Deanship of Graduate Studies
Al-Quds University

Access, Utilization and Compliance to Family Planning Methods among Women and the Role of Health Care Providers as Educators

Areej Awni Mohammed Nawara

M. Sc Thesis

Jerusalem- Palestine

1446 / 2025

Access, Utilization and Compliance to Family Planning Methods among Women and the Role of Health Care Providers as Educators

Prepared By:
Areej Awni Mohammed Nawara

B.SC.: Islamic University-Palestine

Supervisor: Dr. Areefa SM Alkasseh

A Thesis Submitted in Partial Fulfillment of Requirement for the Degree of Master of Mother and Childhood Nursing / Faculty of Health Professions / Al-Quds University

1446 / 2025

Al-Quds University

Deanship of Graduate Studies

MCH Program /Nursing Department

Thesis Approval

Access, Utilization and Compliance to Family Planning Methods among Women and the Role of Health Care Providers as Educators

Prepared by: Areej Awni Mohammed Nawara
Registration No.: 22112739

Supervisor: Dr. Areefa SM Alkasseh

Master's thesis submitted and accepted. Date: 27/3/2025
The names of the signatures of the examining committee members are as follows:

1. Head of committee: Dr. Areefa SM Alkasseh Signature
2. Internal examiner: Dr. Hamza Abdeljawad Signature
3. External examiner: Dr. Ahmed A. Najim Signature

Jerusalem- Palestine

1446/2025

Dedication

To my beloved mother, Amna

To support and be a safe haven, my beloved father, Awni

To the dearest to my heart, my second mother, Aziza

To my kind Uncle Mazen

To my dear brothers, Mohammed and Mazen

To my dear sister, Retaj

Areej Awni Mohammed Nawara

Declaration

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

Signed:

Areej Awni Mohammed Nawara

27/3/2025

Acknowledgement

Firstly, thank Allah, the only God, for the spiritual guidance and blessings bestowed upon me.

I want to express my sincere and heartfelt gratitude to my supervisor, Dr. Areefa Alkasseh, Head of the Midwifery Department at the Nursing College of the Islamic University of Gaza, for her guidance and encouragement, which have been invaluable. She has also served as a great mentor, supporting me throughout my studies.

I would also like to sincerely thank the discussion committee members: the Honorable Dr Hamza Abdeljawad, the internal examiner, and the Honorable Dr Ahmed Najim, the external examiner. Who kindly discussed this thesis and enriched it with their valuable comments. May God bless them.

Areej Awni Mohammed Nawara

List of abbreviations

COC	Combined Oral Contraceptive
DMPA	Depo Medroxy Progesterone Acetate
FP	Family Planning
GS	Gaza Strip
HCPS	Health Care Provider's
IUDs	Intra-Uterine Device
LARC	Long-acting Reversible Contraceptive
MoH	Ministry of Health
OCP	Oral Contraceptive Pills
OHC	Oral Hormonal contraceptive
PCBS	Palestinian Central Bureau of Statistics
PHCC	Primary Health Care Center
STDs	Sexually Transmitted Diseases
UN DESA	United Nations Department of Economic and Social Affairs
UNRWA	United Nations Relief and Works Agency for Palestinian Refugees
WB	West Bank
WHO	World Health Organization

Abstract

The use of contraceptives is necessary for the spacing of each birth to reduce complications that may occur to the mother and her child, and improve the mother's and her child's health status. The studies aimed to assess women's access, utilization, and compliance with family planning (FP) methods, as well as the role of healthcare providers (HCPs) in educating them in the Gaza Strip (GS)**.** The study uses a cross-sectional descriptive design to explore access, utilization, compliance, and the role of HCPs in FP education. Data will be collected through self-administered questionnaires from 361 women attending primary healthcare centers in the southern and mid-zone GS. A combination of quota and consecutive sampling was applied. The questionnaire includes sections on socio-economic factors, FP use, access, compliance, and HCPs roles. The study tools have been selected, and the rate of Cronbach's alpha is 0.910 to measure stability. A pilot study on 36 women was done to explore the appropriateness of the study instruments; data were analyzed using SPSS version 25. Ethical approval ensures confidentiality and voluntary participation. Findings revealed significant factors affecting FP access utilization and compliance, including spousal communication 85.6%, husband's influence 82.5%, and healthcare providers' guidance 70.6%. Also, the study revealed that women were using contraceptives 70.8%, the copper IUD, 21.7%. Implants 2.2%. The level of women's access to different contraceptive options, including access to hormonal methods like pills and patches, and condoms, 62,8%, and access to copper IUDS, 62.2%. Additionally, the study found a contraceptive compliance rate of 78%. Health education programs about contraceptives are 83%. Socio-demographic factors such as age, education, employment, and income were found to influence access and compliance with FP methods, $P<0.05$, with younger 43.6%, less educated (53.1% women, 45.3% husbands), and unemployed women 16.7%. Increasing reproductive wellness includes both access to and use of FP methods. Healthcare professionals are essential in informing people about their alternatives so they can make well-informed decisions. The success of FP programs increases when rules are effectively followed. To enhance compliance, HCPs need more training in FP counselling and to be given access to a variety of strategies. To promote trust and improve communication between patients and providers, healthcare professionals must receive ongoing education.

Table of contents

List of Tables

List of Figures

List of Annexes

Chapter One

Introduction

1.1 Background

Family planning (FP) involves couples being aware of and working to reduce the time interval between each child and the next by using family planning methods (Wani et al., 2019; World Health Organization [WHO], 2016). FP has numerous advantages, including increasing the country's economic growth, empowering women to become a vital component of society, and enhancing their educational and employment opportunities (Erkalo & Gecho, 2017). Even though there are numerous kinds of contraception, the two most common types are modernized and ancient. The most common recent FP includes sterilization, tubal ligation, contraceptive implants, contraceptive pills, male and female condoms, emergency contraceptive pills, spermicidal foams, and sponges. Conventional methods of contraception include calendar methods, withdrawal methods, and traditional Techniques for cervical mucous and lactational amenorrhea (Ndumbaro & Ochieng, 2021).

Access to safe and effective FP methods is an essential element of receiving high-quality care for women's health because it reduces unplanned pregnancy and has the potential to prevent 60% of maternal deaths and 57% of infant deaths globally (Uwajeneza et al., 2023).

The use of FP methods reduces the serious health complications associated with pregnancy for mothers and their children. If there is a spacing of births for two years, the infant mortality rate decreases by 45%, and when there is a spacing of births for three years, the mortality rate falls to 60% (Alenezi & Haridi, 2021). According to global and regional statistics, Palestine has the lowest percentage of family planning (FP) methods used compared to Turkey (74.4%), Jordan (62.2%), Lebanon (62.3%), Egypt (60.6%), and Iran (82%) (Alshawish, 2021).

Women aged 15-49 must adhere to and comply with family planning methods because women have the highest fertility rate at this stage (G.K. & Onyekachi, 2020). Studies have indicated that women's commitment and compliance with contraceptive use limit frequent births at a rate of less than 1% (Tomaszewski et al., 2017; Kost et al., 2008; Trussell, 2004).

Health education contributes to increasing women's access to appropriate contraceptives and reduces complications of pregnancy and childbirth. The high quality of teaching and health counselling has enhanced women's access to family planning (FP) services (Cavallaro et al., 2020).

In addition, the international FP program contributes to advising, mentoring, and educating women on FP, which in turn enhances women's access to services promptly by their specific visits without the need for reconsideration (Mruts et al., 2022). Healthcare Providers (HCPs) are the first and primary line of FP service delivery, for example, through health education on the correct use of contraceptives and various methods of use. Healthcare professionals are crucial in providing women with comprehensive and accurate information to help them make informed decisions and achieve the best possible outcomes (Sion et al., 2022).

The purpose of this study was to assess women's access, utilization, and compliance with family planning (FP) methods and to identify the role of healthcare providers (HCPs) as effective educators to women at Primary Health Centers (PHCCs) in the Gaza Strip (GS).

1.2 Research Problem

FP is an essential and necessary source for women, their families, and society in all social, health and economic aspects (Ndumbaro & Ochieng, 2021). Statistics indicate that (1,1) million women out of (1,9) million women lack FP methods and that nearly 190 million women do not want to have children. However, they do not use means to prevent reproduction (United Nations Department of Economic and Social Affairs [UN DESA], 2019). Countries with moderate and small economies severely lack FP (UN DESA, 2020). Several reasons have a connection with sudden pregnancy, leading to risks during pregnancy and childbirth, including lack of maternal and child Health services, low incomes, social problems, women's lack of access to health facilities and lack of awareness. Moreover, the fact that the woman cannot use contraceptives will have serious consequences (Yazdkhasti et al., 2015; Olatade et al., 2021). Contraceptive compliance and access remain at their lowest level. Approximately 214 million Women in developing countries do not have access to and do not comply with family planning methods (Ndikom et al., 2018).

According to the researcher's experience, few studies have discussed the use and accessibility of FP methods. However, no study in Gaza mentioned the role of HCPs in health education for women about the use of contraceptive methods and women's compliance with FP methods. This study contributes to identifying existing socio-demographic and cultural issues that prevent the use of FP methods and plays a role in developing a new approach to increasing the use and adherence to contraceptives and increasing women's access to contraceptives. Research also contributes to innovative ideas to reduce factors affecting contraceptive use and adherence, such as demographic, social, economic, and cultural factors. The study also discovers the role of HCPs in educating women about and adhering to the correct use of contraceptives.

1.3 Justification of the Study

Worldwide studies have shown that the frequent use of FP methods in the past quarter of a century has led to a decrease in maternal mortality by reducing the number of unintended pregnancies, complications of pregnancy, and successive pregnancies with no interval between each child and the other (Brunner Huber et al., 2018; Singh & Darragh, 2011). Therefore, contraceptives promote the overall health of mothers and children (Yazdkhasti et al., 2015). However, the prevalence of FP methods is not constant among countries, with ratios in Mozambique (11,3%) consisting of Kapa (21.5%), Bangladesh (54.0%), and Sweden (72.1%) (Chavane et al., 2017). In Jordan, FP methods are provided free of charge to those with health insurance and are almost free for women who do not have health insurance. In Iraq, the expansion of family planning methods reached 58% (44% currently used, 14% previously used). The rates of using family planning methods in Jordan (63%) and Tunisia (67%) are notable (Alrawi, 2021).

In Palestine, 54.8% of women aged 15-49 use family planning methods. The ratio indicates an improvement, albeit slow (44.0), as Palestinian women increasingly use non-traditional family planning methods. Compared to the above study, Palestine is still less utilized than Iraq, Tunisia and Jordan. In Palestine, the government and United Nations Relief and Works Agency for Palestinian Refugees (UNRWA) clinics cover the needs of women for free contraceptives. However, unintended pregnancies may affect women negatively (Böttcher et al., 2018). This study offers numerous benefits for women in Gaza. It explains the role of midwives and nurses in educating women about the importance of family planning methods in preventing complications that may occur to them and their child, and urging them to adhere to these methods to achieve the desired results

1.4 General purpose of the study

This study assesses women's access, utilization, and compliance with family planning methods and the role of healthcare providers in educating them in the Gaza Strip**.**

1.5 Objectives of the study

1. To determine the prevalence of the current use of FP methods among women in the GS.
2. To assess the level of access, utilization and compliance with family planning methods in the GS.
3. To Clarify the factors affecting women's access, utilization, and compliance with family planning methods in the GS.
4. To investigate the relationship between contraceptive access, utilization and compliance with family planning methods, and socio-demographic factors (age, occupation, educational level, number of children).
5. To assess the role of HCPs in educating women about family planning methods in the GS.

1.6 Research Questions of the Study

1. What is the prevalence of current family planning method use among women in the GS?
2. What is the level of women's access to family planning methods in the GS?
3. What factors can clarify women's access, utilization and compliance with FP methods in the GS?
4. What is the relationship between contraceptive access, family planning methods, and socio-demographic factors (age, occupation, educational level, number of children)?
5. What is the relationship between contraceptive utilization and socio-demographic factors (age, occupation, educational level, number of children) and family planning methods among Women in the GS?
6. What is the level of women's use of FP methods in the GS?
7. What is the level of women's compliance with contraceptive use in GS?
8. What is the GS's relationship between contraceptive compliance and socio-demographic factors (age, occupation, educational level, and number of children)?
9. What is the role of HCPs in educating women about family planning methods in the GS?

1.7 Context of the Study

1.7.1 Demographic Context

Historical Palestine covers a total area of 27,009 square kilometers. The West Bank (WB) and GS comprise 6209 square kilometers of the proposed State Palestine, which accounts for 22.95% of the historical territory. A total of 5,844 kilometers make up the West Bank, which accounts for 21.6% of the ancient territory of Palestine (Annexe 1). The GS occupies 365 square kilometers (approximately 1.35%) of Palestine's broad historical land area (Annexe 2). The border is 79 kilometers long, and the southern edge of Sinai is (240) kilometres long; The distance between Rafah and Ra's Taba and Aqaba Bay is (10.5) kilometres id-2022, there will be roughly (14.3) million Palestinians globally, of these, 5.35 million will be Palestinians, according to population projections made by the Palestinian Central Bureau of Statistics. (2.72) million men and (2.63) women live in Palestine. In 2022, the population of the WB was projected to be (3.19) million, made up of (1.62) million men and (1.57) million women, while the population of the Gaza Strip was projected to be 2.17 million, made up of (1.10) Million men and (1.07) million women. Midway through 2022, 38% of Palestine's the population is predicted to be in the (0–14) age range, with 36% of those living in the West Bank and (41%) in the GS. According to estimates, the percentage of people aged 65 and older is expected to be 3% in Palestine, 4% in the West Bank (WB), and 3% in the Gaza Strip (GS) by mid-2022 (Palestinian Central Bureau of Statistics). Population increase, migration, age distribution, and socioeconomic circumstances all have an impact on Palestine's demographic landscape, which includes the Gaza Strip. The population is 5.7 million as of 2024, of which 2.3 million live in the Gaza Strip and the remaining number in the West Bank. Gaza's youthful age structure results from its high fertility rate, birth rate, and population density ([PCBS], 2024).

1.7.2 Economics of Palestine

As a result of the aggression against Gaza in 2023, Palestine's economy was devastated, particularly by the destruction of factories and the most critical components of production. The barriers between the West Bank and Gaza constitute an obstacle to exchanging goods between the two regions. According to the Palestinian Central Bureau of Statistics, unemployment rates in the GS and the West Bank reached 74% and 45%, respectively, during the last quarter of 2023. The total unemployment rate in Palestine was 46%. Shortages of goods and rising prices in the Gaza Strip have significantly increased poverty, with prices rising to 9.7% in the Gaza Strip, 4.8% in the West Bank, and 6% in Palestine in general (PCBs, 2023).

1.7.3 Healthcare system

The Ministry of Health plays a significant role in providing primary, secondary, and Tertiary health care services, covering four sectors: public, private, non-governmental, and UNRWA (Ministry of Health [MoH], 2023).

1.7.4 Primary Health Care Centres in Gaza

Israel's war on Gaza has disrupted health services in the GS as a result of the displacement of large populations and the destruction of primary care centres, either wholly or in part, of 11 centres that were thoroughly bombed by the Israeli occupation and 28 that were out of work owing to the displacement of citizens from the area and the partial destruction of the facility. The number of women reluctant to utilize centers offering maternal and child health services has notably decreased by 18% compared to previous years. Additionally, more than 50,000 women lacked access to maternal and child health services. The Deir al-Balah, Al-

Zawada, and Khan Younis government clinics are among the most important healthcare facilities in the Gaza Strip, providing free medical services to citizens and improving healthcare. The Deir al-Balah government clinic is one of the leading centers offering primary and therapeutic care in the central region, while the Al-Zawada clinic offers a variety of medical services, including tests and specialized clinics. The Khan Younis clinic, on the other hand, is a key hub for serving the local population and providing primary care through a qualified medical staff and modern equipment. These clinics play an important role in alleviating the burden on major hospitals, making them an integral part of the healthcare system in the region (Ministry of Health, 2023).

1.7.5 Primary care centers by level

The Ministry of Health in the Gaza Strip has organized primary care centers on three levels to provide essential services to the population. The first level is health Posts and Primary healthcare centers, which offer basic services like maternal and child health, immunization programs, and basic diagnostics. The second level is comprehensive health centers, which handle a wider range of health services, including outpatient consultations, minor surgeries, dental, and specialist consultations. The third level is district and specialized health centers, which provide more specialized services and serve as referral points for patients requiring more complex treatments. The tiered system plays a vital role in managing the population's health needs, but faces challenges such as limited resources and ongoing political and logistical constraints. The MoH is working on enhancing these levels of care to improve public health outcomes in Gaza (Ministry of Health, 2023).

1.7.6 Family Planning Methods in the Gaza Strip

The prolonged fighting and scarcity of resources in Gaza have had a significant impact on family planning and reproductive health services. Due to the destruction of infrastructure, lack of medical supplies, and restricted access to healthcare facilities, the Ministry of Health (Moh) in Gaza reports that access to these services has drastically decreased, exacerbating the already overburdened healthcare system (United Nations Relief and Works Agency [UNRWA], 2023). Moreover, the rise in maternal and neonatal mortality in Gaza has been alarming. Between October and December 2023, the incidence of miscarriages increased by 300%, mainly due to health complications from limited access to healthcare and heightened stress among pregnant women. Family planning services are less available as of 2023 than in nearby areas. In October 2023, an Israeli airstrike destroyed the Gaza clinic of the Palestinian Family Planning and Protection Association (PFPPA), a vital supplier of reproductive health care. There are now acute shortages of maternal health care and contraceptive supplies as a result of this devastation and the prolonged blockade. The region's already severe health situation has been made worse by the destruction of healthcare facilities and the limited supply of medical supplies, which have made it harder for women in Gaza to get essential family planning and reproductive health treatments (UNFPA, 2023). A study was conducted by LaGore et al. (2024). This study reported that the rate of women’s use of contraceptives in Gaza was 61%, accounting for the highest proportion of use of IUDs (35.4%) and the lowest rate of use (3.3%) of implants. Several factors were observed affecting the use of contraceptives, including the difficulty of accessing the health facility and contraceptives due to the Israeli war on Gaza, which contributed to the closure of the crossings and the placement of barriers in the roads and separation of the Strip, and women’s awareness of the importance of contraceptives.

1.8 Theoretical definitions

1.8.1 Family planning:

The World Health Organization (WHO) defines Family Planning (FP) as enabling individuals and Couples to plan and achieve their desired number of children, as well as the spacing and timing of their births. It is achieved using contraceptive methods and the treatment of involuntary infertility. A woman's ability to space and limit her pregnancies directly impacts her health and well-being and the outcome of each pregnancy (WHO, 2016).

1.8.2 Access

Enabling access focuses on assisting individuals in obtaining the right medical services

In addition to maintaining overall well-being (Gulliford et al., 2002).

1.8.3 Healthcare Utilization

The quantification or description of the use of services by individuals to prevent and care for health problems, promote health maintenance and well-being, or obtain information about their health Status (Gellman, 2020)**.**

1.8.4 Compliance

Refers to the use of an FP method in an ongoing and consistent manner for the prevention of pregnancy (Mir T. H,2023).

1.8.5 Role of HCPs as Educators

A health educator is a professionally trained individual who serves in various roles and is specifically equipped to use appropriate educational strategies and methods to facilitate the development of policies, procedures, interventions, and systems that promote the health of individuals, groups, and communities (Gold & Miner, 2002).

1.9 Operational definitions

1.9.1 Access

Refers to the availability of contraceptive methods for women and the facilitation of obtaining them without trouble and hardship.

1.9.2 Utilization of contraceptive methods

When a woman of reproductive age reported using any method of FP or Contraceptives such as injectables, regular pills, emergency pills, Implanon, intrauterine Devices, condoms, and surgical procedures.

1.9.3 Compliance with Contraceptive Methods Use

It is defined as the correct use (according to the method-specific prescriptions given by a medical professional and/or in written form as a patient information leaflet) of a Contraceptive method.

1.9.4 Role of HCPs and educators on family planning

They are doctors, nurses and midwives who work in family planning services, and their responsibility is to educate women and give them comprehensive guidance on each method of contraception to help them make an informed decision about contraceptive use.

Chapter Two

Conceptual Framework and Literature Review

This chapter is divided into two main parts, the first one is entitled "conceptual framework" and the second part is the literature review.

2.1 Conceptual framework

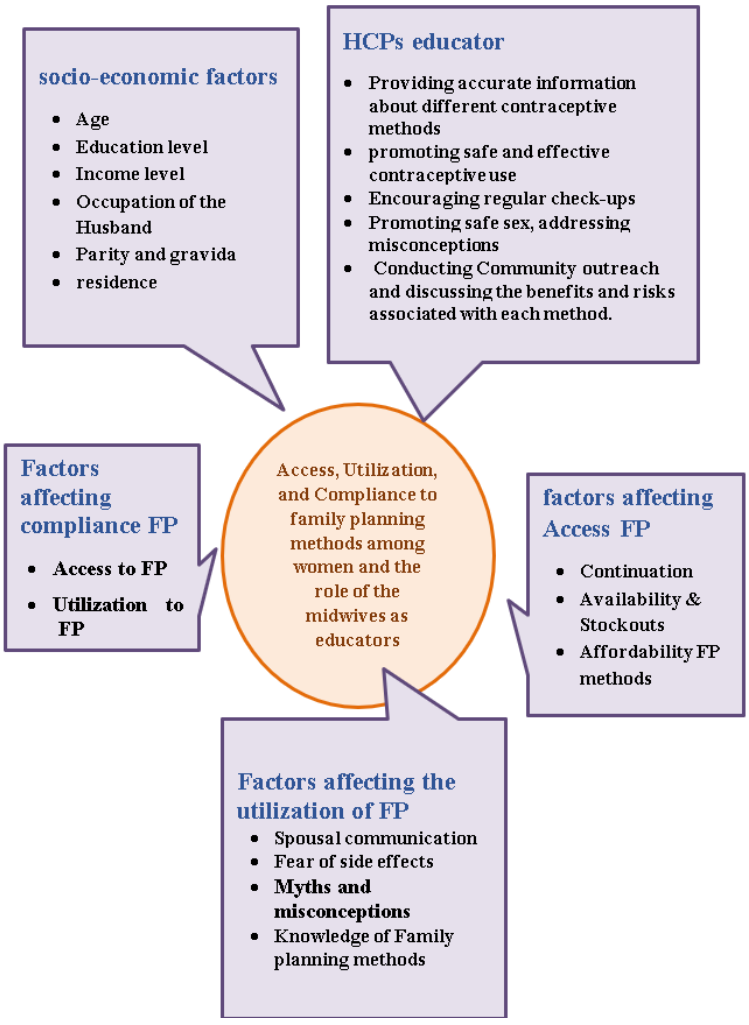


Figure (2.1): Conceptual Framework (Self-developed)

The researcher designed the conceptual framework based on a review of the available literature. The conceptual framework serves as a map that guides the design and Implementation of the study, as well as its effect mechanism for Illustration and summarization **.**

2.1.1 The whole study variables.

2.1.1.1 Dependent Variable:

The study's independent variable encompasses the socio-economic factors influencing women's access to, use, and compliance with family planning methods. These factors include age, education level, income level, occupation of the husband, parity, gravida, and residence. Exploring these factors in any population group facilitates existing efforts to improve family planning methods (Kanwal Aslam et al., 2016).

2.1.1.2 Independent variable:

Factors influencing access, use, compliance with family planning (FP) methods, and the role of HCPs in health education from the women's perspective. Factors affecting access to family planning methods include (continuation, availability & Stockouts and affordability of FP methods). Factors affecting the use of contraceptive methods have also been mentioned, including (spousal communication, fear of side effects, myths and misconceptions, knowledge of Family planning methods). Factors influencing women's compliance with family planning methods have also been identified, including (switch and satisfaction). The role of HCPs as health educators in women's use, compliance and access to Contrace ptive methods was also clarified. It includes several elements, including (providing accurate information about different contraceptive methods, promoting safe and effective contraceptive use, encouraging regular check-ups, promoting safe sex, addressing misconceptions, conducting Community outreach and discussing the benefits and risks associated with each method)

2.2 Literature Review

2.2.1 Utilization of Family Planning Methods

Contraceptives are used worldwide and encompass both modern and traditional methods. The World Health Organization (2018) noted that modern contraceptives are effective in reducing the proportion of unintended pregnancies and determining the timing of birth among each child (WHO, 2018). In the world, at least 56% of women use unconventional contraceptives, and 6% of women use traditional contraceptives (Agbana et al.,2023; Buglaeva, 2021). The use of family planning methods has been widespread in most countries of the world, as many women have 200 million women in fertility in non-developed countries using traditional contraceptives because of the difficulty of accessing modern contraceptives (Sedgh et al., 2014; WHO, 2018). Agbana et al. (2023) noted in their study that 24% of women at the reproductive stage in sub-Saharan Africa use non-traditional family planning methods to reduce unintended pregnancy and birth spacing compared to 5% of women using traditional methods.

In addition, awareness-raising programs have been implemented on women's contribution to the proper and effective use of contraceptives, but in sub-Saharan Africa, there is still difficulty in the use of contraceptives (Tsui et al., 2017; Lee et al., 2022).

According to the World Health Organization (WHO), 225 million women in the reproductive age group in developing countries want to space their births apart. WHO also explained that the expansion of family planning methods in the region ranged from 23 to 6 per cent to 28.5

per cent from 2008 to 2015 in Latin America and the Caribbean, where contraceptive use expanded by 66.7 per cent (WHO, 2016).

In non-developed countries, contraceptives are challenging to use correctly, leading to interruptions and unintended pregnancies (Sadgh et al., 2016). In addition to the widespread availability of contraceptives in primary care centres, there is little use of different contraceptive methods. However, the ideal and effective use of various methods of contraception reduces the incidence of illness and death of the mother and her child, promotes reproductive health, reduces population explosion and contributes to the population's lack of disease. The use of contraceptives to reduce pregnancies in women with complications in pregnancy and childbirth also contributes to lowering early childbirth and thereby reducing the risk of death (Beson et al., 2018; WHO, 2018). A study was conducted in Uganda by Kigongo et al. (2024). This study revealed that factors affecting women's access to contraceptives included women's fear of the side effects of contraceptives, lack of encouragement from health workers to use contraceptives optimally, and lack of sufficient privacy between the woman and the family planning service provider. The low monthly income of the family also plays an important role in women's lack of access to health facilities. Following and during the Israeli occupation aggression, which reached extremely low levels, couples' inclination to forgo having children due to the current circumstances and out of concern for the health of mothers and children will cause mortality and birth rates to drop dramatically after mid-2024 (PCBs, 2023).

Jordan's fertility rate was 2.7, Egypt's was 3.3, Lebanon's was 2.7, and Yemen's was 3.7 (World Bank, 2018). Palestine's contraceptive expansion rate among women of childbearing age was 57.3% (Hassan et al., 2024). The proportions of contraceptive use in Jordan, Morocco, and Tunisia were 61%, 67.4%, and 64.4%, respectively. Compared to Arab countries, Palestine has the lowest contraceptive expansion rate (Kabakian-Khasholian et al., 2020). The most used method in Palestine was IUD, with a usage ratio of 26.1%, followed by the use of pills and a usage ratio of 6.9% (Hassan et al., 2024). A study in Palestine found that factors affecting non-use of contraceptives included misconceptions and myths (Böttcher et al., 2019).

2.2.2 Factors affecting utilization of family planning methods

2.2.2.1 Spousal communication on family planning methods

Active couples' discussion about family planning methods leads to good decisions about the spacing between newborns and understanding the benefits and harms of contraceptives (Zelalem et al., 2021). Practical family discussions are crucial in helping couples find a suitable contraceptive that suits their needs and enables them to access quality family care (Olawole-Isaac et al., 2018). Discussion with couples also helps reduce the side effects of family planning, infectious sexual diseases and unplanned pregnancy (Islam et al., 2010).

The family assimilates the importance of family planning methods to the husband's contribution to easy access to contraceptives without the need for the wife to take contraceptives without the husband's knowledge. Many families that engage in discussions tend to reduce the number of births and the desire to have female children, reducing problems and differences between spouses (Amos, 2019). Other factors impede the use of contraceptives, such as couples' lack of understanding of their wives' desired contraceptives, unplanned pregnancies and sexually transmitted diseases (Islam et al., 2010; Mulatu et al., 2022).

Studies have shown a close relationship between the marital debate about contraceptives and the use of family planning methods (Sharan &Valente, 2002; Link, 2011; Behara et al., 2016). In addition, the frequent discussion among couples about family planning methods has a significant benefit in the use of unconventional contraceptives. Previous studies have shown that a male husband's satisfaction with contraceptives contributes to the effective use of family planning (Acharya et al., 1996; Abranam et al., 2010).

Women with social stigma are affected by the misuse of contraceptives in non-developed countries such as India. There are many impediments to the use of family planning methods, such as differing wives' wishes from couples and determining the timing of birth to avoid unintended pregnancy (Zelalem et al., 2021). Kabagenyi (2014) also noted in a study that spousal panic due to poor discussion among couples poses a significant obstacle to contraceptive use. Other studies have also shown that the male husband's contribution has a significant impact on women's unhindered access to and use of contraceptives (Mulatu et al., 2022).

In some developing countries, various customs and traditions prevail, including the notion that access to family planning is primarily women's responsibility rather than men's (Kriel et al., 2019). In addition, only women benefit from contraceptive use without men's participation in family planning programmes, which constitutes an obstacle to contraceptive use. (prata et al., 2017). A male husband's refusal to use contraceptives is one of the factors impeding the wife's access to contraceptives (Ajah et al., 2015).

2.2.2.2 Fear of side effects

Through family planning providers and their expertise in this area, many complications affecting contraceptives have been identified, resulting in a reduction in contraceptive use and difficulty in starting use. For example, increased or interrupted periods, weight gain, nausea, headaches, vomiting, and cardiovascular problems. There is a fear of future complications, such as not giving birth, and side effects during childbirth, such as bleeding (Rademacher et al., 2018; Staveteig, 2017). A 2014 methodological study found that women do not have access to contraceptives because of the centres' inability to provide contraceptives. The other reason is the fear of contraceptive complications on their health. The ratios in the study countries were distributed as follows: 28% in Africa, 23% in Asia, and 35% in Latin America and the Caribbean (WHO, 2018).

Fear of contraceptive complications in women can occur because of prior knowledge of rare complications, as well as misconceptions among women who have used contraceptives or past knowledge from surrounding women that they have suffered from contraceptive use (Schrumpf et al., 2020). Various systematic reviews in sub-Saharan Africa have explored why most women do not want to use contraceptives because of the fear of childlessness and death. This study indicated that it was necessary to implement awareness-raising programmes urging and encouraging women to use contraceptives (Ackerson & Zielinski, 2017).

The family planning service provider must also advise women before and during the use of family planning methods to assist them in obtaining appropriate contraceptives without any side effects. WHO also noted the need to assess women's health status to help them and provide them with proper means without complications (WHO, 2010).

2.2.2.3 Myths and misconceptions about the use of family planning methods among women

Common customs and traditions in societies are among the most critical factors impeding the use of family planning methods (Odwe et al., 2021; Guage et al., 2015). In developed and developing countries, misconceived customs and traditions are the most critical factor in women discontinuing contraceptives even though they do not want to give birth (Stevens et al.,2023).

Recommendations indicate that it is necessary to give women guidance on the benefits and harms of contraceptives, not as perceived by women. It is essential to inform women that these beliefs are incorrect and have no basis in reality, and service providers must correct this misinformation (Kaur and Blumenthal, 2021). Some studies have indicated that these guidelines contribute to reducing the spread of misconceptions about contraception and contribute to the proper and effective use of contraception (Halpern et al., 2013; Cavallaro et al., 2020).

2.2.2.4 Knowledge of Family planning methods

Adequate understanding of contraceptives is the key element in effective and sustained contraceptive use. Insufficient understanding affects the decline in contraceptive use and lack of access to contraceptive services in places where contraceptive services are provided (MacPhail et al., 2010).

A study by Woodaynew & Bekele (2021) indicated that inadequate understanding of the benefits and harms of contraception significantly affects effective use, leading to unintended pregnancy. Tamir et al. (2007) explained in their study that many factors influence the understanding of contraceptive use, including when to use, not knowing the benefits and harms of contraception, not having access to family planning, and not accessing centres to access the services provided. In their initial study in India, Thapa et al. (2014) found that 69% had heard of different methods of family planning, 65% of women had heard of contraception after having one child or having an abortion, and 71.3% after multiple births.

2.2.3 Sociodemographic factors affecting utilization of FP methods

2.2.3.1 Age

Age is an essential factor in knowing a woman's commitment to contraceptives and the ability to space births and others. Women who are frequently born are also more likely to use contraceptives due to the desire to reduce reproduction (Sensoy et al., 2018).

Sensoy et al. (2018) also explored that women of different ages use contraceptives and explained in their study that older women use more methods of pregnancy than younger ones, indicating a relationship between increasing the woman's age and increasing the use of family planning methods. According to Solanke (2017), in rural Bangladesh and Ghana, there is a relationship between older women who do not want to give birth and the increased use of contraceptives. Oche noted that contraceptive use increases at age 39 and begins to decline gradually. She found a close relationship between 20-39-year-olds, the most commonly used in family planning, and women under 20 in Kenya (Oche, 2018).

In most previously reported studies, age was found to contribute effectively to contraceptive use, as the older the women were, the more they used contraceptives because they did not want to have more children.

2.2.3.2 Employment

In non-developed countries, women suffer from family planning problems due to poverty and low pregnancy rates, leading to risks of unplanned pregnancy. Women cannot rely on themselves for family planning because they lack family income (Oluwole, 2012). The economic factor enhances the woman's health and reproductive status, allowing her to utilize family planning methods effectively without hindrance (Choudhury et al., 2018). It also strengthens women's ability to make easy decisions about contraceptive use. It also enables women to increase their economic income and thus have access to and use contraceptives easily compared to women with unemployment (Chodlury et al., 2018).

Adequate and correct use and commitment to contraceptives. The work also contributes to the lady's economic empowerment, which makes her self-fulfilling, leading her to want to reduce her family size (Islam, 2016; Palamuleni, 2013). It also noted that working women are exposed to work pressures and that working environments may be uncomfortable for the lady, making her think about postponing childbirth, and the environment around the woman ultimately does not promote reproduction (Palamuleni, 2013). A study conducted in Nigeria found that working women do not want to give birth and use modern family planning methods. The study indicated that working women use modern contraceptives compared to non-working women (Solanke, 2017).

2.2.3.3 Religion

The Islamic religion agrees with the organization of the family. The Holy Quran states that it is necessary to breastfeed children for two years to improve the health and reproductive status of the lady and contribute to the completion of the child's development (Abdi et al.,2020). He explained the honourable prophetic ratio that the isolation contraceptive was used (El Hamr, 2010). Islam encourages the spacing of births but prohibits birth control because those who live male and female are God (LaGore et al.,2024).

2.2.3.4 Living with children

In sub-Saharan Africa, most women do not use contraceptives after childbirth because of certain social and cultural factors affecting use, including the desire to increase the number of births. Women are not entirely free to decide whether to use contraceptives (Compton et al.,2023). China's study also indicated that women with multiple births are more likely to use contraceptives because of awareness of contraceptive complications (Bankole& Malarcher,2010). A study conducted in China by Machiyama et al. (2018) indicated that the choice of contraceptives depends on the number of children. Women without children prefer to use condoms, and natural immunity is the external factor compared to women with children, who like to use injections and implants.

2.2.4 Birth control method

2.2.4.1 Long-acting reversible contraceptive methods

2.2.4.1.1 Intrauterine device

Intrauterine devices are small, often T-shaped birth control devices that are inserted into a woman's uterus to prevent pregnancy and are considered one of the long-acting reversible contraceptive forms (Winner et al., 2012). It is placed in the uterus to prevent pregnancy by damaging or killing sperm. It is allowed for use in situations where the use of pills is contraindicated. It is forbidden to use it in women who suffer from infections such as pelvic inflammatory disease and who have more than one partner. There are two types of IUDs: hormonal IUDs and copper (Cu) IUDs. Among types of birth control, they, along with birth

control implants, result in the highest satisfaction among users (Obstetricians & Gynecologists, 2012).

IUDs are the most widely used form of reversible contraception, with more than 180 million users worldwide (Speroff & Darney, 2010). The IUDs do not affect breastfeeding and can be inserted immediately after delivery (Gabbe et al., 2016) and immediately after an abortion (Steenland et al., 2011), and fertility returns to normal immediately after removal (Falcone et al., 2007).

2.2.4.1.2 Hormonal IUD

Levonorgestrel, a progesterone hormone, is released into the uterus by this kind of IUD. This hormone causes the cervix's mucous membrane to thicken. Thereby preventing sperm from reaching the eggs and fertilizing them. Also, it thins the uterine lining, or endometrium, to prevent fertilized eggs from implanting and developing. Compared to the Copper Intrauterine Device (Cu-IUD), it is more successful in preventing pregnancy (Ortiz & Crocatto, 2007). According to Furlong (2002), the five-year cumulative pregnancy rate per 100 users was 0.5, and the five-year Pearl rate was 0.11.

2.2.4.1.3 Copper IUD

It is the kind of IUD that is most frequently used. The uterine fluid contains the expelled copper ions from the Cu-IUD. An inflammatory response occurs in the uterine lumen as a result. Women who use this kind of IUD consequently have elevated copper levels in their vaginal tract secretions (Tal et al., 2016). This material is thought to be poisonous and damaging to sperm, impairing their ability to move and preventing them from sterilizing eggs. If fertilization occurs, Cu-IUDS can remain in the body for up to ten years, preventing fertilized eggs from implanting in the endometrium (Ortiz & Croxatto, 2007).

2.2.4.1.4 Implant

Implants are a long-acting, reversible form of progestin-only contraception that constantly releases a very tiny amount of progestin into the bloodstream. Jadelle, Implanon, and Sino-implant are the three implants currently offered. Implants are very convenient for women who use them; following one client action, they begin functioning right away and give extremely trustworthy contraceptive protection for up to three or five years. A simple, short surgical procedure performed under local anaesthesia is all that is needed to implant one or two matchstick-sized plastic rods beneath the skin of the inner upper arm (WHO, 2011; Ortayli, 2002).

Some women also like that implants can be used discreetly and that laboratory testing and pelvic exams are not required. Furthermore, implants do not interfere with sexual activity and have no negative or premature effect on a person's capacity to conceive again following removal (Jacobstein and Stanley, 2013). It is advised that you use an IUD for continuous birth control if you have had unprotected sex in the last few days and need to prevent pregnancy.

2.2.4.2 Barrier methods

It serves as a barrier to keep sperm from getting to the eggs and could protect from STDs. These low-cost, simple-to-use techniques are safe for nursing and can be applied right after childbirth; however, unlike other treatments like injections and IUDS (Szucs,2020).

According to Trussel & Guthrie (2011), only 18 to 28 out of every 100 women who use them become pregnant; these procedures are ineffective in preventing conception. Other methods

that work include spermicide, condoms, sponges, diaphragms, and cervical caps. Condoms and spermicides are two of the most utilized techniques in basic care for men. Typically, male condoms are constructed from lamb intestinal membrane or latex (Mahdy et al.,2017). Latex condoms reduce the risk of spreading sexually transmitted diseases (STDS), while lambskin condoms do not prevent STDs (Workowski and Bolan, 2015). Spermicides are chemicals that inactivate sperm, and the most common spermicidal agent is nonoxynol-9 (N-9). It is available in several concentration forms (foam, Jelly, cream and suppository) (Grimes et al., 2013).

2.2.4.3 Sterilization

Sterilization is divided into two types: female sterilization, which involves tying the fallopian tubes, and male sterilization, which involves cutting the vas deferens. Both are safe, have no side effects, are permanent, and are inexpensive (Sharma & Gupta, 2024). They also help improve sexual desire between spouses. Female sterilization is more common than male sterilization (Raza et al., 2023).

2.2.4.4 Tubal sterilization

The intentional blocking, removal, or partial removal of the fallopian tubes to permanently prevent pregnancy in females is known as tubal sterilization (Clark et al., 2021; Geriepy et al., 2022). Sterilization is the most widely used method of contraception in the world and is quite successful at preventing conception. When a patient wishes to have permanent contraception, the operation is recommended. In the immediate postpartum and post-abortion periods, during a cesarean delivery, and at any point during the menstrual cycle, it can be carried out (American College of Gynaecologists, 2019). Around half of all sterilization procedures are carried out in the US, and a significant portion of sterilization procedures conducted globally take place in the first few months after childbirth (Floyd, 2021).

Interval procedures are carried out beyond the first postpartum or postabortal phase. Currently, a mini-laparotomy or laparoscopic procedure is used to sterilize the tubules. Hysteroscopic devices were also employed, although they are no longer in production (Dains et al., 2016). Historically, postpartum sterilization was usually achieved by partial salpingectomy through a mini-laparotomy, and interval sterilization was usually achieved by laparoscopically occluding the tubes with clips, bands, or electrocautery (Dains et al., 2016). Complete bilateral salpingectomy, on the other hand, has more recently emerged as the preferred sterilization technique for interval and postpartum procedures due to its ability to reduce the risk of epithelial ovarian cancer and post-sterilization contraceptive failure while maintaining surgical risk (Castellano et al., 2017; Kim et al., 2019; Runnebaum et al., 2023). Pregnancy after sterilization is possible but uncommon. Younger ages are linked to higher rates of contraceptive failure. The cumulative 10-year failure rate of tubal sterilization using traditional occlusive methods or postpartum partial salpingectomy ranges from 7.5 to 54.3 pregnancies per 1,000 sterilization procedures, depending on the technique employed and the patient's age at the time of sterilization. It is noteworthy that although long-term failure rates following a full bilateral salpingectomy are not yet known, they should ideally be close to 0% (Marino et al., 2017).

According to Hanson et al. (2017), there is a comparatively significant chance of an ectopic pregnancy following post-sterilization. Additional procedural hazards include bleeding, infection, harm to adjacent organs, and problems with the incision and anesthesia, much like with any surgical treatment.

2.2.4.5 Vasectomy

A vasectomy is a surgical procedure in which the vas deferens are severed or tied in men. Sperm from the testicles is delivered by a tube called the vas. A vasectomy is intended to give men who do not want any more children permanent birth control. It is a long-term family planning technique widely accepted in developed nations (Mohamad et al., 2014). However, obstacles still prevent married men from receiving it in most African nations, including Ethiopia (Nerso et al., 2020). Although South Africa (0.7%) and Namibia (0.4%) have the highest recorded vasectomy rates in Africa, these figures are still well below the global norm (Anderson et al., 2012).

2.2.4.6 Hormonal methods

Hormones are used in hormonal birth control treatments to control or stop ovulation and avoid pregnancy. There are several ways to transfer hormones into the body, including intrauterine systems, skin patches, pills, injections, vaginal rings, and implantable rods. These techniques thin the uterine lining and thicken cervical mucus, which helps prevent sperm from accessing the egg and impede ovulation (Bradley et al., 2023). Long-acting and short-acting hormonal methods include progestin-only methods, transdermal combined hormonal patches, transvaginal combined hormonal methods, intramuscular combined hormonal injectable methods, and combined oral contraceptive (COC) methods (Bradley et al., 2023).

2.2.4.6.1 Vaginal ring

The ring has a diameter of around two inches and is thin and flexible. It provides a combination of progestin and ethinyl estradiol. After the ring is placed inside the vagina, it distributes hormones continuously for three weeks. In the fourth week, women remove it; seven days later, they replace it with a new ring (Roumen et al., 2001). According to Kovacs and Briggs (2015), this technique prevents ovulation and is quickly absorbed by the vaginal epithelium, producing a stable serum concentration. For women who suffer from certain medical disorders, such as heart disease or hypertension, a vaginal ring might not be advised. Furthermore, it may increase the risk of venous thrombosis, such as with COCAs (Lete et al., 2007). Nonetheless, it is considered safe and efficient in controlling the menstrual cycle and easing related symptoms (Kerns & Darney, 2011).

2.2.4.6.2 Injectable Birth Contraceptive

Global injectable contraceptives were introduced as a novel form of birth control. There isn't a birth control method that is 100% safe and effective. Most treatments' adverse effects are more of an annoyance than a danger to life. In addition to providing women with convenience, privacy, and effective and safe protection, injectable contraceptives are used to prevent conception. Reproductive women in 130 countries worldwide utilize Depo medroxyprogesterone acetate (DMPA) (WHO, 2018). Many women view amenorrhea brought on by injectable contraceptives as advantageous and practical. Women's opinions may be crucial in shaping family planning strategies to enhance client satisfaction, promote continuation, and increase method adherence. After a year, the effectiveness, safety, and patient satisfaction of injectable contraceptives were evaluated in two sizable open-label phase 3 trials. Both formulations were well tolerated, and neither study reported any pregnancies. When used correctly and consistently, injectable contraceptives are more than 99% effective (Srivastava et al., 2012). The most common reason for stopping treatment is the occurrence of side effects. However, patients may also stop for legitimate reasons, such as visiting the center once every three months for a repeat injection (Bairagya et al., 2021).

2.2.4.6.3 Contraceptive patch

The term “the patch” refers to a transdermal patch that is used to prevent pregnancy by releasing synthetic estrogen and progestogen hormones. When used properly, they have been demonstrated to be just as effective as the combination oral contraceptive pill; however, when used frequently, the patch may be more effective (Nanda & Burke, 2011). Compared to Ocs, a transdermal patch has several advantages. There is reduced fluctuation in estrogen plasma concentrations, which may lessen side effects such as nausea associated with high peak estrogen levels. Overall estrogen exposure, as indicated by the area under the concentration curve (AUC), is larger with the Ortho Evra patch than with the combination oral contraceptives (COCs), even though peaks and troughs are reduced. Another significant benefit is that, unlike taking a contraceptive pill every day, the user only needs to replace the patch once a week, which may lead to better adherence (Galzote et al.,2017).

2.2.4.6.4 Oral contraceptive methods

Depending on the hormones contained, oral hormonal contraceptives (OHC) may have additional benefits for users, such as the treatment of dysmenorrhea, premenstrual tension, acne, and ovarian cysts (Schindler, 2010). However, as with any drug treatment, there is a chance of experiencing adverse events, which are defined as “any unneeded medical occurrences in a patient administered a medicinal product and which are not necessarily associated with a causal relationship with this treatment” (Tozetto et al., 2022).

According to Vieira et al. (2007), using OHC may result in various previously documented side effects, ranging from common ones, such as irregular bleeding and gastrointestinal, metabolic, and neurological consequences, to more uncommon and severe ones, including cardiovascular and thromboembolic events. According to a systematic study, the risk of myocardial infarction and ischemic stroke is 1.6 times higher for users of combined OHC compared to non-users across a range of doses, generations, and kinds (Roach et al., 2015). Furthermore, previous reviews have not discovered any connection between users' weight increase and low-dosage OHC use (Gallo et al., 2014).

Despite the widespread use of the OHC method, there is a lack of knowledge regarding its potential negative effects. To determine how much women in the US knew about the hazards associated with using combined oral contraceptives (OHC) and the efficacy of various treatments, a study involving 500 women was conducted. The effectiveness of traditional contraceptive methods, such as male condoms and combination oral pills, was overestimated by about two-thirds of women. Additionally, 56.2% of respondents thought that the risks associated with combined OHCs were equivalent to those of a pregnancy for women. Regretfully, women are still mostly ignorant about the security and efficacy of contraceptives (Kakaiya et al., 2017).

2.2.5 Access to contraceptives

Adequate access to contraceptives for women is critical in reducing unplanned pregnancies, reducing maternal and child mortality and reducing unsafe abortion (Ahmed et al., 2012; Do and Kurimoto, 2012). Several awareness-raising programs have been established around the world on the correct and effective use of contraceptives to reduce inadequate access to contraceptives despite the programs established at the time. However, there are still many problems with underutilization and women's inability to access contraceptives that work for them in non-developed countries (Hatcher Robert Anthony, 2007). Where many States have worked to develop access to effective contraceptives and safety, this work is one of the most important achievements in maintaining women's and their children's health (Chandra - Mouli et al., 2014).

2.2.6 Factors affecting the Accessibility of family planning methods

2.2.6.1 Continuation

There are several factors affecting women's lack of continuity with contraceptives, including the desire to try another method and the fear of contraceptive risk (Ali et al., 2012). Failure to maintain contraceptive use affects women's health risks (Saferi et al.,2019). In most parts of the world, where contraceptive prevalence varies from medium to high, most unintended pregnancies result from contraceptive failure (Littlejohn, 2012; Moreau et al., 2009). In addition, unplanned pregnancies have a negative impact on women. This includes a detrimental impact on the health of the mother and her child and mental stress (Gipson et al., 2008).

2.2.6.2 Availability & Stockouts of Family Planning Methods

Muhoza et al. (2017) noted that about 1 million women in the fertility period have difficulty accessing primary healthcare centres. Additionally, there is some evidence that the relationship between the lack of access to different contraceptives and the difficulty of obtaining them varies from country to country (Ali et al., 2018; Babazadeh et al., 2018; Zimmerman et al., 2019).

Various countries face several problems when accessing contraceptives, including each country's decision-making. Access to contraceptives varies from country to country, posing a dilemma for women's access to the means they prefer. Barriers in different countries also pose a problem that impedes contraceptive access (USAID, 2018). Lack of access to contraceptives and their low presence in health centres adversely affect women, as women do not have access to contraceptives appropriate to their needs and wishes. Customs, traditions and economic income also play an important role in their preferences, which is an obstacle due to the lack of contraceptives in some countries (Brown and Eisenberg, 1995; Wang & Mallick, 2019).

The lack of contraceptives in health facilities limits proper contraceptive compliance. This reduces its effectiveness or sustainability, increasing family size (Ross and Hardee, 2018; Grindlay et al., 2016). In addition, the presence of many different contraceptives effectively contributes to reducing the risk of unplanned pregnancies (DHS Program, 2017).

2.2.6.3 Affordability FP methods

One of the primary obstacles to utilizing family planning services is the cost. Significant financial barriers prevent many women in low- and middle-income nations from using contraception (Miller et al., 2019). For people without sufficient health insurance or financial support, the cost of hormonal contraceptives, IUDs, and barrier methods, among other family planning techniques, can be prohibitive (Guttmacher Institute, 2022). Financial difficulties might also cause inconsistent contraceptive use. Unplanned births are more likely to occur in women who cannot afford the upfront expenditures of contraception, such as IUDs or implants. They may instead choose to forgo contraception entirely or use less effective forms (Frost et al., 2018).

Implementing government policies and initiatives is crucial in making family planning techniques more accessible and affordable. Women's financial burdens can be lessened by participating in funded family planning programs, such as those offered by international organizations and government health departments (WHO, 2021). Programs offering free or inexpensive contraceptives, for example, have the potential to improve significantly low-income individuals' access to and use of these medications (Bongaarts & Casterline, 2019). Policies like comprehensive reproductive health services and insurance coverage for

contraception, in addition to direct funding, are essential. By making family planning more affordable and accessible, these policies can enhance health outcomes and reduce economic disparities in access to family planning (Simmons et al., 2020).

2.2.7 Compliance with family planning methods

Some concepts have been added to "adherence": dosage compliance and treatment persistence. While the latter refers to regular usage, the former refers to taking the prescribed medication. The degree to which a person follows the healthcare provider's agreed-upon advice is known as contraceptive adherence. When it comes to contraceptives that are taken by mouth, adherence is defined as taking the pill usually every day and following a set of guidelines to avoid getting pregnant when under supervision or when receiving therapies that go against them (de Molina-Fernandez et al., 2023).

Different contraceptive methods have different efficacies in preventing conception, which can be attributed in part to the efficacy and adherence to the method (Freeman, 2004). Although barrier techniques like condoms are less common among married couples, they do need a high level of commitment from both the users and their partners (Adinma et al., 2010; Al-Shawakh et al., 2020). Globally, injectables (DMPA) and oral contraceptive pills (OCP) are generally the most commonly used (Centers for Disease Control and Prevention [CDC], 2010). However, consistent and appropriate use is necessary to maximize their efficacy in preventing unexpected pregnancies and their consequences (Peyman et al., 2009).

According to research on general medication use, non-adherence remains one of the most underappreciated reasons for the care gap (Reed et al., 2014). According to studies evaluating family planning services in Lilongwe, Malawi, 32-35% of family planning clients quit contraception use within 48 weeks, primarily owing to side effects, partner dissatisfaction, and inadequate preinitiation counselling (Haddad et al., 2013). Similarly, a study reported significant cessation rates among rural Kenyan women in discordant couples (Ngure et al., 2011). According to Cebeci Save et al. (2004), beliefs, attitudes, and everyday activities impact consistent and proper contraceptive use.

2.2.8 Role of health care providers as educators in family planning methods

Guidance on family planning methods is necessary to provide a safe and effective service because it helps a woman choose a suitable method for herself and her husband, thereby limiting unintended pregnancy and abortion. It also plays a crucial role in mitigating psychological stress, dispersion, and physiological changes associated with previous pregnancies (Stanback et al., 2015; Lee, 2014). There are several elements through which guidance on contraceptives is provided, including initiating a friendly relationship with the woman, assessing the woman's wishes, explaining the benefits and harms of contraceptives to help her avoid fear of contraceptive harm and making the right decision to avoid reproductive health problems (Festin, 2020).

Guidance on six-stage contraceptives includes welcoming and treating a woman well, assessing the woman's desired contraceptives, explaining to her how to use contraceptives properly, and telling her when to visit a primary care centre (Institute for Reproductive Health & Georgetown University, 2005). Another model, consent, was an effective decision-making model, finding and solving problems that impeded employment between the provider and the woman, working to change contraceptives and finding another appropriate way (Institute for Reproductive Health & Georgetown University, 2005).

In Ethiopia, Abebaw (2019) noted that 87.3% of family planning providers have sufficient information and experience to guide women to the proper use of contraceptives, and 90.2%

provide guidance regularly and effectively. Many factors affect the provision of effective guidance by family planning providers, including the failure to accommodate the needs and desires of the lady, insufficient clarification from the service provider of the various contraceptive methods due to time constraints and lack of training on family planning protocols by service providers, which makes it difficult for women to obtain adequate information due to the lack of knowledge and expertise of service providers (Saka et al., 2012). Several factors also hinder the provision of counselling, including the failure to schedule visits in primary care centers for women, which leads to congestion and chaos (Shahidzadeh-Mahani et al., 2008). Nursing has become essential for women to receive appropriate guidance and support (Tuoane et al., 2004).

2.2.9 Gap in literature

Compared to previous studies conducted in Palestine regarding the role of family planning service providers as health educators, this study highlighted this role. This study also contributed to knowing the rate of women's access to contraceptives and their availability, as it was noted that, due to the war conditions, there was a decrease in the availability of contraceptives compared to the pre-war conditions. Due to the lack of Ministry of Health reports on this subject, this study came to show the difficulty and lack of access to contraceptives. This is due to the presence of roadblocks and the closure of the crossings of the Gaza Strip.

Chapter Three

Materials and Methods

In this chapter, the researcher presents the methodology used in this study, including the study design, study population, study sample, eligibility criteria, study period, validity of the study instrument, data collection, data entry, statistical analysis, and ethical and administrative considerations.

3.1 Study design

The researcher used a cross-sectional descriptive design. This design is crucial for understanding the relationship between the subordinate and autonomous study variables without the researcher's intervention. One of the benefits of this design is that it can be applied to the population in a short period of time. It is also easy and does not require large amounts of money, and it is used to understand the characteristics of the population (Wang& Cheng, 2020).

3.2 Setting of the study

The study was conducted in primary health care centers (PHCCS) of the Ministry of Health (Moh) that provide family planning services in the southern and mid-zone Governorate of Gaza, specifically at the Deir al-Balah PHCC, Khan Yunis PHCC, and Zawada PHCC.

3.3 Period of study

The study was conducted from 2023 to 2025. It was a long study period due to the Israeli aggression on the Gaza Strip from 10-2023, which is still ongoing, and this led to a break in the research study.

3.4 Target population

Includes women attending government primary care centers selected for family planning. According to health reports issued by the Palestinian Ministry of Health in selected centers, the number of women attending to organize their families in the selected primary healthcare centers was 5,952 (Ministry of Health, 2023).

3.5 Sampling process and sample size

The researcher employed a combination of two sampling techniques, utilizing quota sampling methods to represent southern and mid-zone governorates of GS, followed by a consecutive sampling method. As the first stage of quota sampling, and in accordance with the administrative geographical distribution of Gaza, the researcher distributes the southern and mid-zone GS into three governorates (mentioned earlier). As in the second stage, the three main FP clinics from the representative governorate were selected to represent the corresponding governorate. Finally, the consecutive Sampling technique was used, in which every woman meeting the inclusion criteria was invited to participate in the study until the required sample size from each clinic was achieved. According to the Epi-Info program, the suggested Optimal sample size for data collection is 361 women (Annex 3).

3.6 Eligibility criteria

Inclusion criteria

1. Women attending selected primary care centers for family planning.
2. Women who agreed to participate in the study.
3. Women's ability to read and write.

3.7 Instruments of study

The researcher constructed a self-administered questionnaire (Annexe 4) based on a review of the literature and past experiences to assess the factors affecting access, utilization, and compliance with the FP method among women in GS, was the role of healthcare providers as educators in the FP method. The questionnaire was validated by distributing it to a panel of experts (Annexe 5).

The questionnaire is divided into five domains

First domain: socio-economic factors among women, including age, educational

Level, income level, occupation of the husband, parity, gravida, and residence.

• Second domain: It contains 24 yes-or-no questions about the Factors affecting women's access, utilization and compliance with FP methods.

• Third domain: It contains 23 Likert scale questions about women's Access to family planning methods.

• Fourth domain: It was divided into eight options, and this question was optional to assess the percentage of women currently using family planning methods.

Fifth domain: It comprises 12 Likert scale questions assessing women's compliance with family planning (FP) methods.

• Sixth domain: It contains 19 Likert scale questions about factors affecting health, as well as education about family planning methods.

Scientific rigor

3.8 Validity

Content validity is defined as the degree to which items in an instrument reflect the Content to which the instrument was generalized; it is highly recommended to apply Content validity during the development of a new instrument. In general, content validity Involves the evaluation of a new survey instrument to ensure that it includes all essential items and eliminates undesirable items related to a particular construct domain (Taherdoost, 2016). The validity of the questionnaire was examined by a group of experts in topic content and research methodology to assess the clarity of the items and ensure that they cover the domains of the questionnaire.

3.9 Reliability of the instrument

The reliability of an instrument is the degree of consistency with which it measures the attribute it is intended to measure. The test is the scores obtained are compared by calculating a reliability coefficient. One common method for calculating reliability is to use Cronbach's Alpha coefficient. Table 3.1 presents the Cronbach's Alpha values for each domain of the questionnaire administered to the participants. The table illustrates the reliability of the domains, with a Cronbach's Alpha value of 0.910 for the entire questionnaire in the pilot sample, indicating good reliability for the entire questionnaire.

Table (3.1): Reliability of the research for each domain of the questionnaire

No.	Domains	No. of item	Cronbach's Alpha
D1	Factors affecting women's access, utilization and compliance with FP methods	24	0.914
D2	access to the FP method among the study participants	23	0.973
D3	FP type use among the study participants	7	0.918
D4	Women's compliance with contraceptive use	11	0.771
D5	The role of HCPs in educating women about FP methods	19	0.976
Total		84	0.910

3.10 Pilot study

A pilot study was conducted with 35 participants (10% of the sample) to test the Reliability of the questionnaire. The northern GS was excluded due to the roadblocks imposed by the Israeli occupation between the north and south of the Strip. The city of Rafah was also excluded from the southern GS due to the displacement of its residents by the massive Israeli bombardment. Therefore, the researcher selected clinics that were easy to access.

3.11 Data entry and statistical analysis

After collecting and entering the data into the Statistical Package for the Social Sciences (SPSS) software version 25.0, a frequency analysis was conducted to ensure no missing data. In the case of missing data, a case-wise deletion was performed. Once data integrity was achieved, frequency analysis was conducted to present baseline characteristics. Continuous variables were presented as means and standard deviations, while categorical variables were presented as frequencies and percentages. A normality analysis was performed before

analyzing statistical relationships to determine whether a parametric or non-parametric analysis should be used. A statistically significant relationship will be assumed if the P value is less than 0.05.

3.12 Data collection technique

A study conducted by the researcher on the central and southern GS selected three primary care centers. The researcher obtained an approval form from the Palestinian Ministry of Health, which the managers of the selected centers signed.

The researcher met clinic nurses to facilitate the collection of data from women attending selected primary care centers.

The researcher explained the purpose of the study to the women and provided instructions before they completed the questionnaire.

The researcher explained that filling out the questionnaire is optional and that an approval form is required. The time allocated for completion is 20 minutes.

3.13 Ethical and administrative considerations

Academic approval was requested from Al-Quds University (Annexe 5). Administrative approval was obtained from the Health Research Department in the Ministry of Health (MoH) for conducting this study at Government hospitals (Annexe 6).

Before distributing the questionnaire to the women, approval was obtained from the Health Research Ethics Committee.

To ensure the participants' rights, a consent form was used to indicate that participation was voluntary, confidentiality was ensured for all, and the approximate time required to complete the questionnaire (Annex 7).

Chapter Four

Results

4.1 Socio-demographic data of participants

Table (4.1): Socio-demographic data of participants

Socio-demographic data	Groups	N	%
Age (years)	Less than 18	14	3.9%
	18-30	157	43.6%
	31-40	118	32.8%
	41-50	58	16.1%
	Above 50	13	3.6%
Region	Khan-Younis	223	61.9%
	Deir al-Balah	120	33.3%
	Al-Zawayda	17	4.7%
Level of education for women	Primary School or Less	38	10.6%
	Secondary School	191	53.1%
	Diploma	22	6.1%
	Bachelor's Degree	106	29.4%
	Master's Degree or more	3	0.8%
Level of education for husband	Primary School or Less	81	22.5%
	Secondary School	163	45.3%
	Diploma	24	6.7%
	Bachelor's Degree	82	22.8%
	Master's Degree or more	10	2.8%
Occupation for women	Employed	60	16.7%
	Unemployed	300	83.3%
Occupation for husband	Employed	114	31.7%
	Unemployed	246	68.3%
Poverty level	Less than 1000	272	75.6%
	1000-1500	60	16.7%
	1600-2000	20	5.6%
	More than 2000	8	2.2%

The socio-demographic data presented in Table 4.1 highlights key trends among participants, with the largest age group being 18-30 (43.6%). Most participants were from Khan-Younis (61.9%). Educational attainment was generally low, with most women (53.1%) and husbands (45.3%) completing secondary school. Employment showed a significant gender gap, with only 16.7% of women employed compared to 31.7% of husbands. Economic hardship was prevalent, as 75.6% of households had a monthly income under 1000 NIS.

4.2 Obstetric history of participants

Table (4.2): Obstetric history of participants

Obstetric history	Groups	N	%	Mean±SD
Number of previous pregnancies	3 or less	134	37.2%	4.41±2.34
	4-6	169	46.9%	
	7 or more	57	15.8%	
Number of previous deliveries	2 or less	159	44.2%	3.09±2.33
	3-4	99	27.5%	
	5 or more	102	28.3%	
How many children do you currently have	2 or less	161	44.7%	
	3-4	97	26.9%	
	5 or more	102	28.3%	1.32±1.00
Number of previous abortions	No	52	14.4%	
	1-3	284	78.9%	
	4 or more	24	6.7%	

The obstetric history data presented in Table 4.2 reveal significant patterns regarding pregnancy, delivery, and childbearing experiences among participants. Most women had experienced between four to six pregnancies (46.9%), with a mean of 4.41±2.34, indicating high fertility. Regarding deliveries, 44.2% reported two or fewer, while 28.3% had five or more, with a mean of 3.09±2.33, reflecting variability in reproductive outcomes. Regarding the number of living children, 44.7% had two or fewer, while 28.3% had five or more, with a mean of 1.32±1.00. Notably, 78.9% reported one to three previous abortions, highlighting a high incidence of pregnancy loss.

4.3 Contraceptive use and health insurance status among participants

Table (4.3): Contraceptive use and health insurance status among participants

Contraceptive use and health insurance	Groups	N	%
Have you ever used contraceptives	Yes	255	70.8%
	No	105	29.2%
Do you have health insurance?	Yes	257	71.4%
	No	103	28.6%
Do you have any chronic health conditions affecting your decision to use a contraceptive	Yes	58	16.1%
	No	302	83.9%
Duration of contraceptive use	Don't use it	96	26.7%
	Less than a year	46	12.8%
	1-2 years	94	26.1%
	More than 3 years	124	34.4%

The data in Table 4.3 show trends in contraceptive use and health insurance among participants. A majority (70.8%) reported using contraceptives, while 29.2% had not, indicating broad acceptance of family planning. Additionally, 71.4% had health insurance, leaving 28.6% without coverage, which could limit access to healthcare. Health conditions had minimal impact on contraceptive use, with only 16.1% reporting health-related barriers. Most participants (34.4%) used contraceptives for over three years.

4.4 Factors affecting women's access, utilization and compliance with FP methods among the study participants

Table (4.4-A): Factors affecting women's access, utilization and compliance with FP methods among the study participants

Factors affecting women's access, utilization and compliance with FP methods	Yes		No	
	N	%	N	%
1. Do you discuss with your husband before you start using family planning methods	308	85.6%	52	14.4%
2. Is the husband a powerful factor in family planning methods?	297	82.5%	63	17.5%
3. Do the religious factors affect your Access and compliance with family planning methods?	225	62.5%	135	37.5%
4. You care that your husband agrees about the method of FP that has been chosen	280	77.8%	80	22.2%
5. Is it okay for you to choose any FP method without telling your husband?	98	27.2%	262	72.8%
1. Are you afraid to use the FP method to avoid complications?	211	58.6%	149	41.4%
2. Have you ever experienced any complications after using contraceptives?	166	46.1%	194	53.9%
3. Does family planning affect your normal sexual intercourse	128	35.6%	232	64.4%
4. Is a lack of knowledge and awareness of family planning methods negatively affecting you, and making you not use family planning methods	165	45.8%	195	54.2%
5. Is poor treatment by service providers (nurses and midwives) a factor influencing contraceptive use	237	65.8%	123	34.2%
6. Does the level of support and encouragement from healthcare providers impact compliance with family planning methods	251	69.7%	109	30.3%
7. Do the side effects that can be caused by contraceptive use affect women's compliance	215	59.7%	145	40.3%
8. Contraceptives in your area are easy	195	54.2%	165	45.8%
9. Is the cost of contraceptives a factor influencing your decision to use them	163	45.3%	197	54.7%
10. Do you find it difficult to get a medical consultation on contraceptives	197	54.7%	163	45.3%
11. Are there long waiting times for family planning services	216	60.0%	144	40.0%
12. Do you feel that you have complete freedom to decide whether to use contraceptives	226	62.8%	134	37.2%
13. Are there social or family pressures affecting your decision to use contraceptives	125	34.7%	235	65.3%

Table (4.4-B): Factors affecting women's access, utilization and compliance with FP methods among the study participants

Factors affecting women's access, utilization and compliance with FP methods	Yes	No		
	N	%	N	%
1. Are you concerned or stressed when considering contraceptive use due to its potential side effects	182	50.6%	178	49.4%
2. Do you find it difficult to continue using contraception for a long time	188	52.2%	172	47.8%
3. Have you ever stopped using contraceptives because of their dissatisfaction	178	49.4%	182	50.6%
4. Do you feel that healthcare providers provide you with sufficient information about contraceptives	254	70.6%	106	29.4%
5. Do you find that the level of health education available on contraceptives is insufficient	165	45.8%	195	54.2%
6. Do you feel that the community around you support the use of family planning methods	238	66.1%	122	33.9%

4.5 Distribution of the level of access to the FP method among the study participants

Table (4.5-A): Distribution of the level of access to FP method among the study participants

Access to the FP method		Strongly disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly agree (5)	Mean	SD	% Mean	Rank
1. I find it easy to access hormonal contraceptives (e.g., pills, patches, and implants).	N	47	88	44	126	55	3.15	1.31	63	20
	%	13.1%	24.4%	12.2%	35.0%	15.3%				
2. I find it easy to access barrier contraceptives (for example, condoms and diaphragms).	N	44	86	58	115	57	3.14	1.29	62.8	21
	%	12.2%	23.9%	16.1%	31.9%	15.8%				
3. I find it easy to access reversible prevention methods (e.g., IUD, implants)	N	43	91	66	99	61	3.12	1.29	62.4	23
	%	11.9%	25.3%	18.3%	27.5%	16.9%				
4. I find it easy to access a contraceptive method that is appropriate to society's customs and traditions	N	28	80	47	135	70	3.39	1.24	67.8	18
	%	7.8%	22.2%	13.1%	37.5%	19.4%				
5. I find it easy to access a contraceptive suitable for my age	N	25	42	44	150	99	3.71	1.19	74.2	4
	%	6.9%	11.7%	12.2%	41.7%	27.5%				
6. I find it easy to access contraception from a healthcare provider	N	32	36	43	156	93	3.67	1.21	73.4	6
	%	8.9%	10.0%	11.9%	43.3%	25.8%				
7. I find it easy to access contraceptives from clinics that provide family planning services.	N	26	47	44	148	95	3.66	1.2	73.2	7
	%	7.2%	13.1%	12.2%	41.1%	26.4%				
8. I find it easy to access the contraceptive I want	N	32	52	45	139	92	3.58	1.26	71.6	13
	%	8.9%	14.4%	12.5%	38.6%	25.6%				
9. I find it easy to get a contraceptive that fits my lifestyle	N	29	31	34	144	122	3.83	1.22	76.6	2
	%	8.1%	8.6%	9.4%	40.0%	33.9%				
10.My family planning methods vary depending on my social situation.	N	31	44	51	145	89	3.6	1.22	72	11
	%	8.6%	12.2%	14.2%	40.3%	24.7%				
11.I think family planning methods for me vary depending on my economic situation	N	31	60	43	135	91	3.54	1.27	70.8	15
	%	8.6%	16.7%	11.9%	37.5%	25.3%				

Table (4.5-B): Distribution of the level of access to FP method among the study participants

Access to the FP method		Strongly disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly agree (5)	Mean	SD	% Mean	Rank
12.The availability of the contraceptive methods that my husband wants helps us improve sexual relations and achieve the desired number of children	N	30	30	29	133	138	3.89	1.24	77.8	1
	%	8.3%	8.3%	8.1%	36.9%	38.3%				
13.Access to family planning means satisfactory consequences for me and my husband in improving physical and general health	N	39	41	37	134	109	3.65	1.31	73	8
	%	10.8%	11.4%	10.3%	37.2%	30.3%				
14.The access to family planning that suits my health status is 4 available	N	34	44	45	144	93	3.61	1.25	72.2	10
	%	9.4%	12.2%	12.5%	40.0%	25.8%				
15.It's easy to get a consultation from healthcare providers about the best way for me	N	40	31	49	134	106	3.65	1.29	73	8
	%	11.1%	8.6%	13.6%	37.2%	29.4%				
16.There is adequate awareness in society about available family planning methods	N	35	45	57	134	89	3.55	1.26	71	14
	%	9.7%	12.5%	15.8%	37.2%	24.7%				
17.I find that the cost of contraception is appropriate, and I can afford it	N	31	52	58	112	107	3.59	1.28	71.8	12
	%	8.6%	14.4%	16.1%	31.1%	29.7%				
18.I feel that privacy is reserved when I use family planning methods in health facilities	N	30	28	47	160	95	3.73	1.18	74.6	3
	%	8.3%	7.8%	13.1%	44.4%	26.4%				
19.I find family planning tools readily available even in emergency or urgent need	N	61	63	47	121	68	3.2	1.38	64	19
	%	16.9%	17.5%	13.1%	33.6%	18.9%				
20.I think modern family planning methods (such as technological applications) are sufficiently accessible and accessible	N	72	58	58	96	76	3.13	1.44	62.6	22
	%	20.0%	16.1%	16.1%	26.7%	21.1%				
21.I feel that the community around me supports my use of family planning methods	N	26	43	50	130	111	3.71	1.22	74.2	4
	%	7.2%	11.9%	13.9%	36.1%	30.8%				
22.Religious institutions provide sufficient support to access family planning methods	N	28	69	56	111	96	3.49	1.28	69.8	16
	%	7.8%	19.2%	15.6%	30.8%	26.7%				
23.I find that available family planning methods are of high quality and reliable	N	38	60	67	101	94	3.43	1.32	68.6	17
	%	10.6%	16.7%	18.6%	28.1%	26.1%				
Total										

The data in Table 4.5 highlight the factors influencing women's access to family planning (FP) methods, and the total score of the domain was 70.4%. The highest-ranked factor (77.8%) emphasizes the importance of spousal agreement on contraceptive methods to improve sexual relations and achieve the desired family size. Closely following (76.6%), the ease of accessing a contraceptive that fits a woman's lifestyle is crucial for consistent use. Conversely, the lowest-ranked factor (62.4%) highlights challenges in accessing reversible prevention methods, indicating barriers to availability.

4.6 Distribution of FP type uses among the study participants

Table (4.6): Distribution of FP type uses among the study participants

FP type uses	Yes		No	
	N	%	N	%
Copper IUD	78	21.7%	282	78.3%
Hormonal IUD	27	7.5%	333	92.5%
Pills	64	17.8%	296	82.2%
Condom	41	11.4%	319	88.6%
Injection	21	5.8%	339	94.2%
Implant	8	2.2%	352	97.8%
Others	31	8.6%	329	91.4%

The data in Table 4.6 presents the distribution of FP methods among the study participants, revealing key preferences and trends. The Copper IUD was the most commonly used method, with 21.7% of participants opting for it. Pills followed closely at 17.8%, while condoms were used by 11.4%. The Implant, however, had the lowest usage rate at 2.2%. Other methods like the Hormonal IUD (7.5%) and Injection (5.8%) were less popular, possibly due to availability, acceptance, or side effects. The "Others" category accounted for 9.6%, indicating some reliance on alternative FP methods.

4.7 Distribution of the level of women's compliance with contraceptive use among the study participants

Table (4.7): Distribution of the level of women's compliance with contraceptive use among the study participants

		Never (0)	Rarely (1)	Sometimes (2)	Often (3)	Always (4)	Mean	SD	% Mean	Rank
1. Use contraceptives on time	N	76	14	33	40	197	2.74	1.62	68.5	3
	%	21.1%	3.9%	9.2%	11.1%	54.7%				
2. I didn't complain about using family planning methods	N	114	14	43	53	136	2.23	1.71	55.75	9
	%	31.7%	3.9%	11.9%	14.7%	37.8%				
3. Use a particular method to remind me to take contraception on time	N	132	12	39	29	148	2.14	1.79	53.5	10
	%	36.7%	3.3%	10.8%	8.1%	41.1%				
4. Ask my care provider before changing or the pills	N	78	12	21	38	211	2.81	1.64	70.25	2
	%	21.7%	3.3%	5.8%	10.6%	58.6%				
5. I stop using family planning methods because of some complications	N	117	16	37	41	149	2.25	1.75	56.25	8
	%	32.5%	4.4%	10.3%	11.4%	41.4%				
6. Try to use the prescribed method of family planning regularly.	N	42	17	36	40	225	3.08	1.4	77	1
	%	11.7%	4.7%	10.0%	11.1%	62.5%				
7. When I forget to use the prescribed method of family planning, I use an additional method of contraception	N	166	12	24	35	123	1.83	1.82	45.75	12
	%	46.1%	3.3%	6.7%	9.7%	34.2%				
8. Timely use of contraceptives to avoid pregnancy while using the prescribed method	N	84	10	28	39	199	2.72	1.66	68	4
	%	23.3%	2.8%	7.8%	10.8%	55.3%				
9. Attend regular appointments with the health care provider to follow up on contraceptive use	N	82	17	24	48	189	2.68	1.65	67	5
	%	22.8%	4.7%	6.7%	13.3%	52.5%				
10. Change contraception on the recommendation of the healthcare provider	N	87	19	26	36	192	2.63	1.69	65.75	6
	%	24.2%	5.3%	7.2%	10.0%	53.3%				
11. keep using contraception even if I experience mild side effects	N	132	26	24	42	136	2.07	1.78	51.75	11
	%	36.7%	7.2%	6.7%	11.7%	37.8%				
12. Continue using contraception even during travel or significant changes in daily routine	N	110	8	19	41	182	2.49	1.77	62.25	7
	%	30.6%	2.2%	5.3%	11.4%	50.6%				
Total							**2.47**	**0.78**	**61.75**	

The data presented in Table 4.7 analyses women's compliance with contraceptive use, showing moderate adherence with a total domain mean score of 2.47 (SD = 0.78) and an overall percentage mean of 61.75%. The highest compliance was noted for Item 6: "Try to use the prescribed method of family planning regularly," scoring 77%, indicating strong consistency in contraceptive use. Item 4: "Ask my care provider before changing or the pills," had a 70.25% score, highlighting reliance on healthcare providers for guidance. However, the lowest scores were for Item 7 (45.75%) and Item 3 (53.5%), suggesting gaps in corrective actions and reminder systems for contraceptive use.

4.8 Distribution of the role of HCPs in educating women about FP methods among the study participants

Table (4.8-A): Distribution of the role of HCPs in educating women about FP methods among the study participants

		Strongly disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly agree (5)	Mean	SD	% Mean	Rank
1. Healthcare providers are responsible for educating women about contraceptives	N	16	23	18	130	173	4.17	1.08	83.4	7
	%	4.4%	6.4%	5.0%	36.1%	48.1%				
2. I got enough information on each contraceptive method to choose the one that fits with me	N	23	49	32	120	136	3.83	1.25	76.6	17
	%	6.4%	13.6%	8.9%	33.3%	37.8%				
3. I have confidence in the quality of health education on contraceptives provided by health service providers	N	27	32	49	135	117	3.79	1.20	75.8	18
	%	7.5%	8.9%	13.6%	37.5%	32.5%				
4. It is necessary to design health education programs on family planning methods to meet the needs and preferences of individual ladies	N	17	19	33	116	175	4.15	1.09	83	8
	%	4.7%	5.3%	9.2%	32.2%	48.6%				
5. A health educator could address illusions and myths about the use of family planning methods	N	16	31	52	141	120	3.88	1.10	77.6	15
	%	4.4%	8.6%	14.4%	39.2%	33.3%				
6. Health providers know the potential complications of contraceptives	N	20	30	38	155	117	3.89	1.12	77.8	14
	%	5.6%	8.3%	10.6%	43.1%	32.5%				
7. I feel comfortable discussing the potential benefits of using family planning with health providers	N	16	20	25	157	142	4.08	1.04	81.6	9
	%	4.4%	5.6%	6.9%	43.6%	39.4%				
8. Health care providers maintain confidentiality and women's privacy when educating health on contraceptives	N	11	16	25	134	174	4.23	0.98	84.6	2
	%	3.1%	4.4%	6.9%	37.2%	48.3%				
9. It is necessary to discuss all available methods of family planning in a health facility as much as possible	N	16	15	19	134	176	4.22	1.03	84.4	3
	%	4.4%	4.2%	5.3%	37.2%	48.9%				
10.Gestures and body language are important to communicate information well during health education on contraceptives	N	7	10	25	150	168	4.28	0.86	85.6	1
	%	1.9%	2.8%	6.9%	41.7%	46.7%				
11.It is necessary to ask health providers about your past medical history to determine the appropriate contraceptive	N	13	24	24	120	179	4.19	1.06	83.8	5
	%	3.6%	6.7%	6.7%	33.3%	49.7%				

Table (4.8-B): Distribution of the role of HCPs in educating women about FP methods among the study participants

		Strongly disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly agree (5)	Mean	SD	% Mean	Rank
12.Health education is likely to contribute to increasing women's awareness of the potential complications that may arise from using family planning methods.	N	20	13	16	134	177	4.21	1.07	84.2	4
	%	5.6%	3.6%	4.4%	37.2%	49.2%				
13.It is necessary to use visual means to help explain different contraceptive methods	N	15	22	48	120	155	4.05	1.09	81	10
	%	4.2%	6.1%	13.3%	33.3%	43.1%				
14.It's necessary to tell me about the contraceptives available in the health facility	N	11	21	29	126	173	4.19	1.02	83.8	5
	%	3.1%	5.8%	8.1%	35.0%	48.1%				
15.health providers must talk about potential complications when using contraceptives	N	17	21	31	155	136	4.03	1.06	80.6	11
	%	4.7%	5.8%	8.6%	43.1%	37.8%				
16.Health providers use easy and simple words when providing health education about contraceptives.	N	18	31	42	133	136	3.94	1.14	78.8	13
	%	5.0%	8.6%	11.7%	36.9%	37.8%				
17.Health care providers provide me with all options available for family planning methods commensurate with my health and personal status	N	12	27	31	160	123	4.01	1.03	80.2	12
	%	3.4%	7.6%	8.8%	45.3%	34.8%				
18.The husband is involved in education sessions on family planning methods to promote common understanding	N	52	54	64	96	94	3.35	1.39	67	19
	%	14.4%	15.0%	17.8%	26.7%	26.1%				
19.Education about family planning methods must continue after starting to use the means to ensure optimal use	N	27	35	35	127	136	3.86	1.23	77.2	16
	%	7.5%	9.7%	9.7%	35.3%	37.8%				
Total							**4.02**	**0.50**	**80.4**	

The data presented in Table 4.8 highlights the positive role of HCPs in FP education, with a mean score of 4.02 (80.4%). The highest-ranked factors were the importance of non-verbal communication (85.6%) and maintaining confidentiality (84.6%). However, areas for improvement include involving husbands in FP education (67%) and increasing confidence in the quality of health education (75.8%), indicating gaps in male engagement and concerns about the effectiveness of the education provided by HCPs.

4.9 Relationship between socio-demographic factors and contraceptive use with the level of access to FP methods among women in the GS

Table (4.9-A): Relationship between socio-demographic factors and contraceptive use with the level of access to FP methods among women in the GS

Sociodemographic data	Categories	The level of access of FP methods			Statistical Analysis 1			
		Mean (Max=5)	SD	% Mean	T	F	P-value	Post Hoc
Age (years)	Less than 18	3.87	0.27	77.40		35.848	0.000*	18-30 and less than 18 > others groups*
	18-30	3.77	0.29	75.40				
	31-40	3.42	0.48	68.40				
	41-50	3.10	0.55	62.00				
	Above 50	3.04	0.71	60.80				
Region	Khan-Younis	3.48	0.46	69.60		2.031	0.133	
	Deir al-Balah	3.59	0.58	71.80				
	Al-Zawayda	3.62	0.25	72.40				
Level of education for women	Primary School or Less	3.79	0.27	75.80		35.717	0.000*	Master's Degree or more < others*
	Secondary School	3.70	0.36	74.00				
	Diploma	2.97	0.68	59.40				
	Bachelor's Degree	3.26	0.51	65.20				
	Master's Degree or more	2.42	0.29	48.40				
Level of education for husband	Primary School or Less	3.73	0.32	74.60		35.409	0.000*	Primary School or Less and Secondary School > others *
	Secondary School	3.69	0.38	73.80				
	Diploma	3.05	0.60	61.00				
	Bachelor's Degree	3.18	0.51	63.60				
	Master's Degree or more	3.02	0.64	60.40				
Occupation for women	Employed	3.08	0.53	61.60	8.853		0.000*	
	Unemployed	3.61	0.45	72.20				
Occupation for husband	Employed	3.21	0.47	64.20	5.323		0.000*	
	Unemployed	3.67	0.45	73.40				

Table (4.9-B): Relationship between socio-demographic factors and contraceptive use with the level of access to FP methods among women in the GS

Sociodemographic data	Categories	The level of access of FP methods			Statistical Analysis 1			
		Mean (Max=5)	SD	% Mean	T	F	P-value	Post Hoc
Economic income (NIS)	Less than 1000	3.64	0.45	72.80		31.044	0.000*	More than 2000 < others*
	1000-1500	3.30	0.37	66.00				
	1600-2000	3.02	0.63	60.40				
	More than 2000	2.57	0.25	51.40				
How long has your marriage been	Less than a year	3.58	0.43	71.60		32.915	0.000*	More than 10 years < others
	1-5 years	3.85	0.21	77.00				
	6-10 years	3.76	0.26	75.20				
	More than 10 years	3.32	0.55	66.40				
Number of previous pregnancies	3 or less	3.56	0.53	71.20		1.624	0.199	
	4-6	3.47	0.48	69.40				
	7 or more	3.58	0.48	71.60				
Number of previous deliveries	2 or less	3.55	0.51	71.00				
	3-4	3.46	0.48	69.20		1.114	0.329	
	5 or more	3.55	0.51	71.00				
How many children do you currently have	2 or less	3.54	0.51	70.80		1.011	0.365	
	3-4	3.46	0.49	69.20				
	5 or more	3.55	0.51	71.00				
Number of previous abortions	No	3.57	0.59	71.40		0.385	0.681	
	1-3	3.51	0.49	70.20				
	4 or more	3.57	0.41	71.40				

The data in Table 4.9 examines the relationship between socio-demographic factors and access to FP methods. Significant differences were found across age, education, employment status, economic income, and marriage duration, with younger women, those with lower education levels, and unemployed individuals reporting higher access. Conversely, no significant relationships were found between the number of pregnancies, deliveries, children, or abortions and FP access. The findings underscore the importance of age, education, income, and marital duration in influencing women's access to FP methods in the GS.

4.10 Relationship between socio-demographic factors and contraceptive use with the level of women's compliance with contraceptive use among women in the GS

Table (4.10-A): Relationship between socio-demographic factors and contraceptive use with the level of women's compliance with contraceptive use among women in the GS

Sociodemographic data	Categories	The level of women's compliance with contraceptive use			Statistical Analysis			
		Mean	SD	% Mean	T	F	P-value	Post Hoc
Age (years)	Less than 18	1.98	0.88	49.50		15.525	0.000*	18-30 vs. others groups*
	18-30	2.75	0.77	68.75				
	31-40	2.44	0.60	61.00				
	41-50	2.00	0.76	50.00				
	Above 50	1.94	0.83	48.50				
Region	Khan-Younis	2.51	0.81	62.75		1.043	0.353	
	Deir al-Balah	2.39	0.75	59.75				
	Al-Zawayda	2.57	0.54	64.25				

Table (4.10-B): Relationship between socio-demographic factors and contraceptive use with the level of women's compliance with contraceptive use among women in the GS

Sociodemographic data	Categories	The level of women's compliance with contraceptive use			Statistical Analysis			
		Mean	SD	% Mean	T	F	P-value	Post Hoc
Level of education for women	Primary School or Less	2.10	0.90	52.50		17.774	0.000*	Master's Degree or more and Diploma < others*
	Secondary School	2.72	0.62	68.00				
	Diploma	1.84	0.83	46.00				
	Bachelor's Degree	2.34	0.78	58.50				
	Master's Degree or more	0.78	0.63	19.50				
Level of education for husband	Primary School or Less	2.22	0.77	55.50		13.381	0.000*	Diploma < others*
	Secondary School	2.75	0.63	68.75				
	Diploma	1.86	0.85	46.50				
	Bachelor's Degree	2.39	0.86	59.75				
	Master's Degree or more	2.15	0.49	53.75				
Occupation for women	Employed	2.00	0.73	50.00	-4.902		0.000*	
	Unemployed	2.57	0.76	64.25				
Occupation for husband	Employed	2.18	0.76	54.50	1.336		0.182	
	Unemployed	2.61	0.76	65.25				
Economic income (NIS)	Less than 1000	2.56	0.70	64.00		18.394	0.000*	More than 2000 < others*
	1000-1500	2.42	0.84	60.50				
	1600-2000	2.07	0.80	51.75				
	More than 2000	0.75	0.39	18.75				
How long has your marriage been	Less than a year	2.35	0.97	58.75		12.781	0.000	6-10 years > others
	1-5 years	2.47	0.94	61.75				
	6-10 years	2.92	0.62	73.00				
	More than 10 years	2.31	0.70	57.75				
Number of previous pregnancies	3 or less	2.41	0.77	60.25		1.598	0.204	
	4-6	2.47	0.80	61.75				
	7 or more	2.63	0.72	65.75				
Number of previous deliveries	2 or less	2.43	0.79	60.75		0.570	0.566	
	3-4	2.47	0.80	61.75				
	5 or more	2.54	0.74	63.50				
How many children do you currently have	2 or less	2.43	0.79	60.75		0.569	0.566	
	3-4	2.47	0.81	61.75				
	5 or more	2.54	0.74	63.50				
Number of previous abortions	No	2.32	0.81	58.00		1.172	0.311	
	1-3	2.50	0.77	62.50				
	4 or more	2.49	0.81	62.25				

The data in Table 4.10 examine the relationship between socio-demographic factors and women's compliance with contraceptive use in the GS. Significant differences were found across age, education, employment, income, and marital duration, with women aged 18-30, those with secondary education, unemployed women, and those with lower incomes showing higher compliance. No significant differences were found in the number of pregnancies, deliveries, children, or abortions. These findings highlight key factors influencing contraceptive compliance, offering insights for targeted interventions to improve adherence.

4.11 Relationship between socio-demographic factors and contraceptive use with the role of HCPs in educating women about FP methods among women in the GS

Table (4.11): Relationship between socio-demographic factors and contraceptive use with the role of HCPs in educating women about FP methods among women in the GS

Sociodemographic data	Categories	The role of HCPs in educating women about FP methods			Statistical Analysis			
		Mean	SD	% Mean	T	F	P-value	Post Hoc
Age (years)	Less than 18	3.79	0.46	75.80		19.857	0.000*	18-30 vs. other groups
	18-30	4.26	0.27	85.20				
	31-40	3.88	0.58	77.60				
	41-50	3.79	0.53	75.80				
	Above 50	3.69	0.51	73.80				
Region	Khan-Younis	3.95	0.53	79.00		5.854	0.003*	Khan-Younis vs. others *
	Deir al-Balah	4.13	0.42	82.60				
	Al-Zawada	4.12	0.48	82.40				
Level of education for women	Primary School or Less	4.06	0.43	81.20		23.289	0.000*	
	Secondary School	4.18	0.30	83.60				
	Diploma	3.31	0.92	66.20				
	Bachelor's Degree	3.87	0.52	77.40				
	Master's Degree or more	3.67	0.58	73.40				
Level of education for husband	Primary School or Less	4.10	0.38	82.00		20.454	0.000*	Diploma > others*
	Secondary School	4.17	0.36	83.40				
	Diploma	3.38	0.68	67.60				
	Bachelor's Degree	3.84	0.59	76.80				
	Master's Degree or more	3.97	0.32	79.40				
Occupation for women	Employed	3.68	0.55	73.60	-5.809		0.000*	
	Unemployed	4.09	0.46	81.80				
Occupation for husband	Employed	3.80	0.63	76.00	2.523		0.012*	
	Unemployed	4.12	0.39	82.40				
Economic income (NIS)	Less than 1000	4.11	0.40	82.20		30.147	0.000*	More than 2000 < others*
	1000-1500	3.96	0.44	79.20				
	1600-2000	3.44	0.81	68.80				
	More than 2000	2.95	0.78	59.00				
How long has your marriage been	Less than a year	3.67	0.68	73.40		17.994	0.000*	Less than a year < others *
	1-5 years	4.13	0.36	82.60				
	6-10 years	4.30	0.23	86.00				
	More than 10 years	3.90	0.54	78.00				
Number of previous pregnancies	3 or less	3.97	0.55	79.40		1.913	0.149	
	4-6	4.02	0.47	80.40				
	7 or more	4.12	0.43	82.40				
Number of previous deliveries	2 or less	3.96	0.56	79.20		1.710	0.182	
	3-4	4.05	0.45	81.00				
	5 or more	4.07	0.44	81.40				
How many children do you currently have	2 or less	3.97	0.56	79.40		1.555	0.213	
	3-4	4.05	0.45	81.00				
	5 or more	4.07	0.44	81.40				
Number of previous abortions	No	4.10	0.42	82.00		0.960	0.384	
	1-3	4.00	0.52	80.00				
	4 or more	4.04	0.42	80.80				

The data in Table 4.11 explores socio-demographic factors influencing women's perceptions of HCPs role in FP education in the GS. Significant differences were found in age ($P < 0.001$), region ($P = 0.003$), education ($P < 0.001$), employment ($P < 0.001$), income ($P < 0.001$), and marital duration ($P < 0.001$). Women aged 18–30, those with secondary education, unemployed women, and lower-income earners reported higher perceptions of HCPs' role. No significant differences were observed in pregnancies ($P = 0.149$), deliveries ($P = 0.182$), children ($P = 0.213$), or abortions ($P = 0.384$).

Chapter Five

Discussion

5.1 Socio-demographic data of participants

The study indicated that the category is greater than the rate among respondent women aged 18-30 at 43.6%. Similar to a study conducted by Mulatu et al. (2020). This study aimed to assess the use of modern contraceptives and the factors affecting their use. The study found that the average age of the women responding to the study was 28.5. The study also indicated that the largest category of women with secondary education is 53.1%. Compared to a study entitled "Obstacles affecting the use of contraceptives", the study found that women who were in secondary school accounted for 26.2% of the total number of women involved in the study, which is different from the current study (Beyene et al., 2023). The study reported that the unemployment rate in the GS for 2024 was 75.1%, consistent with the PCBS 2023 report, which indicated an unemployment rate of 74% (PCBS, 2023). A study in Ethiopia aimed at assessing women's contraceptive compliance rate found that 42.2% of the population had a 9.2 % unemployment rate (Mitku et al., 2022).

According to the customs and traditions of the Gazans, they form an early society, contributing to the study's findings, which indicated that the largest age group in the study was unexpectedly between 18 and 30. Furthermore, the customs and traditions of the Gazans limit women's opportunities for education upon marriage. The study also indicated a significant increase in the rate of disability, as a result of the ongoing aggression on the Gaza Strip.

5.2 Obstetric history of participants

The study also found that women with 6-4 children are the most responsive to the study, at a rate of 46.4%. A study by Beyene et al. (2023) aimed to assess the impediments affecting contraceptive use. The study noted that the rate of women with more than three children was 32.26%. The Gazan society prefers male children more than females, and this plays an important role in giving birth to many children.

5.3 Contraceptive use and health insurance status among participants

The study also reported that women participating in the study had a 70.8% use of contraceptives. The study, conducted by Endriyas et al. (2017), was titled "Factors Affecting Women's Use of Contraceptives." The study found that the prevalence rate of contraceptive use was 53.3%. The study was carried out by Negash et al. (2023). In the current study, the contraceptive prevalence rate was 28.1%. In the Gaza Strip, women are seeking to reduce the number of children they have due to the current circumstances of displacement caused by the ongoing Israeli aggression on the Gaza Strip. This is consistent with the rate of women's use of contraceptives in this study.

5.4 Factors affecting women's access, utilization and compliance to FP methods among the study participants

The study also noted that it is necessary to discuss with couples before using FP, but they would rather use contraceptives (85.6%). The study was also carried out by Challa et al. (2020). The study aimed to discover the relationship between marital discussion and contraceptive use. The study showed that the discussion between couples was minimal and was at a rate of 20%. A study congruent with the current study was conducted by Islam et al. (2021). Its title was Discussion between couples and its impact on contraceptive use, where the rate of discussion among couples was 82%. A study congruent with the current study was conducted by Islam et al. (2021). Its title was Discussion between couples and its impact on contraceptive use, where the rate of discussion among couples was 82%. The study also reported that the women participating in the study experienced side effects of contraceptive use, estimated at 59.7%. A study conducted in Kenya by Rothschild et al. (2022) was titled "Side Effects Affecting Contraceptive Use." The study indicated that the rate of side effects in participating women was 52%. A study conducted in Ethiopia by Beyene et al. (2023) was titled Impediments Affecting Contraceptive Use. The study indicated that 35.6% of women faced side effects when using contraceptives.

The current study also added that women suffer from contraception because it affects intercourse, and is estimated to be 35.6%. Compared to the study conducted in Kenya by Rothschild et al. (2022), this study aimed to assess the factors affecting contraceptive use. The study indicated that contraceptives affect intercourse at a rate of 51%.

Economic hardship and political instability in Gaza further complicate contraceptive use. Women living in poverty are more likely to experience difficulties in affording or accessing a variety of contraceptive methods. As a result, they may rely on less effective or more readily available options, which can increase the likelihood of experiencing side effects. Moreover, the ongoing political situation in Gaza has led to frequent shortages of medications and healthcare services, exacerbating the challenges related to contraceptive access and use. Also, individual physiological characteristics, such as hormonal balance, body weight, and age, can also influence how women in Gaza experience side effects from contraceptive use. Hormonal contraceptives, such as oral pills, injectables, or implants, can have varied effects on different women depending on their body’s response to hormones.

5.5 Distribution of the level of access to the FP method among the study participants

Women's average access to hormonal contraceptives such as pills and patches was 62.8%, and women's access to barrier contraceptives such as condoms was 62.8%, and copper IUD was 62.2%. According to Gaza's geographical nature, there were no barriers on roads that impeded access to contraceptives. Still, in 2023, an Israeli war on Gaza led to the displacement of people from their places of residence. Barriers had been placed on roads, limiting access to health facilities. The closure of the crossings also resulted in women not having access to the contraceptives they wanted and preferred.

5.6 Distribution of FP type uses among the study participants

The study also added that women's average access to contraceptives, according to their economic status, was 70.8%. A study conducted in India by Dehingia et al. (2019) was titled "Access to Contraceptives." This study showed that women arriving according to their economic status were at a rate of 58%. The Gaza Strip suffers from difficult economic conditions due to the ongoing blockade and the restrictions imposed on movement and the

economy. These conditions directly affect the ability of families to meet their basic needs, including child care. Therefore, many couples resort to contraceptive methods as a way to reduce the number of children and ensure a better quality of life for them.

5.7 Distribution of the level of women's compliance with contraceptive use among the study participants

The study found that the contraceptive obligation rate was 98%, compared to a study conducted in Uganda by Bakesiima et al. (2023) titled "Factors Affecting Women's Commitment to Contraceptives." The participation rate among women in the study was 44%. The current study also added that the rate of women's substitution of contraceptives because of the side effects of contraceptives was estimated at 65.7%. Also, a study was conducted in Uganda by Bakesiima et al. (2023). According to the study, the rate of contraceptive substitution was 61% among women. The study also added that the rate of women discontinuing contraceptive use is 23.3%. Compared to a study conducted in Uganda, this study found that the rate of discontinuation of contraceptive use among women was 8.8% (Bakesiima et al., 2023). the results in Gaza, there was considerable interest in women's commitment to use contraceptives on the part of those who wanted to give birth. However, because of the war in Gaza, women committed themselves to contraceptives for fear of the severe consequences of emergency pregnancies, such as war (Lagore et al., 2024).

In comparison to the results in Gaza, there was considerable interest in women's commitment to use contraceptives on the part of those who wanted to give birth. However, because of the war in Gaza, women committed themselves to contraceptives for fear of the severe consequences of emergency pregnancies, such as war (Lagore et al.,2024).

5.8 Distribution of the role of HCPs in educating women about FP methods among the study participants

The current study also indicated that women's average access to health education by health providers was 90.8% compared to a survey conducted in the United States by Hele et al. (2024). The study aimed to assess the level of women's health education. According to the study, health education about family planning methods provided by women was estimated at 54%. The study also indicated that above-average women received enough information on how to choose the right contraceptives for them (83.4%). A study conducted in India by Dehingia et al. (2019) was titled "Factors Affecting Women's Health Education." The study indicated that women who received enough information about each contraceptive method were at a rate of 12%. Healthcare providers in the Gaza Strip play a pivotal role as educators in family planning.

Their ability to provide accurate information, offer counseling tailored to individual needs, and address the cultural and economic barriers that women face is essential for improving family planning use in GS. Empowering healthcare providers to act as educators not only enhances women’s knowledge but also promotes better reproductive health outcomes, ensuring that women can make informed decisions about their bodies, health, and future.

5.9 Relationship between socio-demographic factors and contraceptive use with the level of access to FP methods among women in the GS

The results of this study emphasize the critical role of socio-demographic factors in determining women's access to FP methods in the GS. Age was a significant factor, with younger women (18–30 years) reporting higher access, in line with findings from previous

studies (Khan et al., 2023). This could reflect increased awareness and greater willingness to utilize FP methods among younger women. Additionally, education level played a crucial role, as women with lower education levels reported better access to FP services. This might be due to socio-economic challenges or limited knowledge about family planning in higher educational groups. Conversely, women with higher educational attainment were less likely to have access, highlighting potential barriers faced by educated women in seeking FP services. Employment status also emerged as a significant determinant, with unemployed women exhibiting higher access to FP services. This suggests that unemployment may reduce financial barriers, thereby making FP methods more accessible. In contrast, women with higher incomes showed lower access, indicating that despite economic advantages, financial constraints and lack of awareness could still impede access to FP services. Additionally, marital duration was found to influence FP access, with women married for shorter periods reporting better access. These findings are consistent with studies by Mohapatra et al. (2022), which highlighted similar socio-demographic influences on family planning access and practices. These findings underline the importance of considering socio-demographic characteristics when designing policies and interventions aimed at improving access to family planning in the GS. Tailored strategies are needed to address these disparities and promote equitable access for all women, regardless of their socio-demographic background.

5.10 Relationship between socio-demographic factors and contraceptive use with the level of women's compliance with contraceptive use among women in the Gs

The relationship between socio-demographic factors and contraceptive use, focusing on women's compliance with contraceptive use in the GS was studied. The findings reveal significant differences across various socio-demographic variables, with age showing the strongest association ($F = 15.525$, $P < 0.001$). Women aged 18–30 exhibited the highest compliance (68.75%), while those aged 50 and above had the lowest compliance (48.50%). This pattern aligns with previous studies (Ahirwar et al., 2021; Solanke et al., 2023), where younger women tend to show better compliance due to increased awareness and motivation to use contraceptives. Education level also emerged as a significant factor, with women having secondary education reporting higher compliance, similar to findings in other studies (Omodele et al., 2025). Interestingly, those with a master's degree had lower compliance, possibly reflecting a lack of direct focus on contraceptive use in higher education. Employment status also played a critical role, with unemployed women exhibiting higher compliance, which may be attributed to the flexibility of time and less financial strain. Furthermore, economic income showed a clear inverse relationship with compliance: women with incomes greater than 2000 NIS had significantly lower compliance. Duration of marriage also influenced compliance, with those married for 6–10 years reporting the highest compliance. However, factors like the number of pregnancies, deliveries, and children did not significantly impact compliance, indicating that the socio-economic and educational factors play a more critical role in shaping compliance levels. These results underscore the need for targeted interventions that address these socio-demographic factors to improve contraceptive compliance.

5.11 Relationship between socio-demographic factors and contraceptive use with the role of HCPs in educating women about FP methods among women in the GS

The study examines the relationship between socio-demographic factors and contraceptive use, focusing on the role of HCPs in educating women about FP methods in the GS. The analysis reveals statistically significant differences across various socio-demographic

variables, with age being the most prominent ($F = 19.857$, $P < 0.001$). Women aged 18–30 had the highest scores (85.2%) regarding HCP education, while those aged 50 and above reported the lowest (73.8%). Post hoc analysis showed that younger women (18–30) had significantly higher scores compared to other age groups ($P < 0.05$). Regional differences were also significant ($F = 5.854$, $P = 0.003$), with women from Deir al-Balah and Al-Zawayda reporting higher scores compared to those from Khan-Younis. Education level was another critical factor ($F = 23.289$, $P < 0.001$), with women having a Secondary School education showing the highest scores (83.6%). Employment status also influenced the results, as unemployed women reported higher scores (81.8%) than employed women (73.6%). Economic income showed a clear trend, with women earning less than 1000 NIS having the highest scores (82.2%), while those earning more than 2000 NIS had the lowest scores (59.0%). Additionally, marital duration played a significant role, with women married for 6–10 years reporting the highest scores (86.0%). These findings highlight the importance of addressing socio-demographic factors such as age, region, education level, employment status, and economic income in designing effective FP education programs (Daramola et al., 2024; Khawaja et al., 2024; Ayirebi et al., 2025).

Chapter Six

Conclusion and Recommendations

6.1 Conclusion

Women’s access to, use of and compliance with contraceptives in the southern GS are influenced by demographic factors (education, employment, age, etc.) and common cultural beliefs about the use of contraceptives, such as myths and misconceptions about the use of contraceptives. In addition, women’s access, use and compliance is influenced by the role of health-care providers as health teachers on the optimal use of contraceptives. The level of encouragement of health workers to use contraceptives properly and optimally contributes to women’s commitment to optimal use. The researcher recommended developing health education programs tailored to women’s needs, focusing on involving husbands to meet their wishes and achieve the goal of reproductive health.

6.2 Recommendations

Based on the study results, the researcher recommended the following:

For policymakers:

1. Increasing women's knowledge of family planning services provided to them through health education programs encourages women to make optimal use of contraceptives.
2. Promote the design of new health education programs and involve the husband in them for informed decision-making on family planning use.
3. Providing women with appropriate contraceptive methods
4. Encouraging couples to attend the health center on time.
5. Enhancing the design of special schedules for women's attendance at the health facility to minimize crowding and ensure they receive appropriate services.
6. Providing women with good treatment by service providers to encourage them to use and comply with contraceptive methods.

For woman:

1. Women should adhere to contraceptive methods and use them at the appropriate time.
2. The husband and wife must understand each other's desires to obtain a suitable contraceptive method.
3. Women must commit to attending the primary health care center to benefit from the use of contraceptives.

4. All couples should space their children, plan for each pregnancy, and prepare for it in advance.

For future researchers:

1. To conduct a mixed-methods (quantitative and qualitative) research study to explore the factors influencing use, access, compliance, and the role of healthcare providers as educators in this method.
2. To conduct a community study to investigate the same issues discussed in this study outside the healthcare systems
3. To conduct a study to examine the level of knowledge, practice and attitude of women regarding the use of contraceptives in the Gs.
4. To conduct a study examining the level of health education provided to women from the perspective of healthcare providers.

Reference

- Abdi, B., Okal, J., Serour, G., & Temmerman, M. (2020). "Children are a blessing from God"–a qualitative study exploring the socio-cultural factors influencing contraceptive use in two Muslim communities in Kenya. Reproductive Health, 17(1), 44.
- Abebaw, Y., Berhe, S., Abebe, S. M., Adefris, M., Gebeyehu, A., Gure, T., … & G/Egziabher, M. A. (2019). Providers' knowledge on postpartum intrauterine contraceptive device (PPIUCD) service provision in Amhara region public health facility, Ethiopia. PloS one, 14(4), e0214334.
- Abraham, W., Adamu, A., & Deresse, D. (2010). The involvement of men in family planning: an application of the transtheoretical model in Wolaita Soddo Town, South Ethiopia. Asian Journal of Medical Sciences, 2(2), 44-50.
- Acharya, R., & Sureender, S. (1996). Inter-spousal communication, contraceptive use, and family size: A relationship examined in Bihar and Tamil Nadu. Journal of Family Welfare, 42(4), 5-11.
- Ackerson, K. and Zielinski, R. (2017). Factors Influencing the Use of Family Planning in Women Living in Crisis-Affected Areas of Sub-Saharan Africa: A Review of the Literature. Midwifery, 54(2017), 35-60.
- Adera, A., Belete, T., Gebru, A., Hagos, A., & Gebregziabher, W. (2015). Assessment of the Role of Men in Family Planning Utilization in Edaga-Hamuse Town, Tigray, North Ethiopia. Am J Nurs Sci, 4(4), 174.
- Adinma, J. I., Ikeako, L., Adinma, E. D., Ezeama, C. O., & Ugboaja, J. O. (2010). Awareness and practice of post abortion care services among health care professionals in southeastern Nigeria. The Southeast Asian Journal of Tropical Medicine and Public Health, 41(3), 696-704.
- Agbana, R. D., Michael, T. O., & Ojo, T. F. (2023). Family planning method discontinuation among Nigerian women: Evidence from the 2018 Nigeria Demographic and Health Survey. Journal of Taibah University Medical Sciences, 18(1), 117-124.
- Ahirwar, R. K., Kumar, S., Gupta, S., Niranjan, A., Prajapati, K., & Rawal, S. (2021). A study to assess the socio-demographic factors and knowledge, attitude, and practice of family planning methods in the Lohpeeta migrant tribe located in Shivpuri, central India. *Journal of Family Medicine and Primary Care, 10*(3), 1308-1312.
- Ahmed, S., Li, Q., Liu, L., & Tsui, A. O. (2012). Maternal deaths averted by contraceptive use: an analysis of 172 countries. The Lancet, 380(9837), 111-125.
- Ajah, L. O., Dim, C. C., Ezegwui, H. U., Iyoke, C. A., & Ugwu, E. O. (2015). Male partner involvement in female contraceptive choices in Nigeria. Journal of Obstetrics and Gynaecology, 35(6), 628-631.
- Alenezi, G. G., & Haridi, H. K. (2021). Awareness and Use of Family Planning Methods among Women in Northern Saudi Arabia. Middle East Fertility Society Journal, 26(1), 1-8.
- Ali, M. M., & Cleland, J. (2010). Oral Contraceptive Discontinuation and Its Aftermath in 19 Developing Countries. Contraception, 81(1), 22-29 .
- Ali, M. M., Cleland, J. G., Shah, I. H., & World Health Organization. (2012). Causes and Consequences of Contraceptive Discontinuation: Evidence from 60 Demographic and Health Surveys.

- Ali, M., Farron, M., Dilip, T. R., & Folz, R. (2018). Assessment of Family Planning Service Availability and Readiness in 10 African Countries. Global Health: Science and Practice, 6(3), 473-483 .
- Alrawi, Y. (2021). Exploring Barriers to Family Planning Service Utilization and Uptake among Women in Iraq Eastern Mediterranean Health Journal, 27(8), 818-825.
- Al-Shawakh, M. R., Mostafa, N. M., & Saleh, L. M. (2020). Assessment of Nurses' Knowledge and Practice Regarding Family Planning Counseling in Healthcare Centers, Lattakia. Universal Journal of Public Health, 8(4), 148-154.
- Alshawish, E. (2020). Experience in Using Contraceptive Implants & Emergency Contraceptive Pills in Palestine. Diversity and Equality in Health and Care, Vol. 17, No. 5.
- Amere, L. T. (2020). Knowledge and Utilization of Family Planning Services among Women of Reproductive Age in Ilishan Community Health Center, Ogun State. Midwifery, 4(1), 94-110.
- American College of Obstetricians and Gynecologists. (2019). ACOG Practice Bulletin No. 208: benefits and risks of sterilization. Obstetrics and gynecology, 133(3), e194-e207.
- Amos, M. (2019). Contraceptive method choice and spousal communication: Examining the effect of family planning method using an instrumental variable approach. Sexual & Reproductive Healthcare, 22, 100458.
- Anderson, J. E., Jamieson, D. J., Warner, L., Kissin, D. M., Nangia, A. K., & Macaluso, M. (2012). Contraceptive sterilization among married adults: national data on who chooses vasectomy and tubal sterilization. Contraception, 85(6), 552-557.
- Argago, T. G., Hajito, K. W., & Kitila, S. B. (2015). Clients' satisfaction with family planning services and associated factors among family planning users in Hossana town public health facilities, South Ethiopia: facility-based cross-sectional study. International Journal of Nursing and Midwifery, 7(5), 74-83 .
- Askew, I., & Brady, M. (2013). Reviewing the evidence and identifying gaps in family planning research: The unfinished agenda to meet FP2020 goals.
- AyanoWakjira, B. (2017). Assessment of Client Satisfaction on Family Planning Services Utilization in Wonji Hospital, Ethiopia, 2016. J ClinDiagn Res, 5(137), 2376-0311.
- Ayirebi, I., Mabou, G. T., Nsiah, R. B., Gmanyami, J. M., Kyei11, S., Charlotte, Y. D., ... & Yeboah, A. K (2025). Assessing the Prevalence and Factors Influencing Male Involvement in Family Planning Services in an Urban Ghanaian Community.
- Babazadeh, S., Lea, S., Kayembe, P., Akilimali, P., Eitmann, L., Anglewicz, P., & Bertrand, J. (2018). Assessing the contraceptive supply environment in Kinshasa, DRC: trend data from PMA2020. Health policy and planning, 33(2), 155-162 .
- Bairagya, A., Basu, G., Mondal, R., & Roy, S. K. (2021). Prevalence and reasons behind the use of injectable contraceptives among women of reproductive age: A cross-sectional survey in rural areas of Nadia District, West Bengal. Journal of Family Medicine and Primary Care, 10(7), 2566.
- Bakesiima, R., Gemzell-Danielsson, K., Beyeza-Kashesya, J., Cleeve, A., Larsson, E. C., & Chalo Nabirye, R. (2023). Adherence to modern contraceptives among female refugee adolescents in northern Uganda: A prospective single cohort study. Open Access Journal of Contraception, 169-180.
- Bankole, A., & Malarcher, S. (2010). Removing barriers to adolescents' access to contraceptive information and services. Studies in family planning, 41(2), 117-124.

- Behera, J., Sarkar, A., Mehra, S., Sharma, P., & Mishra, S. U. (2016). Encouraging young married women (15–24 years) to improve intra-spousal communication and contraceptive usage through community-based intervention package in rural India. J Contracept Stud, 1(4), 22-29 .
- Beson, P., Appiah, R., & Adomah-Afari, A. (2018). Modern contraceptive use among reproductive-aged women in Ghana: prevalence, predictors, and policy implications. BMC women's health, 18(1), 157.
- Beyene, K. M., Bekele, S. A., & Abu, M. K. (2023). Factors affecting utilization of modern contraceptive methods among women of reproductive age in Ethiopia. Plos one, 18(11), e0294444.
- Bintabara, D., Ntwenya, J., Maro, I.I. *et al.* Client satisfaction with family planning services in areas of high unmet need: evidence from the Tanzania Service Provision Assessment Survey, 2014-2015. *Reprod Health* **15**, 127 (2018). (https://doi.org/10.1186/s12978-018-0566-8).
- Birhanu, Z., Assefa, T., Woldie, M., & Morankar, S. (2010). Determinants of Satisfaction with Health Care Provider Interactions at Health Centres in Central Ethiopia: A Cross-Sectional Study. BMC Health Services Research, 10, 1-12.
- Boglaeva, L. V. (2021). Contraceptive method mix in the context of family planning programmes in developing countries. Population and Economics, 5(3), 56-75.
- Bongaarts, J., & Casterline, J. B. (2019). Fertility Transition: Is Sub-Saharan Africa Different? Population and Development Review,45(4),123-144. (https://doi.org/10.1111/padr.12281).
- Böttcher, B., Abu-El-Noor, M., & Abu-El-Noor, N. (2019). Choices and services related to contraception in the Gaza Strip, Palestine: perceptions of service users and providers. BMC women's health, 19(1), 165. (https://doi.org/10.1186/s12905-019-0869-0).
- Bradley, S. E., Polis, C. B., Micks, E. A., & Steiner, M. J. (2023). Effectiveness, safety, and comparative side effects. Contraceptive technology. 22nd ed. Burlington, MA: Jones-Bartlett Learning.
- Bradley, S. E., Schwandt, H., & Khan, S. (2009). Levels, trends, and reasons for discontinuation of contraception. DHS analytical studies, 20 .
- Brown, B. P., Chor, J., Hebert, L. E., Webb, M. E., & Whitaker, A. K. (2019). Shared negative experiences of long-acting reversible contraception and their influence on contraceptive decision-making: a multi-methods study. Contraception, 99(4), 228-232.
- Brown, S. S., & Eisenberg, L. (1995). Unintended pregnancy and the well-being of children and families. JAMA, 274(17), 1332-1332.
- Brunner Huber, L. R., Smith, K., Sha, W., & Vick, T. (2018). Interbirth interval and pregnancy complications and outcomes: the Pregnancy Risk Assessment Monitoring System findings. Journal of Midwifery & Women's Health 436-445.
- Böttcher, B., Abu-El-Noor, N., Aldabbour, B., Naim, F. N., & Aljeesh, Y. (2018). Maternal mortality in the Gaza Strip: a look at causes and solutions. BMC Pregnancy and childbirth, 18, 1-8.
- Castellano, T., Zerden, M., Marsh, L., & Boggess, K. (2017). Risks and Benefits of Salpingectomy at the Time of Sterilization. Obstetrical & Gynaecological Survey, 72(11), 663-668.
- Cavallaro, F. L., Benova, L., Owolabi, O. O., & Ali, M. (2020). A systematic review of the effectiveness of counselling strategies for modern contraceptive methods: what works and what doesn't? BMJ sexual & reproductive health, 46(4), 254-269.

- Cavallaro, F. L., Benova, L., Owolabi, O. O., & Ali, M. (2020). A systematic review of the effectiveness of counselling strategies for modern contraceptive methods: what works and what doesn't. BMJ sexual & reproductive health, 46(4), 254-269.
- Cebeci Save, D., Erbaydar, T., Kalaca, S., Harmancı, H., Calı, S., & Karavus, M. (2004). Resistance against contraception or medical contraceptive methods: a qualitative study on women and men in Istanbul. The European Journal of Contraception & Reproductive Health Care, 9(2), 94-101.
- Centers for Disease Control and Prevention CDC. (2010). U S. medical eligibility criteria for contraceptive use. MMWR. Recommendations and reports: Morbidity and mortality weekly report. Recommendations and reports, 59(RR-4), 1-86.
- Challa, S., Shakya, H. B., Carter, N., Boyce, S. C., Brooks, M. I., Aliou, S., & Silverman, J. G. (2020). Associations of spousal communication with contraceptive method use among adolescent wives and their husbands in Niger. *PloS one*, *15*(8), e0237512. https://doi.org/10.1371/journal.pone.0237512.
- Chandra-Mouli, V., McCarraher, D. R., Phillips, S. J., Williamson, N. E., & Hainsworth, G. (2014). Contraception for Adolescents in Low- and Middle-Income Countries: Needs, Barriers, and Access. Reproductive health, 11, 1-8.
- Chavane, L., Dgedge, M., Bailey, P., Loquiha, O., Aerts, M., & Temmerman, M. (2017). Assessing Women's Satisfaction with Family Planning Services in Mozambique. Journal of Family Planning and Reproductive Health Care, 43(3), 222-228.
- Chilinda, I., Cooke, A., & Lavender, D. T. (2021). Contraceptive Unmet Needs in Low- and Middle-Income Countries: A Systematic Review. African Journal of Reproductive Health, 25(2), 162-170.
- Choudhury, S., Erausquin, J. T., & Withers, M. (Eds.). (2018). Global Perspectives on Women's Sexual and Reproductive Health Across the Lifecourse (pp. xvii-441). Springer International Publishing.
- Church, K., & Mayhew, S. H. (2009). Integration of STI and HIV prevention, care, and treatment into family planning services: a review of the literature. Studies in family planning, 40(3), 171-186.
- Clark, N. V., Endicott, S. P., Jorgensen, E. M., Hur, H. C., Lockrow, E. G., Kern, M. E., … & Cohen, S. L. (2018). Review of sterilization techniques and clinical updates. Journal of Minimally Invasive Gynaecology, 25(7), 1157-1164.
- Cleland, J., Harbison, S., & Shah, I. Q. (2014). Unmet Need for Contraception: Issues and Challenges. Studies in Family Planning, 45(2), 105-122.
- Cohen, R., Sheeder, J., & Teal, S. B. (2019). Predictors of discontinuation of long-acting reversible contraception before 30 months of use by adolescents and young women. Journal of Adolescent Health, 65(2), 295-302.
- Compton, S., Nakua, E., Moyer, C., Dzomeku, V., Treleaven, E., Otupiri, E., & Lori, J. (2023). Contraceptive use by number of living children in Ghana: Evidence from the 2017 maternal health survey. PloS one, 18(12), e0295815. (https://doi.org/10.1371/journal.pone.0295815).
- Curtis, SL., Blanc, AK. (1997). Determinants of contraceptive failure, switching, and discontinuation: an analysis of DHS contraceptive histories. Macro International DHS Analytical Reports, no. 6. Calverton, MD.
- D'Souza, P., Bailey, J. V., Stephenson, J., & Oliver, S. (2022). Factors influencing contraception choice and use globally: a synthesis of systematic reviews. The European Journal of Contraception & Reproductive Health Care, 27(5), 364-372.

- Danis, R. B., Della Badia, C. R., & Richard, S. D. (2016). Postpartum permanent sterilization: could bilateral salpingectomy replace bilateral tubal ligation? Journal of minimally invasive gynecology, 23(6), 928-932.
- Daramola, K. T., Olatunji, M. B., Adako-Iyanda, O., Pelumi, O. T., Oluwaseyi, A. A., & Grace, A. K. (2024). Influence of Socioeconomic Determinants on Access and Utilization of Family Planning Services among Women of Reproductive Age in Oyo West Local Government Area, Oyo State, Nigeria. *American Journal of Biomedicine and Pharmacy*, *1*(8), 60-71.
- Darroch, J. E &., Singh, S. (2011). Estimating unintended pregnancies averted from Couple-years of protection (CYP). New York: Guttmacher Institute, 1. (10).
- De Molina-Fernandez, M. I., Reyes-Martí, L., De la Flor-López, M., Aguarón-García, M. J., Roca-Biosca, A., Rubio-Rico, L., Raventós Torner, R. D., & Valls-Fonayet, F. (2023). Medication Adherence and Contraceptive Counselling. Healthcare (Basel, Switzerland), 11(9), 1304.
- Dehingia, N., Dixit, A., Averbach, S., Choudhry, V., Dey, A., Chandurkar, D., ... & Raj, A. (2019). Family planning counselling and its associations with modern contraceptive use, initiation, and continuation in rural Uttar Pradesh, India. Reproductive Health, 16, 1-11.
- DHS Program. (2017). The Service Provision Assessment (SPA). https://dhsprogram.com/What-We-Do/Survey-Types/SPA.cfm, accessed 7 July 2020.
- Do, M., & Kurimoto, N. (2012). Women's empowerment and choice of contraceptive methods in selected African countries. International perspectives on sexual and reproductive health, 23-33.
- Downey, M. M., Arteaga, S., Villaseñor, E., & Gomez, A. M. (2017). More than a destination: contraceptive decision making as a journey. Women's health issues, 27(5), 539-545.
- El Hamri, N. (2010). Approaches to family planning in Muslim communities. BMJ Sexual & Reproductive Health, 36(1), 27-31.
- Endriyas, M., Eshete, A., Mekonnen, E., Misganaw, T., Shiferaw, M., & Ayele, S. (2017). Contraceptive utilization and associated factors among women of reproductive age group in Southern Nations Nationalities and Peoples' Region, Ethiopia: cross-sectional survey, mixed methods. Contraception and reproductive medicine, 2, 1-9.
- Erkalo, E &., Gecho, Y. (2017). Access and Utilization of Family Planning Methods Among Rural Women: The Case of Mirab Badawacho Woreda, Hadiya Zone, Southern Ethiopia. Humanities and Social Sciences, 5(2), 60-68.
- Falcone, T., & Hurd, W. W. (Eds.). (2017). Clinical reproductive medicine and surgery: a practical guide. Springer.
- Festin, M. P. R. (2020). Overview of modern contraception. Best Practice & Research Clinical Obstetrics & Gynaecology, 66, 4-14.
- Floyd, S. (2021). Access to Postpartum Sterilization ACOG Committee Opinion, Number 827. Obstetrics and gynaecology, 137(6), 1146-1147.
- Food, U., & Board, N. (2001). Institute of Medicine. Dietary Reference Intakes for Vitamin C, Vitamin E, Selenium and Carotenoids.
- Freeman, S. (2004). Nondaily hormonal contraception: considerations in contraceptive choice and patient counselling. Journal of the American Academy of Nurse Practitioners, 16(6), 226-238.

- Frost, J. J., Darroch, J. E., & Remez, L. (2018). Improving contraceptive use in the United States. Guttmacher Institute. Retrieved from (https://www.guttmacher.org/report/improving-contraceptive-use-united-states).
- Fruzzetti, F., Perini, D., Fornaciari, L., Russo, M., Bucci, F., & Gadducci, A. (2016). Discontinuation of modern hormonal contraceptives: an Italian survey. The European Journal of Contraception & Reproductive Health Care, 21(6), 449-454.
- FURLONG, L. (2002). Pregnancy risk when contraception fails. J Reprod Med, 47, 881-885.
- Gabbe, S. G., Niebyl, J. R., Simpson, J. L., Landon, M. B., Galan, H. L., Jauniaux, E. R., Grobman, W. A. (2016). Obstetrics: Normal and Problem Pregnancies E-Book: Elsevier Health Sciences.
- Gallo, M. F., Lopez, L. M., Grimes, D. A., Carayon, F., Schulz, K. F., & Helmerhorst, F. M. (2014). Combination of contraceptives: effects on weight. Cochrane Database of Systematic Reviews, (1).
- Galzote, R. M., Rafie, S., Teal, R., & Mody, S. K. (2017). Transdermal Delivery of Combined Hormonal Contraception: A Review of the Current Literature. International Journal of Women's Health, 315-321.
- Gariepy, Aileen M., et al. "Comparative effectiveness of hysteroscopic and laparoscopic sterilization for women: a retrospective cohort study." Fertility and Sterility 117.6 (2022): 1322-1331.
- Gellman, M. D. (Ed.). (2020). Encyclopedia of behavioral medicine. Cham: Springer.
- Gipson, J. D., Koenig, M. A., & Hindin, M. J. (2008). The effects of unintended pregnancy on infant, child, and parental health: a review of the literature. Studies in family planning, 39(1), 18-38.
- Gold, R. S., & Miner, K. R. (2002). Report of the 2000 Joint Committee on Health Education and Promotion Terminology. Journal of School Health, 72(1), 3-7.
- Grimes, D. A., Lopez, L. M., Raymond, E. G., Halpern, V., Nanda, K., & Schulz, K. F. (2013). Spermicide is used alone for contraception. Cochrane Database of Systematic Reviews, (12).
- Grindlay, K., Turyakira, E., Kyamwanga, I. T., Nickerson, A., & Blanchard, K. (2016). The experience and impact of contraceptive stockouts among women, providers and policymakers in two districts of Uganda. International perspectives on sexual and reproductive health, 42(3), 141-150 .
- Gueye, A., Speizer, I. S., Corroon, M., & Okigbo, C. C. (2015). Belief in family planning myths at the individual and community levels and modern contraceptive use in urban Africa. International perspectives on sexual and reproductive health, 41(4), 191.
- Gulliford, M., Figueroa-Munoz, J., Morgan, M., Hughes, D., Gibson, B., Beech, R., & Hudson, M. (2002). What does 'access to health care' mean? Journal of Health Services Research & Policy, 7(3), 186–188. (https://doi.org/10.1258/135581902760082517).
- Guttmacher Institute. (2022). Contraceptive use in the United States. Guttmacher Institute. Retrieved from(https://www.guttmacher.org/data).
- Haddad, L. B., Cwiak, C., Jamieson, D. J., Feldacker, C., Tweya, H., Hosseinipour, M., … & Phiri, S. (2013). Contraceptive adherence among HIV-infected women in Malawi: a randomized controlled trial of the copper intrauterine device and depot medroxyprogesterone acetate. Contraception, 88(6), 737-743.

- Hale, N., Dehlendorf, C., Smith, M. G., Stapleton, J., McCartt, P., & Khoury, A. J. (2024). Contraceptive Counselling, Method Satisfaction, and Planned Method Continuation Among Women in the U.S. Southeast. Contraception, 132, 110365. (https://doi.org/10.1016/j.contraception.2024.110365).
- Halpern, V., Lopez, L. M., Grimes, D. A., Stockton, L. L., & Gallo, M. F. (2013). Strategies to improve adherence and acceptability of hormonal methods of contraception. Cochrane Database of Systematic Reviews (10).
- Hanson, M., & Pitt, D. (2017). Informed Consent for Surgery: Risk Discussion and Documentation. Canadian Journal of Surgery, 60(1), 69.
- Hassan, S., Masri, H., Sawalha, I., & Mortensen, B. (2024). Perceived Barriers and Opportunities for Providing Quality Family Planning Services among Palestinian Midwives, Physicians, and Nurses in the West Bank: A Qualitative Study. BMC Health Services Research, 24(1), 786.
- Hatcher, R. A. (2007). Contraceptive technology. Ardent Media.
- Hellström, A., Gemzell Danielsson, K., & Kopp Kallner, H. (2019). Trends in Use and Attitudes Toward Contraception in Sweden: Results of a Nationwide Survey. The European Journal of Contraception & Reproductive Health Care, 24(2), 154-160.
- Hookway, N. (2008). Entering the Blogosphere: Some Strategies for Using Blogs in Social Research. Qualitative research, 8(1), 91-113.
- Hudson, M. (2002). What does 'access to health care' mean? Journal of Health services research & policy, 7(3), 186–188.
- Hutchinson, P. L., Do, M., & Agha, S. (2011). Measuring Client Satisfaction and the Quality of Family Planning Services: A Comparative Analysis of Public and Private Health Facilities in Tanzania, Kenya, and Ghana. BMC Health Services Research, 11, 1-17.
- Institute for Reproductive Health & Georgetown University. (2005). Counselling Clients in the Standard Days Method: A Training for Service Providers, Georgetown University, Washington. International Publishing.
- Islam, A. Z., Mondal, M. N. I., Khatun, M. L., Rahman, M. M., Islam, M. R., Mostofa, M. G., & Hoque, M. N. (2016). Prevalence and determinants of contraceptive use among employed and unemployed women in Bangladesh. International Journal of MCH and AIDS, 5(2), 92.
- Islam, M. A., Padmadas, S. S., & Smith, P. W. (2010). Understanding family planning communication between husbands and wives: a multilevel analysis of wives 'responses from the Bangladesh DHS. *Genus*, *66*(1), 1-15.
- Islam, M. S., Alam, M. S., & Hasan, M. M. (2014). Inter-spousal communication on family planning and its effect on contraceptive use and method choice in Bangladesh. Asian Social Science, 10(2), 189.
- Jacobstein, R., & Stanley, H. (2013). Contraceptive implants: providing a better choice to meet growing family planning demand. Global Health: Science and Practice, 1(1), 11-17.
- Jay, M. S., Durant, R. H., & Litt, I. F. (1989). Female adolescents' compliance with contraceptive regimens. Pediatric Clinics of North America, 36(3), 731-746.
- Jejeebhoy, S. J. (1995). Women's education, autonomy, and reproductive behaviour: Experience from developing countries. Oxford University Press.
- Johansson, L., Vesström, J., Alehagen, S., & Kilander, H. (2023). Women's experiences of dealing with fertility and side effects in contraceptive decision

making: a qualitative study based on women's blog posts. Reproductive Health, 20(1), 98.

- Johnson-Mallard, V., Kostas-Polston, E. A., Woods, N. F., Simmonds, K. E., Alexander, I. M., & Taylor, D. (2017). Unintended pregnancy: A framework for prevention and options for midlife women in the United States. Women's midlife health, 3(1), 1-15.
- Kabagenyi, A., Jennings, L., Reid, A., Nalwadda, G., Ntozi, J., & Atuyambe, L. (2014). Barriers to Male Involvement in Contraceptive Uptake and Reproductive Health Services: A Qualitative Study of Men's and Women's Perceptions in Two Rural Districts in Uganda. Reproductive health, 11, 1-9.
- Kabakian-Khasholian, T., Quezada-Yamamoto, H., Ali, A., Sahbani, S., Afifi, M., Rawaf, S., & El Rabbat, M. (2020). Integration of sexual and reproductive health services in the provision of primary health care in the Arab States: status and a way forward. Sexual and Reproductive Health Matters, 28(2), 1773693.
- Kakaiya, R., Lopez, L. L., & Nelson, A. L. (2017). Women's perceptions of contraceptive efficacy and safety. Contraception and reproductive medicine, 2, 1-6.
- Kanwal Aslam, S., Zaheer, S., Qureshi, M. S., Aslam, S. N., & Shafique, K. (2016). Socioeconomic Disparities in the Use of Family Planning Methods among Pakistani Women: Findings from the Pakistan Demographic and Health Surveys, PLOS ONE, 11(4), e0153313. (https://doi.org/10.1371/journal.pone.0153313).
- Kaoje, U. A., Sambo, M. N., Oche, M. O., Saad, A., Raji, M. O., & Isah, B. A. (2015). Determinants of Client Satisfaction with Family Planning Services in Government Health Facilities in Sokoto, Northern Nigeria. Sahel Medical Journal, 18(1), 20-26.
- Kaur, S., & Blumenthal, P. D. (2021). Global myth-busting in family planning. Current Opinion in Obstetrics and Gynecology, 33(6), 458-462.
- Kerns, J., & Darney, P. (2011). Vaginal ring contraception. Contraception, 83(2), 107-115.
- Khan, G. R., Baten, A., & Azad, M. A. K. (2023). Influence of contraceptive use and other socio-demographic factors on under-five child mortality in Bangladesh: semi-parametric and parametric approaches. Contraception and Reproductive Medicine, 8(1),22.
- Khawaja, F., Khan, G. N., Nasir, A., & Khowaja, K. (2024). Assessing the association between socio-demographic variables and contraceptive usage in married men residing in Korangi District, Karachi, Pakistan. *Journal of Asian Midwives (JAM)*, *11*(1),15-28.
- Kigongo, E., Tumwesigye, R., Anyolitho, M. K., Musinguzi, M., Kwizera, G., Achan, E., … & Omech, B. (2024). Access to Family Planning Services and Associated Factors Among Young People in Lira City, Northern Uganda. BMC Public Health, 24(1), 1146.
- Kim, A. J., Barberio, A., Berens, P., Chen, H. Y., Gants, S., Swilinski, L., … & Chang-Jackson, S. C. (2019). The trend, feasibility, and safety of salpingectomy as a form of permanent sterilization. Journal of Minimally Invasive Gynecology, 26(7), 1363-1368.
- Kost, K., Singh, S., Vaughan, B., Trussell, J., & Bankole, A. (2008). Estimates of contraceptive failure from the 2002 National Survey of Family Growth. Contraception, 77(1), 10-21.
- Kovacs, G. & Briggs, P. (2015). Lectures in Obstetrics, Gynaecology and Women's Health, Springer International Publishing.

- Kriel, Y., Milford, C., Cordero, J., Suleman, F., Beksinska, M., Steyn, P., & Smit, J. A. (2019). Male partner influence on family planning and contraceptive use: perspectives from community members and healthcare providers in KwaZulu-Natal, South Africa. Reproductive health, 16, 1-15.
- Lagore, A., Kridli, S., & Piscotty, R. (2024). Contraceptive Use in the Gaza Strip: A Systematic Review.
- Lee, A. S. (2014). Improving contraceptive compliance through an evidence-based educational program. Journal of Evidence-Based Women's Health Journal Society, 4(1), 40-46.
- Lee, H., Kindane, E. G., Doh, Y. A., & Nam, E. W. (2022). Determinants of Modern Family Planning Methods in Ethiopia: A Community-Based, Cross-Sectional Mixed Methods Study. Dialogues in Health, 1, 100025.
- Lete, I., Doval, J. L., Prez-Campos, E., Snchez-Borrego, R., Correa, M., de la Viuda, E., . . . Martnez, M. T. (2007). Factors affecting women's selection of a combined hormonal contraceptive method: the TEAM-06 Spanish cross-sectional study. Contraception, 76(2), 77-83.
- Link, C. F. (2011). Spousal Communication and Contraceptive Use in Rural Nepal: An Event History Analysis. Studies in family planning, 42(2), 83-92.
- Littlejohn, K. E. (2012). Hormonal contraceptive use and discontinuation because of dissatisfaction: differences by race and education. Demography, 49(4), 1433-1452 .
- Machiyama, K., Casterline, J. B., Mumah, J. N., Huda, F. A., Obare, F., Odwe, G., … & Cleland, J. (2017). Reasons for the unmet need for family planning, with attention to measuring fertility preferences: protocol for a multi-site cohort study. Reproductive health, 14, 1-11.
- Machiyama, K., Marston, C., LaChance, N. T., Adda-Balinia, T., & Tapsoba, P. (2018). How are educated women in Ghana regulating fertility without high levels of modern contraceptive use?
- MacPhail, C., Pettifor, A., Pascoe, S., & Rees,H. (2010). Contraceptive use and pregnancy among post-partum South African women: nationally representative cross-sectional survey.
- Mahdy, H., Shaeffer, A. D., & McNabb, D. M. (2017). Condoms.
- Malmborg, A., Brynte, L., Falk, G., Brynhildsen, J., Hammar, M., & Berterö, C. (2020). Sexual function changes attributed to hormonal contraception use–a qualitative study of women experiencing negative effects. The European Journal of Contraception & Reproductive Health Care, 25(3), 169-175.
- Marino, S., Canela, C. D., & Nama, N. (2017). Tubal Sterilization.
- Merz, A. A., Gutiérrez-Sacristán, A., Bartz, D., Williams, N. E., Ojo, A., Schaefer, K. M., … & Avillach, P. (2021). Population attitudes toward contraceptive methods over time on a social media platform. American Journal of Obstetrics and Gynaecology, 224(6), 597. e1.
- MFantahun, M., Chala, F., & Loha, M. (1995). Knowledge, Attitude, and Practice of Family Planning among Senior High School Students in North Gonder. Ethiopian medical journal, 33(1), 21–29.
- Miller, W. B., Stecklov, G., & Westoff, C. F. (2019). The effect of economic development on the use of contraception. Population Research and Policy Review, 38(1), 27-48. (https://doi.org/10.1007/s11113-018-09511-3).
- Ministry of Health (2023): Health annual report, Gaza, Palestine.

- Ministry of Health, Gaza (2023). Primary healthcare system and services in Gaza: Overview and challenges. Ministry of Health, Gaza. Retrieved from (https://www.moh.ps).
- Mir T. H. (2023). Adherence Versus Compliance. *HCA healthcare journal of medicine*, *4*(2), 219–220. (https://doi.org/10.36518/2689-0216.1513).
- Mitiku, H. D., Lemma, M. W., Chekole, Y. B., & Chekole, Y. T. (2022). Hierarchical Analysis of Contraceptive Compliance Among Rural Women of Reproductive Age in Awi Zone, Northwest Ethiopia. Patient preference and adherence, 1279-1293.
- Mohamad Ali, B., Shamloul, R., Ramsauer, J., Bella, A. J., Scrinzi, U., Treu, T., & Jungwirth, A. (2014). The effect of vasectomy on the sexual life of couples. The Journal of Sexual Medicine, 11(9), 2239-2242.
- Mohapatra, V., Panda, N., & Misra, S. (2022). Family planning practices among women seeking induced abortion: an institution-based cross-sectional study from Eastern India. *Journal of Family Medicine and Primary Care*, *11*(10), 6339-6344.
- Moreau, C., Bouyer, J., Bajos, N., Rodríguez, G., & Trussell, J. (2009). Frequency of discontinuation of contraceptive use: results from a French population-based cohort. Human Reproduction, 24(6), 1387-1392.
- Mruts, K. B., Tessema, G. A., Gebremedhin, A. T., Scott, J., & Pereira, G. (2022). The effect of family planning counselling on postpartum modern contraceptive uptake in sub-Saharan Africa: a systematic review. Public Health, 206, 46-56.
- Muhoza, P., Koffi, A. K., Anglewicz, P., Gichangi, P., Guiella, G., OlaOlorun, F., … & Radloff, S. (2021). Modern Contraceptive Availability and Stockouts: A Multi-Country Analysis of Trends in Supply and Consumption. Health Policy and Planning, 36(3), 273-287.
- Mulatu, T., Sintayehu, Y., Dessie, Y., & Deressa, M. (2020). Modern Family Planning Utilization and Its Associated Factors among Currently Married Women in Rural Eastern Ethiopia: A Community-Based Study. BioMed research international, 2020(1), 6096280
- Mulatu, T., Sintayehu, Y., Dessie, Y., & Dheresa, M. (2022). Male Involvement in Family Planning Use and Associated Factors Among Currently Married Men in Rural Eastern Ethiopia. *SAGE Open Medicine*, *10*, 20503121221094178.
- Nanda, K., & Burke, A. (2011). Contraceptive patch and vaginal contraceptive ring. Contraceptive Technology, 20th ed., Ardent Media, Inc., Atlanta, Georgia.
- Ndikom, C., Ojo, O. C., & Ogbeye, G. B. (2018). Women's choice, satisfaction, and Compliance with contraceptive methods in selected hospitals of Ibadan, Nigeria. Journal of Midwifery and Reproductive Health, 6(1), 1113-1121.
- Ndumbaro, F., & Ochieng, L. M. (2021). Access to Information on Family Planning (FP) Methods Among Married Women of Reproductive Age in Ilala District, Dar es Salaam, Tanzania. University of Dar es Salaam Library Journal, 16(1), 114-98.
- Ndziessi, G., Bintsene-Mpika, G., & Bileckot, R. (2017). User Satisfaction with Family Planning Services in Government Health Centres in the Democratic Republic of the Congo. African Journal of Reproductive Health, 21(3), 70-75.
- Negash, B. T., Chekol, A. T., & Wale, M. A. (2023). Modern contraceptive method utilization and determinant factors among women in Ethiopia: Multinomial logistic regression mini-EDHS-2019 analysis. Contraception and Reproductive Medicine, 8(1), 40.
- Nesro, J., Sendo, E. G., Yesuf, N. T., & Sintayehu, Y. (2020). Intention to use vasectomy and associated factors among married men in Addis Ababa, Ethiopia. BMC Public Health, 20, 1-8.

- Ngure, K., Baeten, J., Lingappa, J., Heffron, R., Musingila, P., Irungu, E., … & Mugo, N. (2011). P1-S6. 02 Contraceptive discontinuation by rural Kenyan women in HIV discordant partnerships after exiting an HIV prevention trial. Sexually Transmitted Infections, 87(Suppl 1), A196-A196.
- Nguyen, B. T., & Allen, A. J. (2018). Social Media and the Intrauterine Device: A YouTube Content Analysis. BMJ Sexual & Reproductive Health, 44(1), 28-32.
- Nkwonta, C. A., & Messias, D. K. (2019). Male Participation in Reproductive Health Interventions in Sub-Saharan Africa: A Scoping Review. International Perspectives on Sexual and Reproductive Health, 45, 71-85.
- Obstetricians, A. C. o., & Gynaecologists. (2012). Adolescents and long-acting reversible contraception: implants and intrauterine devices. Committee Opinion No. 539. Obstet Gynecol, 120(983), 8.
- Obwoya, J. G., Wulifan, J. K., & Kalolo, A. (2018). Factors Influencing Contraceptive Use Among Women in Juba City, South Sudan. International Journal of Population Research, 2018, 1-7.
- Oche, O., Ango, J., Dahiru, T., Gana, G., Liman, R., Mormoni, K., & Ibrahim, B. (2018). Fertility Desires and Contraceptive Practices of Rural Women in Sokoto, Northwestern Nigeria. International Journal of TROPICAL DISEASE & Health, 29(2), 1-10.
- Odwe, G., Wado, Y. D., Obare, F., Machiyama, K., & Cleland, J. (2021). Method-specific beliefs and subsequent contraceptive method choice: Results from a longitudinal study in urban and rural Kenya. PloS one, 16(6), e0252977.
- Olatade, M. J., Aisosa, O. J., Titilope, M. B., Oluwadamilare, A., Ihunanya, O. M Amere, L. T. (2020). Knowledge and Utilization of Family Planning Services among Women of Reproductive Age in Ilishan Community Health Center, Ogun State. Midwifery, 4(1), 94-110.
- Olawole-Isaac, A., Oni, G. A., Oladosun, M., & Amoo, E. O. (2018). Inter-spousal communication: A means for achieving concordant fertility goals. African Population Studies, Vol. 32, No. 1.
- Olohiomeru, I. G. (2014). Is Education the Best Contraceptive? International Journal of Education and Research, Vol. 2, No. 7 .
- Oluwole, O. K. (2012). Factors influencing the choice of contraceptive methods by HIV positive women in the Cofimvaba area (Doctoral dissertation, Stellenbosch: Stellenbosch University .
- Omodele, S. A., Timothy, F., Ogunwumiju, M. E., Kehinde, D., & Ayinde, A. O. (2025). The Role of Socio-Cultural and Economic Factors in Shaping Family Planning Practices among Women in Ibarapa West Local Government Area, Oyo State, Nigeria. *International Journal of Integrative and Modern Medicine*, *3*(2), 6-15.
- Ortayli, N. (2002). Users' perspectives on implantable contraceptives for women. Contraception, 65(1), 107-111.
- Ortiz, M. a. E., & Croxatto, H. B. (2007). Copper-T intrauterine device and levonorgestrel intrauterine system: biological bases of their mechanism of action. Contraception, 75(6), S16-S30.
- Palamuleni, M. E. (2013). Socio-economic and demographic factors affecting contraceptive use in Malawi. African Journal of Reproductive Health, 17(3), 91-104.
- Palestinian Central Bureau of Statistics (2023): Statistical yearbook of Palestine.
- Palestinian Central Bureau of Statistics. (2024). Population estimates in Palestine: 2024. PCBS. (https://www.pcbs.gov.ps).

- Pedro, J., Brandão, T., Schmidt, L., Costa, M. E., & Martins, M. V. (2018). What do people know about fertility? A systematic review on fertility awareness and its associated factors. Upsala Journal of Medical Sciences, 123(2), 71-81.
- Peterson, H. B., Xia, Z., Hughesa, J. M., Wilcox, L. S., Tylora, L. R., Trussell, J., & US Collaborative Review of Sterilization Working Group. (1996). The risk of pregnancy after tubal sterilization: findings from the US Collaborative Review of Sterilization. American Journal of Obstetrics and Gynaecology, 174(4), 1161-1170.
- Peyman, N., Hidarnia, A., Ghofranipour, F., Kazemnezhad, A., Oakley, D., Khodaee, G., & Aminshokravi, F. (2009). Self-efficacy: Does it predict the effectiveness of contraceptive use in Iranian women? EMHJ-Eastern Mediterranean Health Journal, 15 (5), 1254-1262.
- Polit, D. F., & Beck, C. T. (2017). Resource manual for nursing research. Generating and assessing evidence for nursing practice. 10th ed. Wolters Kluwer Health, Lippincott, Williams & Wilkins, Philadelphia.
- Prata, N., Bell, S., Fraser, A., Carvalho, A., & Neves, I. (2017). Partner support for family planning and modern contraceptive use in Luanda, Angola. African Journal of Reproductive Health, 21(1), 35-48.
- Rademacher, K. H., Sergison, J., Glish, L., Maldonado, L. Y., Mackenzie, A., Nanda, G., & Yacobson, I. (2018). Menstrual bleeding changes are NORMAL: proposed counselling tool to address common reasons for non-use and discontinuation of contraception. Global Health: Science and Practice, 6(3), 603-610.
- Raza, F., Colwell, B., Washburn, D. J., & Maddock, J. E. (2023). Predictors of modern contraceptive use among married women in Pakistan, India and Bangladesh.
- Reed, J., England, P., Littlejohn, K., Bass, B. C., & Caudillo, M. L. (2014). Consistent and inconsistent contraception among young women: Insights from qualitative interviews. Family Relations, 63(2), 244-258.
- Roach, R. E., Helmerhorst, F. M., Lijfering, W. M., Stijnen, T., Algra, A., & Dekkers, O. M. (2015). Combined oral contraceptives: the risk of myocardial infarction and ischemic stroke. Cochrane Database of Systematic Reviews, Issue 8.
- Ross, J., & Hardee, K. (2013). Access to contraceptive methods and prevalence of use. Journal of biosocial science, 45(6), 761–778.
- Rothschild, C. W., Richardson, B. A., Guthrie, B. L., Kithao, P., Omurwa, T., Mukabi, J., ... & Drake, A. L. (2022). Contributions of side effects to contraceptive discontinuation and method switch among Kenyan women: a prospective cohort study. BJOG: An International Journal of Obstetrics & Gynaecology, 129(6), 926-937.
- Roumen, F., Apter, D., Mulders, T., & Dieben, T. (2001). Efficacy, tolerability and acceptability of a novel contraceptive vaginal ring releasing etonogestrel and ethinyl oestradiol. Human Reproduction, 16(3), 469-475.
- Runnebaum, I. B., Kather, A., Vorwergk, J., Cruz, J. J., Mothes, A. R., Beteta, C. R., … & Sehouli, J. (2023). Ovarian cancer prevention by opportunistic salpingectomy is a new de facto standard in Germany. Journal of Cancer Research and Clinical Oncology, 149(10), 6953-6966.
- Safari, W., Urassa, M., Mtenga, B., Changalucha, J., Beard, J., Church, K., … & Todd, J. (2019). Contraceptive use and discontinuation among women in rural North-West Tanzania. Contraception and reproductive medicine, 4, 1-10.
- Saka, M. J., Yahaya, L. A., & Saka, A. O. (2012). Counselling and client-provider interactions related to family planning services in Nigeria. J Educ Pract, 3(5), 16-25.

- Saloranta, T. H., Gyllenberg, F. K., But, A., Gissler, M., Laine, M. K., & Heikinheimo, O. (2020). Free-of-charge long-acting reversible contraception: two-year discontinuation, risk factors, and reasons. American Journal of Obstetrics & Gynecology, 223(6), 886. e1.
- Schindler, A. E. (2010). Non-contraceptive benefits of hormonal contraceptives. Minerva ginecologica, 62(4), 319-329.
- Schrumpf, L. A., Stephens, M. J., Nsarko, N. E., Akosah, E., Baumgartner, J. N., Ohemeng-Dapaah, S., & Watt, M. H. (2020). Side effect concerns and their impact on women's uptake of modern family planning methods in rural Ghana: A mixed-methods study. BMC women's health, 20, 1-8.
- Sedgh, G., Ashford, L. S., & Hussain, R. (2016). Unmet need for contraception in developing countries: Examining women's reasons for not using a method. New York: Guttmacher Institute,
- Sedgh, G., Singh, S., & Hussain, R. (2014). Intended and unintended pregnancies worldwide in 2012 and recent trends. Studies in family planning. 45(3), 301- 314.
- Sensoy, N., Korkut, Y., Akturan, S., Yilmaz, M., Tuz, C., & Tuncel, B. (2018). Factors Affecting Women's Attitudes Toward Family Planning. Fam Plann, 13(33), 2.
- Shahidzadeh-Mahani, A., Omidvari, S., Baradaran, H. R., & Azin, S. A. (2008). Factors Affecting the Quality of Care in Family Planning Clinics: A Study from Iran. International Journal for Quality in Health Care, 20(4), 284-290.
- Sharan, M., & Valente, T. W. (2002). Spousal communication and family planning adoption: effects of a radio drama serial in Nepal. International Family Planning Perspectives, 16-25 .
- Sharan, M., & Valente, T. W. (2002). Spousal communication and family planning adoption: effects of a radio drama serial in Nepal. International Family Planning Perspectives, 16-25.
- Sharma, H. L., & Gupta, A. (2024). Effective contraceptive methods and sterilization in India: some results on socio-demographic differentials. Discover Social Science and Health, 4(1), 1-20.
- Simmons, R. B., Schriver, M., & Stamps, P. (2020). Contraceptive Access and Reproductive Health Policy: A Review of Recent Developments. Journal of Health Policy, 45(2), 209-226. (https://doi.org/10.1093/jhp/45.2.209).
- Skogsdal, Y. R. E., Karlsson, J. Å., Cao, Y., Fadl, H. E., & Tydén, T. A. (2018). Contraceptive use and reproductive intentions among women requesting contraceptive counselling. Acta Obstetricia et Gynecologica Scandinavica, 97(11), 1349-1357.
- Soin, K. S., Yeh, P. T., Gaffield, M. E., Ge, C., & Kennedy, C. E. (2022). Health Workers' Values and Preferences Regarding Contraceptive Methods Globally: A Systematic Review. Contraception, 111, 61–70.
- Solanke, B. L. (2017). Factors influencing contraceptive use and non-use among women of advanced reproductive age in Nigeria. Journal of Health, Population and Nutrition, 36, 1-14.
- Solanke, B. L., Oyediran, O. O., Awoleye, A. F., & Olagunju, O. E. (2023). Do health service contacts with community health workers influence the intention to use modern contraceptives among non-users in rural communities? Findings from a cross-sectional study in Nigeria. *BMC Health Services Research*, *23*(1), 24.
- Speroff, L., & Darney, P. D. (2010). A Clinical Guide to Contraception: Lippincott Williams & Wilkins.

- Srivastava, R. K., Tanwar, H., Singh, P., & Patro, B. C. (2012). Injectable contraceptives to expand the basket of choice under India's family planning programme: An update.
- Stanback, J., Steiner, M., Dorflinger, L., Solo, J., & Cates, W. (2015). WHO tiered-effectiveness counselling is rights-based family planning. Global Health: Science and Practice, 3(3), 352-357.
- Staveteig, S. (2017). Fear, opposition, ambivalence, and omission: results from a follow-up study on unmet need for family planning in Ghana. PloS one, 12(7), e0182076.
- Steenland, M. W., Tepper, N. K., Curtis, K. M., & Kapp, N. (2011). Intrauterine contraceptive insertion postabortion: a systematic review. Contraception, 84(5), Falcone, T., Hurd, W. W., & Abacan, C. (2007). Clinical Reproductive Medicine and Surgery: 447-464. Springer.
- Stevens, R., Machiyama, K., Mavodza, C. V., & Doyle, A. M. (2023). Misconceptions, Misinformation, and Misperceptions: A Case for Removing the "Mis-" When Discussing Contraceptive Beliefs. Studies in Family Planning, 54(1), 309-321.
- Szucs, L. E. (2020). Condom and contraceptive use among sexually active high school students—Youth Risk Behavior Survey, United States, 2019. MMWR supplements, 69.
- Taherdoost, H. (2016). Validity and reliability of the research instrument: How to test the validation of a questionnaire or survey in research. International Journal of Academic Research in Management, Vol. 5, No. 3.
- Tal, M., Katz, B., Debisschop, M. J., Wilson, P. & Shikhman, O. (2016) Intrauterine Contraceptive Device. Google Patents.
- Tamire, M., Chalaand, F., & Lola, M. (2007). Knowledge, attitude and practice of family planning among high school students in North Gondar. Ethiopian Medical Journal 33: 21-22.
- Tessema, G. A., Mahmood, M. A., Gomersall, J. S., Assefa, Y., Zemedu, T. G., Kifle, M., & Laurence, C. O. (2017). Client and facility-level determinants of quality of care in family planning services in Ethiopia: A multilevel modelling approach. PLoS One, 12(6), e0179167.
- Thapa, S., Rani, A., &Mishra, C.P. (2014). Knowledge, attitude and belief about contraception in post-partum and post-abortal women in a tertiary care Centre. Int J Reprod Contracept Obstet Gynecol 3: 533-539.
- Thobani, R., Jessani, S., Azam, I., Reza, S., Sami, N., Rozi, S., … & Saleem, S. (2019). Factors Associated with the Discontinuation of Modern Contraceptive Methods in Low-Income Areas of Sukh Initiative Karachi: A Community-Based Case-Control Study. PloS one, 14(7), e0218952.
- Tomaszewski, D., Aronson, B. D., Kading, M., & Morisky, D. (2017). Relationship between self-efficacy and patient knowledge regarding adherence to oral contraceptives, as measured by the Morisky Medication Adherence Scale (MMAS-8). Reproductive health, 14(1), 1-7.
- Tozetto, H. C. D. M., Tiguman, G. M. B., Nicoletti, M. A., & Aguiar, P. M. (2022). Adverse events related to oral hormonal contraceptive use in undergraduate pharmacy students: a cross-sectional study. Brazilian Journal of Pharmaceutical Sciences, 58, e21335.

- Trussel, J., & Guthrie, K. (2011). Choosing a Contraceptive: Efficacy, Safety, and Personal Considerations. Contraceptive Technology, 20th ed., Ardent Media, Inc., Atlanta, Georgia.
- Trussell, J. (2004). Contraceptive failure in the United States. Contraception, 70(2), 89-96.
- Tsui, A. O., Brown, W., & Li, Q. (2017). Contraceptive practice in sub-Saharan Africa. Population and Development Review, 43(Suppl 1), 166.
- Tuoane, M., Madise, N. J., & Diamond, I. (2004). Provision of family planning services in Lesotho. International Family Planning Perspectives, 77-86.
- UNFPA. (2023). Women in Gaza are cut off from accessing maternal health supplies as the aid blockade enters its fourth week. (https://www.unfpa.org/press/women-gaza-cut-accessing-maternal-health-supplies-aid-blockade-enters-fourth-week).
- United Nations Relief and Works Agency for Palestine Refugees (UNRWA). (2024). The role of UNRWA in Gaza's economy. (https://www.unrwa.org).
- United Nations Relief and Works Agency. (2023). UNRWA situation report #165: Situation in Gaza Strip and West Bank, including East Jerusalem. (https://www.unrwa.org/resources/reports/unrwa-situation-report-165-situation-gaza-strip-and-west-bank-including-east-jerusalem).
- United Nations (2019). Department of Economic and Social Affairs, Population Division. Family Planning and the 2030 Agenda for Sustainable Development.
- United Nations (2020). Department of Economic and Social Affairs, Population Division. World Family Planning.
- USAID. (2015, September). Health Information System (HIS) Assessment Report. USAID Office of Human Capital and Social Impact. (https://pdf.usaid.gov/pdf_docs/PA00WCWP.pdf).
- Uwajeneza, P., Evans, M., Meharry, P., Mukamana, D., Babenko-Mould, Y., Munezero, P., & Kanimba, A. M. (2023). Nurses and midwives' experience in providing fertility awareness-based methods, including natural family planning methods in Rwanda. International Journal of African Nursing Sciences, 18, 100537.
- Vieira, C. S., Oliveira, L. C. O. D., & Sá, M. F. S. D. (2007). Hormônios femininos e hemostasia. Revista Brasileira de Ginecologia e Obstetrícia, 29, 538-547.
- Wang, W., & Mallick, L. (2019). Understanding the relationship between family planning method choices and modern contraceptive use: an analysis of geographically linked population and health facilities data in Haiti. BMJ global health, 4(Suppl 5), e000765.
- Wang, X., & Cheng, Z. (2020). Cross-Sectional Studies: Strengths, Weaknesses, and Recommendations.Chest,158(1S),S65–S71. (https://doi.org/10.1016/j.chest.2020.03.012).
- Wani, R. T., Rashid, I., Nabi, S. S., & Dar, H. (2019). Knowledge, Attitude, and Practice of Family Planning Services among Healthcare Workers in Kashmir: A Cross-Sectional Study. Journal of Family Medicine and Primary Care, 8(4), 1319.
- Winner, B., Peipert, J. F., Zhao, Q., Buckel, C., Madden, T., Allsworth, J. E., & Secura, G. M. (2012). Effectiveness of long-acting reversible contraception. New England Journal of Medicine, 366(21), 1998-2007.
- Wodaynew, T., & Bekele, D. (2021). Assessment of Knowledge, Attitude, and Practice of Contraceptive Use among Postpartum Women in Jimma University Medical Center, Jimma Town, Southwest Ethiopia. Int J Womens Health Wellness, 7(2), 130.

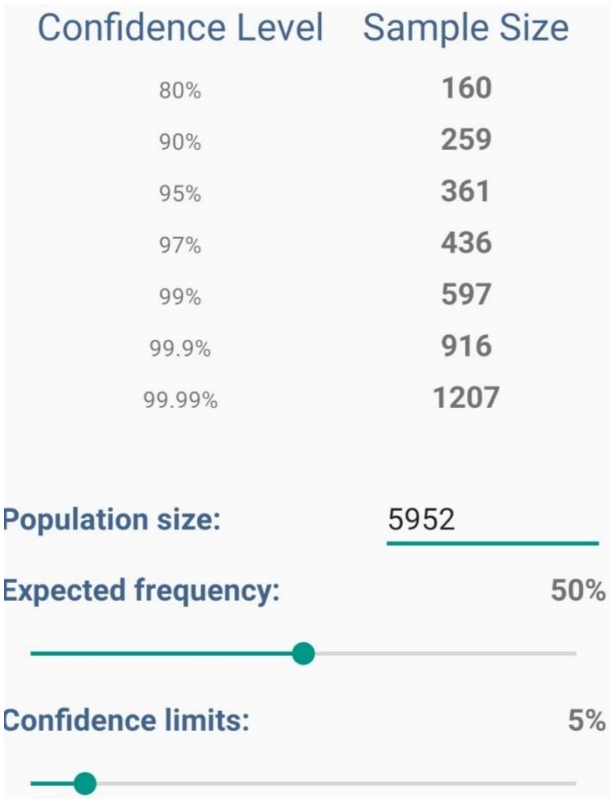
- Wogu, D., Lolaso, T., & Meskele, M. (2020). Client satisfaction with family planning services and associated factors in Tembaro District, Southern Ethiopia. Open Access Journal of Contraception, 69-76.
- Wood, S. N., Karp, C., & Zimmerman, L. (2020). Women's sexual experiences as a side effect of contraception in low- and middle-income countries: evidence from a systematic scoping review. Sexual and Reproductive Health Matters, 28(1), 1763652.
- Workowski, K. A. & Bolan, G. A. (2015). Sexually Transmitted Diseases Treatment Guidelines, 2015. Mmwr. Recommendations And Reports: Morbidity And Mortality Weekly Report. Recommendations And Reports, 64, 1.
- World Bank. (2018). Fertility rate, total (births per woman). (https://data.worldbank.org/indicator/SP.DYN.TFRT.IN),
- World Bank. (2024). Economic monitoring report on the West Bank and Gaza: April 2024. (https://www.worldbank.org).
- World Health Organization, (2016). Family planning.
- World Health Organization. "Family Planning: A Global Handbook for Providers: 2011 Update: Evidence-Based Guidance Developed Through Worldwide Collaboration" (2011).
- World Health Organization. (2010). World health statistics 2010. Available at http://www.who.int/whosis/whostat/EN WHS10/ [Accessed on 11 September 2018]
- World Health Organization. (2016). Family planning and contraception (http://www.who.int/topics/family planning/en/).
- World Health Organization. (2018). Family planning and contraception. Retrieved from (http://www.who.int/mediacentre/factsheets/fs351/en/).
- World Health Organization. (2018, February 8). Family planning/Contraception. (https://www.who.int/news-room/fact-sheets/detail/family-planning-contraception) Accessed 27 Dec 2018.
- World Health Organization. Family Planning: A Global Handbook for Providers. 2018. May, [cited 2020 Dec 13]. Available from https://www.who.int/publications/i/item/family-planning---a-global-handbook-for-providers).
- Wyatt, K. D., Anderson, R. T., Creedon, D., Montori, V. M., Bachman, J., Erwin, P., & LeBlanc, A. (2014). Women's values in contraceptive choice: a systematic review of relevant attributes included in decision aids. BMC women's health, 14, 1-13.
- Yazdkhasti, M., Pourreza, A., Pirak, A., & Fatemeh, A. B. D. I. (2015). Unintended pregnancy and its adverse social and economic consequences for the health system: A narrative review article. Iranian Journal of Public Health, 44(1), 12
- Zelalem, D., Worku, A., Alemayehu, T., & Dessie, Y. (2021). Association of Effective Spousal Family Planning Communication with couples' modern contraceptive use in Harar, eastern Ethiopia. Open access journal of contraception, 45-62.

Annexes

Annex (1): Palestine map

Annex (2): Gaza strip

Annex (3): Sample size calculation



Annex (4): Consent form

عزيزتي المشاركة

يسعدني مشاركتك الفعالة في بحث بعنوان الوصول، الاستخدام والامتثال لوسائل تنظيم الأسرة بين السيدات ودور مقدمي الرعاية الصحية كمثقفين.

أنا الباحثة أريج نوارة من برنامج صحة الأم والطفل بكلية المهن الصحية -جامعة القدس أبو ديس.

ان هذا البحث يشكل جزء ضروري من دراستي للحصول على درجة الماجستير في المهن الصحية برنامج ماجستير صحة الأم والطفل.

وقد تم اختيارك ضمن مجموعة متلقي خدمات تنظيم الأسرة في العيادات الحكومية للإجابة على العبارات الواردة فيها، إذا كنت موافقة على المشاركة في هذه الدراسة يرجى التكرم بقراءة العبارات التالية بدقة والإجابة عنها بموضوعية لما في ذلك من أثر كبير على صحة النتائج والنصائح التي سوف يتوصل اليها الباحث. مع التأكيد بأن هده البيانات سوف تستخدم لأغراض البحث العلمي فقط وسيتم التعامل معها بسرية تامة.

ملاحظة/ الوقت اللازم لتعبئة الاستبانة كاملة تستغرق 15 دقيقة فقط

الباحثة: أريج نوارة

رقم جوال :0599714707

Annex (5): Tool of study

I. Demographic factors

Age Less than 18 18- 30 31-40 41-50 above 50
Governorate Rafah Khaniones Deir al-Balah Gaza North
Level of education for women Primary Schools Secondary Schools Bachelor's Degree Master's Degree Other
Level of education for husband Primary Schools Secondary Schools Bachelor's Degree Master's Degree Other
Occupation for women Employed Unemployed
Occupation of husband Employed Unemployed
Number of previous pregnancies ……? Number of previous abortions ……..? Number of previous deliveries ……...?
economic income Less than 1000 NIS 1000-1500 NIS 1600-2000 NIS More than 2000 NIS
How many children do you currently have……?
How long has your marriage been Less than a year 1-5years 6years more than 10years
Have you ever used contraceptives? Yes No
Do you have health insurance? Yes No
Do you have any chronic health conditions affecting your decision to use contraceptives? Yes No
Duration of contraceptive use Don't use it. Less than a year 1-2 years more than 3 years

II. Factors affecting women's access, utilization and compliance with FP methods

Items	Yes	No
Do you discuss family planning methods with your husband before using them?		
Is the husband a powerful factor in the use of family planning methods?		
Do religious factors affect access and compliance with family planning methods?		
You care that your husband agrees with the method of FP that has been chosen		
Is it okey for you to choose any FP method without telling your husband?		
Are you afraid to use FP method to avoid their complication?		
Have you ever experienced any complications after using contraceptives?		
Does family planning affect your normal sexual intercourse?		
Lack of knowledge and awareness of family planning methods negatively affects you and makes you not use family planning methods		
Is poor treatment by service providers (nurses and midwives) a factor influencing contraceptive use		
Does the level of support and encouragement from healthcare providers impact compliance with family planning methods?		
Do the side effects that can be caused by contraceptive use affect women's compliance		
Contraceptives in your area are easy		
Is the cost of contraceptives a factor influencing your decision to use them		
Do you find it difficult to get a medical consultation on contraceptives?		
Are there long waiting times for family planning services		
Do you feel that you have complete freedom to decide whether to use contraceptives?		
Are there social or family pressures affecting your decision to use contraceptives		
Are you concerned or stressed when considering contraceptive use due to its potential side effects?		
Do you find it difficult to continue using contraception for a long time?		
Have you ever stopped using contraceptives because of dissatisfaction?		
Do you feel that health care providers provide you with sufficient information about contraceptives?		
Do you find that the level of health education available on contraceptives is insufficient?		
Do you feel that the community around you support using family planning methods?		

III/ Assessing the level of access to FP methods

Items	Strongly disagree	Disagree	Neither agree	Nor disagree	Agree	Strongly agree
I find it easy to access hormonal contraceptives (e.g., pills, patches, and implants).						
I find it easy to access barrier contraceptives (for example, condoms and diaphragms).						
I find it easy to access reversible prevention methods (e.g., IUD, implants)						
I find it easy to access a contraceptive method that is appropriate to society's customs and traditions						
I find it easy to access contraceptives suitable for my age						
I find it easy to access contraception from a healthcare provider						
I find it easy to access contraceptives from clinics that provide family planning services.						
I find it easy to access the contraceptive I want						
I find it easy to get a contraceptive that fits my lifestyle						
My family planning methods vary depending on my social and economic situation.						
I think family planning methods may vary depending on my economic situation						
The availability of contraceptive methods that my husband wants helps us improve sexual relations and achieve the desired number of children						
Access to family planning has had satisfactory consequences for my husband and me, improving our physical and general health.						

Access to family planning that suits my health status is always available						
I have provided sufficient information that aligns with my health.						
Getting consultations from healthcare providers about the best way for me is easy.						
There is adequate awareness in society about available family planning methods.						
I find that the cost of contraception is appropriate, and I can afford it						
I feel that privacy is preserved when I use family planning methods in health facilities						
I find family planning tools readily available even in emergency or urgent need						
I think modern family planning methods (such as technological applications) are sufficiently accessible and accessible						
I feel that the community around me supports my use of family planning methods						
Religious institutions provide sufficient support to access family planning methods.						
I find that available family planning methods are of high quality and reliable						

V. The proportion of each FP type used among women

What method of contraception are you currently using**?**

Methods	**Use**
Copper IUD	
Hormonal IUD	
Pills	
Condom	
Injection	
Implant	
Others	

VII. The level of women's compliance with contraceptive use

Items	Always	Sometimes	Often	Rarely	Never
Use contraceptives on time					
I didn't complain about using family planning methods					
Use a particular method to remind me to take my contraception on time					
Ask my care provider before changing the pills					
I try to follow the legal date for using the FP					
I stopped using family planning methods because of some complications					
When I forget to use the prescribed method of family planning, I use an additional method of contraception					
Timely use of contraceptives to avoid pregnancy while using the prescribed method					
Attend regular appointments with the health care provider to follow up on contraceptive use					
Change contraception on the recommendation of the healthcare provider					
keep using contraception even if I experience mild side effects					
Continue using contraception even during travel or significant changes in daily routine					

VIII. The role of HCPs in educating women about FP methods

Item	Strongly disagree	Disagree	Neither agree	Nor disagree	Agree	Strongly agree
Health care providers are responsible for educating women about contraceptives						
I got enough information on each contraceptive method to choose the one that fits me						
I have confidence in the quality of health education on contraceptives provided by health service providers						
it is necessary to design health education programs on family planning methods to meet the needs						

and preferences of individual ladies						
A health educator could address illusions and myths about the use of family planning methods						
Health providers have knowledge about potential complications of contraceptives						
I feel comfortable discussing the potential benefits of using family planning with health providers						
Health care providers maintain confidentiality and women's privacy when educating health on contraceptives						
It is necessary to discuss all available methods of family planning in a health facility as much as possible						
Gestures and body language are important to communicate information well during health education on contraceptives						
Health providers must talk about potential complications when using contraceptives						
Health providers use easy and simple words when teaching health education about contraceptives.						
It is necessary to ask health providers about your past medical history to determine the appropriate contraceptive						
Health education is likely to contribute to increasing women's awareness of the complications that may occur when using family planning methods						
It's necessary to tell me about the contraceptives available in the health facility						

It is necessary to use visual means to help explain different contraceptive methods						
Health care providers give guidance on how to act in the event of health complications when using contraceptives						
Health care providers provide me with all options available for family planning methods commensurate with my health and personal status						
The husband is involved in education sessions on family planning methods to promote common understanding						
Education about family planning methods must continue after starting to use the means to ensure optimal use.						

العوامل الديموغرافية

العمر أقل من 18 من 18-30 31-40 41-50 أكثر من 50
المحافظة رفح خانيونس دير البلح غزة الشمال
المستوى التعليمي للسيدة ابتدائي ثانوي بكالوريوس ماجستير غيرة
المستوى التعليمي للزوج ابتدائي ثانوي بكالوريوس ماجستير غيرة
هل تعملي نعم لا
هل زوجك يعمل نعم لا
معدل الدخل الشهري اقل من 1000 شيقل من 1000-1500 شيقل 1600-2000 شيقل أكثر من 2000 شيقل
عدد الولادات السابقة.....؟ عدد الحمولات السابقة .....؟ عدد حالات الإجهاض.....؟
كم عدد الأطفال الأحياء لديكِ حاليًا؟ .....
كم مضى على زواجك؟ أقل من سنة من 1-5 سنوات من 6-10 سنوات أكثر من 10 سنوات
هل سبق لك استخدام وسائل منع الحمل من قبل؟ نعم لا
هل لديكِ تأمين صحي؟ نعم لا
هل تعانين من أي حالة صحية مزمنة تؤثر على قرار استخدام وسائل منع الحمل؟ نعم لا
المدة الزمنية لاستخدام وسيلة منع الحمل لا استخدمها أقل من سنة من 1-3 سنوات أكثر من 3 سنوات

عوامل تؤثر على الوصول، الاستخدام والامتثال لوسائل تنظيم الأسرة بين السيدات

العناصر	نعم	لا
هل تستشيري زوجك قبل البدء في الاستخدام		
هل يعتبر الزوج عامل قوي في استخدام أساليب تنظيم الأسرة		
هل يؤثر العامل الديني على الاستخدام، الوصول والامتثال لأساليب تنظيم الأسرة		
أنتي تهتمي بإن زوجك من ضروري أن يوافق على طريقة التي يتم اختيارها		
هل من المقبول إن تختاري طريقة لوسيلة منع الحمل دون إخبار زوجك		
هل أنتي خائفة من مضاعفات استخدام أساليب تنظيم الأسرة		
هل سبق لك أن واجهت اي مضاعفات بعد استخدام موانع الحمل		
هل يؤثر وسائل تنظيم الأسرة على الجماع		
هل قلة المعرفة والوعي بأهمية وسائل منع الحمل تؤثر سلبا عليك وتجعلك لا تستخدمي لا تستخدمي أساليب تنظيم الأسرة		
سوء المعاملة من قبل مقدمي الخدمات (الممرضات والقابلات) عامل يؤثر على استخدام موانع الحمل		
هل يؤثر مستوى الدعم وتشجيع من قبل مقدمي الرعاية الصحية على الامتثال لأساليب تنظيم الأسرة		
هل تؤثر الاثار الجانبية التي يمكن أن تسببها استخدام موانع الحمل على امتثال المرأة		
وسائل منع الحمل في منطقتك سهل؟		
هل تعتبر تكلفة وسائل منع الحمل عاملاً مؤثراً على قرارك باستخدامها؟		
هل تجدين صعوبة في الحصول على استشارة طبية حول وسائل منع الحمل؟		
هل هناك أوقات انتظار طويلة للحصول على خدمات تنظيم الأسرة؟		
هل تشعرين بأن لديكِ الحرية الكاملة في اتخاذ قرار استخدام وسائل منع الحمل؟		
هل هناك ضغوط اجتماعية أو عائلية تؤثر على قرارك باستخدام وسائل منع الحمل؟		
هل تشعرين بالقلق أو التوتر عند التفكير في استخدام وسائل منع الحمل بسبب آثارها الجانبية المحتملة؟		
هل تجدين صعوبة في الاستمرار باستخدام وسيلة منع الحمل لفترة طويلة؟		
هل سبق وأن توقفتِ عن استخدام وسيلة منع الحمل بسبب عدم الرضا عنها؟		
هل تشعرين أن مقدمي الرعاية الصحية يوفرون لكِ المعلومات الكافية عن وسائل منع الحمل؟		
هل تجدين أن مستوى التثقيف الصحي المتاح حول وسائل منع الحمل غير كافٍ؟		
هل تشعرين بأن المجتمع المحيط بكِ يدعم استخدام وسائل تنظيم الأسرة؟		

تقييم مستوى الوصول إلى وسائل تنظيم الأسرة

العناصر	موافق بشدة	موافق	محايد	غير موافق	غير موافق بشدة
أجد أنه من السهل الوصول إلى وسائل منع الحمل الهرمونية (مثل الحبوب واللصقات والغرسات).					
أجد أنه من السهل الوصول إلى وسائل منع الحمل الحاجزة (مثل الواقي الذكري والحاجز المهبلي).					
أجد أنه من السهل الوصول إلى طرق الوقاية العكسية (مثل اللولب الرحمي والغرسات).					
أجد أنه من السهل الوصول إلى وسيلة منع الحمل المناسبة لعادات وتقاليد المجتمع.					
أجد أنه من السهل الوصول إلى وسيلة منع الحمل المناسبة لعمري					

أجد أنه من السهل الوصول إلى وسائل منع الحمل من مقدم الرعاية الصحية					
أجد أنه من السهل الوصول إلى وسائل منع الحمل من العيادات التي تقدم خدمات تنظيم الأسرة.					
أجد أنه من السهل الوصول إلى وسيلة منع الحمل التي أريدها.					
أجد أنه من السهل الحصول على وسيلة منع الحمل التي تناسب نمط حياتي					
أعتقد أن وسائل تنظيم الأسرة بالنسبة لي تختلف حسب وضعي الاجتماعي					
أعتقد أن وسائل تنظيم الأسرة بالنسبة لي تختلف حسب وضعي الاقتصادي					
إن توافر وسائل منع الحمل التي يريدها زوجي يساعدنا على تحسين العلاقة الجنسية وتحقيق العدد المطلوب من الأطفال					
إن الوصول إلى وسائل تنظيم الأسرة له نتائج مرضية بالنسبة لي ولزوجي في تحسين الصحة الإنجابية والعامة					
إن الوصول إلى وسائل تنظيم الأسرة التي تناسب حالتي الصحية متاح دائمًا					
من السهل الحصول على استشارة من مقدمي الرعاية الصحية حول الوسيلة الأفضل لي					
هناك توعية كافية في المجتمع حول وسائل تنظيم الأسرة المتاحة					
أجد أن تكلفة وسائل منع الحمل مناسبة ويمكنني تحملها					
أشعر أن الخصوصية محفوظة عند استخدامي لوسائل تنظيم الأسرة في المرافق الصحية					
أجد أن وسائل تنظيم الأسرة متاحة بسهولة حتى في حالات الطوارئ أو الاحتياج العاجل					
أعتقد أن وسائل تنظيم الأسرة الحديثة (مثل التطبيقات التكنولوجية) متاحة بشكل كافٍ ويمكن الوصول إليها					
أشعر أن المجتمع من حولي يدعم استخدامي لوسائل تنظيم الأسرة					
المؤسسات الدينية تقدم دعمًا كافيًا للوصول إلى وسائل تنظيم الأسرة					
أجد أن وسائل تنظيم الأسرة المتاحة ذات جودة عالية وموثوقة					

نسبة استخدام كل نوع من أنواع تنظيم الأسرة بين النساء

ما هي وسيلة منع الحمل التي تستخدمينها حاليًا؟

الوسائل المستخدمة	**الاستخدام**
اللولب النحاسي	
اللولب الهرموني	
الحبوب	
الغرسات	
الواقي الذكري	
الحقن	
وسائل أخرى	

مستوى التزام النساء باستخدام وسائل منع الحمل

العناصر	نعم دائما	غالباً	أحيانا	نادراً	لا أبدا
استخدم وسائل منع الحمل في الوقت المحدد					
لم أشتك من استخدام وسائل تنظيم الأسرة					
استخدم طريقة معينة لتذكيري بتناول وسيلة منع الحمل في الوقت المحدد					
أســـأل مقدم الرعاية الخاص بي قبل التغيير أو تناول الحبوب					
أتوقف عن استخدام وسائل تنظيم الأسرة بسبب بعض المضاعفات					
أحاول اســتخدام الطريقة الموصـــوفة لتنظيم الأســـرة بانتظام					
عندما أنســـى اســـتخدام الطريقة الموصـــوفة لتنظيم الأسرة، أستخدم طريقة إضافية لمنع الحمل					
استخدم وسائل منع الحمل في الوقت المناسب لتجنب الحمل أثناء استخدام الطريقة الموصوفة					
حضــور المواعيد المنتظمة مع مقدم الرعاية الصــحية لمتابعة استخدام وسيلة منع الحمل					
أقم بتغيير وسيلة منع الحمل بناءً على توصية من مقدم الرعاية الصحية					
أستمر في استخدام وسيلة منع الحمل حتى إذا واجهتِ آثارًا جانبية خفيفة					
أستمر باستخدام وسيلة منع الحمل حتى أثناء السفر أو التغيرات الكبيرة في الروتين اليومي					

دور مقدمي الرعاية الصحية في تثقيف النساء حول أساليب تنظيم الأسرة من وجهه نظر السيدات

العناصر	موافق بشدة	موافق	محايد	غير موافق	غير موافق بشدة
مقدمي الرعاية الصـحية مسـؤولون عن تثقيف النسـاء حول وسائل منع الحمل					
حصـــلت على معلومات كافية عن كل وســيلة لمنع الحمل لاختيار الطريقة التي تناسبني					
لدي ثقة في جودة تثقيف الصحي حول وسائل منع الحمل التي يقدمها مقدمو الخدمات الصحية					
من ضـروري تصـميم برامج التثقيف الصـحي حول أسـاليب تنظيم الاسرة لتلبية احتياجات وتفضيلات السيدات					
يتمتع المعلم الصـحي بالقدرة على معالجة الأوهام والاسـاطير حول استخدام أساليب تنظيم الأسرة					
لدى مقدمي الخدمات الصـحية معرفة بالمضـاعفات المحتملة لوسائل منع الحمل					
أشـعر بالراحة عند مناقشـة الفوائد المحتملة لاسـتخدام تنظيم الاسرة مع مقدمي الخدمات الصحية					
يحافظ مقدمو الرعاية الصحية على السرية وخصوصية المرأة عند تثقيف الصحي حول وسائل منع الحمل					

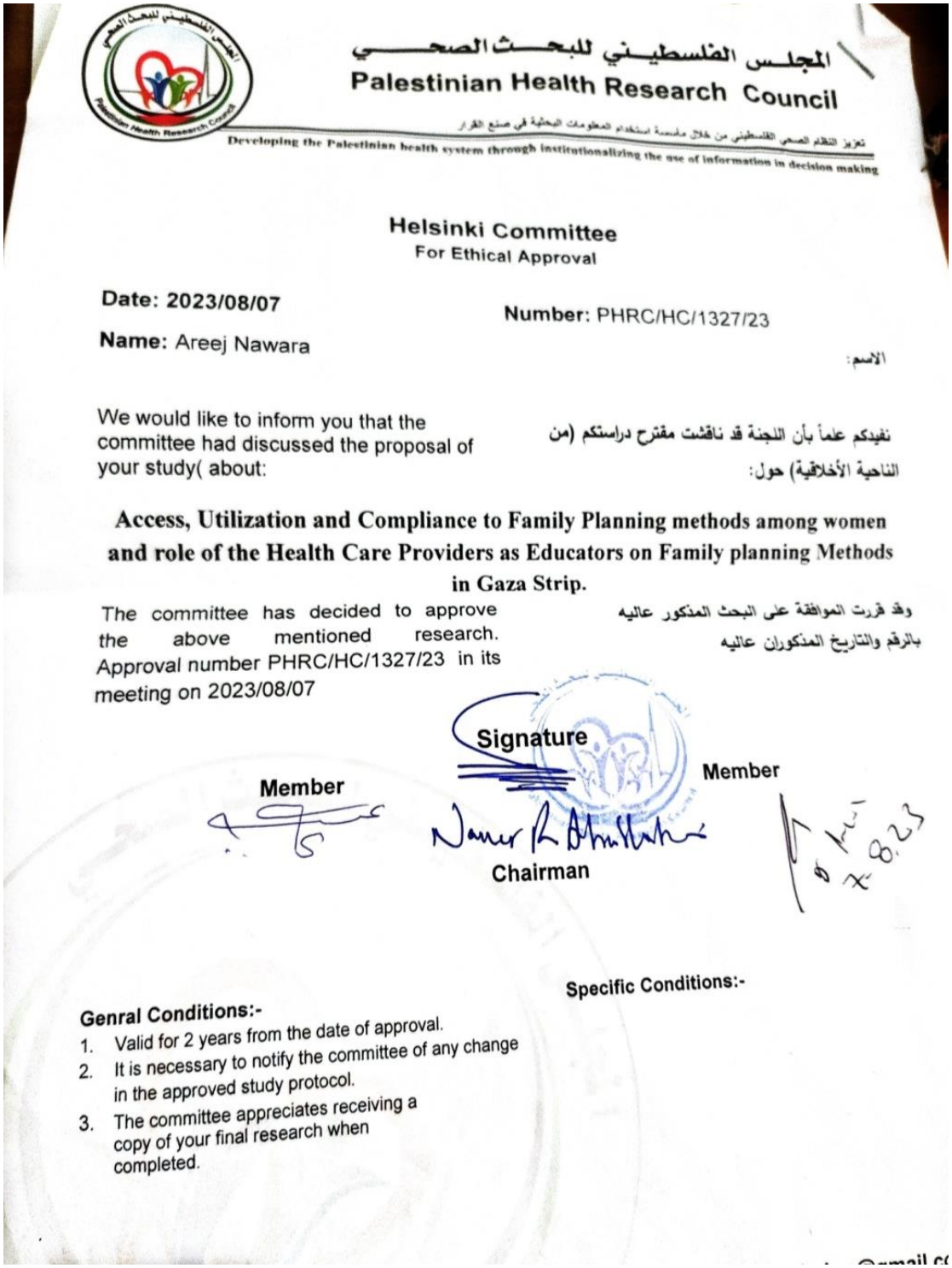
من الضـــروري مناقشـــة شـــرح جميع الطرق المتاحة لتنظيم الاسرة في منشأة صحية قدر الإمكان					
الإيماءات ولغة الجسـد مهمة لتوصـيل المعلومات بشـكل جيد أثناء التثقيف الصحي حول وسائل منع الحمل					
من الضروري أن تسأل مقدمي الخدمات الصحية عن تاريخك الطبي السابق لتحديد موانع الحمل المناسبة					
من المرجح أن يسـاهم التثقيف الصـحي في زيادة وعي المرأة بالمضاعفات التي تحدث عند استخدام أساليب تنظيم الأسرة					
من الضـروري استخدام الوسـائل المرئية للمسـاعدة في شرح وسائل منع الحمل					
من الضـــروري اخباري عن وســـائل منع الحمل المتوفرة في المنشاة الصحية					
يقدم مقدمي الرعاية الصـحية إرشـادات حول كيفية التصـرف في حالة حدوث مضـاعفات صـحية عند اسـتخدام وسـائل منع الحمل					
مقدمي الرعاية الصحية يستخدمون لغة واضحة ومفهومة عند شرح وسائل منع الحمل					
مقدمي الرعاية الصـــحية يقدمون لي جميع الخيارات المتاحة لوســـائل تنظيم الأســـرة بما يتناســـب مع وضـــعي الصـــحي والشخصي					
يتم إشـــراك الزوج في جلســـات التثقيف حول وســـائل تنظيم الأسرة لتعزيز الفهم المشترك					
التثقيف حول وسـائل تنظيم الأسـرة يجب أن يسـتمر بعد البدء في استخدام الوسيلة لضمان الاستخدام الأمثل.					

Annex (6): List of experts

No.	Name	Workplace
1.	Dr. Ahmed Najim	Al-Azhar university, Gaza
2.	Dr. Ayman Abu Mostafa	Palestine collage
3.	Dr. Hatem Al-Dabackah	Palestine collage
4.	Dr. Mohammed Khail	MoH
5.	Dr. Montasser Joudah	Al-Quds University

Annex (7): Helsinki approval

1



المجلس الفلسطيني للبحث الصحي
Palestinian Health Research Council

تعزيز النظام الصحي الفلسطيني من خلال مأسسة استخدام المعلومات البحثية في صنع القرار
Developing the Palestinian health system through institutionalizing the use of information in decision making

Helsinki Committee
For Ethical Approval

Date: 2023/08/07

Number: PHRC/HC/1327/23

Name: Areej Nawara

الاسم:

We would like to inform you that the committee had discussed the proposal of your study(about:

نفيدكم علماً بأن اللجنة قد ناقشت مقترح دراستكم (من الناحية الأخلاقية) حول:

Access, Utilization and Compliance to Family Planning methods among women and role of the Health Care Providers as Educators on Family planning Methods in Gaza Strip.

The committee has decided to approve the above mentioned research. Approval number PHRC/HC/1327/23 in its meeting on 2023/08/07

وقد قررت الموافقة على البحث المذكور عاليه بالرقم والتاريخ المذكوران عاليه

Signature

Member

Member

Chairman

Genral Conditions:-

1. Valid for 2 years from the date of approval.
2. It is necessary to notify the committee of any change in the approved study protocol.
3. The committee appreciates receiving a copy of your final research when completed.

Specific Conditions:-

Annex (8): Admin approval -MoH

State of Palestine
Ministry Of health
Health Information Unit

دولة فلسطين
وزارة الصحة الفلسطينية
وحدة المعلومات الصحية

24376700
2024-11-09

السيد/ة زاهر وضاح دريعان الوحيدي

مدير وحدة المعلومات الصحية

السلام عليكم ورحمة الله وبركاته ...

الموضوع/ تسهيل مهمة الباحث/ة أريج عوني محمد نوارة " جنوب القطاع"

السلام عليكم

تهديكم أطيب التحيات ونود منكم تسهيل مهمة الباحث/ة أريج عوني محمد نوارة الملتحق/ة ببرنامج ماجستير التمريض - جامعة القدس أبو ديس بغزة في إجراء بحث بعنوان

Access, Utilization and Compliance to Family Planning Methods among Women and Role of the Health Care Providers as Educators in Gaza Strip

حيث الباحث/ة بحاجة لتعبئة استبانة عشوائية من عدد من المراجعين في مرافق وزارة الصحة (مراكز الرعاية الأولية: عيادة خانيونس البلد وعيادة الزوايدة و عيادة دير البلح) ، دون اجراء اى تدخل طبي او سحب عينات دم و بما لا يتعارض مع مصلحة العمل وضمن أخلاقيات البحث العلمي، ودون تحمل الوزارة أي أعباء أو مسئولية ، نأمل توجيهاتكم لذوي الاختصاص بضرورة الحصول على الموافقة المستنيرة (Consent Form)من المشاركين.

ملاحظات /

تسهيل المهمة الخاص بالدراسة أعلاه صالح لمدة 3 أشهر من تاريخه.

يرجى التأكد من توافق الاستبانة المرفقة والتي يتم تعبئتها ميدانيا على ان لا يتم أي إضافة او تعديل على الاستبانة المرفقة

يجب اطلاع دائرة البحث الصحي على النتائج قبل النشر

وتفضلوا بقبول التحية والتقدير

علي حسن عبد القادر البلبيسي
رئيس قسم البحوث

التحويلات
المرسل اليه: زاهر وضاح دريعان الوحيدي
نسخة الى:
هاني سلطان ارميح الوحيدي -<

عنوان الدراسة: الوصول والاستخدام والامتثال لوسائل تنظيم الأسرة بين السيدات ودور مقدمي الرعاية الصحية كمثقفين

إعداد: أريج عوني محمد نوارة

إشراف: د. عريفة الكسيح

المستخلص:

تُعد وسائل منع الحمل ضرورية للمباعدة بين الولادات، مما يسهم في تقليل المضاعفات المحتملة التي قد تواجهها الأم وطفلها وتحسين حالتهما الصحية. تهدف الدراسات إلى تقييم مدى الوصول إلى وسائل تنظيم الأسرة واستخدامها وامتثال النساء لها، فضلاً عن دور مقدمي الرعاية الصحية في توعية النساء بشأن تنظيم الأسرة في قطاع غزة. تتبنى هذه الدراسة تصميمًا وصفيًا مقطعيًا لاستكشاف الوصول إلى وسائل تنظيم الأسرة، وطرق استخدامها، ومدى الامتثال لها، إضافة إلى دور مقدمي الرعاية الصحية في التثقيف بهذا المجال. سيتم جمع البيانات من 361 امرأة عبر استبيانات ذاتية من السيدات اللواتي يراجعن مراكز الرعاية الصحية الأولية في المناطق الجنوبية والوسطى من قطاع غزة، حيث سيتم تطبيق مزيج من عينات الحصص والعينات المتتالية. يشمل الاستبيان أقسامًا تتعلق بالعوامل الاجتماعية والاقتصادية، واستخدام وسائل تنظيم الأسرة، ومدى الوصول إليها، والامتثال لها، ودور مقدمي الرعاية الصحية. تم اختيار أدوات الدراسة بمعدل ألفا كرو نباخ 0.910 لقياس الثبات، كما تم إجراء دراسة تجريبية على 36 امرأة لاختبار مدى ملاءمة الأدوات، وتم تحليل البيانات باستخدام برنامج .SPSS تم الحصول على الموافقة الأخلاقية لضمان السرية والمشاركة الطوعية. أظهرت النتائج وجود عوامل مؤثرة في الوصول إلى وسائل تنظيم الأسرة واستخدامها والامتثال لها، من أبرزها التواصل بين الزوجين 85.6%، تأثير الزوج 82.5%، وإرشادات مقدمي الرعاية الصحية 70.6%. كما أظهرت الدراسة أن 70.8% من النساء يستخدمن وسائل منع الحمل، حيث بلغت نسبة استخدام اللولب النحاسي 21.7% والغرسات 2.2%. أظهر الاستبيان أن 62.8% من النساء يصلن إلى وسائل منع الحمل الهرمونية مثل الحبوب واللاصقات والواقيات الذكرية، بينما تبلغ نسبة الوصول إلى اللولب النحاسي 62.2%. بالإضافة إلى ذلك، بلغت نسبة الامتثال لوسائل منع الحمل 78%، كما كان متوسط وصول السيدات الى برامج التثقيف الصحي حول وسائل منع الحمل 83%. كما تبين أن العوامل الاجتماعية والديموغرافية مثل العمر والتعليم والعمل والدخل تؤثر في الوصول إلى وسائل تنظيم الأسرة والامتثال لها($P<0.05$) ، حيث كانت النسبة أعلى بين النساء الأصغر سنًا (43.6%)، والأقل تعليمًا (53.1% من النساء و45.3% من الأزواج)، وكذلك بين النساء غير العاملات (16.7%). تعزيز الصحة الإنجابية يتطلب تحسين الوصول إلى واستخدام وسائل تنظيم الأسرة. يعتبر مقدمو الرعاية الصحية عنصرًا أساسيًا في إعلام الأفراد بالخيارات المتاحة لهم، مما يساعدهم في اتخاذ قرارات مدروسة. يزداد نجاح برامج تنظيم الأسرة عندما يتم الالتزام بالقوانين والإرشادات بشكل فعال. لتعزيز الامتثال، يجب أن يتلقى مقدمو الرعاية الصحية تدريبًا إضافيًا في مجال الاستشارات المتعلقة بتنظيم الأسرة وتزويدهم بمجموعة متنوعة من الاستراتيجيات. كما يجب أن يحصل مقدمو الرعاية الصحية على تعليم مستمر لتعزيز الثقة وتحسين التواصل مع المرضى.