An-Najah National University
Faculty of Graduate Studies

Knowledge, Attitude and Practices of Palestinian Women in Refugee Camps of Nablus Area Towards Family Planning

By

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Submitted in partial Fulfillment of the Requirements for the Degree of Master in Public Health, Faculty of Graduate Studies, at An-Najah National University, Nablus, Palestine

2004

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Dedication

Humbly I dedicate this effort to My Beloved Family
and to the Soul of My Last Grand parents

With Gratitude, Respect
And Love

Acknowledgments

Sincerely, I owe my respectful supervisor Dr. Na’el Abu- Hasan, the favor for finalizing this thesis. It’s only with his patience, scholarly support and hard effort it came to light, to him I present my acknowledgment and deep gratitude.

I also extend my deep appreciation to the members of the committee who donated much of their time and efforts revising the study. Special appreciation is also given to the University administration for the opportunity given to accomplish the study. Many thanks, to Mr. Ismael Abu Ziyadah, and Mr. Samer Dyab for their freely given assistance in the statistical analysis.

Lastly I would like to acknowledge the encouragement and support given by my family, and friends while completing the requirements for the degree.

List of Contents

List of Tables

List of Figures

List of Abbreviations

CBD	Community -Based distribution
CICs	combined Injectable Contraceptives
COCs	Combined Oral Contraceptives
DHS	Demographic and Health Survey
FP	Family Planning
ICPD	International Conference on Population and Development
IEC	Information, education, and communication
IMR	Infant Mortality Rate
IUD	Intra Uterine Device
MCH	Mother and Child Health
MMR	Maternal Mortality Rate
OC	Oral Contraceptive
PCBS	Palestinian Census Bureau for Statistics
POPs	Progestin-only Pills
PICs	Progestin-only Injectables Contraceptives
QI	Quality Improvement
SPSS	Statistical Package of Social Sciences
STI	Sexually Transmitted Infection
STD	Sexually Transmitted Disease
TFR	Total Fertility Rate
UNFPA	United Nation Population Fund
UNRWA	United Nation Relief and Work Agency
WHO	World Health Organization

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Abstract

The current study aimed at exploring and assessing the current level of knowledge, attitudes and practices among women in the refugee camps of Nablus governorate towards family planning as well as their fertility awareness. A specially designed questionnaire was prepared for this purpose and data were collected during the period October- April, 2004. A total of 500 women were interviewed and collected data were analyzed using SPSS. The mean age of the correspondents was 31 years and the mean age of first marriage was 18.7 years. Around 50% of the correspondents were with elementary educational level and 33.8% were with secondary level. Income of around 300 US $ was reported by 81.8% of the correspondents. Total carriages were 2501 and the average family size was 5.9. With respect to knowledge on family planning concept 77.4% of the correspondents were able to define it and 77.8% recognized health as a major benefit. The most common recognized modern methods of contraceptives were IUDs (96.4%), OCs (96.4%), condoms (69.8%) and injections (51%). Natural family planning methods were represented by 35.4% and 15.4% for breast feeding and withdrawal, respectively. The mainly recognized disadvantage of family planning was health side effects of contraceptives (53.6%).

Low level of fertility awareness was observed for menstrual cycle, natural family planning methods and gamete survival. Results show that women are far away of knowing their basic fertile features, and time of ovulation, 45.5% reported to be fertile for 21 days, 52.4% believed that they can get pregnant any time of intercourse, and only one third recognized the first day of bleeding as the first day of the menstrual cycle. Withdrawal as a safe natural method for FP was recognized by 72.8% of the respondents. IUD's, condoms, and OC's were the main modern used contraceptives and represented by 25.2%, 21.4%, and 18.4%, respectively. Breast feeding (19.4%) and rhythm (10%) were the most natural used ones.

Attitudes toward family planning seem to be positively high as 95% of the study population agreed strongly and encouraged it. It was also found that 85.6% of the surveyed women believed that their spouses encourage family planning as well. On the other hand 97% of them agree that FP is a joint partner decision and 80% believed that religion encourages family planning, which is contradictory to what is reported in some Muslim communities.

In conclusion we believe that the highly observed positive attitude is not reflected on practices concerning FP as not good enough for effective outcomes of such programs.

Chapter I

Introduction

1.1 Background

Family planning has been identified by the World Health Organization (WHO) as one of the six essential health interventions needed to achieve safe motherhood. The Safe Motherhood Initiative defined safe motherhood as “a woman’s ability to have a safe and healthy pregnancy and delivery” (Global Initiative-conference, Kenya, 1987).

An estimated 600 000 maternal deaths occur worldwide each year; 99% of them take place in developing countries. WHO estimates that 13% of these deaths are due to unsafe abortion. Worldwide, approximately 50 million women resort to induced abortion, frequently resulting in mortality and adverse health consequence (WHO, 1998). In most countries in the WHO Eastern Mediterranean Region, abortion continues to be an illegal and unsafe procedure and it is legally permitted when pregnancy poses a threat to the mother's life, or if the fetus has no chance of normal survival life (Huntington, *et al.,* 1995; Faour, 1989). By preventing unplanned and high-risk pregnancies, family planning plays an important role in reducing maternal mortality and preventing maternal morbidity.

Family planning enables couples to plan their families and space their children. The umbrella of family planning covers a range of services, including: family planning/birth spacing counseling; provision of family planning methods; infertility diagnosis, treatment and counseling; and reproductive health education (Mroueh, 1982). Studies indicate that the total fertility rate (TFR) of a nation is directly related to its prevalence rate of

contraceptive use. Thus, countries with high TFR tend to have low contraceptive use prevalence rates and vice versa (Mauldin and Sinding, 1993). For instance, WHO statistics for 1996 indicate that 5% of married women in Somalia aged 15-49 years used contraceptives and the TFR was reported to be 6.8, whereas Lebanon had a contraceptive use prevalence rate of 61% and a TFR of 2.5 (WHO, 1997)

Survey research in developing countries estimates that more than 150 million married women of reproductive age would prefer to postpone or avoid pregnancy do not use contraceptives. These women have an "unmet need" for contraception as the case of India were an estimated number of about 31 million women was reported. High percentages of women with unmet need were also reported in the majority of African, Asia, Latin America and Middle Eastern countries. The countries with the highest percentage of women with unmet need are Rwanda (37%), Malawi (36%), and Kenya (36%) (Bulatao, 1998).

In Palestine the base line health survey (MICS 2000) shows disparities between the use of modern contraceptives on one hand (36.7%) and the expressed desire to practice family planning on the other hand (73.5%). The main factors that prohibit contraceptive use were mainly related to desire for more children (68.0%), misperceptions about the side effects of contraceptives (8.8%) and husband/ family opposition (8.5%). Only 1% of those surveyed do not use contraceptives for religious reasons (UNFPA, 2001).

1.2 Obstacles facing family planning in developing countries

Several studies showed that lack of knowledge was the most widely mentioned obstacle about contraception, its use, or its availability, cited by one-quarter of those women with unmet need in developing countries. Effective family planning programs promote wider knowledge about the range of contraceptive methods and their proper uses. Health concerns were the second most widely mentioned obstacle about the health effects of contraception, cited by one-fifth of the respondents in the previously mentioned surveys.

Family planning programs typically incorporate educational components not only to help women choose appropriate methods, but also with other health concerns (personnel hygiene, sexually transmitted disease, etc). These components also help couples better understand the relative risks involved. The health risks associated with contraception are low relative to the risks of a typical pregnancy and especially to the risks of an unintended pregnancy (because a number of such pregnancies are terminated by an unsafe induced abortion).

In developing countries, the mortality risk of an unintended pregnancy carries 20 times the risk associated with use of a modern contraceptive method. Programs that offer a wider variety of contraceptive methods increase the chances that a couple can find a method appropriate for them. Limited supplies and high costs is another obstacle, in some cases contraceptives may simply be unavailable or too expensive for individuals. The cost can be substantial and can reach 20 percent of income in some Sub-Saharan countries. Cultural and

familial barriers to family planning may influence a woman's decision to use contraception. For example, a husband may disapprove because he wants more children or is concerned about health effects, bothered by the inconvenience, or distrustful of traditional methods. Such objections may reflect informational or access issues or health concerns. Except for a woman's personal opposition to contraception, the objections appear to be less prominent where programs are active (Bulatao, 1998).

Figure 1.1 shows the main obstacles against contraceptives use cited in 13 developing countries. Prominently cited obstacles were lack of knowledge, health concerns, high costs, limited supplies, and cultural or personal objections.

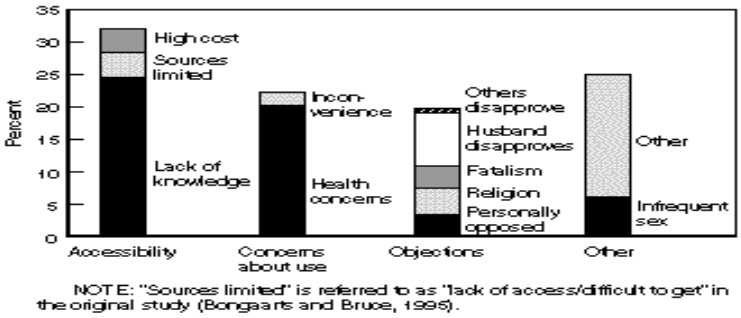

Figure1.1 Obstacles against contraceptives use in developing countries

1.3 Women's health in Palestine

There has been a general improvement in the overall health status of the Palestinians as a result of increased access to primary care and preventive services such as immunization. The infant mortality rate (IMR) is estimated at 25.5 /1,000. The maternal mortality rate (MMR) is estimated at 70 – 80/ 100,000, but reaches 93 – 140 per 100,000 in the extreme age categories (15-19

years and 50-54 years). However, due to the poor reporting systems, these figures are thought to be an underestimate.

With respect to contraceptive use, 51.4% of the currently married women aged 15-49 years use any available contraceptive method, while only 36.7% use modern methods (MICS, 2000). Regional disparity is observed as to the contraceptive use where 54.3% in the West Bank are current users of any method compared to 46.1% in Gaza. Current users of modern methods were 38.8% in the West Bank and 32.7% in Gaza, of which, 24.6% use the intra uterine device (IUD) and 5.8% use pills. This appears to be contradictory to the observed high fertility level, particularly since there is a high awareness among the adult population about family planning reaching 99%. Many factors account for the observed discrepancy. Of these is the young age at first marriage (18 years for women) that contributes to a long childbearing period, which in turns increases the potential number of children per couple. Moreover, women tend to use contraception as a means of spacing or later in their reproductive years after they have the desired number of children (47.7% started a contraceptive method after they had 3 children; 55.9% in Gaza and 43.9% in the West Bank) (PCBS Health Survey 2000; UNFPA, 2001).

1.3.1 Women health in Refugee Camps

United Nations Relief and Work Agency (UNRWA) is the main provider of health services in the refugee camps in Palestine, its medical programs offers comprehensive maternal health care to women in reproductive age including family planning services, infant and child health care, school health services,

nutrition and mental health services. In the last annual report of the health department 2002, the IMR, in the five fields of UNRWA intervention, dropped from approximately 160 deaths per thousand live births in the 1960s to levels that were below the WHO target of 50 deaths per thousand live births for developing countries by the year 2000, the MMR among refugees counted in the West Bank 21.2 per 100,000 live births, and 24.4 in Gaza. TFR among refugees in the West bank 4.1 and 4.4 in Gaza, the prevalence of modern contraceptive among women of reproductive age (15-49) utilizing UNRWA Mother and Child Health (MCH) services were 41.9 in the West Bank and 36.5 in Gaza, percentage of women with birth intervals of less than two years decreased from 47.3% to 38%.

In spite of the notable improvements in the health status of the refugee population, the social, economic and cultural context of women's and children's health remains underrated. There was a steady decrease in the number of pregnant women registered for antenatal care from 73,476 pregnant women in 1995 to 68,843 in 1999 which was accomplished by a steady increase in the number family planning acceptors. This trend reversed during the last 3 years, whereby the number of pregnant women has increased from 70,282 in 2000 to 78,985 in 2002, this increase could be attributed to the improved coverage of antenatal care. It is worth mentioning in this respect that the pace of increase in family planning acceptors during 2002 was slower than previous years, this is attributed to the humanitarian crisis in the West Bank and Gaza and the increased desire among refugee population to have more children coincide with women's own desire or may be pressured to become pregnant to

replace the depleted population and replace children who have died in the violence action taking place for the past 4 years in an attempt to maintain cultural and religious identity (UNRWA, 2002). This was proven through previous studies of the impact of conflict and displacement on reproductive health (WHO 2000).

1.3.2 UNRWA health care program

The UNRWA Health Care program, which is basically community health oriented, provides primary health care to eligible refugee population including medical care services, preventive and curative, health protection and promotion, disease prevention and control and environmental health services. The level of service responds to the needs of the refugees which in turn reflect their residence. Camp residents use UNRWA facilities because of ease of access. Medical statistics show that the demand for the Agency's out- patient medical care services has increased by 53% since the current crisis in the West Bank and Gaza. This demand was mainly due to the fact that increasing number of refugees who were previously able to use services of other health care providers had turned to UNRWA either to sudden impoverishment or due to problems of mobility and access. Many refugees residing outside camps nevertheless, use UNRWA health centers especially for preventive services.

Table 1.1 UNRWA health care programs launched in the West Bank field area of Palestinian.

Services	Programs included
Emergency assistance	Emergency medical care
	Post- injury physical rehabilitation
	Psychological support
Medical care services	Out patient care
	In patient (hospital)care
	Dental (Oral) care
	Rehabilitation (physical care)
	Clinical laboratories
	Radiology units
Health protection and promotion	Mother and child health care
	Family planning services
	School health
	Nutrition
	Mental health
Disease Prevention and Control	Control of communicable diseases
	Vaccine- preventive diseases
	Control of non – communicable diseases
Environmental health	Water and sewerage management
	Solid waste management

Adopted from UNRWA annual report, 2002

1.4 Family planning programs

Family planning helps couples space births, prevent unwanted pregnancies, and avoid sexually transmitted infections (STI's). Family planning programs usually focus on how to make high-quality family planning services accessible to women and men in low-resource settings by improving program management. In recent years, family planning programs have made great progress both in improving the quality of care and overcoming barriers to access. Research is continuing on how to design cost efficient operations that meet individual client needs especially in developing countries. The International Conference on Population and Development (ICPD), Cairo 1994,

emphasized individual human rights over national development and population goals, redefined family planning as one element of comprehensive reproductive health care services, viewed health within a broader social context, and acknowledged the importance of equity and empowerment for women. Since the Cairo meeting, family planning programs have set new goals, including:

1. Client-centered care
2. Quality improvement
3. Integrating family planning with other reproductive health services
4. Addressing social problems that affect women's health, such as domestic violence.
5. Meeting the needs of special groups (adolescents, men, and refugees).

1.5 Key issues in delivering high-quality, cost-effective family planning services in low-resource settings

1.5.1 Increasing access to family planning

Access to contraceptive supplies and services affects the likelihood that people adopt a method, continue using it, or switch methods when they are dissatisfied (Ali, 2001; Ketende *et al.,* 2003; Ross *et al.,* 2002; Steele and Geel, 1999; Steele *et al.*, 1999; Stephenson and Tsui, 2002; Thang and Anh, 2002). In some settings, access may even be more important than a couple's reproductive intentions in determining contraceptive use. Some researchers have speculated that increasing access to family planning actually influences couples' intentions, that is, it prompts them to feel a need for family planning (Magniani *et al.*, 1999; Shelton *et al.,* 1999). Efforts to increase access to

family planning services take many forms because they address five different aspects of accessibility: geographic, economic, administrative, cognitive, and psychosocial (Bertrand *et al.*, 1995). To overcome geographic and economic barriers, family planning programs have experimented with a variety of outreach efforts, ranging from mobile clinics to social marketing of subsidized commodities at retail outlets (Debpuur *et al.*, 2002). One of the best-tested approaches is training volunteer or paid community-based distribution (CBD) workers to make home visits. Research has found that CBD programs overcome social as well as geographic barriers to access, that they can safely deliver oral contraceptives (OC's) and injectables, that they fill unmet need for contraception, and that they reduce discontinuation (Best *et al.*, 1999; Green *et al.*, 2002; Hossain and Phillips, 1996; Katz *et al.*, 1998; Philips *et al.*, 1999; Sultan *et al.*, 2002).

Cognitive and psychosocial accessibility refer to whether clients know where to seek services and whether psychological or social factors discourage them from doing so. In Nepal, for example, uneducated people refuse to seek services because providers treat them so poorly (Schuler *et al.*, 1985). In addition to provider training, a common solution to these barriers involves multimedia communication campaigns to publicize family planning facilities.

1.5.2 Overcoming medical barriers

In recent years, attention has focused on administrative barriers to family planning, that is, unnecessary rules and regulations that burden clients and narrow their contraceptive choices. Example of these are unjustified

regulations including; outdated contraindications, eligibility requirements based on a woman's age, parity, lack of spousal consent, demands for additional procedures that may benefit women's overall health but are unnecessary for safe and effective contraceptive use (Bertrand *et al.,* 1995; Shelton *et al.,* 1992; Stanback *et al.,* 1997). The following example project such problems; requiring women to undergo a pelvic examination before receiving oral contraceptives (Brown and Morgan, 1998).

Global investigations into medical barriers in the early 1990s found that there was a lack of consensus on medical eligibility requirements as well as delays in acting on new research findings (Cottingham and Mehta, 1993; Hardee *et al.,* 1995). As a result, practices varied widely between individual providers. To help overcome these problems and eliminate medical barriers, international experts have codified medical eligibility requirements for contraception. In addition, they have developed checklists to rule out pregnancy among family planning clients (Stanback *et al.,* 1999). It is important to note that eliminating medical barriers should not affect quality of provided health care and safeguards contraceptive use.

1.5.3 Guidelines and indicators

Program guidelines include service policies and standards that specify provider qualifications, levels of performance, as well as clinical protocols and management procedures that give detailed instructions for performing tasks like inserting an IUD (Kols and Sherman, 1998). Well designed guidelines improve the consistency of service delivery and support functions, reduce barriers to

access, guide training and supervision, and establish the criteria by which individual and program performance are judged. No single set of guidelines is appropriate for all family planning programs because guidelines must reflect the social context and service setting as well as the latest scientific evidence. To have an effect on the quality of care, guidelines must be accepted by providers and applied to everyday practices. This only happens when guidelines are feasible and easily understood when they are broadly disseminated throughout the organization, and when they are reinforced by training materials, service manuals, job aids, client materials, supervision criteria, and monitoring systems (Hardee *et al.*, 1998).

1.5.4 Interpersonal communication and counseling

Counseling is central to family planning services, and improvements in client-provider interaction may lead to higher rates of contraceptive adoption, effective use, and continuation (Abdel-Tawab and Roter, 2002; Canto de Cetinha *et al.*, 2001; Luck *et al.*, 2000). Ideally, the counseling process should be client-centered. That means treating all clients with respect, regardless of their age, marital status, ethnic affiliation, or socioeconomic group; maintaining confidentiality; and personalizing the content of each session to fit the client's individual situation (PATH, 1999; Worsley, 2001). This may require training, along with job aids and supervision, to clarify providers' values, overcome their biases, and strengthen their interpersonal communication skills. Other approaches, such as client and community education, accreditation systems,

and self-assessment also can help improve client-provider communication (Heerey *et al.,* 2003).

Good counseling also supports informed choice by clients (EngenderHealth, 2003; Kim *et al.,* 2003; Upadhyay, 2001). It is the provider's job to supply accurate, complete technical information that is relevant to the client's situation and that covers negatives, such as side effects, as well as positives. Research suggests that the amount of time spent with a client is less important than how sharply the information exchange focuses on the client's situation (Leon *et al.,* 2001). Thus providers should discuss a client's childbearing intentions, sexual relationships, partners, and STI risk-taking behaviors as well as technical information. Given complete and balanced information, clients have proven able to make good choices: they are not swayed by provider biases (Baveja *et al.,* 2000). Once a client selects a method, providers have to instruct clients how to use the method safely and effectively. Thus a complete family planning session should cover:

1. Information on side effects and complications
2. Advantages and disadvantages of the methods from the client's point of view
3. Method effectiveness
4. Proper method use once a method has been selected
5. What to do if the method fails or is not used properly
6. The availability of emergency contraception
7. STI and HIV prevention
8. Information on scheduled return visits, re-supply, and unscheduled visits if there are problems (Murphy and Steele, 2000)

1.5.5 Information, education, and communication (IEC) activities

Information, education, and communication (IEC) activities directed to potential clients are able to change individual attitudes and social norms about family planning, to increase knowledge of contraception, to promote discussion of family planning issues with family and friends, to publicize service sites and providers, to encourage people to adopt contraception, and to create demand for high quality care (Babalola *et al.*, 2001; Gupta *et al.*, 2003; Sharan and Valente, 2002). Programs routinely develop client education materials and provider job aids, such as posters, leaflets, and flip charts, to speed the flow of accurate and complete information to clients. Community mobilization activities, including group talks, peer counseling, and live dramas, also have proven their ability to disseminate information, shape attitudes, and change behaviors (Babalola *et al.*, 2001; Brieger *et al.*, 2001). Family planning programs recently have capitalized on the global telecommunication revolution to develop multimedia campaigns that employ radio and television. Research has found that the impact of multimedia campaigns is greater when they are designed systematically and to commercial standards and when they employ multiple, reinforcing communication channels.

1.5.6 Training and performance improvement

When workers lack knowledge or skills, they need training. A continuing program of in-service training is critical for family planning providers to strengthen existing skills and teach new knowledge and skills (Kortman, 1994). Studies show that carefully designed training programs not only improve the

performance of family planning providers and managers but also have a favorable effect on outcomes, such as client knowledge, compliance with return visits, and contraceptive use (Jain *et al.,* 1999). On-job training pairs trainees with experienced co-workers, who can tailor their advice to the setting. Effective on-the-job training is highly structured and utilizes specially developed materials and specially selected instructors (Sullivan and Smith, 1996). Distance education delivers a standardized curriculum to scattered and isolated health workers via print materials, audio tapes, radio and television broadcasts, computer software, or electronic conferencing (Long and Kiplinger, 1999; Storey *et al.,* 1998). As technology becomes more widely available, interactive computer-based training is becoming a cost-efficient option (Knebel, 2000).

1.5.7 Quality improvement strategies

Over the past decade, international family planning programs have shifted priorities to focus on the quality of the services they offer rather than the number of contraceptives distributed (WHO, 2002). Poor-quality services discourage couples from adopting or continuing to use contraceptive methods (Hanifi and Bhuiya, 2001; Henry-Lee, 2001; RamaRao *et al.,* 2003). Bruce's (1990) landmark paper on the quality of care defined six elements essential to good family planning services: method choice, information giving, providers' technical competence, interpersonal relations between providers and clients, follow-up and continuity mechanisms, and an appropriate constellation of services. In defining quality services, however, clients often have different

priorities than providers (Hardee *et al.*, 2001). For example, they frequently place a higher value on respect, privacy, and waiting time than on technical competencies (Aldana *et al.*, 2001). Programs can make major improvements by using available resources including soap and water, IEC materials, and staff time more effectively. Various family planning organizations have developed structured quality improvement (QI) processes, all of which share a common approach: groups of staff members work together to identify problems and opportunities for improvement, collect data on the root causes of a problem, and design and implement a practical solution to the problem (Buxbaum *et al.*, 1993; Cross *et al.*, 2002).

1.5.8 Integrated services

Integrated services have taken many different forms depending on pre-existing service delivery systems, political will and available resources (Lush *et al.*, 1999). In some areas, family planning services are offered through a department or clinic that is part of a general purpose health facility. Here integration may mean increased coordination between departments, so that providers screen and refer patients for other services available onsite (Vernon and Foreit, 1999). For vertical family planning programs, integration usually means adding services that are directly relevant to existing clientele, for example, addressing STI's or domestic violence. Such programs have been more successful when they have applied existing expertise to new problems for example, advocating STI prevention in counseling sessions than when they have added totally new activities, for example, clinical services to treat STI's

(Shelton, 1999). Family planning associations in Latin America and the Caribbean have succeeded in transforming attitudes, both internal and external, toward their mission and in expanding the range of services offered (Helzner, 2002). In some countries, however, attempts to integrate services have failed because of limited administrative support; inadequate training, equipment, drugs, and space; unresolved conflicts between family planning and STI guidelines; and the inability to overcome existing hierarchies and lines of authority (Lush, 2002; Mayhew, 2000; Mayhew *et al.*, 2000).

1.5.9 Policy making

The policy environment, which includes political support, formal population and health policies, laws, and regulations, shapes access to and the quality of family planning and reproductive health care. Policy makes its influence felt in a host of ways, it determines what services the public health system offers, where, and at what price; it regulates contraceptives and contraceptive advertising; it sets restrictions on providers and determines eligibility requirements for clients; and it allocates funding and other resources (Bertrand *et al.,* 1994; CRLP, 2000). Indeed, national population and family planning policies help explain the variation in the timing and extent of fertility declines in developing countries over the latter half of the twentieth century (Lush *et al.,* 2000). Over the course of the twentieth century, family planning policies evolved in response to shifting rationales, from demographic to public health to human rights, and in response to global challenges (Seltzer, 2002). In recent years, the provision of family planning services has been deeply affected

by two fundamental policy changes: health sector reforms to improve efficiency and cost-effectiveness and with a move toward a reproductive health approach focused on individual needs (Ashford, 2001; Finkle and McIntosh, 2002). Health sector reforms such as decentralization, innovative financing, streamlined operational policies, and increased private-sector participation have the potential to increase the efficiency, equity, and quality of family planning services.

1.5.10 Advocacy

The commitment of national leaders, favorable policies and laws, adequate financing, and popular support are essential to ensuring broad access to good quality family planning and reproductive health services (Upadhyay and Robey, 1999). Advocacy uses persuasive communication to gather that support. Carefully planned activities including, public awareness campaigns, direct lobbying of legislators and policy makers, and working with the press, can spur public discussion and raise the profile of an issue, secure political commitment and legal changes, and even encourage changes in personal behavior and social norms. Because of the controversial nature of family planning, advocacy has always been essential. Its importance has grown in recent years, as proponents of family planning have begun advocating for dramatic shifts in national policies and programs.

1.5.11 Barriers to family planning programs

However, true access requires more than conveniently located services. Potential family planning clients may face a variety of barriers. For example,

the cost of transportation, services, and supplies may be unaffordable; they may not know where to seek services; or they may fear side effects too much to act. In some settings, conditions at the service delivery point discourage clients from seeking services; family planning clients have complained about limited hours, long waits, and rude treatment by clinic staff, and unreliable supplies of contraceptives. Unnecessary medical barriers, such as outdated contraindications or parity requirements, also may prevent clients from receiving the contraceptive method they prefer. Still other obstacles to family planning are rooted in the cultural and social context. Fear of disapproval by family and neighbors discourages some potential clients, and individual providers and entire programs may deny services to unmarried adolescents for cultural reasons. The low status of women often poses a barrier: although more than two thirds of family planning users worldwide are women, in many societies' women lack the power to make independent decisions about using contraceptives or seeking service.

1.6 Fertility awareness and contraceptives

1.6.1 Fertility awareness

Fertility awareness includes the understanding basic information about fertility and reproduction, identifying the signs and symptoms of fertility during the woman‘s fertility cycle, applying this information to oneself, discussing it with a partner, and with health professionals. Fertility awareness is important since it is fundamental to understanding and making informed decisions about family planning choice and reproductive health, fundamental to understanding and using natural family planning, whether to plan or avoid

pregnancy. It also helps women to value their fertility, which can be easily damaged by infections, especially sexually transmitted diseases, many of which can result in fertility problems.

1.6.2 Contraceptives

Family planning methods both natural and artificial use fertility awareness to identify the fertile and infertile phases of a woman‘s menstrual cycle which involves observing the natural signs and symptoms or clinical indicators of fertility. Different birth control methods have different modes of action related to their composition.

Male condoms are thin sheaths made of rubber, vinyl or natural products which are placed on the penis once it is erect. Male condoms may be treated with a spermicide for added protection. Male condoms prevent sperm from gaining access to the female reproductive tract and prevent microorganisms (STDs, including HBV and HIV/AIDS) from passing from one partner to another (latex and vinyl condoms only).

Female condoms are thin sheaths of polyurethane plastic with polyurethane rings at both ends. They are inserted into the vagina before intercourse. Like male condoms, they prevent sperm from gaining access to the female reproductive tract and prevent microorganisms (STDs, including HBV and HIV/AIDS) from passing from one partner to another.

A diaphragm is a dome-shaped latex (rubber) cup which is inserted into the vagina before intercourse and covers the cervix. Diaphragms prevent sperm from gaining access to the upper reproductive tract (uterus and fallopian

tubes) and serve as a holder of spermicide. Spermicides are chemicals (usually nonoxynol-9) that inactivate or kill sperm. They are available as aerosols (foams), creams, vaginal tablets, suppositories, and dissolvable films. Spermicides cause the sperm cell membrane to break, which decreases sperm movement (motility and mobility) and their ability to fertilize the egg.

Breastfeeding is a natural method that depends on the physiologic effect of suckling to suppress ovulation. To be effective, breastfeeding should be exclusive including day and night feed and associated with absence of menses.

In natural family planning, a couple voluntarily avoids sexual intercourse during the fertile phase of the woman's cycle or has intercourse during the fertile phase to achieve pregnancy. There are four types of NFP: calendar rhythm method, basal body temperature, cervical mucus and symptom-thermal. The intrauterine device (IUD) is a small T-shaped flexible device inserted into the uterine cavity. IUDs can be inert, copper-releasing or progestin-releasing. Copper-releasing IUDs interfere with the ability of sperm to pass through the uterine cavity or the implantation of the embryo within the uterine cavity. Progestin-releasing IUDs also thicken the cervical mucus and change the endometrial lining.

Progestin-only Pills (POPs) and combined oral contraceptives (COCs) are pills that contain the hormones estrogen and progestin. They are taken daily at a given time and usually suppress ovulation, thicken the cervical mucus (preventing sperm penetration) change the endometrium (making implantation

less likely), and reduce sperm transport in the upper genital tract (fallopian tubes).

The Norplant system consists of six small flexible capsules made of Silastic® tubing which are filled with a synthetic progestin (levonorgestrel). The capsules are inserted just under the skin on the inner side of a woman's upper arm using a minor surgical procedure. Norplant implants work by thickening cervical mucus, changing the endometrium and reducing sperm transport. They provide highly effective contraception for up to 5 years.

The two combined injectable contraceptives (CICs), Cyclofem® and Mesigyna®, are injections of the hormones estrogen and progestin which are administered once a month. CICs suppress ovulation, thicken the cervical mucus (preventing sperm penetration) change the endometrium (making implantation less likely), and reduce sperm transport in the upper genital tract (fallopian tubes). Depo-Provera® and Noristerat® are the two progestin-only injectables contraceptives (PICs). Both are injections of the hormone progestin. They are administered every 3 or 2 months, respectively. PICs work by thickening cervical mucus, changing the endometrium, reducing sperm transport in the upper genital tract and suppressing ovulation.

1.7 Aims of the study

Only in 1995 UNRWA launched its first family planning program in the field area of West Bank and Gaza, before that date it was a taboo to address such issues in Refugee Camps due to political restrictions (Health Area Officer,

2004). The program was a result of a two base line studies conducted in both Refugee Camps of West Bank and Gaza, separately, in 1993 and 1994, respectively. Results showed clear evidence of unmet need of contraceptives, and the lack of awareness and poor knowledge concerning adopting different modern contraceptive methods.

There were no other studies to the researcher knowledge conducted in the area of family planning in these marginalized communities, rather than UNRWA itself, and having the fact that these refugee camps are over crowded and live in poor social and economic conditions. So the current study aimed at exploring and assessing the current level of knowledge, attitudes and practices among women in the refugee community towards family planning and the use of contraceptive methods. An added value to this study is the fertility awareness component, since this area is seldomly targeted or discussed in the Palestinian society on a wide range, and has been neglected in the planning of offered reproductive health programs.

Chapter II
Methodology

2.1 Study population and data collection

The study population consisted of 500 ever married women falling in the age group (15-49) years. Data were collected using a specially designed questionnaire during the period October-April, 2004. The questionnaire was divided into four main areas covering; demographic information, knowledge on FP, fertility awareness, attitude toward FP and actual practices of the correspondents. One to one interviews with respondents were utilized for collecting data and answering the questionnaire from door to door in the refugee camps of Asker, Balata, and No.1 in Nablus governorate. Three female volunteers from UNRWA Women Centers collected the data. Women were interviewed at homes, the most comfortable and private atmosphere to tackle such a sensitive subject. Collected data were then analyzed using SPSS (Statistical Package for Social Sciences) program.

Table 2.1 Distribution of study population according to place of residence

Location	ulation size	nber of cases
Balata refugee camp	20681 capita	200
Asker refugee camp	13894 capita	200
No. 1 refugee camp	6221 capita	100

Adopted from UN website, www. un.org/ unrwa/ refugees/ westbank 2001

Chapter III
Results

3.1 Demographic data

Data presented in table 3.1 shows that the majority of the studied population 81.2% was in the age groups 21-30 and 31-40. With respect to educational level, 85.6% of the study population was with secondary educational level or less. A clear evidence of low family income was found as the majority 81.8% were with monthly income of less than 300 US dollars.

Table 3.1 Age groups, educational and income levels among study population.

Age	≤ 20 yrs.	29 (5.8%)
	21-30	187 (37.4%)
	31-40	219 (43.8%)
	≥ 40 yrs.	65 (13%)
Education	Illiterate	16 (3.2%)
	Primary	243 (48.6%)
	Secondary	169 (33.8%)
	Diploma	43 (8.6%)
	University	29 (5.8%)
Income / NIS	≤ 1500	409 (81.8%)
	1500- 2000	55 (11%)
	≥ 2000	36 (7.2%)

3.1.1 Family size and carriages

Data presented in table 3.2 shows the number of carriages among study population. The average family size was 5.9 and the average number of children per family was 5.002. Around 83% of the study population was with a total number of carriages between 1 and 7. Miscarriage rates of 50.7%, 30.1%, 10%, 5.7%, and 3.5% were reported for once, twice, three times, four times and more than 5 times, respectively.

Table 3.2 Carriage and miscarriage frequency among study population

Total No. of Carriages	**No. (%)**	**Total outcome**	**Miscarriages frequency**	**No. (%)**	**Total**
1	62 (12.4)	62	1	116 (50.7)	116
2	44 (8.8)	88	2	69 (30.1)	138
3	72 (14.4)	216	3	23 (10)	69
4	54 (10.8)	216	4	13 (5.7)	52
5	58 (11.6)	290	5	0	0
6	70 (14)	420	6	2 (.9)	12
7	52 (10.4)	364	7	6 (2.6)	42
8	29 (5.8)	232			
9	24 (4.8)	216			
10	14 (2.8)	140			
11	8 (1.6)	88			
12	3 (0.6)	36			
13	7 (1.4)	91			
14	3 (0.6)	42			
Total		2501			429

Total births = Carriages – Miscarriages / 2501 - 429 = 2072

Total live births = total population – parents / 2974 - 1000 = 1974

Deaths = total births – total live births / 2072 - 1974 = 125

3.2 Family planning knowledge

Data presented in table 3.3 showed that 77.4% of the study population knew the concept of family planning, while 14.6% believe that it means limiting number of born children and 8% do not know the concept at all.

With respect to knowledge on benefits of family planning the following percentages of 77.8%, 77.4%, 64.2%, 26.6%, 1.8% and 3% were reported by the correspondents for health, economic, social, educational, political and other factors, respectively.

Knowledge on used family planning methods were reported in the following percentages of 96.4%, 96.4%, 69.8%, 51%, 39.8%, 35.4%, 34.4%, 32.2%, 3.6%, 15.4% for IUD, pills, condoms, injectabels, rhythm, breast feeding, suppository, abstinence, basal body temperature, and withdrawal,

respectively. Reported disadvantages on family planning showed that 53.6% of the study correspondents believe that used family planning methods have negative health side effect.

Table 3.3 Family planning knowledge concerning concepts, benefits, methods and disadvantages.

Family Planning	**Knowledge**	**(No. %)**
Concept	Spacing	387 (77.4%)
	Limiting	73 (14.6%)
	Don't know	40 (8%)
Benefits	Economic	387 (77.4%)
	Social	321 (64.2%)
	Political	9 (1.8%)
	Health	389 (77.8%)
	Educational	133 (26.6%)
	others	15 (3%)
Method	IUD	482 (96.4%)
	Pills	482 (96.4%)
	Injections	255 (51%)
	Suppository	172 (34.4%)
	Rhythm	199 (39.8%)
	Condoms	349 (69.8%)
	Breast Feeding	177 (35.4%)
	Abstinence	161 (32.2%)
	Basal Body Temp.	18 (3.6%)
	Withdrawal	77 (15.4%)
Disadvantages	Economic	21 (4.2%)
	Social	41 (8.2%)
	Political	33 (6.6%)
	Health	268 (53.6%)
	Educational	2 (.4%)
	others	137 (27%)

3.3 Fertility awareness

Data presented in table 3.4 includes a set of questions used to measure knowledge towards fertility awareness among study population. The first set of questions (1-7) related to knowledge on menstrual cycle. It was found that 45.8% believe that women are fertile for more than 21 days of the menstrual cycle, 52.4% believe that women can get pregnant any time of intercourse, 7.6%

believe that women can't get pregnant during period, 75.6% knew that fertilization is associated with the release of the ova around day 14, 78.8% recognize ovulation symptoms of abdominal pain, 90.8% realize that stress may affect the menstrual cycle, only 30.4% recognize the first day of bleeding as the first day of the cycle.

The second set of questions (8-12) was related to knowledge awareness regarding natural family planning. It was found that 72.8% consider withdrawal (being careful) as a natural family planning method. Only 12.6% knew that basal body temperature is a natural family planning method. Breast feeding was considered as an effective family planning method by 59.6%, 64.6% of the study population believes that natural family planning is suitable only for women with regular periods and 49% believe that women can conceive immediately after contraceptive cessation.

The third set of questions (13-17) related to knowledge on gamete release and survival time. It was found that 41.4% of the study population thinks that sperms can live in fallopian tube waiting to fertilize the egg, 21.6% believe that sperms can survive for up to five days in optimum conditions, 30.6% believe that ovum can survive for three day if not fertilized, 39.8% believe that women can ovulate twice in the cycle and 42.8% knew that pre-ejaculatory fluid may contain live sperms.

It is important to note that statistically significant differences were observed according to place of residence and better understanding was found among women living in Balata and No.1 camps compared to those from Askar camp (χ^2 = 0.657, df= 2, ***P*** = 0.001). Such variations is mainly due to the fact that half of Askar camp women (new site) have no access to any family planning public programs provided by UNRWA within the same area. It was also found that knowledge on contraceptive methods were significantly varied (χ^2 = 63.368 df= 1, ***P*** = 0.001). Variation on knowledge of methods could be

due to the fact that women were only exposed to what was available in UNWRA clinics.

Table 3.4 Knowledge towards fertility awareness among study population*

Question	Yes (No. %)	No (No. %)
1. A woman is fertile for more than 21 days of her menstrual cycle	229 (45.8%)	271 (54.2%)
2. Any time a woman has intercourse there is a chance of pregnancy	262 (52.4%)	238 (47.6%)
3. A woman cannot get pregnant during a period	38 (7.6%)	462 (92.4%)
4. A couple planning pregnancy should aim to have intercourse on day 14	378 (75.6%)	122 (24.4%)
5. Some women can recognize ovulation by a sharp pain in the abdomen	394 (78.8%)	106 (21.2%)
6. Anxiety or stress can delay a woman's period	454 (90.8%)	46 (9.2%)
7. First day of cycle is day of bleeding	152 (30.4%)	348 (69.6%)
8. Withdrawal or 'being careful' is a natural method of family planning	364 (72.8%)	136 (27.2%)
9. Temperature method is a very reliable way of avoiding pregnancy	63 (12.6%)	437 (87.4%)
10. Breast-feeding is an effective contraceptive	298 (59.6%)	202 (40.4%)
11. Natural Family Planning is only suitable for women with regular periods	323 (64.6%)	177 (35.4%)
12. Most women conceive immediately after stopping contraception	245 (49%)	255 (51%)
13. Sperm can live in the fallopian tube awaiting the release of an egg	207 (41.4%)	290 (58.6%)
14. Sperm can survive for up to five days in optimum conditions	108 (21.6%)	392 (78.4%)
15. A woman's ovum (or egg) lives for three days if not fertilized.	153 (30.6%)	347 (69.4%)
16. A woman can ovulate twice in a cycle	199 (39.8%)	301 (60.2%)
17. Pre-ejaculatory fluid may contain sperms	214 (42.8%)	286 (57.2%)

Questionnaire adopted from Knight, J. and Pyper, C. (2003). Fertility UK - National fertility awareness & family planning service for the UK. http://www.fertilityuk.org/

3.4 Family planning practices

Data presented in table 3.5 shows the reasons for use of contraceptives, used methods, obstacles for contraceptives use and side effects of such methods. With respect to the reasons for use of contraceptives, 32.6% of the women reported that health reasons were behind their practice, while 26%, 19%, 14%, 6.4% and 1.4% reported the use of contraceptives due to economical, political , social and cultural and religion reasons, respectively.

The most commonly used methods of contraception were IUD (25.2%), condoms (21.4%), breast feeding (19.4%), pills (18.4%) and rhythm (10%). Other methods were represented in small percentages.

The reasons behind the lack of contraceptives use were cultural (21.6%), religion (13.6%), economic (9.1%), political (8%) and health reasons (7.8%).

The reported side effects of different used contraceptives were stress (30.6%), vaginal irritation (29.6%), bleeding (25.9%), obesity (16.6%) and other side effects (25.4%).

Table 3.5 Practices concerning family planning.

Family Planning / birth control		**(No. %)**
Reason for use of contraceptives	Religion	07 (1.4)
	Economic	130 (26)
	Social	70 (14)
	Political	95 (19)
	Cultural	32 (6.4)
	Health	163 (32.6)
	others	03 (0.6)
Used contraceptive method	IUD	126 (25.2)
	Pills	92 (18.4)
	Injections	18 (3.6)
	Suppository	16 (3.2)
	Rhythm	50 (10)
	Condoms	107 (21.4)
	Breast Feeding	97 (19.4)
	Abstinence	23 (4.6)
	Basal Body Temp.	000
	Withdrawal	39 (7.8)
Obstacles against con. use	Religion	12 (13.6)
	Economic	8 (9.1)
	Social	3 (3.4)
	Political	7 (8)
	Cultural	19 (21.6)
	Health	39 (7.8)
Contraceptive side effects	Obesity	68 (16.6)
	Stress	125 (30.6)
	Bleeding	106 (25.9)
	Inflammations	121 (29.6)
	Others	127 (25.4)
	No side effects	123 (24.6)

3.5 Family planning attitudes

Several questions were asked aiming at evaluating the attitude of the study population towards family planning. The findings presented in table 3.6 showed that only 3.4% against family planning. Data also showed that 85.6% believe that their husbands approve family planning and only 9.8% believe that their husbands against family planning. When asked about whose decision for family planning, 97% of the respondents believed that such decision is a joined one. With respect to spouse use of contraceptives, 63% of the women believed that men should be involved in the process. Data presented in this table showed that 80.8% agree that religion encourage family planning, while 63.6% believe that traditions discourage family planning.

Table 3.6 Attitudes toward family planning

Statement	Agree No. %	Disagree No. %	No opinion No. %
I encourage family planning	475 (95)	17(3.4)	8 (1.6)
My spouse encourage family planning	428 (85.6)	49(9.8)	23 (4.6)
Family planning is a joint partner decision	485 (97)	11(2.2)	4 (0.8)
Your spouse should use a family planning method also	315 (63)	147(29.4)	38 (7.6)
Religion encourages family planning	404 (80.8)	75(15)	21 (4.2)
Traditions encourage family planning	128 (25.6)	318(63.6)	54 (10.8)

Chapter IV
Discussion and conclusion

4.1 Age, educational level, income, family size and knowledge on family planning

Age, educational level and income are among the various socioeconomic determinants of fertility. The finding of 37.5% of the study population within age groups 21-30, indicates that women in this age group are still in their best years of reproductive age. Age group 31-40 was represented by 43.8% and is also still capable of child bearing. Clear evidence in support of this assumption can be deduced from the findings of low educational level (3.2% illiteracy, 48.6% elementary and 33.8% secondary) and low income (81.8% with family income around 300$) as shown in table 3.1. Studies from India seems to strongly indicate that education tends to increase the age at first marriage, thereby decreasing the number of years that can be devoted to child bearing (Jeffery and Basu 1996). This relationship between women's education and age at marriage has been found in almost all fertility studies. Another study shows that in almost every country in South Asia, women with education get married "roughly two to five years later than uneducated women" (Cleland and Jejeebhoy 1996). A study of 26 developing countries sponsored by the United Nations finds that age at marriage invariably increases with the level of education in all of the countries examined, despite the fact that "the age at marriage varies widely across countries" (United Nations 1995). Besides delaying marriage, female education has been observed to be associated with greater numbers of women not marrying at all. Women with higher education levels are more likely to be able to organize their lives outside the realm of marriage and family. For example, in Thailand, only about 1.9 per cent of women without education do not marry, whereas 14.6 per cent of highly educated women do not marry (United Nations 1995). Among married Egyptian women ages 25 to 29, with no education, married at age 18, and had their first child by age 20; those with a secondary or higher education married at an average of 23 and had their first child at age 25 (El –Zanaty *et .al*, 2000).

Turkey's 1998 Demographic and Health Surveys (DHS) showed that 22% of girls aged 15 to 19 years who had no education or not completed primary school were already mothers or pregnant, compared with only 2% of girls who completed secondary or higher education (Turkey, DHS, 1998).

Thus, the findings on education, income and age at marriage (mean value of 18.7 years) in the current study all tend to indicate that we are far away from recognizing family planning concepts and aims. It also emphasizes the need to focus on education in general and educational programs related to family planning programs in particular if we have to achieve the expected outcome of most offered family programs. The most possible explanation for young marriage age among the studied populations is the fact that female students tend drop out of school after the ninth grade. This is due to the fact that UNRWA educational system supports Refugee Camps with free schooling to this stage and after that student have to join other governmental schools in near by areas and this adds a further financial burden on families.

Findings on the rates of carriages, miscarriages and family size are presented in Table 3.2. Estimated average number of children per family was 5.9 and up to 50% of the studied families have between 4-7 children. Our data with respect to family size is inconsistent with that reported for Palestinian population (7.06) in a study conducted in 1997 by University of Bier Ziet (Human Development File, 1997), however, it is slightly higher than that of 5.5 reported by among Refugee Camp inhabitance (Kaileh, 1993). The findings of high rates of carriages might partially explain the high incidence of miscarriages (5.83%) as increased number of carriages is considered to be a risk factor.

Knowledge regarding concept of family planning reflects the effectiveness of the educational sessions offered by health care provider's in the area in general and among study population in particular. Despite the above mentioned low rates of general education, correspondents still seems to benefit

from educational counseling sessions, related to family planning, as 77.4% were able to define family planning (Table 3.3), however, when it comes to practice only 6.4% related use of contraceptives was due to such knowledge (Table 3.5).

With regard to knowledge on the benefits of family planning, 77.8%, 77.4% and 64.2% of the correspondents recognized the health, economical and social values of family planning, respectively (Table 3.3). Again the practice of family planning does not reflect this knowledge. Findings presented in table 3.5 shows a clear gap between practice and reported knowledge. This is evident from reported reasons for adoption of family planning as 32.6%, 26% and 14% of the correspondents reported the use for health, economic and social reasons, respectively (Table 3.5).

Almost all of the correspondents reported that they knew of IUDs and OCs (96.4%). Knowledge on other modern methods including condoms, injections and suppositories were represented by 69.8%, 51% and 34.4%, respectively. A noticeable increase in the rate of knowledge was observed compared to previously reported data in this respect (Kaileh, 1993). This increase is most likely a result of advances in this field as well as a reflection to various family planning programs launched by UNRWA and other nongovernmental organizations over the past decade.

It is important to note that 35.4% recognizes breast feeding as a family planning method and 15.4% recognized withdrawal. Reviewing the international standards, withdrawal in not even a recognized method and exclusive breast feeding is a temporary one. The fact that 19.4% use breast feeding and 7.8% use withdrawal methods indicates that these women are at high risk of conception without being aware of it. Such findings emphasize the important role of informed choice about childbearing and contraceptive use in family planning programs (Gertner, 1989). Informed choices are most likely to meet a person's needs when they reflect individual desires and values, are based

on accurate, relevant information, and are medically appropriate (AVSC International, 1998).

Regarding disadvantages of the various method of family planning, 53.6% were aware of different health side effects (Table 3.3); however, when asked about obstacles towards use of family planning, only 7.8% reported health disadvantages as an obstacle (Table 3.5).

4.2 Fertility awareness

Fertility and reproductive health are largely neglected areas in health education. This ignorance and the lack of easily available accurate information about the increasingly popular natural methods of family planning, means that women are frequently denied the full range of family planning choices. The results of a survey carried out in 1993 in six Western European countries found that the majority of women lacked knowledge concerning basic facts about menstruation, fertility and pregnancy.

Data presented in table 3.4 included set of questions related to fertility and reproductive health. The finding of 45.5% of the correspondents believe that women are fertile for a period of 21 days of the menstrual cycle, strongly indicates wide misunderstanding regarding the process of ovulation and timing of conception (Q1; Table 3.4). The finding of 52.4% who believe that women can get pregnant any time of intercourse also support the above conclusion of misunderstanding regarding the process of ovulation and timing of conception as it is only possible to conceive from intercourse during the fertile time, which is determined by ovulation and sperm survival in fertile mucus (Q2; Table 3.4). Only one third of the questioned women recognize the first day of bleeding is the first day of the cycle. Such finding again emphasizes lack of fertility knowledge and awareness (Q7; Table 3.4).

Natural family planning methods is commonly believed to be only 80% effective against pregnancy (Wise report, 1993). The findings of the current

study showed that 72.8% of the study population recognizes withdrawal as safe natural method, thus reflecting a poor knowledge as the WHO does not define it as a natural method.

Although several family programs were launched in recent years targeting Refugee Camps, the findings on fertility awareness indicates a limited success for such programs and this might be due to the fact that UNRWA, main health providers for this sector, concentrated on the promotion side of contraceptive use and side effect rather than approaching reproductive health in general. Another possible explanation for such observation is the lack of organized sessions, supervision, and media and follow up implemented by most of these programs.

4.3 Family planning; practices and attitudes

The way that specific method attributes accord with individual values and health beliefs affects choices (Heise, 1997; Rosenstock, 1974). Some people choose condoms or fertility awareness-based methods because they believe that using hormonal methods will disrupt natural body rhythms that they want to maintain, while these methods will not (Goodkind & Phan, 1997). The finding of the current study clearly reflects that contraceptive choice is based on beliefs rather than informed choice. This is evident from the reported percentages of used contraceptive methods (IUDs, 25.2%; condoms, 21.4%; breast feeding 19.4%; OCs, 18.4% and rhythm, 10%). Looking at theses figures one can clearly deduce that such choices were based on superficial knowledge (59.6% believe that breast feeding is effective contraceptive; table 3.4), not informed choices, for example the second and third frequent used methods were condoms and breast feeding. Most people value such methods attributes as effectiveness, safety and absence of side effects; although, breast feeding is known to be temporary and conditional. Thus the finding of around 20% of the studied population relies on breast feeding rendering them at high risk of conceiving

(Table 3.5). When compared with other methods neither condoms nor breast feeding were as safe or effective as pills and injections. The use of withdrawal method by 7.8% is another example of choices based on beliefs and superficial knowledge. Once again these findings emphasize the need of well designed programs based on needs and knowledge of women in the area as well as evaluation of the currently implemented programs in the field.

With respect to individual values and personal characteristics, people differ widely in their reproductive intentions, awareness of reproductive rights, perceived risk of becoming pregnant, attitudes about contraception, ability to make decisions, and other factors that affect family planning decisions (Dixon-Mueller, 1999; Gandotra & Das, 1996; Heise, 1997). People also differ in their cultural and religious beliefs, and some do not use family planning at all or avoid certain methods because of their values or beliefs (Delbanco *et al.*, 1996). Despite reported high attitude towards family planning (female, 95%; spouses, 85.6%), 12.4% of the studied population do not use family planning at all (Table 3.6). The most obvious reported reasons (Table 3.5) for this were cultural (21.6%), religion (13.6%) and economic reasons (9.1%). Such findings are consistent with most reports in this regard were cultural and religious beliefs seems to affect family planning decision (Delbanco *et al.*, 1996; Dixon-Mueller, 1999). However, high positive attitude rates (religion 80%; tradition 25.6%) found in the current study contradict the actual practice of correspondents (Table 3.6).

A person's marital status, the stability of the marriage, communication with the person's partner, and status within the family influence family planning decisions (Kazi and Sathar, 1986). Some women say that contraceptive use is not an individual decision but one made by the couple or the family (Dixon-Mueller, 1993). In the current study, 97% of surveyed women reported that family planning should be a joint partners decision, thus reflecting a high positive attitude towards this issue. This rate is higher than reported in the

Philippines were 88% of women surveyed in 1994–1995 said that family planning is often a family decision (Adair *et al.*, 2001). In many other countries women, however, think that contraceptive use is an individual decision and that they do not involve partners and family members and some of them even visit family planning clinics and use contraceptives without their husbands' knowledge (Barnett, 1999; Konate *et al.*, 1999; Delbanco *et al.*, 1996).

4.4 Recommendations and concluding remarks

1. Education in general and reproductive health education in particular are areas of weakness that requires more attention in order to promote better knowledge and practices regarding family planning. This can be achieved through family planning programs and or integrated through the educational curriculum.

2. The findings of the current study seems to indicate that most offered family programs lack of organized counseling sessions, supervision, follow up and evaluation. Thus, it is essential, to adopt family planning programs that suits the needs and are based on previous knowledge of the concerned sector.

3. Family planning programs should also target males and not be restricted to women as both are involved and responsible in decision making.

4. Fertility awareness is below acceptable levels, thus there seems to be an urgent need to tackle this issue.

5. Findings on family planning practices does not seem to reflect the observed high positive attitude of the studied population, thus there is a need to promote healthy behavior through the improvement of users skills and knowledge.

6. It is essential to launch a culture and gender sensitive media (IEC) campaigns on reproductive health targeting different population groups including women, youth and health professionals.

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Appendices

هذه الاستبانة صممت لاغراض البحث العلمي والدراسة فقط، وستعتبر المعلومات الواردة بها سرية وغير قابلة للنشر الا باذن خطي وخاص من صاحب الرسالة.

تحوي الاستبانة اربعة محاور، بيانات شخصية للمبحوث، المعرفة، المواقف، والسلوك تجاة استخدام وسائل تنظيم النسل، نرجو الاجابة على ما ورد مع الشكر والتقدير لتعاونكم في اتمام البحث..

بيانات شخصية:

1. رقم الاستبانة:_____
2. الموقع:_____
3. العمر: _____
4. مستوى تعليم المراة (المبحوث) :

امي مرحلة اساسية مرحلة ثانوية دبلوم جامعي

5. العمل: تعمل لا تعمل
6. نوع العمل_____
7. مستوى تعليم الزوج:

امي مرحلة اساسية مرحلة ثانوية دبلوم جامعي

8. عمل الزوج:_____
9. الدخل الشهري بالشيكل :_____
10. تاريخ الزواج/ سن الزواج: _____
11. عدد افراد الاسرة:_____
12. هل يوجد بين افراد عائلتكم من يعاني اعاقة خلقية؟ نعم لا
13. اذا كان نعم ، هل كان ذلك لاسباب: وراثية مرضية سلوكية
14. عدد حالات الاجهاض: _____
15. عدد مرات الحمل: _____
16. عدد المواليد:

الرقم	افراد الاسرة (الذكور ، والاناث)	تاريخ الولادة
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		

المعرفة:

17. ماذا يعني لك تنظيم النسل ؟

الرقم	التعريف	نعم	لا
1.	تباعد الاحمال		
2.	تحديد النسل		
3.	اخرى حدد:		

18. ما هي وسائل تنظيم النسل التي تعريفينها؟

الرقم	الوسيلة	نعم	لا
1	اللولب		
2	حبوب		
3	ابر		
4	تحاميل		
5	العد		
6	الواقي الذكري		
7	الرضاعة الطبيعية		
8	العزل		
9	نظام قياس الحرارة		
10.	اخرى حدد		

19. ما هي الفوائد المرجوة من استخدام وسائل تنظيم االنسل ؟

الرقم	الفائدة	ن	لا
1	اقتصادية		
2	اجتماعية		
3	سياسية		
4	صحية		
5	تعليمية		
6	اخرى حدد		

20. ما هي الاثار الجانبية من استخدام وسائل تنظيم النسل؟

الرقم	الاثار	نعم	لا
1	اقتصادية		
2	اجتماعية		
3	سياسية		
4	صحية		
5	تعليمية		
6	اخرى حدد		

21. اجيبي بنعم او لا او قابل للنقاش على كل من الاسئلة التالية.

الرقم	السؤال	نعم	لا	قابل للنقاش
.1	المراة قابلة للاخصاب 21 يوم من بعد الدورة الشهرية			
.2	يعتبر الحمل الطبيعي ملائما فقط، في حالة انتظام الدورة الشهرية			
.3	يعتبر القذف الخارجي من وسائل تنظيم الاسرة			
.4	يمكن للحيوان المنوي ان يعيش خمسة ايام في الظروف المثالية			
.5	يمكن للبويضة غير الملقحة ان تعيش ثلاثة ايام بعد طرحها و في حالة عدم تلقيحها			
.6	هنالك فرصة لحدوث الحمل عند أي جماع			
.7	يمكن حصول الحمل اثناء الدورة الشهرية			
.8	عند التخطيط للحمل ، على الزوجين القيام بالجماع يوم 14 من الدورة الشهرية			
.9	يمكن للمراة الاباضة مرتين خلال الدورة الشهرية الواحدة			
.10	استخدام نظام قياس الحرارة هي وسيلة ناجعة لمنع الحمل			
.11	من الطبيعي وجود افرازات مهبلية لزجة وشفافة بين الدورات			
.12	تشعر بعض النساء بالام حادة في اسفل البطن وهي اشارة للاباضة			
.13	يمكن للحيوان المنوي ان يعيش في قناة فالوب بانتظار طرح البويضة			
.14	يمكن للقلق والتوتر ان يؤخرا موعد الدورة الشهرية لدى المراة			
.15	وسائل تنظيم الحمل الطبيعية لها فعالية 80% فقط في منع الحمل			
.16	اليوم الاول من الدورة الشهرية هو اول يوم يحدث فية النزف			
.17	غالبية النساء تحمل مباشرة بعد التوقف عن استخدام وسائل تنظيم الحمل			
.18	الجماع قبل الاباضة مباشرة يزيد من احتمالية انجاب طفل ذكر			
.19	تعتبر الرضاعة الطبيعية من موانع الحمل الفعالة			
.20	السائل اللزج والذي يفرز من الذكر قبل القذف يمكن ان يحوي على حيوانات منوية			

22. ما هو مصدر معلوماتك عن موضوع تنظيم النسل؟

الرقم	المصدر	نعم	لا
.1	صديقة		
.2	مثقفة صحية		
.3	طبيب		
.4	وسائل اعلام		
.5	عائلة زوجك		
.6	عائلتك		
.7	اخرى ، حدد		

المواقف من وجهة نظرك الشخصية:

الرقم	الموقف	نعم	لا	محايد
.23	هل انت مع تنظيم النسل؟			
.24	هل زوجك مع تنظيم النسل؟			
.25	هل تعتقدي ان قرار تنظيم النسل يجب ان يكون مشترك بين المراة وزوجها؟			
.26	هل تعتقدي ضرورة استخدام زوجك ايضا وسيلة لتنظيم النسل؟			
.27	هل تعتقدي ان الدين يشجع تنظيم النسل؟			
.28	هل تعتقدي ان العادات والتقاليد تشجع تنظيم النسل؟			
.29	هل تعتبري حجم اسرتك كبير؟			

30. عدد الاطفال المثالي ؟ _____

السلوك:

31 .هل أستخدمت وسائل تنظيم النسل؟

نعم، (انتقل للسؤال التالي) لا، انتقل الى السؤال رقم(35)

32. أي نوع استخدمت ؟

الرقم	الوسيلة	نعم	لا	الفترة الزمنية للاستخدام
.1	اللولب			
.2	حبوب			
.3	ابر			
.4	تحاميل			
.5	العد			
.6	الواقي الذكري			
.7	الرضاعة الطبيعية			
.8	العزل			
.9	اخرى حدد :			

33.اي من الاسباب التالية كان سببا لاستخدامك وسيلة لتنظيم النسل:

الرقم	الاسباب	نعم	لا
.1	دينية		
.2	اقتصادية		
.3	اجتماعية		
.4	سياسية		
.5	ثقافية		
.6	صحية		
.7	اخرى حدد		

34.هل حصل لديك أي مضاعفات خلال استخدام وسائل تنظيم النسل؟

الرقم	المضاعفات	نعم	لا
1.	سمنة زائدة		
2.	عصبية		
3.	نزيف		
4.	التهابات مهبلية		
5.	فطريات		
6.	جلطات قلبية		
7.	الذبحة الصدرية		
8.	اخرى حدد :		

35.اي من الاسباب التالية كان سببا لعدم استخدامك وسيلة لتنظيم النسل:

الرقم	الاسباب	نعم	لا
8.	دينية		
9.	اقتصادية		
10.	اجتماعية		
11.	سياسية		
12.	ثقافية		
13.	صحية		
14.	اخرى حدد		

36. انت حامل الان؟
نعم، (انتقل الى السؤال الاخير) لا، (انتقل للسؤال التالي)

37. تستخدمين وسيلة لتنظيم الاسرة الان؟
نعم، (انتقل للسؤال التالي) لا، (انتقل للسؤال 39)

38. شارك زوجك في اختيار هذة الوسيلة ؟
نعم لا

39. تخططين للحمل في المستقبل؟
نعم لا، لماذا؟

---

40. ستستخدمين وسيلة لتنظيم النسل بعد ولادتك؟
نعم لا

جامعة النجاح الوطنية
كلية الدراسات العليا

المعرفة والاتجاهات والممارسات حول تنظيم الأسرة لدى النساء في مخيمات مدينة نابلس

إعداد

كنار وائل أمين القاضي

إشراف

الدكتور نائل أبو الحسن

قدمت هذه الاطروحة استكمالا لمتطلبات درجة الماجستير في الصحة العامه بكلية الدراسات العليا في جامعة النجاح الوطنية في نابلس، فلسطين

2004

المعرفة والاتجاهات والممارسات حول تنظيم الأسرة
لدى النساء في مخيمات مدينة نابلس

إعداد
كنار وائل أمين القاضي
إشراف
الدكتور نائل أبو الحسن

الملخص

هدفت الدراسة الحالية إلى تقييم وتقصي مدى مستوى المعرفة والاتجاهات والممارسـات لـدى النساء من سكان المخيمات في محافظة نابلس تجاه تنظيم الأسرة و مفاهيم الخصوبة. ولتحقيق ذلك تم إعداد إستبانه صممت خصيصا لهذا الغرض. أجريت الدراسة في الفترة ما بين تشرين أول – نيسـان 2004 وشملت 500 امرأة تم اختيارها بطريقة عشوائية منتظمة. تم جمع المعلومـات مـن خـلال المقابلة الشخصية ومن ثم تم تحليلها إحصائيا باستخدام البرنامج الإحصائي SPSS. كـان متوسـط الأعمار لدى عينة الدراسة 31 عاما، في حين كان متوسط العمر عند الزواج 18.7عاماً.

تشير نتائج الدراسة أن حوالي 50% من العينة كن في مستوى تعليمي أساسي، في حين كانـت نسبة المتعلمات في المرحلة الثانوية 33.8% وتبين كذلك أن ما نسبته 81.8% من عينة الدراسة كـن من العائلات ذوي الدخل المحدود وأن متوسط دخل الأسرة الشـهري حـوالي 300 دولار. بلغـت حالات الحمل الكلية لدى العينة 2501 وكان متوسط الحجم للعائلة 5.9.

أما فيما يتعلق بمدى المعرفة، تبين أن ما نسبته 74.4% من عينة الدراسةّ يدركن مفهوم تنظيم الأسرة، و ما نسبته 77.8% منهن اقر بوجود فوائد صحية لتنظيم الأسرة. أما بخصـوص المعرفـة بوسائل تنظيم الأسرة فكانت الوسائل الميكانيكية (اللولب) وحبوب منع الحمل من أكثرها معرفة وتمثل كل منها بنسبة 96.4%، تلا ذلك المعرفة بالواقي الذكري والحقن حيث كانت نسـبة المعرفـة لهـذه الوسائل 69.8% و51% على التوالي، أما وسائل تنظيم الأسرة الطبيعية فقد تم التعرف على كل مـن الرضاعة الطبيعية بنسبة 35.4% والقذف الخارجي بنسـبة 15.4%، وأجمـع مـا نسـبته 53.6% بسلبيات لتنظيم الأسرة اقتصرت على الآثار الجانبية لموانع الحمل.

تشير نتائج الدراسة إلى تدني ملحوظ في مستوى الوعي اتجاه مفـاهيم الخصـوبة والمتعلقـة بالدورة الشهرية، ومفاهيم تنظيم الأسرة الطبيعية ونشاط الجاميتات حيث أظهرت النتائج أن النساء كن بعيدات كل البعد عن فهم أساسيات الخصوبة حيث اعتقد ما نسبته 45.5% منهن أن المـر أه قابلـة

للإخصاب لمدة 21 يوم من الدورة، في حين لوحظ أن ما نسبته 52.4% يعتقدن بوجود إمكانية للحمل في أي وقت يحدث فيه جماع، واستطاع الثلث فقط تحديد ومعرفة اليوم الأول في حساب الدورة الشهرية. ولقد تبين أن ما نسبته 72.8% من النساء يعتقدن بأن القذف الخارجي هو وسيلة آمنة من وسائل تنظيم الأسرة.

فيما يتعلق بوسائل تنظيم الأسرة المستخدمة فقد تبين أن ما نسبته 25.2% يستخدمن الوسائل الميكانيكية (اللواب) في حين يعتمد ما نسبته 21.4% على الواقي الذكري وتستخدم ما نسبته 18.4% الحبوب، واعتمدت ما نسبته 19.4% و10% الرضاعة الطبيعية والعد كوسائل طبيعية على التوالي.

كانت الاتجاهات المرتبطة بتنظيم الأسرة على درجة عالية من القبول ويستنبط ذلك من ارتفاع نسبة المؤيدات لتنظيم الحمل والتي بلغت 95% فيما يعتقد ما نسبته 85.6%، من النساء أن أزواجهن من المؤيدين لذلك، ومن جهة أخرى تعتقد ما نسبته 97%، من النساء بأن قرار تنظيم الأسرة هو قراراً مشتركاً للزوجين وأن ما نسبته 80% يعتقدن أن الدين لا يتعارض وتنظيم الأسرة.

بناء على ما تقدم، فإننا نؤمن أن الاتجاهات الايجابية والملاحظة لا تنعكس على واقع الحال في الممارسات وأنها لا تكفي لإعطاء محصلة نهائية وفاعلة للبرامج التي تعني بالموضوع في المنطقة.