوجك لما تزوجتي؟ ..... سنة

8. أكم سنة صار لك متزوجة؟ ..... سنة

9. أكم سنة عمر زوجك؟ ..... سنة

10. أكم سنة خلص زوجك دراسة ؟ ..... سنة

11. بيشتغل زوجك؟
1. نعم
2. لا (انتقلي الى سؤال 13)

12. ايش بيشتغل ؟
----

13. بساعدك زوجك في شغل البيت في الوقت الحاضر؟
1. نعم
2 . لا, ليش ----------

14. هل تعيشين أنت و زوجك و أولادك في بيت مستقل أم في بيت العائلة؟
1. في بيت مستقل 2. في بيت العائلة
3 . في شقة, داخل بيت العيلة

القسم الثاني : تاريخ الأمومة

1. عمرك حملتي؟
1 . نعم
2 . لا

2. انتي حامل في الوقت الحاضر؟
1 - نعم
2 - لا
3 - غير متأكدة

3. أخر مرة حملتي فيها, كنت حابة تحملي؟
1. نعم (انتقلي إلى سؤال رقم 6)
2. لا (استمري)
3. لا اعرف (انتقلي إلى سؤال رقم 6)

4. ليش ما كنتيش حابة تحملي في المرة الأخيرة؟

1. عدم الرغبة في إنجاب المزيد من الأطفال
2. الانتظار بعض الوقت
3. غير ذلك, (حددي)

.....

5 . ليش حملتي حمل انت ما بدكيش اياه؟

1. ليس لديك معلومات عن منع الحمل
2. رغبة الزوج
3 . رغبة عائلة الزوج
4. أسباب أخرى ,(حددي).....

6. إذا أنت مش حامل في الوقت الحاضر, عندك رغبة تحملي الأن ؟

1. نعم
2 . لا
3. لا ادري

7. طيب, عندك رغبة تخلفي في المستقبل؟

1. نعم
2. لا
3. لا ادري

8. اكم طفل بتحبي يكون عندك؟

1. ..... طفل
2. لا ادري

9. عمرك حكيتي مع زوجك عن عدد الأطفال اللي بدكم تخلفوهم؟

1 . نعم 2. لا

10. مين عادة يقرر عدد الأطفال في أسرتك؟

1 . زوجك 2. انتي
3. انتي و زوجك
4. عائلة زوجك
5. عائتك
6. أخر (حددي) .....

11. اكم ولد وبنت معك؟(خلفتيهم و لسه عايشين)

.....

12. هل ماتلك اولأد او بنات؟
1. نعم 2.لا (انتقلي الى سؤال 15)

13. اكم واحد ماتلك؟ .....

14. لو الست مخلفة 2 أو أكثر, نسألها عن الفترة الزمنية ما بين اخر اثنين؟
.....

القسم الثالث : تنظيم الاسرة

1. شو معنى تنظيم الأسرة بالنسبة لك؟
1. باستطاعتي إنجاب الأطفال متى أريد 2. المباعدة بين الولادات
3. تحديد النسل 4. لا ادري
4. آخر, حددي.....

2. عمرك سمعتي عن وسائل تنظيم الأسرة؟ (يعني المباعدة بين الولادات)
1. نعم 2. لا

3. ايش هي الوسائل الي سمعتي عنها؟
.....

4. بتعرفي كيف تستخدميها؟
1. نعم 2. لا
3. تعرف استعمال بعضها

5. ممكن تشرحي كيف ممكن تستخدميها؟
.....

6. في حالة استعمالك للوسيلة, من وين بتجيبيها؟
1. طبيب خاص
2. صيدلية
3. مستشفيات حكومية
4. مستشفى غير حكومي
5. عيادة حكومية
6. عيادة وكالة
7. جمعية تنظيم وحماية الأسرة
8. أخر (حددي)
.....

7. قديش بدك وقت عشان توصلي لهناك؟ ..... دقيقة

8. لو بدك تعرفي معلومات عن وسائل تنظيم الأسرة, من وين بتفضلي تجيبيها؟

1. طبيب خاص
2. عيادة حكومية
3. عيادة وكالة
4. جمعية تنظيم وحماية الأسرة
5. وسائل الأعلام, لو توفرت
6. اخرى
(حددي) .....

9. عمرك استعملتي وسيلة منع حمل ؟

1. نعم 2. لا

10. اكم مرة استعملتيها؟

.....

11. تقريبا, اكم سنة متواصلة استعملتيها؟ (اذا كانت اكثر من مرة, اكم سنة استعملتها آخر مرة؟)

.....

12. عندك رغبة تستعملي وسيلة من وسائل تنظيم الاسرة في ال 12 شهر الجاية؟

1. نعم (انتقلي الى سؤال رقم 16)
2. لا (انتقلي إلى سؤال رقم 17)
3 . لا ادري (انتقلي إلى سؤال رقم 17)
4. حاليا, بستعمل وسيلة.(استمري)

13. ايش هي الوسيلة الي بتستعمليها؟ .....

14. اكم سنة الك بتستعمليها؟ .....سنة

15. اكم سنة او شهر بدك تستمري باستخدام وسيلة تنظيم الاسرة سواء هذه الوسيلة او غيرها؟

1. ..... شهر .....سنة
2. لغاية ماتبطلي تخلفي
3. لا أدري

16. شو الوسيلة اللي بتفضلي تستعمليها؟

1. الحبوب 2. اللولب
3. الربط 4. عازل/ كوندوم
5. الابر 6. التحاميل
7. طريقة العد
8. لا اعرف
9. آخر (حددي) .....

17. مين اللي في العيلة عندك بقررنوع وسيلة تنظيم الأسرة؟

1. زوجك 2. انتي

3. انتي و زوجك

4. عائلة زوجك 5. عائلتك

7 - اخر (حددي) .....

18. انتي بتايدي تنظيم الأسرة؟

1. نعم 2. لا

19. (اذا كانت الاجابة نعم) شو فوائد تنظيم الأسرة؟

1. أسباب مادية (أستطيع أن أنجب أطفالا حين أستطيع رعايتهم واعتني بهم)

2. من اجل صحة أفضل للام

3. من اجل حياة مهنية أفضل للأم (حتى تستطيع أن تتطور مهنيا)

4. أطفال اقل

5. لا ادري

6. أخر, (حددي) ----------

20. (اذا كانت الاجابة لا) ليش ما بتايدي تنظيم الأسرة؟

1. خوفا من الأعراض الجانبية

2. غير فعالة

3 . حابة أجيب كمان أطفال

4. أسباب دينية

5. أسباب سياسية

6. أخر, (حددي) ----------

22. على فرض أنه كل المواليد عاشوا, قديش لازم يكون الفرق بين مولود واللي بعده؟

1. .....سنة 2. لا ادري

23. لو خلفتي عدد كاف, وكانت معظم خلفتك أولاد فهل سيكون عندك الرغبة في مزيد من الحمل علشان يجيك بنات؟

1. نعم 2. لا

3. لا اعرف

24. لو خلفتي عدد كاف, وكانت معظم خلفتك بنات, فهل سيكون عندك الرغبة في مزيد من الحمل عشان يجيك أولاد؟

1. نعم 2. لا 3. لا اعرف

25. ايش الأسباب التي تخليكي تخلفي كثير؟ (السؤال للسيدات اللواتي يردن انجاب عدد كبير من الاطفال اكثر من 4 اطفال)

1. **عزوة وقوة للعائلة**
2. **مصدر دخل**
3. **حتى يديروا بالهم علينا عند ما نعجز**
4. **عشان جوزي ما يتجوز علي**
5. **عشان بحب الخلفة**
6. **من كثرة حكي الناس والأقارب**
7. **عشان يعوض محل إعاقات الأطفال**
8. **غير ذلك / حددي**

.....

26. برأيك الدين يمانع في استعمال موانع الحمل لتنظيم الأسرة؟

1. نعم 2. لا 3. لا اعرف

27. لو بدك استشارة بأى موضوع من مواضيع تنظيم الأسرة برأيك لمين بتحبي تروحي أول؟

1. طبيب عام	**2. ممرضة**
3. صديقة	**4. جارة**
5. حماة	**6. زوج**
7. أخصائي	**8. امك**
9. غير ذلك /	

حددي.....

28. إذا حبيتي تروحي على عيادة عشان تنظيم الأسرة, برأيك لازم توخذي إذن من حدا؟

1. نعم 2. لا

إذا كانت الإجابة نعم, من مين .....

29. من وجهة نظرك تنظيم الاسرة بتعارض مع وضعنا السياسي و معركتنا مع اسرائيل؟

1. نعم 2. لا 3. لا أعرف

30. اكم دخل الأسرة؟ 1._____شيكل او دولار

2. لا اعرف

31. اذا كانت المبحوثة تعمل نسالها , هل تساهمين في مصروف البيت؟

1. نعم 2. لا 3. لا اجابة

شكرا لتعاونكم

غادة أبو نحلة

استبيان الزوج

1. أكم سنة عمرك؟ ..... سنة

2. أكم سنة خلصت دراسة ؟..... سنة

3. هل بتشتغل؟
   1. نعم (استمر) 2. لا (انتقل الى سؤال 5)

4. ايش بتشتغل؟
   ---

5. قديش كان عمرك أول ما تزوجت؟ ..... سنة

6. قديش كان عمر زوجتك لما تزوجت؟ ..... سنة

7. كم سنة صار لك متزوج؟ ..... شهر ..... سنة

8. أكم سنة عمر زوجتك؟ .....

9. بتساعد زوجتك في شغل البيت؟
   1. نعم 2 . لا, ليش

.....

10. أكم طفل (ولد, بنت) بتحب يكون عندك؟ ..... طفل
    2 - لا ادري

11. عمرك حكيت مع زوجتك عن عدد الأطفال اللي بدكم تخلفوهم؟
    1. نعم 2. لا

12. مين عادة يقرر عدد الأطفال في أسرتك؟
    1 . انت
    2. زوجتك
    3. انت و زوجتك
    4. عائلتك
    5. عائلة زوجتك
    6. أخر (حدد).....

13 . شو معنى تنظيم الأسرة بالنسبة لك؟

1 - باستطاعتي إنجاب الأطفال متى أريد
2 - المباعدة بين الولادات
3 - تحديد النسل
4 - أخر (حدد) .....

14. عمرك سمعت عن وسائل تنظيم الأسرة؟ (يعني المباعدة بين الولادات)

1. نعم (استمر) 2. لا (انتقل الى سؤال رقم 17))

15. من وين سمعت عن وسائل تنظيم الأسرة؟

1. الزوجة
2. العيادة (المركز الصحي, حكومة او وكالة)
3. اصدقاء
4. جار
5. وسائل الاعلام
6. مصادر اخرى,

حدد.....

16. ايش الوسائل الى بتعرفها او سمعت عنهاا؟

.....

17. لو بدك تعرف معلومات او استشارة باي موضوع من مواضيع تنظيم الأسرة, وين ممكن تروح؟

1. عيادة تنظيم الأسرة (الحكومة)
2. عيادة تنظيم الأسرة "الوكالة"
3. عيادة تنظيم الأسرة "مؤسسة خاصة"
4. طبيب عام
5. ممرض
6.اخصائي
7. لا ادري

18. هل عادي انك تروح على عيادة تنظيم الأسرة؟

1. نعم 2. لا,

ليش.....

18. هل ترى ان وسائل الاعلام خاصة التلفزيون , وسيلة جيدة للشرح و التعريف بوسائل تنظيم الاسرة؟

1. نعم
2. لا
3. لا أدري

19. عندك رغبة بان تستعمل انت و زوجتك وسيلة من وسائل تنظيم الاسرة في ال 12 شهر الجاية؟

1. نعم
2. لا (انتقل إلى سؤال رقم 21)
3. لا ادري (انتقل إلى سؤال رقم 21)
4. حاليا , نستعمل وسيلة.

20. شو الوسيلة اللي بتفضل تستعملوها في حالة الاجابة بنعم او الوسيلة الي بيستعماوها في الوقت الحاضر في حالة الاجابة بانهم يستعملون وسيلة حاليا ؟

1- الحبوب
2 - اللولب
3 - التعقيم
4 - عازل/ كوندوم
5 - اى وسيلة
6 - لا اعرف
7 - طريقة العد
8 - اخر (حدد) .....

21. مين اللي في العيلة عندك بقرر استعمال وسيلة تنظيم الاسرة؟

1 . انت
2. زوجتك
3. انت و زوجتك
4. عائلتك
5. عائلة زوجتك
6. أخر (حدد) .....

22. هل بتايد تنظيم الأسرة؟

1. نعم
2. لا

23. (اذا كانت الاجابة لا) نسال ليش ما بتايد تنظيم الأسرة؟

1 - خوفا من الأعراض الجانبية
2 - غير فعالة
3- عدم رغبة الزوجة
4- حابب أجيب كمان أطفال
5- أسباب دينية
6- أخر, (حدد)

.....

.....

24. (اذا كانت الاجابة نعم نسال) شو فوائد تنظيم الأسرة؟

1- أسباب مادية (أستطيع أن أنجب أطفالا حين أستطيع رعايتهم واعتني بهم)
2- من اجل صحة أفضل للام
3. من اجل حياة مهنية أفضل للأم (حتى تستطيع أن تتطور مهنيا)
3- أطفال اقل (اعتناء اكثر و تربية افضل و بيت اهدأ)
4- لا ادري
5- أخر, (حدد)

.....
.....

25. على فرض أنه كل المواليد عاشوا, قديش لازم يكون الفرق بين مولود واللي بعده؟

1. .....سنة 2. لا ادري

26. لو خلفت عدد كاف, وكانت كل خلفتك أولاد فهل سيكون عندك الرغبة في مزيد من الحمل علشان يجيك بنات؟

1. نعم 2. لا
3. لا اعرف

27. لو خلفت عدد كاف, وكانت كل خلفتك بنات, فهل سيكون عندك الرغبة في مزيد من الحمل عشان يجيك أولاد؟

1. نعم 2. لا
3. لا اعرف

28. برأيك الدين يمانع في استعمال موانع الحمل لتنظيم الأسرة؟

1. نعم 2. لا
3. لا أعرف

29. من وجهة نظرك تنظيم الاسرة بتعارض مع وضعنا السياسي و معركتنا مع اسرائيل؟

1. نعم 2. لا 3. لا أعرف

30. كم دخل الأسرة؟ 1._____شيكل او دولار
2. لا اعرف

شكرا لتعاونكم

غادة ابو نحلة

Consent form and covering letter

Knowledge, Attitudes and Practice regarding Family Planning among Palestinian couples in Gaza-Strip, Palestine

Serial No.:…….
Code No.:……..

Dear Participant:

You are chosen to participate for this research "Knowledge, Attitudes and Practice regarding Family Planning among Palestinian couples in Gaza-Strip, Palestine".

This study is being carried out as a part of the requirement for the degree of public health at Al-Quds University, School of public health-Palestine.

This study is expected to provide us with results and information which could help health providers and policy makers either in MOH or in UNRWA, in planning and improving the services provided generally to Palestinian families and particularly to Palestinian woman.

You have the right to accept or to refuse the interview; also you have the right to refuse to answer any question in the interview.

I appreciate your participation in this research. You need to answer the interviewer questions that will not take more than fifteen minutes.

Confidentiality will be provided and maintained. No need to write your name.

This study is self funded. The researcher obtained consent from the concerned committee.

The researcher

Ghada Abou Nahla Date: ……..

Questionnaire

The first part: Participant background

1. Name: ……

2. Serial number: …….…….

3. Date of Birth: ……

4. How old are you? ……years

5. Years of education …….years

6. Do you work outside home?

    1. Yes (continue)
    2. No (move to question 8)

7. Occupation……..

8. Age at marriage ……years

9. Age of husband at marriage ……..years

10. Years of marriage…….years

11. Age of husband…….years

12. Years of education of husband…….years

13. Does your husband work?

    1. Yes

    2. No (move to question 15)

14. Occupation of husband …….

15. Does your husband help you in house work?

    1. Yes

    2. No, Why…….

16. Type of home

    1. Uniocular

    2. Family house

    3. In apartment inside family house

The second part: Maternal history

1. History of pregnancy

    1. Yes
    2. No

2. Are you Pregnant now?

    1. Yes
    2. No
    3. Not sure

3. Desire of pregnancy in the last time
    1. Yes (move to question 6)
    2. No (continue)
    3. Don't know (move to question 6)

4. Reasons of undesired pregnancy
    1. Don't want more children
    2. Waiting some time
    3. Others,…….

5. Reasons of unwanted pregnancy
    1. Lack of FP knowledge
    2. Husband's desire
    3. Husband's family desire
    4. Others …….

6. If you not pregnant now, do you like to be pregnant at this time?
    1. Yes
    2. No
    3. Don't know

7. Desire of pregnancy in the future
    1. Yes
    2. No
    3. Don't know

8. The desired number of children you want to have
    1. ……children
    2. Don't know

9. Had you ever talk with your husband about the number of children you want to have?
    1. Yes
    2. No

10. Who decides the number of children in the family?

1. Husband
2. Wife
3. Both husband and wife
4. Husband's family
5. Wife's family
6. Others, ……

11. How many live children you have? ……..children

12. Did you have died children?
1. Yes
2. No (move to question 14)

13. Number of died children ……children

14. If the women have two children or more, ask about birth interval between the last two children, ……years

The third part: Family Planning

1. What does family planning means to you?
1. I can have children when I want
2. Birth spacing
3. Limitation of fertility
4. Don't know
5. Others, …….

2. Have you ever heard about family planning?
1. Yes
2. No (move to question 5)

3. What are family planning methods you have heard about?
……

4. Do you know how to use these methods?
1. Yes
2. No
3. Some of them

5. From where you get the method?
1. Private doctor
2. Pharmacy
3. Governmental hospitals
4. NGOs hospitals
5. Governmental health center
6. UNRWA health center
7. Family planning
8. Others, ……...

6. Time required to reach the heath facility ……minutes

7. From where you get information about family planning?

1. Private doctor 2. Governmental health center
3. UNRWA health center 4. Family planning
5. Mass media 6. Others ……

8. Have you ever used family planning method?

1. Yes
2. No (move to question 11)

9. How many times you used these methods? ……..

10. How many continuous years you have used it in the last time? ……years

11. Do you have the desire to use family planning method in the next 12 months?

1. Yes (move to question 15) 2. No (move to question 16)
3. Don't know (move to question 16)
4. Now, I am using a method (continue)

12. What is the method used? …….

13. How many years you have used the method? ……years

14. How many years you want to use it in the future?

1. …….years 2. Up to stop fecundity
3. Don't know

15. What is the desired methd for you?

1. Pills 2. Intra uterine device
3. Tubal ligation 4. Condom
5. Injections 6. suppositories
7. Counting 8. Don't know
9. Others, …….

16. Reasons of not using contraceptives

1. Want to have children 2. Husband desire
3. husband's family desire 4. Religions causes
5. Others, ……

17. Who decides to the method of FP to be used in the family?

1. Husband 2. Wife
3. Both husband and wife 4. Husband's family
5. Wife's family 6. Others, …….

18. Do you approve family planning?

1. Yes 2. No

19. If yes, what are the benefits of family planning?

1. Economic benefits 2. Better woman health
3. Better professional life of woman 4. Fewer children
5. Don't know 6. Others, ……

20. If no, why you don't approve family planning?

1. side effects 2. Not effective
3. Want to have more children 4. Religious causes
5. Political causes 6. Others, …….

21. The desired birth interval by you

1……years 2. Don't know

22. If you have all of your children boys, would you want to have girls?

1. Yes 2. No 3. Don't know

23. If you have all of your children girls, would you want to have boys?

1. Yes 2. No 3. Don't know

24. Reasons to have many children

1. Power of the family 2. Source of income
3. To take care of us when become old
4. for husband not to marry another time
5. Because I like to have more children
6. Over talking of relatives and other people
7. To replace the disabled children
8. Others, ……

25. Do you believe that religious is against family planning?

1. Yes 2. No 3. Don't know

26. If you want any counseling in family planning, where do you go?

1. General practitioner 2. Nurse
3. Friend 4. Neighbor
5. Husband's mother 6. Husband
7. Specialist 8. Wife's mother
9. Other, …….

27. If you want to use FP method, do you must take permission?

1. Yes 2. No

If yes, from whom? ……..

28. Is our political situation against FP?

1. Yes 2. No 3. Don't know

29. Family income

1. ……..NIS 2. Don’t know

30. If the participant works, ask her if she participates in family income

1. Yes 2. No 3. No answer

Thank you for your cooperation

Husband's Questionnaire

1. How old are you? ……years

2. Years of education …….years

3. Do you have a job?
    1. Yes (continue)
    2. No (move to question 5)

4. Occupation……..

5. Age at marriage ……years

6. Age of wife at marriage ……..years

7. Years of marriage…….years

8. Age of husband ……..years

9. Do you help your wife in house work?
    1. Yes
    2. No, Why…….

10. The desired number of children you want to have
    1. ……children
    2. Don't know

11. Had you ever talk with your wife about the number of children you want to have?
    1. Yes
    2. No

12. Who decides the number of children in the family?
    1. Husband
    2. Wife
    3. Both husband and wife
    4. Husband's family
    5. Wife's family
    6. Others, ……

13. What does family planning means to you?
    1. I can have children when I want
    2. Birth spacing
    3. Limitation of fertility
    4. Don't know
    5. Others, …….

14. Have you ever heard about family planning?
    1. Yes
    2. No (move to question 17)

15. The source of FP information
    1. Wife
    2. Health center
    3. Friends
    4. Neighbor
    5. Mass media
    6. Others,……

16. What are FP methods you know or heard about them?
……..

17. If you want to know information about FP, from where you can get them?
    1. Government FP clinic
    2. UNRWA FP clinic
    3. NGO's FP clinic
    4. General practitioner
    5. Nurse
    6. Specialist
    7. Don't know

18. Is it easy for you to visit FP clinic?
    1. Yes
    2. No, why……

19. Do you see that mass media especially T.V, are good way to provide FP information?
    1. Yes
    2. No
    3. Don't know

20. Do you have a desire to use FP in the next 12 months?
    1. Yes
    2. No, (move to Q. 22)
    3. Don't know (move to Q. 22)
    4. Now, we are using FP method

21. What is the method you preferred to use?
    1. Pills
    2. IUD
    3. Sterilization
    4. Condom
    5. Any method
    6. Don't know
    7. Counting
    8. Other,……

22. Who decide the used method of FP in the family?
    1. Husband
    2. Wife
    3. Husband and wife
    4. Husband's family
    5. Wife's family
    6. Others,……..

23. Do you approve FP?
    1. Yes
    2. No

24. (If the answer no) Ask why you don't approve FP?

1. Because of side effects
2. Not effective
3. Against wife desire
4. Like to have more children
5. Religious reasons
6. Others,……

25. (If the answer yes) Ask what is the benefit of FP?

1. Financial reasons
2. For better maternal health
3. Better professional health
4. Less children
5. Others,……...

26. The desired birth interval.

1……years
2. Don't know

27. If you have all of your children boys, would you want to have girls?

1. Yes 2. No 3. Don't know

28. If you have all of your children girls, would you want to have boys?

1. Yes 2. No 3. Don't know

29. Do you believe that religious is against family planning?

1. Yes 2. No 3. Don't know

30. Is our political situation against FP?

1. Yes 2. No 3. Don't know

31. Family income

1. ……..NIS 2. Don't know

Thank you for your cooperation

Annex (5)

Calculation of the statistical significance of the difference between family planning knowledge among women and men participating in the study.

$$t = \frac{A\% - B\%}{SE}$$

$$SE = \sqrt{a^2 + b^2}$$

$a^2 = (SE\ A\%)^2 = 4.84$

$b^2 = (SE\ B\%)^2 = 7.29$

$$t = \frac{74.7 - 57.9}{\sqrt{a^2 + b^2}}$$

$$\mathbf{t = \frac{16.6}{3.48} = 4.77}$$

$d.f = N1 + N2 = 722$

$$\mathbf{p < 0.001}$$

$$a = SE\ A\% = \frac{SD}{\sqrt{n}} \times 100$$

$$= \frac{\sqrt{0.75 \times 0.25}}{\sqrt{380}} \times 100$$

$$= \frac{0.43}{19.5} \times 100 = 2.2$$

$$b = SE\ B\% = \frac{\sqrt{0.58 \times 0.42}}{\sqrt{344}} \times 100$$

$b^2 = 7.29$

SE for the difference

$$= \sqrt{a^2+b^2} = \sqrt{4.84+7.29}$$

$$= \sqrt{12.13} = 3.48$$