UNIVERSITY OF BIELEFELD
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REPRODUCTIVE HEALTH HUMAN RIGHTS
Women's Knowledge, Attitude, and Practices toward Their Reproductive Health Rights in Palestine

Dissertation submitted for the fulfillment of the award of the degree doctor of Public Health (Dr.PH.) at the School of Public Health, University of Bielefeld, Germany

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Dedication

I wish to dedicate this dissertation to:

my parents,

my source of inspiration. Who taught me how to be independent, creative and never give up, and who raised me up to think of others the same way I think of myself.

my husband Taher,

my best friend, love and partner in life, who kept body and soul together during the creation of this work and who supported me on the front line wholeheartedly.

and

my little sweet angel Toleen,

who inspired me always with her smile that is full of hope to keep working on women's rights and women's health.

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ACRONYMS

CCP	Center for Communication Programs
CESCR	The United Nations Committee on Economic, Social and Cultural Rights
CI	Confidence Interval
DHS	Demographic and Health Survey
ICPD	International Conference of Population and Development in Cairo
IAC	The Inter-African Committee
IIMT	Institute for International Medical Terms
IPPF	International Planning Parenthood Federation
IPV	Intimate Partner Violence
Juzoor	Foundation for Health and Social Development Origination
LAM	Lactational amenorrhea
MCH clinics	Mother and Child Health Care clinics
MOH	Ministry of Health
OR	Odds Ratio
PalMOH	Palestinian Ministry of Health
PHC	Primary Health Care
PCBS	Palestinian Central Bureau of Statistics
UNICEF	United Nations Children Fund
UNFPA	United Nation Population Fund
UNHCHR	United Nation High Commissioner for Human Rights
UNRWA	United Nations Relief and Works Agency for Palestine Refugees in The Near East
RHC	Reproductive Health Care
RH	Reproductive Health
RHR	Reproductive Health Rights
SBA	Skilled Birth Attendants
SCT	Social Cognitive Theory
SPPS	Statistical Package for Social Science
TBA	Traditional Birth Attendant
TPB	Theory of Planned Behavior
WCLAC	Women's Center for Legal Aid and Counseling
WHO	World Health Organization

ABSTRACT

Reproductive health rights ensure that people are able to have satisfying and safe sex life and that they have the capacity to reproduce with freedom to decide, when and how often to do so. Reproductive health rights also include the access of women to high quality health care services that help in protecting women during pregnancy and childbearing and providing the couples with the best chances of having healthy. In addition, reproductive health rights might be an important indicator for women's health.

Studied that were conducted In Palestine before had not focused on assessing women's perception on their reproductive health rights while receiving the health care. Therefore, the main purpose of this study was to assess knowledge, perception, attitude, and practices of reproductive health rights among the Palestinian women of reproductive age (15-49). Specifically, the objective was to assess women's perception of their reproductive health rights while receiving their reproductive health care (in particular: reproductive health rights concepts and meaning, family planning, antenatal care, delivery care and postnatal care). In addition, the present study aimed to assess women's perception towards wife beating and the best marriage age for women.

In order to achieve this purpose, a cross sectional study was conducted in 2006 at three clinics that provide Mother and Child Health Care in the West Bank. The clinics were located in the three largest cities in the West Bank: Jenin in the north, Ramallah in the center, and Hebron in the south. A total of 450 women (150 women in each site) in reproductive age (15-49) were interviewed using a structured questionnaire. The questionnaire assessed several issues related to reproductive health such as: understanding of reproductive rights, knowledge and use of family planning methods, antenatal care, delivery care, postnatal care, attitudes towards domestic violence and age at first marriage. Response rate of the study was 99.4%.

Generally, the results of this study revealed that women had positive understanding of their reproductive health rights. Women mentioned the right to have good access to health care during and after the course of pregnancy as their first important right. The majority of women were able to identify the modern contraceptives and most women mentioned that they made the fertility decision together with their husbands. Women started antenatal care at a relatively early stage of their pregnancy (before 4-month pregnancy), and 78.2 % of women made six or

more antenatal care visits during their entire pregnancy. Almost all women delivered their last child in medical institutions and under medical supervision. Women were most likely more satisfied from the private health facilities than from the governmental facilities. Although the majority of women considered postnatal care necessary (66.1%), only 36.6% of women obtained postnatal care. Sixty-five percent of women agreed with at least one reason for wife beating. The mean age of first marriage among the 450 women was 20 years old and the median was 19, while half of the women perceived the best age of their daughter's marriage between 17 and 20 years old.

Based on the results of this study, it is recommended to consider these results when planning for any women's health programs and projects. In order to improve health care services based on women's needs and priorities, we also recommend setting new policies and regulations that protect women against violence and organizing public education programs to change women's perception towards intimate partner violence and age at first marriage. Empowering women through education and open employment opportunity might help women in making decisions regarding their fertility and taking an active role when they experience any reproductive health rights violation. Future research should expand to include Gaza strip and to include men, adolescent, health care providers, health policy makers and key law and religious leaders.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF MODELS, DIAGRAMS AND OTHERS

CHAPTER ONE

INTRODUCTION

Since the International Conference of Population and Development in Cairo (1994), reproductive health had been recognized as a holistic term that ensures women's three important aspects of health: physical, social and psychological health. In practical terms, reproductive health services include: family planning, perinatal care, safe delivery and postnatal care, infertility prevention and treatment, reproductive tract infection and sexually transmitted diseases diagnosis and treatment. Women's reproductive health rights ensure that women should receive and practice their reproductive life freely and responsibly, free of discrimination, coercion, or violence (Saw, 2006).

Cook (1992) and Shaw (2006) had summarized and discussed the 11 main reproductive health rights which are: The right to life as the basic human right for each person, in practical example for it's violation is the high maternal mortality rates related to avoidable and preventable reasons. Right to liberty and security, as an example forced sterility and forced pregnancy. Right to equality and to be free of discrimination is another important right where any discrimination based on gender, social status, language or any other discrimination might have deteriorating consequences on women's reproductive health. Right to privacy while receiving any reproductive and sexual health care such as family planning and using contraceptives. Right to freedom of thought as women should be offered all necessary information relevant for their health without any preconceived assumptions based on their religion, tradition or others. Right to choose whether or not to marry and to found a family such as forced early marriage. Right to decide whether she wants to have children or and when. Right to the health care and health protection during the process of pregnancy, delivery and after birth and other reproductive health morbidity, that health care should be provided with a high quality services, should be accessible, acceptable, and affordable for each women. Right to benefit from scientific process where any new evidenced based medications or techniques should be available for women's health care. The right of political assembly and political participation is considered important for women's health advocacy and women's empowerment. Finally, right to be free from torture and ill treatment such as sexual violence, domestic violence and any unnecessary health examination.

Reproductive health rights can be used as an indicator for women's health in general and quality of health care system in specific. When women achieve their reproductive health rights; it means that they have achieved the optimal level of health care (Saw, 2006). In order to assess reproductive health rights as an indicator for high quality health care system, women's perception and understating of their rights is one important step in that assessment. In addition, studying women's reproductive health care and give attention to women's perception towards their rights might be one of the most important key issues in setting reproductive health programs or future intervention. In order to get the reproductive health rights terminology closer to women's understanding, reproductive health rights need to be interpreted at each reproductive health care provided and those 11 rights mentioned above has been described under each of the health care services such as family planning, antenatal care etc. which would make it more practical terminology for each of the health care policy makers, health care providers and women themselves.

Few studies in Palestine had previously discussed women's health rights (Women's Center for Legal and Social Counseling, 2000, 2004, 2006). However, none of these studies have assessed women's perception towards the importance of their rights while receiving the reproductive health care which might be the practical meaning of reproductive health rights. Therefore, this study will add very important information to the Palestinian literature and can help together with the previous studies in building a future health programs and setting the health care policy based on women's needs and rights.

The purpose of this study was to assess knowledge, perception, attitude, and practices of reproductive health rights among the Palestinian women of reproductive age (15-49). This study gives idea on women's knowledge, attitudes and practices of their reproductive health rights specifically for the main reproductive health care issues such as family planning, perinatal care, delivery care and postnatal care. It also assesses women's perception regarding domestic violence and best age of marriage which were recognized as very important aspects in reproductive health rights. In addition to bringing women's needs out of their personal point of views to the health agenda which should be further used in the future while setting health programs and plans for the reproductive health policies.

This dissertation deals in details with five main themes, namely: the general terms of reproductive health rights, family planning and contraceptives, reproductive health care (perinatal, delivery and postnatal), domestic violence and women's attitudes towards intimate partner violence and age at first marriage.

The first theme, which is the reproductive health rights, has been presented throughout the dissertation chapters by providing information about the three main rights summarized by Cook (1992): (1) freedom from all forms of discrimination, (2) liberty and security, marriage and the foundation of families, private and family life and information and education, and (3) access to health and the benefits of scientific progress. These reproductive health rights were presented in details discussing their history, meaning and providing examples for their violation on women's health. The results of women's perception and understating of this theme were presented and discussed, practical recommendations were also provided.

Family planning theme was addressed by providing background information about the importance of family planning and using contraceptives, unmet needs, fertility decisions, and family planning rights. Women's knowledge, attitudes and practices of family planning and contraceptives results, discussion and recommendation were also provided.

Reproductive health care theme (antenatal care, delivery care and postnatal are) was presented in the dissertation by providing background information about each of the reproductive heath care services, importance and purposes, women's rights in each of the reproductive health care and women's attendance problems and hindering factors were presented and discussed.

Violence against women and women's perception towards intimate partner violence were addressed here in terms of women's acceptance of wife beating under certain conditions and the factors associated with their attitudes and the main results were presented and discussed. Finally, the age at first marriage theme was presented in the dissertation by providing background information regarding the marriage tradition, marriage process in the Arab countries and in Palestine, problems related to marriage at early age and women's perception of the best age of marriage for their daughters were all presented in details.

This dissertation includes 10 chapters as follows: The first chapter provides a general introduction for the study. Chapter 2 presents briefly the country of Palestine including population and demography as well as the Palestinian health care system, and provides a baseline idea about the Palestinian women's situation including maternal mortality and morbidity, fertility rate, education, employment and marriage and divorce. Chapter 3 provides the theoretical frame work for this study. It presents the integrative model of theories adopted from the National Cancer Institute, Theories at a Glance, (2005) so as to discuss women's reproductive health care practices (behavior) together with the theory of Gender and Power to discuss some themes of the study. Chapter 4 provides a detailed literature review regarding the five above mentioned themes of the study. Chapter 5 formulates the study purposes, objectives and hypotheses, Chapter 6 addresses the methodology of the study including: study design, sampling and target population, study tool, pilot testing, study analyses and the dependent and the independent variables for each of the five study themes, ethical considerations and study major strength and limitations. Chapter 7 presents the results of the study starting from the description of the sample as social and demographic characteristics and then provides the results for each of the five study themes. Chapter 8 discusses the results of each study theme separately and provides strength and limitations for studying each theme. Chapter 9 provides recommendations for each study theme and specific guidelines to be used in developing new women's health programs, projects and future research. Finally, chapter 10 provides conclusions from this study for each study theme followed by general conclusions. The entire study tool and other materials used in the study were provided in the appendices.

I hope that this study will motivate health policy makers, health planners in Palestine as well as donor organizations to consider its results when planning further studies, projects or programs which will help to improve the health status of the Palestinian women by gaining their rights that they themselves consider very important for their reproductive health. I also hope that the health care providers can get the advantage of this study by gaining information on women's issues and rights and consider them in the clinical practices.

CHAPTER TWO

COUNTRY PROFILE

2.1. Geographical distribution of the Palestinian land

Palestinian National Authority (PNA) territories are about 6,020km (West Bank 5,655km; 130km long, 40-65km in width and Gaza Strip 365km; 45km long and 5-12km in width). While, the total area that currently is fully controlled by the Palestinians is approximated 438km (Palestinian Academic Society for the Study of International Affairs (PASSIA), 2008).

West Bank is divided into five districts and each district divided into urban, rural and camp areas. West Bank is also divided into three geographical regions. The Northern region includes the districts of Nablus, Jenin and Tulkarem; the Center region includes the districts of Ramallah and Jerusalem; the South region includes Bethlehem, Hebron (Al-Khaliel) district; and the Jordan valley region which includes Jericho district. Up to 60% of the population who lives in the West Bank lives in approximately 400 villages and nineteen refugee camps. The largest two districts, in terms of geographical distribution and population, were Hebron and Nablus, followed by Ramallah and then Jenin.

Gaza strip is a narrow piece of land located on the coast of the Mediterranean Sea. It is considered number one crowded place in the world with an area of 36Km2 and the population of 1.4 million (2003) and mainly concentrated in cities, small villages and eight refugee camps.

Although West Bank area is considered small, there are observable differences in between districts, in terms of tradition, culture, life style and living conditions. It is also different in the level of education, economic status, conservativeness and religious affiliation. As people lives in Hebron and Nablus considered being the most to have industrial work and commercial influences in Palestine, while it was known generally that the inhabitants of north of Palestine are more educated compared to the south of West Bank as Hebron etc. As an example of the differences in terms of tradition and culture, people in Hebron is known to be well connected to the family and many still live in an extended family, they still appreciate the family component and more conservative in terms of women's issues and women's rights as they

have the earliest age of marriage among both girls and boys compared to the people living in both the middle and north of West Bank

It's also worth to mention that most of the companies and all the ministries and governmental institutions are found in Ramallah which is located in the center of West Bank that of course attracts most people for working and living in Ramallah from the other districts. In addition to difficulty in movement in West Bank due to the closures and check points that the Israeli militarily built permanently in between districts and temporarily between villages and cities and overall political instability, people tend to immigrate internally from their villages and cities form north and south of Palestine to the middle of West Bank (Ramallah city).

2.2. Palestinian population in Palestine

The population of Palestine is estimated to be 3.88 million at the end of 2006; 2.44 million (62.8%) in West Bank and 1.44 million (37.1%) in Gaza strip. According to the distribution of the population by district; In West Bank, Hebron district has the highest proportion of population (542,593) at 13.95% of the total population and 22.1% of the West Bank population followed by Nablus from the north region with a total inhabitance of 336,380, then Ramallah district in the center of West Bank with a total population of 290,401 which is 11.8% of the total population of West Bank. Then Jenin district with a total population of 261,785 which is 10.7% of West Bank. And the least populated district was Jericho which is 1.1% of the total population (Palestinian Central Bureau of Statistics recent estimates till mid 2006).

It was estimated by the end of 2003 that 42.6% of the population in Palestine is refugees (1.6 million, out of which 695,000 in West Bank and 897,000 in Gaza strip (Labor force survey, 2003).

Regarding the age groups of the Palestinian population, the recent estimates of the Palestinian Central Bureau of Statistics till mid 2006 was 45.7% (46.0% males and 45.4% females) of the population are under the age of 15 years old. The number of males in the Palestine at end of 2006 was about 2 million compared with 1.95 million females; the sex ratio is 102.8 males per 100 females. In the West Bank males total is 1.3 million compared with 1.2 for females, the sex ratio is 102.8. In Gaza Strip, the males total is 745 thousand compared with 726 thousand females; the sex ratio is 102.7 males per 100 females.

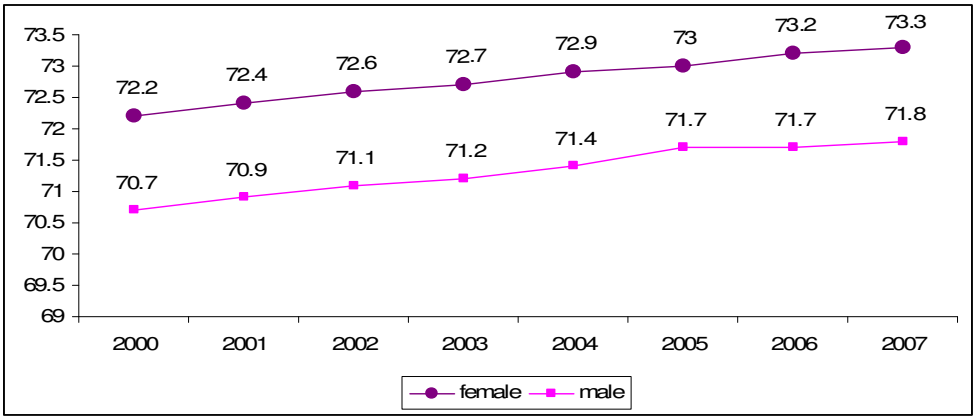
The crude birth rate in Palestine had dropped from 42.7 births per 1000 population in 1997 to 36.7 in the year 2006, but there are differences between West Bank and Gaza were the crude birth rate In West Bank was 41.2 births in 1000 and dropped to reach 33.7 between 1997 and 2006. It had slightly declined in Gaza from 45.4 to 41.7 in the same years.

The crude death rate in Palestine had declined from 4.8 deaths per 1000 population in the year of 1997 to 3.9 in the year of 2006. There is a slight difference Between West Bank and Gaza. As in West Bank, it was declined from 5.1 to 4.0 per 1000 population and in Gaza 4.7 to 3.8 per 1000 population in the same years.

The population natural increase rate was estimated by the end of 2006 to be 3.3 (3.0 in West Bank and 3.8 in Gaza strip). The decline in mortality rates and high fertility rate would lead to a high rate of natural increase in the population.

The decline in the mortality rate in the Palestinian Territory led to longer life expectancy to reach 71.7 years for males and 73.2 years for females in 2006. There are regional discrepancies; life expectancy in the West Bank is 71.9 years for males and 73.6 years for females compared with 71.4 years for males and 72.5 years for females in Gaza Strip. See figure 2.1.

Figure 2.1. Life expectancy in Palestine by sex



(Source: Palestinian Central Bureau of Statistics, women and men report, 2007).

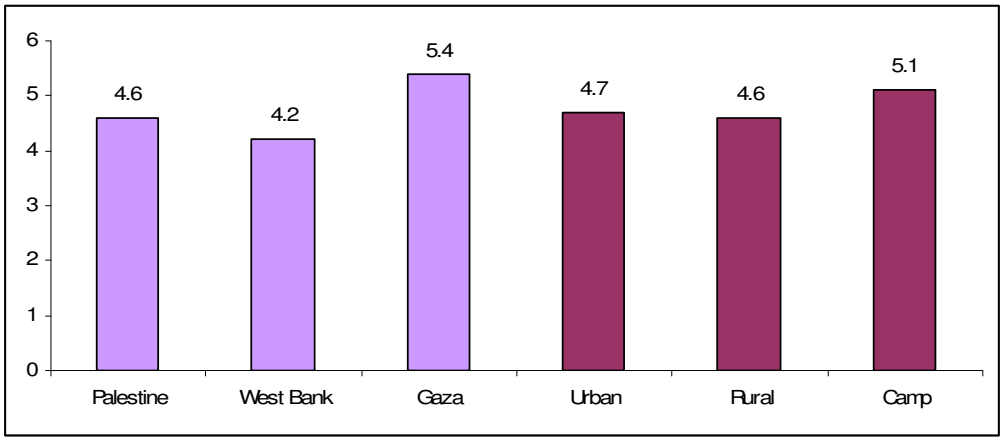
In Palestine the dependency ratio (economically dependent part of the population to the productive part per 100) indicated it has been dropped from 101.3 in 1997 to 94.2 in 2006 where it declined from 94.7 in 1997 to 88.5 in 2005 in the West Bank and from 114.5 in 1997 to 104.7 in Gaza Strip in 2005.

2.3. Women in Palestine

According to a recent community based study maternal mortality In West Bank in the year 2001 and 2002 maternal mortality were 29.2 and 36.5 per 100,000 live births, respectively (Al Adili et al, 2006). While in relation to maternal morbidity uterine prolapse was found to be one of the major maternal morbidity in Palestine at rate of 39.1% in West Bank and 26.3% in Gaza. Moreover, it shows more in rural areas than in urban. (Palestinian Central Bureau of Statistics, DHS-2004).

The total fertility rate in Palestine is 4.6 in the Palestinian Territory (5.4 in the Gaza strip and 4.2 in West Bank), according to data of the Palestinian Family Health Survey, 2006. See figure 2.2.

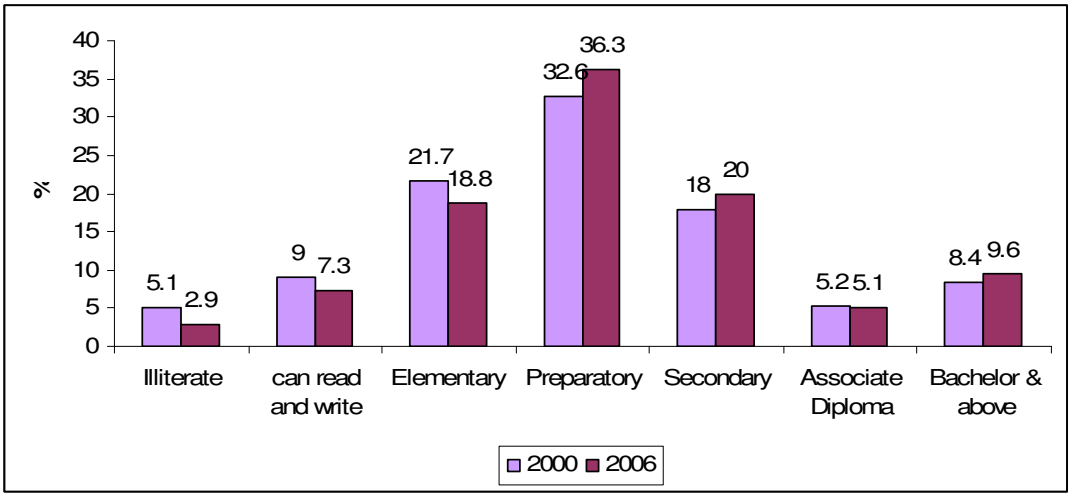
Figure 2.2. Total fertility rate by region and locality in Palestine



(Source: Palestinian Central Bureau of Statistics – Family health Survey, 2006)

The literacy proportion among women reached 89.8% in 2006 which is an increase of 7.0% compared with 2000. Meanwhile, the literacy rate among men increased from 94.4% to 97.1%, an increase of 2.9% for the same period. While the percentage of persons (15 years and over) who have bachelor and above in 2006 was 9.6% for males and 6.2% for females, while it was 8.4% for males and 3.8% for females in 2000. See figure 2.3.

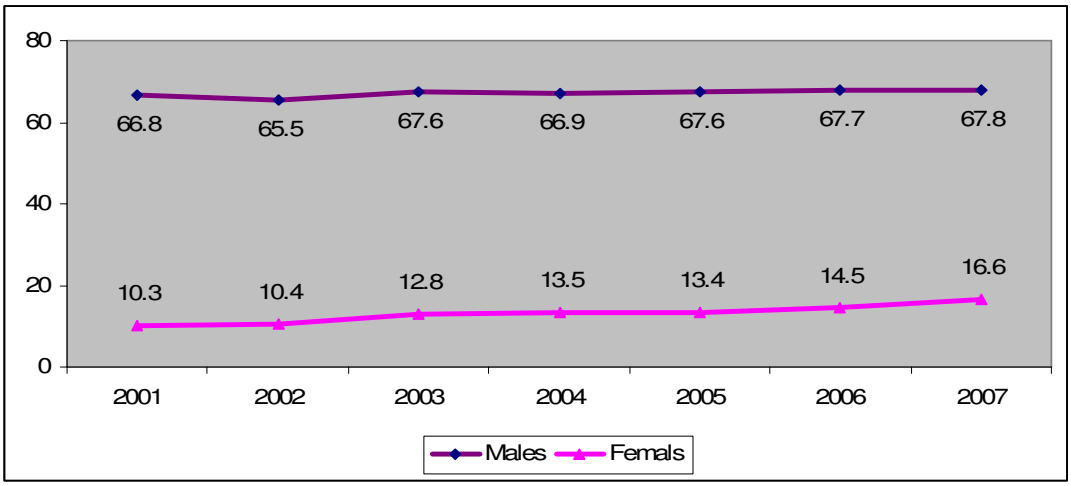
Figure 2.3. Percentage distribution of Palestinian females (15 years and over) by educational attainment, 2000, 2006



(*Source: Palestinian Central Bureau of Statistics - Education, 2006)*

The participation proportion for women in the national employment positions was (15 years and over) in the year 2001 was 10.3%. It increased to 16.6% in the second quarter 2007. As seen in figure 2.4

Figure 2.4. Labor force participation proportion for Palestinian persons aged (15 Years and over) by sex, 2001-2007.



(Source: Palestinian central Bureau of statistics Family Survey, 2007)

According the Palestinian Central Statistics Bureau survey of marriage and divorce (2000) the median age of first marriage of males and females in Palestine is at constant rise; it

reached 24.2 years for males and 19.1 years for females in 2001 as it was in 1997, 23.0 for males and 18.0 years for females (West Bank 19.1, Gaza 18.8 years)

Early marriage is wide speared in Palestine were 53.4% of married women aged 15-19, and 41.6% aged (20-24) in the year 2001. Divorce percentages are not high in Palestine and it showed more among younger couples.

2.4. Health care system in Palestine

2.4.1. Primary health care

According to the Ministry of Health (MOH) 2005 annual report there are 654 primary health care centers (PHC) in Palestine; these centers providing health care for about 3.8 million people (129 centers in Gaza and 525 centers in West Bank). The Classification of PHC according to the providers shows that, the MOH is considered the main provider with 63.6% from the total PHC centers, followed by the NGOs with 28.3%, then UNRWA with 8.1%. These centers offer different health services according to the clinic level, these services include maternal and child health care, care of chronic diseases, daily care, family planning, dental, mental services and other services according to the specific center level. All these clinics provide maternal and child health care services in both providing care and the referral services.

- **Primary health care in West Bank**

MOH owns and operates 357 PHC centers, out of which 94 level I (as village health room with 2-3 visits of physician per week), 169 level II, 84 level III, and 10 level IV. There are 77 centers with family planning clinics, 17 centers have oral and dental clinics, 59 centers have specialized clinics and 85 centers have medical laboratories. In 2004, about 2,083,249 visits were reported compared with 1,298,186 in 2000; with an annual average of 1,794,017 visits in the last five years. The ratio of visits per person was 0.9 in 2004 compared with 0.7 in 2000.

2.4.1. Hospitals services

The secondary health care delivery system is a mix of governmental, non-governmental, UNRWA and private sectors. With the development of governmental health insurance, the MOH is responsible for a significant portion of the secondary health care delivery system and some tertiary care activities.

In Palestine, there are 78 hospitals furnished with 4,824 beds. The population/hospital ratio is 47,922. The average bed capacity per hospital is 59.99 beds. In Gaza there are 22 hospitals, the population/ hospital ratio was 60,783. The average bed capacity per hospital is 76.9 beds. In West Bank including Jerusalem, there are 56 hospitals. The ratio of population per hospital was 41,824 and the average bed capacity per hospital is 51.55 beds.

- **Maternity hospitals**

In Palestine there are 54 maternity hospitals (39 in West Bank and 17 in Gaza). There is unequal distribution of hospitals among the regions. For example, the central West Bank of has most available private hospitals and overall hospital services, at 38 668 persons per hospital operated by all sectors, followed by the southern West Bank at 42,161 persons/hospital, and 61 548 persons per hospital for the northern West Bank, and a high of 89,148 persons per hospital for the Gaza Strip. More details are available in table 2.1.

Table 2.1. Hospital distribution in West Bank and Gaza and the total population served by specific region.

Type of hospital provider	Northern West Bank	Central West Bank	Southern West Bank	Gaza Strip
Ministry of health (MOH)	5	1	4	8
UNRWA	1	-	-	-
NGO	6	2	4	5
Private	3	4	9	2
Total	15	7	17	15
Population	923 212	270 678	716 740	1 337 236
Population per MOH hospital	184 642	270 678	179 185	167 155
Population per NGO hospital	135 869	135 339	179 185	267 447
Population per Private hospital	307 737	67 670	79 638	668 618
Population per hospital in sector	61 548	38 668	42 161	89 148

(Source: adopted from *Giacaman et al, 2005)*

2.4.3. Laboratories and blood banking

The laboratory services in the MOH are offered to the Palestinians at three categories: Central, Intermediate and Peripheral. The total number of laboratories in MOH was 140. In West Bank: There are 67 laboratories in the PHC clinics governorates and 18 laboratories of NGOs facilities with which MOH is contracted. There were 311 technicians running the laboratory services in the intermediate laboratories, with an annual average workload of 14,754 tests per technician (15,063 in WB and 14,535 in G). While, 183 technicians worked in the peripheral laboratories with an annual average workload of 7,185 tests per technician

(6,923 in West Bank and 7,55 in Gaza).The total number of technicians in the MOH laboratories were 530 in 2004

2.4.4. Human health resources

In Palestine, (according to the MOH 2004 annual report) the health providers (MOH, NGOs, private, and UNRWA) employ 16,935 permanent employees, 8,882 in West Bank and 8,053 in Gaza. The majority works for the MOH (53.6%). Among these employees, 70.5% are health professionals distributed as follows: 3,093 doctors, 293 dentists, 329 pharmacists, 4,905 nurses, 574 midwives, and 2,739 paramedics.

2.4.5. Health insurance

According to the Palestinian Central Bureau of Statistics end of year 2004 the total percentages of Palestinian population who are insured are 76.1% (65.3 in West Bank and 93.7 in Gaza). There are 4 types of insurance in Palestine: governmental, military, UNRWA, social security and private. The percentages of people insured by each insurance provider was 51.8% with government, 4.1% with military, 32.9%, with UNRWA, 2.3 with social security, 1.7 with private. Some people living in Jerusalem mainly having Israeli ID were insured by Israel health insurance (6.1%). The percentages of females who are not insured in Palestine are 23.5%.

- **Governmental health insurance**

In Palestine, the MOH provided free of charge health insurance to about 189,934 families in 2001, 207,434 families in 2002, and 94,449 families in 2003 (MOH annual report, 2004). Out of the over all percentages of the governmental insurance there were 43.2% in West Bank and 66.8% in Gaza by end of 2004 (Palestinian Central Bureau of Statistics, 2004).

Types of governmental health insurance participation

- Compulsory

  It is the insurance that mainly covered all governmental municipalities, employees, and retired employees. It was about 56.6% out of the total governmental health insurance in 2003.

- Voluntary

  This is mainly open to the rest of the population voluntarily, but this showed a massive decline in the last years to reach 2% of the families in the year 2003, due to the deterioration in the Palestinian economy.

CHAPTER THREE

THEORETICAL FRAMEWORK

This study will discuss the theoretical framework that would help in measuring women's knowledge, attitude, and practices toward their reproductive health rights in Palestine. These rights in the study purpose will be discussed through reproductive health care sections including antenatal, delivery, postnatal, and family planning. Reproductive health rights as a term and its major important points will be also separately discussed in terms of women's knowledge and attitudes. Part of the study objectives will focus on intimate partner violence and early marriage as important key issues of reproductive health rights. Through the review of many public health theories, its more likely that this study could be analyzed and discussed based on a combination of four main theories which has the three level of influences: intrapersonal level, which was defined as the "*individual characteristics that influence behavior, such as knowledge, attitudes, beliefs, and personality traits"* , interpersonal level which was also defined *as" Interpersonal processes and primary groups, including family, friends, and peers that provide social identity, support, and role definition"* , and at the community level which might be a combination of many factors as institutional, social and public policy, these factors assign certain rules, regulations, policies, social norms, and cultures that all might limit or facilitate the person's health behavior (National Cancer Institute, 2005).

Theory of Planned Behavior will be discussed as part of the intrapersonal level; Social Cognitive Theory will be discussed as part of interpersonal levels. And in terms of the community level, the Theory of Community Organization might be very suitable for discussing the reproductive health rights as an overall concept and the theory of Gender and Power (TGP) which could help in discussing many issues in the study such as violence against women and early marriage phenomena.

3.1. Intrapersonal level

3.1.1. Theory of Planned Behavior

Theory of Planned behavior explains the interaction between the behavior and beliefs, attitudes and intentions within the individual (intrapersonal); Table 3.1 explains the major concepts of the theory and its potential application in this study:

Table 3.1. Theory of Planned Behavior

Concept	Definition	Measurements approach	Potential applicability in this study
Behavioral intention	Perceived likelihood of performing behavior	Are you likely or unlikely to perform the behavior?	Assessing women's current and future attendance and use of reproductive health care
Attitudes	Personal evaluation of the Behavior	Do you see the behavior as good, or bad?	Assessing women's attitude's towards the necessity and the importance of major reproductive health care such as family planning, postnatal care, and antenatal care etc.
Subjective norm	Beliefs about whether key people approve or disapprove of the behavior; motivation to behave in a way that gains their approval	Do you agree or disagree that most people approve or disapprove of that behavior?	Assessing key people influencing women's use the health care particularly contraceptive use and assessing women's role in the over all decision making process as the household level and at her health status level.
Perceived behavioral control	Belief that one has, and can exercise control over performing the behavior	Do you believe (Performing the behavior) is up to you or not up to you?	This was assessed several times in the study in each of the reproductive health care use.

(Table 3.1. adapted from the National Cancer Institute, Theories at a Glance, NIH publication NO. 05-3869, September 2005)

3.2. Interpersonal level

Theories discussing the interpersonal interaction assume that individuals exist within and influenced by (1) social environment that included family members, coworkers, friends,

health professionals and others, (2) the opinions, thoughts, advices and supports of the surrounding people (National Cancer Institute, 2005)

3.2.1. Social Cognitive Theory

Social Cognitive Theory was strongly related to most public health studies and programs (Kirby et al, 1994; Kirby, 2001; Kenndy et al, 2007) as it (SCT)" *describes a dynamic, ongoing process in which personal factors, environmental factors, and human behavior exert influence upon each other"*(Galnz et al, 2002). There are three main factors that affect the likelihood that the person will go for this behavior or change this behavior according to the SCT, as: (1) self-efficacy, (2) goals, and (3) out come expectations. If the person has a good level of self confidence and a goal to reach as well as hoping to achieve something in need, he/she will keep going in this behavior no matter how many obstacles will get. Simply if a person do not feel having control over their health behavior, will not be motivated to act or to persist through challenges which could be coming from the surrounding environment, people, or system. Other important point in this theory that behavior is not a product of the environment and the person, and environment is not a product of the person and behavior (Institute of Medicine, 2002). In this study I assume that if women do not have enough knowledge and positive attitudes towards their reproductive health rights they will not be motivated to go and ask or work to achieve such rights, they will be hindered by many surrounding obstacles such as family interaction, cultural perspectives, environmental constrains and health care system. Table 3.2 presents the main components of SCT and its applicability in the study.

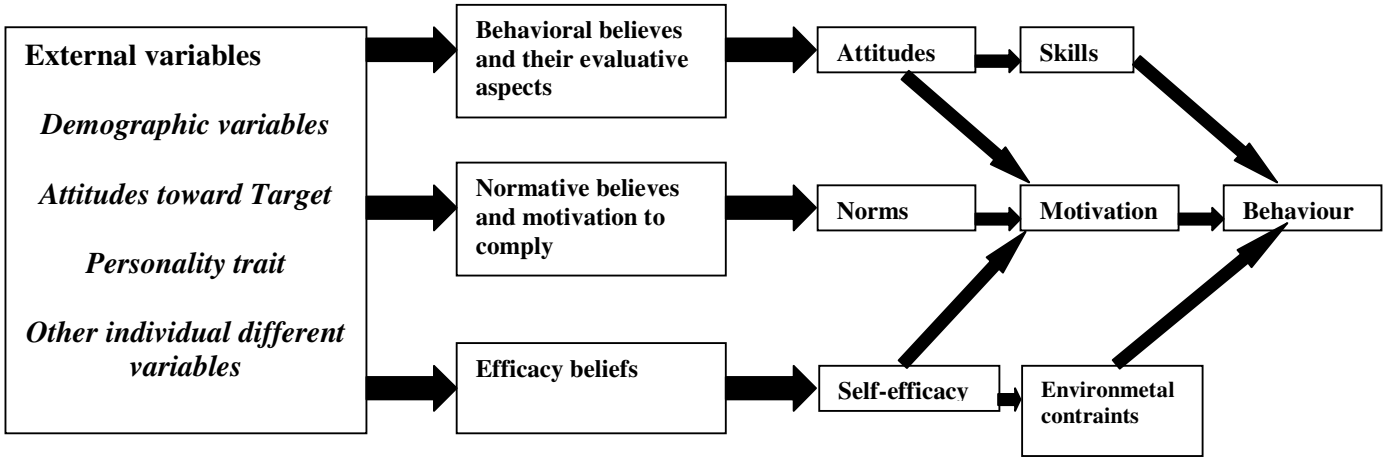
Table 3.2. Social Cognitive Theory – Key concepts and reproductive health human rights (the present study)

Concept	Definition	Potential applicability in this study
Reciprocal determinism	The dynamic interaction of the person, behavior, and the environment in which the behavior is performed	Assessing women's demographic, personal, and social characteristics that might influence the health practice.
Behavioral capacity	Knowledge and skill to perform a given behavior	Assessing women's knowledge of the importance of each of the health practices (such as contraceptives names and use, postnatal health problems and ways to deal with them)
Expectations	Anticipated outcomes of a behavior	Assessing women's perception towards the need and importance for each of the women's health practices.
Self-efficacy	Confidence in one's ability to take action and overcome barriers	Assessing women's ability to be able make self-decisions of using any of health practices.(such as fertility decisions, using health care services)
Observational learning (modeling)	Behavioral acquisition that occurs by watching the actions and outcomes of others' behavior	That might take a role in a descriptive study through assessing the major influencing persons on practicing health behavior.(such as family, husband and extended family)
Reinforcements	Response to a person's behavior that increase or decrease the likelihood of reoccurrence	This would take place more in an implementation projects, but in this study, it might be applied through women's level of satisfaction from the health practice and women's belief that they would repeat this behavior.

(Table 3.2. adapted from the National Cancer Institute, Theories at a Glance, NIH publication NO. 05-3869, September 2005)

The National Cancer Institute (2005) describes through a model (model 3.1) the components of SCT as an integrative interaction between self efficacy, environmental, and individual factors and how these together impacts behavior.

Model 3.1 Integrative model of Social Cognitive Theory



(Model 3.1. adapted from the National Cancer Institute, Theories at a Glance, NIH publication NO. 05-3869, September 2005)

This model assumes that there are many factors that might determine health and help to shape healthy behaviors. And here they mentioned them as an external variables as : (1) **Demographic** variables which are mainly individual age, education, social status, residence and etc. (2) **Attitudes** which are our beliefs and feelings, whether right or wrong, influence our health behaviors and ultimately our health. Attitudes are often more difficult to change than knowledge or behavior. (3**) Personality trait**, which is other important personal factors that help in shaping the personality as it can identify the susceptibility for diseases such as heredity. (4**) Other individual variables**, such as race or ethnicity etc.

Knowledge- could be also added as part of the demographic characteristics when taking it as educational level, and in the attitude part when discussed the general knowledge of the health behavior and the awareness of health problems. Knowledge is often the first step for changing lifestyles to improve health and well-being.

3.3. Community level

Since this study works on a very important public health issue where the main purpose is to make change at the community level, and because community is the heart of public health, theories of the community level, as the Theory of Community Organization and the Theory of Gender and Power might help understand this study.

3.3.1 Theory of Community Organization

Theory of Community Organization,, *is a process through which community groups are helped to identify common problems, mobilize resources, and develop and implement strategies to reach collective goals. Strict definitions of community organizing assume that the community itself identifies the problems to address (not an outside change agent) "*(National Cancer Institute, 2005).

Table 3.3 presents the community organization theory components and its potential application on the study.

Table 3.3. Community Organization Theory – potential application in this study (Reproductive health human rights)

Concept	Definition	Potential applicability in this study
Empowerment	A social action process through which people gain mastery over their lives and their communities	Assessing women's empowerment characteristics (such as education, employment, and others) and its effect of their understanding of health practices as well as their reproductive health rights
Community capacity	Characteristics of a community that affect its ability to identify, mobilize around and address the problem	Review of the community capacity such as health organization availability, affordability, as well as political environment.
Participation	Engagement of community members as equal partners ; reflects the principle " never do for others what they can do for themselves"	Assessing the priorities of reproductive health rights that women consider in order to build future implementation programs accordingly
Relevance	Community organization that "starts where the people are"	Basic assessment of women's knowledge, attitudes and practices
Issue selection	Identify immediate, specific, and realizable target for change that unify and build community strength.	Main study purpose

Critical consciousness	Awareness of social, political, and economic forces that contribute to social problems	Review all the surrounding social, cultural, political, and personal environment surrounding the reproductive health rights issue

(Table 3.3 adapted from the National Cancer Institute, Theories at a Glance, NI publication NO. 05-3869, September 2005)

3.3.2. Gender and Power Theory

The Gender and Power theory is an integrative theory of all pervious gender based theories that was defined as a social structural model that seeks to understand women's risk as a function of different structures. According to the theory, three major structures characterized the gendered relationships between men and women; one is sexual division of labor, which examines economic inequities favoring men. Second is Sexual division of power, which examines inequities and abuses of authority and control in relationships and institutions favoring males. Moreover, the third is the structure of Cathexis, which examines social norms and affective attachments. The three structures overlapping but distinct and serve to explain the gender roles that men and women assume (Connell, 1987).

These three domains (labor, power, and cathexis) can be specifies into several different factors that could increase women's risk of disease, and violence, as well as prescribing specific strategies for reducing women's health risk (Wingood & DiClemente, 2000). In general, public heath level of interventions attempt to modify social norms; reduce barriers to care; influence health resources, and influence laws, policies and cultural norms (U.S. Department of Commerce, 1996; Sweat & Dennison, 1995). For that, Gender and Power Theory might play a strong role in public health women's health program planning and organizing new strategies etc.

In operational and other previous studies, The term" the structure of sexual division of labor" was defined as a women who live at the poverty level; have less than a high school education; are unemployed or underemployed, have a high demand/low control work environment (Coates, 1997); or have limited health insurance or no health insurance (Karasek & Theorell, 1990). Therefore women will be highly dependent on men economically that would put women in more risk of disease exposure and risk of violence (Wingood & DiClemente, 2000; Choi and Ting, 2008). Power was defined by many social and psychological researches as the ability to have control or influence others (Johnson, 1976; Antonovsky, 1988). Some studies had acknowledged that men have a greater power than women do (Johnson, 1976). It was

argued before that women's lower power occurs because of different social roles to which men and women are assigned, as men occupying the bread winner role in their family structure, while women occupying the traditional roles in the home (Eagly, 1987). This inequity between men and women's power may put the women in more danger of medical, physical, and sexual threat. For examples: putting women at more risk of physical and sexual violence (Teitelman et al, 2008; Babcock et al, 1993), dealing with a partner who refuse using safer sex, or contraceptives (Teitelman et al, 2008; Wingood & DiClemente, 1998), limiting women's access to drug and treatment (Heimer et al, 1998), and many more.

Cathexis (social norms and affective attachments), are basically influence women at the social level this structure might shapes „*our perceptions of ourselves and others and limits our experiences of reality"(*Wingood & DiClemente, 2000). While at the institutional level, this structure produces cultural norms that enforce strict gender role and stereotype female sexual behavior (such as creating taboo's regarding women's sexuality) (Wingood & DiClemente, 2000).

According to the structure of social norms and affective attachments, women who accept more the social norms and cultural beliefs related to sexuality are more likely at risk of disease and poorer health out comes. As example for that; women's interest or her partner's interest of conceiving more children (Adler & Tschann, 1993), family or partner mistrust of medical system (Terrell & Terrell, 1995), conservative cultural and gender role (Galambos, 1985), religious affiliation that forbids the use of contraception (Cochran & Beeghley, 1991), and many more.

It is hypothesized that this study of reproductive health human rights could be discussed in terms of empowerment of women to take their self-decision concerning their reproductive health care and using the services and to be able to have their free of choice. In addition, the influence of the women's level of education and employment status may determine their economic influences among the family and their abilities to achieve their reproductive health rights. This could be assumed that gender balance, inside family and at the community level, plays a major role in having the final behavioral practice, which may lead to health consequences at the end. This theory will be more the focus of explaining the results of each of domestic violence part of the study, early marriage, use of health care services and the over all understanding of reproductive health human rights.

CHAPTER FOUR

LITERATURE REVIEW

4.1. Introduction

To start with a very important issue of reproductive health rights, one needs to go back to the International Conference on Population and Development/ ICPD (ICPD- Programme of Action of the Conference (94/5/12), 7.1-7.9, 1994) and look at the definitions of each of reproductive health (RH), Reproductive health care (RHC) and reproductive health human rights (RHHR).

> *"Reproductive health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its function and process".*

It was explained there that reproductive health ensures that people are able to have satisfying and safe sex life and that they have the capacity to reproduce and with freedom to decide, when and how often to do so. Therefore it is understood from the last condition that men and women should have the right to be informed and have good access to high quality, safe, affordable, and effective family planning as well as other methods of their choice for regulating fertility that are not against law. Not to forget the right of access to appropriate and affordable health care services that well enable women to go safely through pregnancy and childbearing and provide couples with the best chances of having a healthy infant (Cook, 1993).

In line with the above definition of reproductive health, reproductive health care is defined as

> *"the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted diseases".(ICPD Programme of Action of the Conference (94/5/12), 7.1-7.9, 1994)*

In the ICPD conference (1994) they set a basic understanding of reproductive health rights, as they did consider it as one of the human rights that are recognized already by many national laws, international human rights and consensus documentations. these rights ensures that each

couple should have the right to decide freely and responsibly the number, spacing and time for their children and to have all the necessary means to do so; available, affordable and accessible. It also ensures that couples should have free of decisions concerning their reproduction life and sexuality free of discrimination that might be based on and means like race, gender, social class, age etc, free of coercion, or/and violence. The document also emphasis the importance of considering both adolescents reproductive health choices and education, equality, denying gender discrimination as a recognizable rights as well as older age men and women's reproductive health rights. They did elaborate that the implementation, support, and provision of these rights should be the direct responsibilities of the government as a mean for protecting women and the overall citizens.

Following the ICPD (1994) conference, it was hard to think of any reproductive health care without taking into consideration women's reproductive health rights such as maternal mortality, maternal morbidity, domestic violence, unmet family planning and early marriage with its health consequences and many others. In that, each of reproductive health issue might be related in one way or another to reproductive health rights violations. Taking an example for that maternal mortality, where most of the causes for maternal death could be avoidable and due to either health care system failure, lack of accessible health services, or poverty (WHO, 1990). Therefore, considering reproductive health human rights while providing the services, setting health policies, and providing health education might be the responsibility and the interest of each one who sets the health policy, works on health issues, health providers and the over all community. Following in this section, I will provide a revision for each of the reproductive health rights together with its reproductive health implications and provide some examples for its violations.

4.2. Reproductive health rights

The major reproductive health rights can be summarized as follows (Cook, 1992):

- Freedom from all forms of discrimination.
- Liberty and security, marriage and the foundation of families, private and family life and information and education.
- Access to health and the benefits of scientific progress.

In the following sections, I will go through each of these rights and present them in terms of definitions, relevant studies, and consequences of their violation by referring to several previous national and international studies (Cook, 1992; 1993; Arab Population conference, 1993; Women Convention Articles).

4.2.1. Freedom from all forms of discrimination

The Women's Convention characterizes women's inferior status and their oppression not just as a problem between men and women, but also as one of specific discrimination against women. The definition in article 1 of the Women's Convention reads the term *"discrimination against women as many distention, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedom in the political, economic, social, cultural, civil or any other field"*

(UN, available at http://www.un.org/womenwatch/daw/cedaw/cedaw.htm, accessed on July, 2008).

The Women's Convention preamble expresses concerns in Paragraph 8 *"That in situations of poverty, women have the least access to food, heath, education, training, and opportunities for employment and other needs"*. This comes consistent with the theory of Power and Gender, the sexual division of power and the sexual division of labor, which persistently serve to maintain gender inequalities at the societal and relational levels (Connell, 1987). Sexual division of labor might limit women's opportunity to find equal employment opportunities, which limit women's equal access to education and formal wage economy that might lead to the exposure for many health consequences such as sexual transmitted diseases and HIV as well as limiting the access to proper health care (Wingood & DiClemente, 2000; Luddy, 2007; Nyamathi et al, 2007; Zhihong & Larsen, 2007). Sexual division of power is closely related to sexual division of labor, where women's economic dependency on men might lead to miss use of the power and authority as well as control in relationships (Wingood & DiClemente, 2000). Economic dependency also serves as an economic inequality, which might force women to go through poverty and underemployment. Several studies in Sub-Saharan Africa have also shown that poorer women might be at higher risk to HIV exposure (Heise & Elias, 1995; Wojcicki, 2005). To add on this, there are several health related conditions that women go through during their life span, for example, a study among

American women was found that about one fifth of women were affected by female related health conditions each year (Kjerulff et al, 2007). It is well known that the cost of prevention and treatments of female health related conditions is estimated to be very high (Kjerulff et al, 2007), which puts poor women and women with no health insurance at the risk of limited utilization of health care services, particularly preventive tests (Ayanian et al, 2000). A previous study also shows that women with no health insurance might receive less perinatal care, which might result in pregnancy related problems and birth related complications (Institute of Medicine, 2004).

Article 12 of the Women's Convention prohibits all forms of discrimination against women in the delivery of health care: *"States parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning."*

Notwithstanding the provision of Paragraph 1 of this article, state parties *" shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation"(* available at http://www.unfpa.org/swp/1997/box6.htm, accessed on July 2008).

Several studies also found that women could be discriminated while receiving health care services for their look, social class, religion, ethnic group or many other factors (Scarinci et al, 2001; Watson, 2002). Studies had shown that immigrant women could be easily discriminated due to their lack of understanding of the health care system, week language skills with limited social access to be improved, religious beliefs that might require special understanding and sensitivity and cultural differences (Hayman, 2001). These limitations that the immigrant women have might also be strong barriers for providing proper and good care from the health care provider, as stated in one qualitative study in Canada health care providers (Teng et al, 2007). Some studies had recognized that gender discrimination has been attributed to women's poor physical and mental health (Krieger et al, 1993; Kobrynowicz & Dranscombe, 1997). These factors were recognized to limit women's access to health care needs that would affect the overall women's health. In Palestine it was found that women could be discriminated du to their social class, lack of proper understanding for medical terms, being

refugees (internal replacement women), or live in a different region of Palestine (WCLAC, 2000).

Closer look at the Arab countries declarations that took place at the Arab population conference, which was held in Amman (1993), had recommended all Arab countries to ratify the United Nations convention of elimination of all forms of discrimination towards women consistently with the national legalization. It also recommended that women should be empowered through clarifying the misunderstanding and mistaken confusion between social values and cultural behaviors and the religious belief. It also invited the participating countries to put a great effort in improving the women's situation, particularly those concerning the relations within the family, employment, social security, health insurance, pensions, maternity leave, appointments, job promotion opportunities, education and etc., through developing new legislations.

4.2.2. Liberty and security, marriage and the foundation of families, private and family life and information and education

4.2.2.1. The right to life and survival

The most important right for the women and children is to avoid death of both of them. This argument entitles women to receive the best reproductive health services. The argument must be expanded, where the threat to the pregnant women's survival comes not from her medical conditioning, but from her membership in a group at high risk of maternal mortality or morbidity due to pregnancy. World wide, WHO had estimated that every year nearly 600,000 women die as a result of pregnancy complications, most of them are in developing countries (WHO, 1990, and 1999). Maternal mortality is considered one of the important human rights issues that stated in the agenda of health policy and research. Maternal mortality is mostly occurring due to avoidable causes, particularly in developing countries (Center for Population and Family Health, 1992; Regional Strategy for Maternal Mortality and Morbidity Reduction, 2002; Health Canada, 2004; The 10/90 report on health research 2003–2004, 2004; Ronsmans & Graham, 2006). Maternal mortality is caused due to direct preventable causes which included postpartum hemorrhage, pre-eclampsia/eclampsia, postoperative bleeding complications, post cesarean sepsis, and uterine rupture; and indirect preventable causes include thromboembolism, cardiac failure and anemia as categorized by Kao et al (1997). For example, hypertensive disorders of pregnancy were found to be the commonest direct causes of maternal deaths in South Africa (Moodley, 2007). Abortion complications and lack of

access to family planning methods and services were also found to be the main direct cause of death in several recent studies and in different settings (Nwogu-Ikojo & Ezegwui, 2007; Ramos et al, 2007). In Egypt in one district study, it was found that complications during cesarean delivery, postpartum hemorrhage and hypertensive disorders were the leading causes of maternal mortality (Abdel-Hady et al, 2007). One interesting study that compared the difference between causes of death among developed and developing countries (rich and poor) found that maternal mortality rates ranged from 10 per 100,000 (in the Netherlands) to 1540 per 100,000 (in Gambia). Moreover, the study summarized the causes of deaths to be HIV/AIDS in Namibia, sepsis and HIV/AIDS in Zambia, pre-eclampsia in the Netherlands and obstructed labour in Gambia. The study concluded that the differences of causes of death between developed and developing countries are more than the issue of rich and poor, other factors such as politics, burden of diseases, social and cultural beliefs and the overall community system can play a major role as well (Van Dillen et al, 2007).

One community based study conducted in 2000 and 2001 in 10 districts in West Bank (Palestine) had found that maternal mortality ratio was 29.2 and 36.5 per 100,000 live births, respectively (Al-Adli, 2006). This study shows that most of the deaths occur due to avoidable causes, mainly due to the inability to timely reach the health care services because of the political instability and restriction of movement that the Palestinians were forced to go through. Below is one example from that study:

*"One young woman with post delivery bleeding needed hospital management, and she had to be referred to a hospital 20 km away. Because of delay at a military checkpoint, it took her 3 times longer than normal to travel the distance and she died before she reached the hospital. Another example is that of a woman who was referred to a district hospital with abdominal pain. On the way to the hospital, she was delayed at a military checkpoint and died there, needlessly arriving at the hospital after 90 min when the trip normally requires only 20 min" (*Adili at al, 2006).

4.2.2.2. The right to liberty and security

The English dictionary (available at http://www.answers.com/topic/liberty, accessed July, 2008) defines liberty as the condition of being free from restriction or control, or the right and power to act, believe, or express oneself in a manner of one's own choosing, or the condition of being physically and legally free from confinement, servitude, or forced labor. These

definitions are very much consistent with what women needs in order to achieve high quality of life. the Political Covenant article 9 (1), provides that *" everyone has the right to liberty and security of the person….no one shall be deprived of his liberty except on such grounds and in accordance with such procedures as are established by law"* (OHCHR, http://www.unhchr.ch/html/menu3/b/a_ccpr.htm, accessed on August, 2008). Cook (1993) states that *"A women's right to liberty transcends her right to protect her life and health, and recognizes her right to reproductive choices as an element of her personal integrity and autonomy that is not dependant on health justification"*

Unmet needs for family planning might have a direct influence on the women's liberty in terms of their ability to make their own free choices of whether she wants to have children or not as well as the use of family planning methods. According to the WHO report 2004, there are still some 123 million women around the world, mostly in developing countries, who are not using contraception in spite of an expressed desire to birth-space or limit the numbers of their births. In addition, 38% of all pregnancies occurring around the world every year were estimated to be unintended; additionally, around 6 out of 10 of such unplanned pregnancies result in an induced abortion. It is important to mention that women need to be free in choosing the number of children and in limiting the number of pregnancies as this would have a direct impact on women's health and well-being as an out come of her pregnancy.

Another example of women's liberty is attributed to the test that the women need to go through during pregnancy; pregnant women must have the choice to make decisions about their behavior in the context of their lives and should not be forced or pushed to do any undesired procedure during pregnancy. However, the free of choice of the pregnant women might comes sometimes in contradiction with the fetal rights and benefits in that; sometimes, a woman's choices are made in ignorance or are informed by deeply held religious or personal beliefs that preclude certain decisions, or result from strong social and psychological pressures (Flagler et al, 1997). Therefore, health care providers should work hard to keep the balance between avoiding pushing women to make choices and in informing them of the advantages and disadvantages and all different possibilities while providing perinatal health care so as to help pregnant women to make informative and less constrained choices (Johnson, 1987).

4.2.2.3. The right to marry and to found a family

Women have the right to marry and to found a family without any force and with full consent, they also have the right to choose their spouse as what article 16 of Women's Convention states (available at http://www.unfpa.org/swp/1997/box6.htm, accessed on July 2008). Furthermore, Article 23 of the Political Covenant and article 10 of the Economic Covenant both recognize the family as the *"natural and fundamental group unit of society"*. The former states that *"The right of men and women of marriageable age to marry and found a family shall be recognized." The later presents that "special protection should be accorded to mothers during a reasonable period before and after childbirth." During such period working others should be accorded paid leave or leave with adequate social security benefits, (Article 10, 2)" (available at the UNHCHR, http://www.unhchr.ch/html/menu3/b/a_cescr.htm, accessed on July 2008).*

These above mentioned rights involve as well that women have the right to plan time, and place the births of children to protect their health and their own. Accordingly, article 16 (1) (e) of the Women's Convention requires states parties to ensure that women enjoy *"rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights"* (http://www.unfpa.org/swp/1997/box6.htm accessed on July 2008). This also could mean that women have the right to decide on all issues that involve their health and their life including choosing the time and the person to marry as well when to formulate a family and have children.

Early marriage is considered as one of the most common occurring violation of these rights. Young girls are frequently induced to marry at the minimum legal age or a lower age because they lack alternatives and other opportunities (Cook, 1993). A study of 40 demographic and health surveys have found that, in many countries, women still marry as young age, as they found that 20-50% of women marry by age 18 and 40-70% of women do marry by their 20th birthday (Singh & Renee, 1996). In Palestine, women still marry at earlier age as the median age of marriage is 19 years old (Elrashidi, 2005). The World Population Monitoring (2003) elaborates more about early marriage main problems, as it usually deprives a girl from her adolescence, reduces her educational opportunities and limit her level of autonomy which will minimize her decision-making power in matters regarding sexual and reproductive health, more importantly that early marriage entails premature child bearing which put premature

women into the risks for pregnancy and births and might increase the chances for divorce. Despite the legislation designed in many countries to eliminate the practice of inducing young girls to marry early, girls in many countries marry shortly after puberty and they are also expected to start having children almost immediately, which will put them at a high risk of pregnancy and child birth complications and out comes (UNFPA- safe motherhood, 2004). The adverse effects of early child bearing are not only biomedical, but also educational and economical in the form of reduced opportunities for the young mothers (UNFPA-safe motherhood, 2004).

4.2.2.4. The right to private and family life

Security and the right for privacy and family life have been discussed in the European convention which specifies conditions under which private and family life may be compromised or scarified to interests of the state. Article II-8 (EU convention available at http://european-convention.eu.int/DraftTreaty.asp?lang=E, accessed on August, 2008) provides that*:*

> *"1. Everyone have the right to respect for his private and family life, his home and his correspondence.*
>
> *2. There shall be no interference by public authority with the exercise of this right except such as is in accordance with law and is necessary in a democratic society in the interests of national security of the country, for prevention of health or morals, or for the protection of the rights and freedom of others."*

In Palestine as in many other countries live under occupation and suffers from political instability, many women were forced due to checkpoints and the refusal of the soldiers to let them pass to the nearest hospital for delivery have delivered there babies at the checkpoints (Red Cross, Palestine 2001; Bosmans et al, 2008). The Palestinian central statistic had reported in the year 2002 that 99 women had delivered their babies at the Israeli checkpoints, where 26 of these infants died shortly after the delivery (Palestinian Central Bureau of Statistics, 2003).

4.2.2.5 Rights regarding information and education

Rights to receive, seek and impart information are protected by all the basic human rights conventions*, (Political Covenant, article 19, available at UNHCHR: http://www2.ohchr.org/english/law/ccpr.htm).* The Women Convention explicitly requires

that women have the right to information and counseling on health and family planning (article 16 available at http://www.unfpa.org/swp/1997/box6.htm, accessed on July, 2008)

Women sometimes seek intentionally for information and sometimes come passively to them. Education and health information might be influenced by the socioeconomic class (as women with a higher class would search though sophisticated online health services) or intentionally require for the health information, while those from the lower class need to find the information in a very passive regular way as a general magazine or a newspaper, however, when women are not educated, it becomes necessary for them to be informed and counseled by health care professionals (Editorial, 2005).

It is important to note that women have the right to receive the health education and the health information and to be able to understand them in order to get the use of this information. Health professionals, intentionally or unintentionally, while transferring the information to the health recipient assume that the later knows nothing and coming from a different lower class in terms of medical information (this exerts an example of privileging expert knowledge and perspectives) (Lee & Garvin, 2003). This privilege takes place in a clinical environment, physicians are experts, patients are laypersons (Roberts & Aruguete, 2000; Falkum & Frde, 2001), and in the public health work, public health professionals are experts while members of the community are considered laypersons (Pederson & Signal, 1994; Lupton, 1995;). One Example of this privilege problem was discussed in a qualitative and exploratory project conducted by Lee & Garvin (2003), in this study one woman received information form a physician and she describes how she perceived the way he did communicated with her as she said that the physicians only tell big wards that she couldn't understand, for that she would prefer to take care of her self without seeking doctors help.

Health care professionals must ensure that women receive information in a matter of exchange and sharing ideas rather than one-way information given channel (Visser & Herbert, 1994; Aarvaa et al, 1997, Lee & Garvin, 2003). Women expressed that their needs had exceeded receiving information only, they want a good communication and a respectful interpersonal relationship which in its terms will facilitate women's understanding for the health information and build a trust relationship in between (Houle et al, 2007)

In conclusion, the right for education serves the reproductive health in many dimensions; women can read about the best contraceptive, they can protect themselves and their children during pregnancy; they gain their autonomy in the family and can have freedom on birth spacing. With education, women will be empowered and will be satisfied in asking all the necessary health related questions, adopt health activities and finally achieving better health outcomes (Philippines & Balayan, 1998; Editorial, 2005). Studies showed that lack of education will make the access to information and services limited and difficult for women, in addition, it will restrict women's movement in terms of searching for the best health services, share in decision-making and life opportunities that might limit women's participation in the community affairs, since leaders are invariably expected to be educated. Consequently, women who lack education will be disadvantaged in terms of participation in productive and community spheres that empower the individual and ensure a better status (Leach, 1998).

4.2.3. The right of access to health care and the benefits of scientific progress.

Under this right there are two major rights which are the right to reproductive health and health care and the right to the benefits of scientific progress

4.2.3.1. Right to reproductive health and health care

Since the definition of the ICPD (1994), reproductive health has taken a holistic definition and had included women's physical, psychological and social health. In practical terms there are ten pillars of reproductive health as described by Egon Diczfalusy (1995): (1) *The status of women, (2) Family planning, (3) Maternal care and safe motherhood, (4) Maternal tract infections and HIV/AIDS, (5) Infertility, (6) Nutrition, (7) Infant child health, (8) Adolescent reproductive health and sexuality, (9) Sexual behaviors and harmful sexual practices, (10) Environmental and occupational reproductive health.*

In the view of the WHO (1994) reproductive health care "*must be a component of all the primary health care services and must incorporate all aspects of reproductive health across the life span of the individual. Health services must be made available to ensure that women benefit from appropriate care throughout their pregnancies, that fertility regulation can be achieved without health hazards, and that unwanted pregnancy can be avoided or its consequences managed safely and humanely. All reproductive health services-for fertility regulation, prevention of fertility, the prevention and management of reproductive tract infections and cancers, the detection and treatment of sexually transmitted diseases, and for maternal health and safe motherhood- must accord with the highest ethical standards"*

(Paper presentation, Cairo, 1994).

Access to reproductive health care services is one of the most important reproductive health rights, as it ensures that all women need to find the reproductive health care and services available, affordable, and reachable (CESCR Committee, 2000).

Several studies have stated that gender inequalities and fragmented health system are important factors that influence women's access to reproductive health care services and family planning (Tian et al, 2007). The cost of the health care service was identified as a barrier for accessing reproductive health care service among several population and diverse settings (Steel et al, 1999; McMcheal et al, 2000; Ambruoso et al, 2005; Ahmed et al, 2006). In a qualitative study conducted in Ghana, it was found that factors such as recommendation and support by friends and relatives to seek care in a health institution, the general environment of the facility, availability of a known person or family member in that facility, confidentiality and privacy in caring were all identified as concerns in accessing reproductive health care and delivery services (Ambruoso et al, 2005). One study in Bangladesh had identified the factors that influence poor women to seek health care as lack of awareness of the kind of health care services available, deficiencies and inconsistencies in the quality of services and lack of close proximity to the healthcare facility (Ahmed et al, 2006). Inability of women to make decisions in terms of their own health care is also an important factor related to hindering access to health care, as reported in a study among women in Nigeria, where relative men and husbands were those who are mainly responsible for making decisions regarding women's health care (Chinyelu et al, 1994). Studies in family planning had found that availability, accessibility (nearby), and quality of family planning services and contraceptives were all identified as some factors that play role in accessing family planning health services as well as continuation in the use of family planning (Steel et al, 1999; Leite & Gupta, 2006).

One qualitative study that have assessed women's satisfaction from receiving health care has concluded that women value the easy access to the heath care centers, comprehensive and coordinated health care and the high quality medical care that is holistic in scope and more than just providing the service related to reproductive health. They looked to a more incorporated physical health, social functioning, family health as well as sexual health and relationships. They also value such modes of treatment that is not only based on surgery and medication but on lifestyle, education and counseling and alternative medicine (Anderson et al, 2001).

In Palestine, the political conflict is limiting the Palestinians from accessing health care by restricting movements including the ambulances and the health care workers through stopping and delaying at the Israeli checkpoints, which results in increased rates of home deliveries and stillbirths in rural areas (O'Brien and Pickup, 2002; Bosmans et al, 2008).

4.2.3.2. The right to the benefits of scientific progress

The scientific development and the creation and development of new medications, methods or practices that had evidently been proven to be effective and improves women's health needs to be available and accessible for all women, Article 15 (1) of the Economic Covenant (available at *http://www.unhchr.ch/html/menu3/b/a_cescr.htm)* recognizes the right of everyone *"to enjoy the benefits of scientific progress and its applications."* Further article 15 (3) from the Economic Covenant and its application *"undertake to respect the freedom indispensable for scientific research…"*

The right to the benefits of scientific progress requires ensuring governmental policies and protocols to facilitate the use of birth-control methodology that is proved to be safe and effective based on research, in addition to favor the interpretations of the existing laws that would facilitate their use.

4.3. Reproductive health rights previous studies in Palestine

In Palestine, There are three main studies that were performed in this regard as follows:

4.3.1. Assessment of women's violations of health rights in West Bank

The first study was conducted in 2000 by Women's Center for Legal and Social Counseling. This study investigated the violations of women's health rights in West Bank by measuring the perception of women's and the health care providers in West Bank. The main purpose of this study was to assess the level of knowledge of women's health rights among both the women and the health care providers, to identify women's rights violations and to come out with recommendations that might serve to improve the knowledge of women's rights and ensure that the health care providers follow these rights.

The main result of this study indicated that women complain of many violations of their rights while they are receiving the health care, such as: long waiting time as the health care providers are taking their coffee break or talking to each other, lack of appropriate medicine,

lack of updated instruments and equipment, in addition to lack of sensitive and respectful health staff.

Health care providers show limited understanding of women's rights, but they recognize that women need to be treated with full respect and care. It was found that about 17%, 12% and 14% of the health care providers lack the knowledge of women's rights of receiving health education, women's respectful treatment while receiving the health care and women's right for counseling and informed choice, respectively. The study showed that there were differences between the knowledge and the practices of women's health rights as more than half of the health providers admit their knowledge of women's health rights while they do not take them into consideration when they provide the health care.

The main study results were the perception of the health institutions as well as the health care providers toward decreasing violations of women's right in health care. Educating women for their rights takes top priorities and interest for both the health organizations as well as for the professionals themselves. With a total mean of 98% then improving the working conditions for the health workers follows, as for what the health professionals thought that when they feel satisfied from their work they will treat the clients in a better way and they will take care of the points of violations (95.1%). There were also differences between the professionals themselves as nurses for example were the least to support the suggestions for supporting women to write and go for a complain from what they would perceive as violation for their health care rights, perhaps because nurses are the most who deals with women and because of the fact that nurses feel not totally protected in case of the complains. Major recommendation from this study was as follows

"Suggestions for the health care institutions:

- Violations of women's reproductive health rights need to have more attention from the health care institution via more researches and better analysis. Research was considered to be the first step in giving some desensitization on the issue of reproductive health rights in Palestine.
- Adding the term of reproductive health right on the health care agenda at policy making level and at the health care institution level by setting plans for avoiding it's violation and encouraging women to seek help in case this happened.

- Identification of the major resources that women can use in case of complaining for any violations in the future in order to improve the health care services and to give women their health rights.
- Work on the perspective of improving the law and the legislative process in order to improve the control of violations in the health care institutions.
- Support the health institutions to make more health training in this regard for their health care providers." (WCLAC, 2000)

"Recommendations for the health care providers

- Prepare and train the health care providers regarding the reproductive health rights and focusing on the ethical aspects of providing the health care services, violations and women complain.
- Inform the health care providers of women's perception of the health care quality while using the services.
- Support the females of the health care providers to support the women's health rights and improve their status to a decision making level.
- Support the health care providers to control the violations for health care services through making conferences and case discussions to avoid recurrence." (WCLAC, 2000)

Recommendations for the women:

The main recommendation was to provide women with the necessary education regarding their rights through organizing workshops at different levels in cities, villages, and camps. (WCLAC, 2000)

4.3.2. Critical review of the Palestinian law concerning women's health and gender

The second study was also performed by Women's Center for Legal and Social Counseling in 2005 and titled: a review study for the sensitivity of the Palestinian laws of the women' s health and gender and its consistency with the international laws and consensus. The authors committee took into consideration World Health Organization indicators, reproductive health indicators and women's health indicators.

This study considered all the legislative law that is found in the Palestinian consensus and analyzed them in relation to women's health whether that they are directly or indirectly

related. It was also concerned with women's employment right including the employed mothers. The law of the social services was also deeply discussed especially those who give women the right to ask for divorce etc.

This review had found that the Palestinian law had achieved several important points in women's rights, but many needs to be included or modified. One of the major conclusions was that the Palestinian law lacks the holistic view of the reproductive health. For example, it does not have any law that deals with violence against women, or clear identification of the earliest age of marriage, health examination before marriage or the health care costs that should be available and affordable for all women. In terms of social and economical law, this study shows that although the law gives the women the right for the maternity leave and the protection during pregnancy in the work place, however, it does not give any attention to the discrimination in finding jobs during pregnancy, maternity leave in case of abortion or still birth or breast feeding time during the working hours.

4.3.3. Assessment of the Palestinian people knowledge of reproductive health rights terminology and its applicability

This third study was conducted in 2004, also by the Women's Center for Legal and Social Counseling and covered both West Bank and Gaza Strip. This qualitative study used focus group discussion with a total sample of 510 participants (383 women and 127 men) from West Bank & Gaza.

"Major discussions and results of that study

- *A noticeable focus on awareness programs including sexual health, the promotion of a positive fatherhood and the prevention of early marriage. However, there was an absence of the calling for specific women related rights.*
- *The call for accountability and monitoring reflected people's right to raise their voices when feeling dissatisfied and the need to consider responsibility and accountability issues in any reform endeavors.*
- *Raising awareness in schools at a young age was emphasized.*
- *The call for infrastructure development, where the focus was on facilities and their geographical distribution, availability of health human resources, especially females and the availability of medical equipment. In addition to availability, accessibility and affordability matters were also raised.*

- *Absence of any call for quality services and the right to choose the service and thus information for better decision making.*
- *In terms of general health, participants stressed the importance of good nutrition especially under a difficult nutritional status in the occupied Palestinian territories.*
- *A strong call was for a comprehensive national health insurance for all people regardless of the ability to pay.*
- *Focusing on the importance of legislation and law enforcement and legal awareness of society as a whole in addition to the needs to change laws (laws on legal age of marriage, marriage and divorce, and women's employment issues) were mentioned.*
- *Focusing on the right to live in a clean and green environment which prevents the spread of disease."* (WCLAC, 2006)

4.4. Reproductive health human rights and public health

To continue in giving introductory information regarding reproductive health human right and since this study is taking part of public health studies, it is important here to explore the relationship between reproductive health human rights and public health and how they are interrelated together.

Starting from the WHO definition of health (1948) "which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity". And "the highest attainable level of health is the fundamental right of every human being". Also United Nations Secretary General, Kofi Anna said that *"It is my aspiration that health will finally be seen not as a blessing to be wished for; but as a human right to be fought for." -*

Human rights, reproductive health rights and United Nations basic declaration and consensus of human rights (1948) gives most people who tend to be vulnerable or disadvantages worldwide a hope that their situation might be better and they will be protected, However these declarations were not legally binding, it was designed to inspire a culture of respect for human rights throughout the world and signaled a commitment to human development (Singh et al, 2007). Since the time of setting and agreeing on these declarations, governments were responsible for ensuring that their population achieves better health through respecting, protecting and fulfilling their rights (such as not violating rights, preventing rights violation, setting legalities, policies, structures and resources that promote and enforce rights) (ESCR,

1995). These responsibilities get further beyond the provision of basic health care and services to reach provision of necessary and healthy nutrition, proper housing and infrastructure, creating job opportunities and many more which by themselves are not health issues but are important items for both human rights and crucially necessary for health (Martikainen et al, 1999; Brunner et al, 1999).

It was clear from the time of WHO had defined health in 1948 the over all perspectives of health had changed from focusing on the health as a physical illness and diseases towards a holistic approach of the human beings taking its entire constituting aspects and the surrounding environment, which include both the psychological as well as the social well-being. This draw the attention to the community as primary health care and to the public health and not only focusing on the individual health as what Alma-Ata conference (1978) had discussed and in its VI and VII declarations that the primary health care is.

„… essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community“

Alma-Ata just encouraged the idea of bringing the health care close to where people live and work as this should be the first level where individuals, family, or community get in contact with the overall health system. What I could conclude here that all community had become a target for the health care system rather than only focusing on the individual's health and that health care system should not be waiting for the health care problems to occur at both the individual level or at the community level to make an action.

Later, public health perspectives had taken both the holistic approach perspectives of health and the principles of primary health care as it was defined as:

"a combination of science, skills and beliefs that is directed to the maintenance and improvement of the health of all the people through collective or social actions, is the science and practice of protecting and improving the health of community, as sanitary measures, and monitoring of environmental hazards, organized efforts of the society to protect, promote and restore people's health (IIMT , 2000).

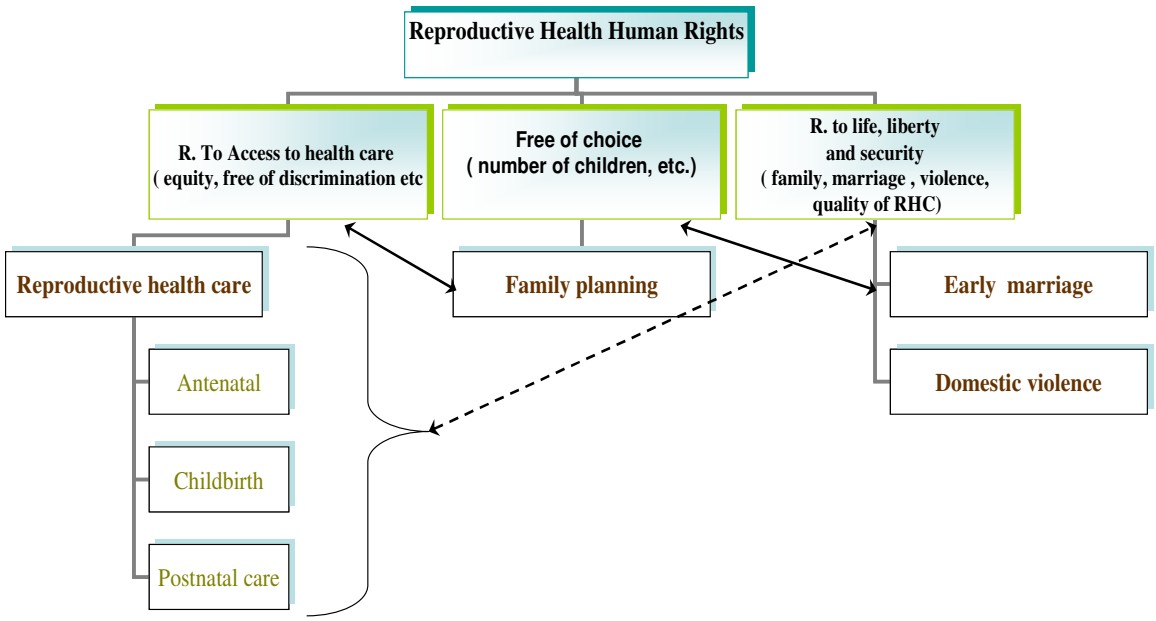
the above background information related to health, primary health care and public health could help to see that public health prevents diseases and epidemics, promotes health through health behavior practices, monitors and searches for all the health related problems at the community level and at the national level, assures the quality of health care services, prevents injures, responds to health disasters at the community level and develops health polices and regulation. Public health works on ensuring that health care services must be available in the community for everyone without discrimination based on factors such as socioeconomic status, community, gender or disability. It ensures also that health should be served with the highest possible quality, taking into consideration acceptability and cultural sensitivity (Gruskin & Loff, 2002). In other words, health needs to be administered in an overall umbrella of respecting people's human rights, not only because its obligated to do so but also because public health will not function and will achieve neither preventing nor promoting health status without people being treated with respect for their rights without discrimination and cultural differences (Gruskin et al, 2007). And since women considered one of the main groups in the over all community, considering women's reproductive health rights while thinking, providing and setting plans for women's health might be very essential as Petchesky (2003) had mentioned that without giving the women their individual rights, women will not exercise their social rights. Therefore, women need to be given their rights related to sexuality, reproduction and health in order to be able to act as a social member in the community.

Although Gruskin (2007) and her colleagues had recognized that the involvement of human rights in public health is in its primary stages and that it requires a long way to go. Worth to mention here is the first experience of engaging public health with human rights (which was in 1980s, that was in the case of global AIDS program at WHO (WHO, 1987). This inclusion of human rights was motivated because evidence was emerging that showed that discrimination was driving people away from prevention and care programmers (Man & Tarantola, 1998). It was expected that elimination of discrimination might encourage people to seek health counseling, testing and adapting behaviors that might prevent further spread of the infection through maintaining the dignity of those HIV positive people. To conclude, reproductive health human rights as well as human rights is an essential components of both primary health care and public health and without taking them into consideration optimal prevention and promotion for health would be difficult to achieve.

4.5. Reproductive health rights and the current study

In the current study, reproductive health rights will be presented as shown in the following model (4.1): in the following order, family planning, reproductive health care, domestic violence, and early marriage. Each topic of them will be reviewed by specifically giving general international literature review about its importance, presenting factors influencing lack of use, measuring the specific reproductive health rights under each topic, showing areas of women's satisfactions in each and providing a review for the important Palestinian previous studies in each topic

Diagram 4.1: Study description



4.6. Family planning and reproductive health human rights

Family planning helps save women's and children's lives and preserves their health by preventing untimely and unwanted pregnancies, reducing women's exposure to the health risks of childbirth and abortion and giving women, who are often the sole caregivers, more time to care for their children and themselves (UNFPA-safe motherhood, 2004). Family planning can also reduce poverty and promote economic growth by improving family well-being, raising female productivity and lowering fertility. It is one of the wisest and most cost-effective investments any country can make towards a better quality of life. On the other

hand, limited access to contraception might constrain women's chances to pull themselves and their families out of poverty (Hobcraft, 2003).

4.6.1. Benefits of family planning

Although many know the importance of family planning, it's important to be listed here in terms of children, community, couple and family and most importantly for women themselves.

World Health organization (WHO, 1994) had summarized the benefits of family planning as the following:

"For CHILDREN

Better health

More food and other resources available

Greater opportunity for emotional support from parents

Better opportunity for education

For COMMUNITY

Reduced strain on environmental resources (land, food, water)

Reduced strain on community resources (health care education)

Greater participation by individuals in community affairs

For COUPLE/FAMILY

Freedom to decide when to have children

Less emotional and financial strain

Increased educational opportunities

Increased economic opportunities

More energy for household activities

More energy for personal development and community activities

For WOMEN

Better health

Less physical/emotional strain

Improved quality of life

Increased educational opportunities

Increased economic opportunities

More energy for household activities

More energy for personal development and community Activities "

(WHO- benefits of family planning p 13, 1994)

4.6.2. Use of family planning methods

The use of modern contraception has risen steadily to 54% of all women currently married or in union since reliable methods became available in the 1960s. The figure rises to 61% when traditional methods are taken into account. As a result, fertility rates continue to fall. In the developing world, the total fertility rate (average number of births per woman) has fallen from over six in the 1960s to under three births per woman today (UNFPA, 2005).

However, ICPD (1994) had estimated that the number of couples of reproductive age would grow by at least 18 million each year during the rest of this decade. However, there is still a scarcity of modern family planning methods as they remain unavailable to at least 350 million couples worldwide, when they want to space or prevent another pregnancy. Survey's suggested that approximately 120 million additional women world-wide would currently be using a modern family planning method if more accurate information and services were accessible to them (ICPD, 1994)

Some family planning methods are dominant. Among them female sterilization, intrauterine devices and oral contraceptives account to be the most contraceptives used worldwide (Haub, 2002). Other contraceptives under development, including a male hormonal method, may soon add to the mix of choices available in wealthier nations. But it will be many years before these methods become available in developing countries (Nass & Strauss, 2004).
Countries have an obligation of making the modern and evidence based contraceptives available for all women and with affordable prices as what Excerpt from the ICPD Programme of Action 1994 had recommended
"All countries should, over the next several years, assess the extent of national unmet need for good-quality family-planning services and its integration in the reproductive health context, paying particular attention to the most vulnerable and underserved groups in the population. All countries should take steps to meet the family-planning needs of their populations as soon as possible and should, in all cases by the year 2015, seek to provide universal access to a full range of safe and reliable family-planning methods and to related reproductive health services which are not against the law. The aim should be to assist couples and individuals to achieve their reproductive goals and give them the full opportunity to exercise the right to have children by choice. (Paragraph 7.16).

4.6.3 Unmet need of family planning

Unmet need refers to sexually active women or couples who are not using contraceptives although they do not want another birth within the next two years, or ever (Casterline, 2000; Speizer, 2006). Casterline (2000) stated that unmet need usually results from growing demand at the community level, service delivery constraints, lack of support from communities and spouses, lack of proper information regarding contraceptives, financial costs of contraceptives and lack of accessible family planning centers or transportation restrictions.

Despite the increase in contraceptive use prevalence, there are some 137 million women still have an unmet need for contraception, and another 64 million are using traditional family planning methods that are less reliable than modern methods (Singh, et al. 2004).

It has been indicated that many women are unsure toward contraception and thus are less likely to use a family planning method, leaving them at risk of a mistimed or unwanted pregnancy (Zabin, 1999). A longitudinal study of unmet need in Morocco found that among women with an unmet need for means of limiting births, more than half had a birth in the three-year follow-up period. And one-third of these births were later reported as unwanted (Westoff & Bankole, 1998). Another study on Burkina Faso, Ghana and Kenya concluded that at least a quarter of women with an unmet need appear to be unsure about their childbearing and might not use family planning, even if it was affordable, accessible, and provided in a high quality setting. Moreover, women who tend to be unsure about their child bearing when they adopt family planning methods, they could be at high risk of contraceptive failure, inconsistent use or discontinuation (Speizer, 2006). This informs us that family planning is much more than providing the contraceptive methods but includes that women's and their family's perception towards using contraceptives must be highly considered.

Traditionally, governments of the developing countries, policymakers and program planners often use unmet need as a measure of the unfulfilled demand for family planning methods and services such as access to family planning methods. It was concluded from a study that investigated the causes of unmet need that, although for many environments, geographical access to services remains a problem, the principal reasons for nonuse are lack of knowledge, fear of side effects and social and familial disapproval (Bongaarts & Bruce, 1995).

Additionally, gender inequality might also give a strong barrier to the use of contraceptives. Boender and his colleagues (2004) had identified several gender related barriers to the use of

family planning at the policy and legal level where policy and decision makers my not put high priority in funding contraceptives because it is viewed as "women's programs". For example, some countries law may require husband's permission before using some contraceptive methods. Barriers in health facilities, as some biased health care provider's fail to offer a range of contraceptives option thinking that women might not understand correctly and might choose the wrong method. Barriers at the community level, as contraceptives viewed as methods that targeted women only and not a concern for men. In addition to the barriers at the individual and couples level, as some women might be afraid from their husband's disapprovals for using contraceptives and the fact that many couples have a difficulty discussing the topic.

It was noticed that when the use of contraceptives increases, unmet needs decrease. Consequently, women will be protected and mistimed pregnancy will be avoided (Westoff & Bankole, 2000). Studies from the Arab region found a regional differences, where unmet need was found to be low in some countries as in Kuwait (9.7%, Shah et al, 2005), little higher as in Jordan (16.3%, Mawajdeh, 2007) or high as in Sudan and in Upper Egypt (30.7% and 34%, respectively; Umbel et al, 2005; Casterline et al, 2003). Fear of side effects, lack of proper information, low level of education, religious beliefs against contraception, husband's objections, health issues and number of living children were all factors that found to be associated with unmet need in the Arabic region (Westoff & Bankole, 1998; Umbel et al, 2005; Casterline et al, 2003; Shah et al, 2005; Mawajdeh, 2007).

4.6.4. Fertility rate and family planning use in Palestine

Reports form Palestinian Central Bureau of Statistics Demographic and Health Survey (DHS, 2004) and the ministry of health (2004) had shown that the total fertility rate is 5.6 and 4.1 for West Bank and Gaza Strip, respectively. DHS (2004) reported that about 78.1% of ever-married women have ever used contraceptives; while only 50.6% of women age 15-49 are currently using contraceptives. Moreover, among the contraceptive methods used, IUD was the main methods, followed by the pills. In addition, around 70% of women start using family planning methods after the second or more births; and about 30.0% use family planning methods after the first birth. The DHS report also showed that the main reasons that reported for not using contraceptives were the desire to have children, objection from the husband's family, reasons based on religious ground and fear from side effects.

4.6.5. Family planning and reproductive health rights

According to the ICPD document (7.12) , the cornerstone of sexual and reproductive health is the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children, and to have the information and means to do so. It also includes the respect for security of the person and physical integrity of the human body (ICPD, 1994). This implies that the use of family planning is a part of the women's right to access to reproductive health care, and the right to the free choice. Family planning client is recognized to have several important rights while receiving the family planning service such as: information, access to services, informed choice, safe service, privacy and confidentiality, dignity, comfort, expression of opinion, and continuity of care (Huezo & Diaz, 1993). This means that the health care providers need to be aware that the family planning client needs to be provided with all preferable, available and appropriate methods, treated with respect for both their opinion and their decisions, provided with a personalized counseling, in addition to be provided with interactive answers to all the related questions (Agency for International Development, 1997).

Law, rules and regulations provided by the international communities had identified a set of very important legal terms that should be recognized while providing the family planning services which are counseling, informed choice and informed consent:

A. Counseling is defined as "*the process of helping clients confirm or make informed and voluntary decisions about their individual care. It is a two-way exchange of information that involves listening to clients and informing them of their options. Counseling is always responsive to each client's individual needs and values"* (Engender health, 2007).
B. *Informed choice is a "voluntary, well-considered decision that an individual makes on the basis of options, information, and understanding. The decision making process should result in a free and informed decision by the individual about whether or not he or she desires to obtain health services and, if so, what method or procedure he or she will choose and consent to receive"* (Engender health, 2007).

All health care providers, regardless of their education background and the service that they provide, must be trained in a way to provide women with a personalized counseling an informed choice.

C. Informed consent *is" the communication between client and provider that confirms that the client has made an informed and voluntary choice to use or receive a medical method or procedure. Informed consent can only be obtained after the client has been given information about the nature of the medical procedure, its associated risks and benefits, and other alternatives. Voluntary consent cannot be obtained by means of special inducement, force, fraud, deceit, duress, bias, or other forms of coercion or misrepresentation*" (Engender health, 2007)

This implies that the client is ought to be given information while provided counseling for family planning about the effectiveness of the methods, effects and side effects, advantages and disadvantages, follow up visits and whether it prevents STDs/HIV (Agency for International Development, 1997).

4.6.6. Decisions on the use of family planning

"The ability of women to control their own fertility is absolutely fundamental to women's empowerment and equality. When a woman can plan her family, she can plan the rest of her life. When she is healthy, she can be more productive. And when her reproductive rights...are promoted and protected, she has freedom to participate more fully and equally in society. Reproductive rights are essential to women's advancement."
- Thoraya A. Obaid, UNFPA Executive Director (UNFPA, 2003)

Decision on the use of family planning can be discussed at two important levels. The first one concerns the health care providers by terms of *"informed choice*", while the second at the family level.

- **Informed choice**

As defined earlier, informed choice is based on the client's proper and correct understanding of received information. Health care providers are usually deciding which medical treatment is best for the client. However, the right of the client to receive full and accurate information and to make their own decision about their health care and their right of informed choice is considered fundamental (CCP, 1989). It is worth to mention that client's preferences, values, and priorities are essential parts of the contraceptive decision making process. Therefore, focusing health providers' attention on informed choice might have a potential to improve the family planning outcomes (Kim et al, 1998, 2003, 2006). The clients should be informed of the choices they have with respect to other methods. Family planning providers should also

inform all method users of the potential disadvantages and side effects, in addition to what they should do if they encounter any of these side effects. This information assists the clients in coping with, and in recognizing the side effects and in decreasing unnecessary discontinuation of temporary methods (El-Zanaty & Way, 2005).

In some cases people may need support in making decisions about using family planning, especially when people tend to be provided with many options where decision making becomes harder. The support should be provided to women to be able to distinguish between pros and cons, or to choose the best method for their situation (O'connor et al, 2003). On the other hand, providers sometimes believe that they know what the client needs best. Although they understand and accept that family planning is primarily the client's choice, they tend to be involved in the process of client's decision making (Kim et al, 1998; Rudy et al, 2003). Therefore, it is important to recognize that the client is totally responsible for their choices in using family planning and that the provider role is to help and supports the clients' efforts to make a choice by informing and interacting (Kim et al, 2005). One of the evidence based guidelines tools that was developed by the WHO in order to improve the quality of family planning services is the decision making tool (Peterson et al, 2004, WHO, 2005). This tool has been tested to be effective in supplying the providers with counseling tips and technical information and in helping the clients to make the decision by providing them with personalized information which clarify their values regarding benefits and risks that leads to aid their choice of family planning option (Kim et al, 2005, 2006, 2007; Chin-Quee, 2007).
Regional countries reports showed that in Egypt, more than half of the family planning clients reported that the provider discussed other methods than what they already use. In addition, similar but slightly smaller proportion was told about the side effects of these methods. About 40% of the users were told what to do if they experienced side effects (El-Zanaty & Way, 2005). However, in Jordan 70% of women were informed about alternative methods, same percentages of clients were informed about the side effects of their method, while 56% were informed about what to do when they experience side effects (Department Of Statistics [Jordan] and Orc Macro, 2002).

- **Decision of using contraceptives at the family level**

Women's autonomy in making decisions regarding the use of family planning methods and fertility regulations has a diverse meaning and contradicting factors. Autonomy has been defined as " *the technical, social and psychological ability to obtain information and to use it as the basis for making decisions about one's private concerns and close relations* " (Dyson

& Moore, 1983). Jejeebhoy (1995) identified five interdependent aspects of women's autonomy: autonomy of knowledge, decision-making, physical autonomy, emotional autonomy, economic, and social autonomy and self-reliance. DHS studies have found that women with decision-making power and autonomy are often better able to meet their reproductive health goals comparing to other women (DHS studies, 2000).

In developing countries, several studies have measured the influence of household decision-making and women's autonomy on the use of contraceptives. One of these studies was conducted in Oman and found that education was a better determinant for contraceptive use than empowerment scale, which was a combined scale from household decision-making and physical autonomy (Al Riyami et al, 2004). Likewise, a study in Pakistan found that decision autonomy was strongly associated with both lifetime and current contraceptive use; it also found that the prominent factors of contraceptive use were the education and the number of living children. However, both autonomy scores (household decisions and physical autonomy) were associated with women's education (and most other socio-demographic characteristics) but they did not appear to mediate the effect of women's education on contraceptive use (Sathar & Mason, 1993). Another study conducted in Egypt showed a different perspective in the influence of autonomy and education. It was found that women with autonomy and input in other domestic areas were more likely to have input on family planning matters and to use contraception. But education and employment only partially mediated the relationship between the non-reproductive and reproductive variables, indicating that these variables should not be used as proxies of Egyptian women's status (Govindasamy & Malhotra, 1996). In Jordan, currently married women who have more say in household decision making are more likely to use a contraceptive method, particularly a modern method, than women with less say in household decision making. Whereas 59% of women who have a say in all five specified decisions are currently using family planning method, only 45 percent of women who have a say in one or two household decisions are current users of contraception (Department Of Statistics [Jordan] and Orc Macro, 2002).

Gender inequality is another factor that plays a significant role in decision autonomy on contraceptive use. Research shows that couples often disagree about the desirability of pregnancy and the use of contraceptives (Speizer, 1999). When this discordance occurs in a situation of male authority, men's opinions about these issues may overrule women's, even though the women often must implement the decisions made on these matters. In some cases,

husbands fear that if they approve of family planning and allow their wife to use it, they will lose their role as head of the family, their wife may be unfaithful, or they may lose face in their community (Watkins et al, 1997). In Jordan for example about 8 percent of women mentioned the reason for not using contraceptives as husband's disapproval, or those women were mainly younger than 30 years old (Department Of Statistics [Jordan] and Orc Macro, 2002). While in Oman, almost half of the women mentioned that the husbands decide whether the contraception shall be used (Al Riyami et al, 2004)

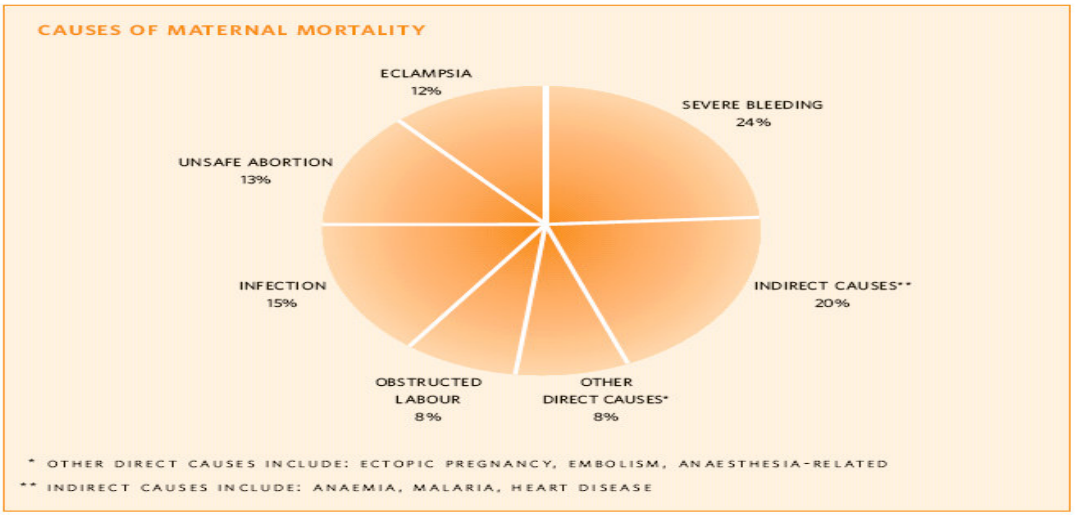
An example for studies that showed a relationship between gender inequality and contraceptive use was a study in Honduras which found that 25% of women and men reported male centered decision-making attitudes and behaviors related to family planning use or family size. The remaining respondents said either that decision-making was shared or that it was handled exclusively by the woman (Speizer, 2005). Another study in Egypt revealed that the majority of women reported that family planning decision making should be made jointly between the two partners (Govindasamy & Malhotra, 1996).

Although Islam is perceived by many people as a hindering factor in using contraceptives and in gender inequalities, one study that interviewed religious leaders in Jordan showed that 82% of male religious leaders and 98% of female religious leaders believed that family planning is in keeping with the tenets of Islam. It also shows that about 90% of religious leaders agreed or agreed strongly with the statement "contraceptive decisions should be made jointly by husband and wife" (Underwood, 2000).

4.7. Reproductive health care and reproductive health rights (antenatal, delivery and postnatal)

It was estimated by the WHO that every year world wide, about 515,000 women die of complications of pregnancy and childbirth (WHO, 2001), a rate of over 1400 maternal deaths each year. In addition to at least 7 million women suffer serious heath problems when they survive childbirth, and an additional estimate of 50 million women who suffer adverse health effects after childbirth (UNFPA, 1999). Globally, maternal mortality ratios present the largest discrepancy in any public health statistics between developed and developing countries (Starrs, 1997).The statistics of women's mortality and morbidity are one indication of the neglect of women's reproductive health and their well-being (Cook, 1993). However, most of the deaths and some of the severe complications could be prevented by cost-effective health interventions (WHO, 1999).

It has been stated that in the course of pregnancy, labour and delivery, women "…in every country and every population develop complications, but women in developing countries are much less likely to get prompt adequate treatment, and are therefore more likely to die" (Maine, 1997). The scarcity of physicians, trained nurses, or midwives and often of skilled birth attendance accounts for much of the incidence of maternal mortality and morbidity (Graham, 2001). Social factors and custom may be also involved; in addition, the health care cost that is often high is a barrier to access reproductive health care among impoverished families (Cook, 2002).The following graph (Figure 4.1) shows the major causes of maternal death globally:



SOURCE: WORLD HEALTH ORGANIZATION. *MATERNAL HEALTH AROUND THE WORLD*. GENEVA, 1997.

This high scale of death is not an unavoidable danger of pregnancy and childbirth. Policy making and decision negligence, devaluation, and discrimination against women often result in a preventable loss of life and tragic results (WHO, 1999). Use of the language of "rights" brings into focus governments' binding obligations under international and national law to ensure a woman's safety throughout pregnancy and childbirth. Among these rights, one right that gives women the right for high quality of health care during pregnancy, childbirth and after childbirth (Cook, 1993).

Experts have identified a number of health-care interventions that contribute to a reduction in maternal mortality (Center of Reproductive Rights, 2005), including ensuring access to high quality of:

- Pre- and post-natal care
- Trained attendants at birth
- Emergency obstetric care
- Family planning

The United Nations Committee on Economic, Social and Cultural Rights (2000) has acknowledged that the right to health necessarily adds a very important responsibility to the government duty to provide health-care services. It has been stated that fulfillment of the right to health care depends upon the "*availability, accessibility, acceptability and quality*" of health care for all individuals and "*the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health."(*CESCR Committee, 2000). Availability of the health care refers to the existence of the service, time necessary to receive the care, trained staff and medical goods and instruments (Kroeger, 1983; Becker et al, 1993; Sarin, 1997). Accessibility of health care refers to the physical and geographical accessibility of the health care services which considered an important variable in the use of health care services (Abbas & Walker, 1986), such as cost and physical barriers (for example, transportation and proper roads, closures and instable political situations). In Bangladesh, it was found that the geographical distance is one of the most important determinants of healthcare service utilization in rural areas (Rahaman et al, 1982).

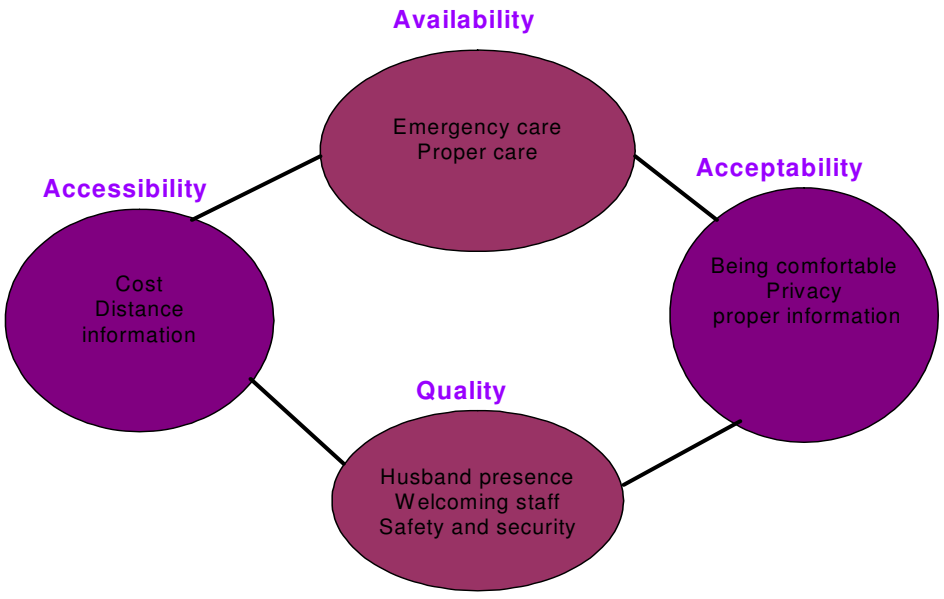
Acceptability refers to the important factors that women's cultural and social beliefs value, such as privacy, age and gender. For example, women in Beirut- Lebanon complained of violation of their privacy during childbirth in teaching hospitals (Khasholian, 2000). In Bangladesh, it was found that older women are more likely to seek maternal health-care than younger women (Chakraorty, 2003). Gender is another factor where many women seem to prefer a female health care provider. For example, in Saudi Arabia, women express clearly that they want to be seen by a female doctor in antenatal care (Nigenda, 2003). In addition, language sensitivity is also one of the important factors regarding the acceptability of health care. For example, In a study of the indigenous Mayan population in Guatemala, research show that Mayan women avoid family planning programs not because they do not want the services, but because they are rarely accessible and served without any cultural or language sensitivity (Cospín, 1998).

Many other factors could also affect the quality of health care, including: poorly-trained, disrespectful and uncaring attitudes of medical staff, deteriorating facilities, inconvenient operating hours, or restrictions on who may stay with a woman at a health-care facility (AbouZahr, 1996). For example, women from Beirut have considered the presence of their husband in the delivery as a necessary support; however, hospitals were not having this policy (Khasholian, 2000).

Perhaps all those working in the field of reproductive health and rights should make a point of listening to women's views (Humble, 1995), in addition to their perceptions which define their health-seeking behaviors and are mirrors of their use of their reproductive health rights (Younis, 1993). Taking into considerations that women's perception of their reproductive health rights depends on many cognitive, cultural, emotional, social, and political factors (Freeman, 1993). However, there is a scarcity of studies that measure and assess women's perception regarding their reproductive health rights worldwide.

In the following literature review: antenatal care, delivery and postnatal care will be discussed taking into consideration the following framework which have been used in assessing women's perception regarding reproductive health rights particularly the right for health care:

Diagram 4.2: Study framework



4.7.1. Antenatal care

Antenatal or perinatal period is the period that starts from the moment the woman becomes pregnant (conception) until the time of delivery. The main objectives of the antenatal care (as recognized by the UNFPA (2004), safe motherhood protocol) are to establish the first contact with the woman and to conduct a health assessment that identifies any current problems and any potential risks. It will also create an opportunity to set a delivery plan taking into consideration each woman's needs, current resources and overall circumstances. The delivery plan should be by itself identified by the woman herself by exploring her delivery intentions about where to deliver and assisted by whom and arrange for any contingency plan in the event of complications (e.g. transportation, place to referral, etc.). The importance of antenatal is to support women in the care of their infant, advice them if necessary, educate them about all the health prevention and promotion aspects necessary during pregnancy, reassure them that pregnancy is a normal process and not a disease and provide them with treatment if appropriate (Petrou et al, 2001). Evidence showed that antenatal care importance for the infants were related to increase growth rate, increased survival and decreased potential for infection (Campbell & Graham, 2006).

During the antenatal visits, a woman needs to go through several physical examinations, not only to ensure her overall health status but also to search for other related factors that could play a role in increasing risks for complications during pregnancy, such as women's age (younger than 17 or older than 40), grand multipara, significantly short stature, and obstetric history of any previous complications including surgery (UNFPA safe mother hood, 2004). Other important element of antenatal care is detecting and managing any arising complications such as pregnancy induced hypertension (pre-eclampcia) which is found to be a common reason for pre-term birth that is in it's turn responsible for increased maternal and perinatal mortality and morbidity in developing countries (Goldenberg et al, 2008). Anaemia is another complication that is found among pregnant women to be related with increased rates of maternal mortality, premature delivery, and low birth weight and others (Mahomed, 2000; Rizvi et al, 2007; Badshah et al, 2008). Studies had shown that about 60% of pregnant women world wide are having anaemia (WHO, 1992). Diabetes Mellitus is also associated with preterm delivery and perinatal mortality (Goldenberg et al, 2008). Ante-partum hemorrhage could also be related to unsafe abortion or spontaneous abortion which is highly associated with maternal mortality (UNFPA, safe motherhood, 2004). In addition, malaria or an STD was found in some studies to be associated with pre-term labor (Noble et al, 2005).

Other newly discussed pregnancy complication is maternal obesity, which was found to be associated with putting women at higher risk of maternal morbidity (Guelinckx et al 2008).

The effectiveness of antenatal care in reducing maternal mortality and morbidity had been debatable (Carroli et al, 2001), since many of the life threatening pregnancy complications are not prevented in antenatal care (Abu Zahar et al, 2003). However, some previous studies had shown that antenatal care reduced the risk of pre term birth (Hoffman et al, 2002), low birth weight (Hoffman et al, 2002) and perinatal death (McCaw et al, 1994).

Part of the antenatal care activities is prevention of diseases by providing prophylactic iron, folic acid, tetanus toxoid immunization, vitamin supplements, iodized oil/salt, antimalarials (according to country policy) and antihelminthics (hockworms) in endemic areas (UNFPA safe mother hood protocol, 2004). It worth's here to mention that health education and counseling during pregnancy are very important components of care, as women need to know about all the aspects that could help in preventing complications and promote their health status and the health of their infants. Such health education should be directed towards women's maternal nutrition, STD/HIV prevention, choosing the best place of delivery criteria, exclusive breast-feeding, immunization and most importantly family planning (WHO, 2005). Family planning counseling during the antenatal care had shown to be as effective as counseling during the postnatal period (Glasier et al, 1996; Ozvaris et al, 1997)

Traditionally, it was recommended by the European model early of the 20th century that the pregnant woman should conduct 12 visits during the pregnancy time-span as follows: once a month during the first 6 month, once every 2-3 weeks for the next 2 months and then once every week until delivery. Many WHO randomized control trial studies have assessed the effectiveness of this high number of visits (Carroli et al, 2001; Viller et al, 2001) and the WHO (2005) reached the conclusion of giving a recommendation of at least four, goal oriented, antenatal visits in case of free of complication pregnancy. Each visit consists of a well established activities as:" *(1) screening for conditions likely to increase adverse outcomes, (2) providing therapeutic interventions known to be beneficial, and (3) educating pregnant women about planning for a safe birth, emergencies during pregnancy and how to deal with them"* (WHO, 2005).

Although the WHO (2005) had reported that the level of antenatal care attendance had increased by 20% worldwide during the 1990s, there are still some parts of the world where the minimum of four antenatal visits were not achieved. Obstacles and factors that were found to be associated with this lack of attendance were studied in several societies. A systematic review study that had been conducted recently by Simkhada et al (2008) found that in developing countries the following factors were associated with antenatal care lack of attendance, namely: sociodemographic factors such as low level of women's education, low level of husband's education, high number of children women's have, unmarried pregnant women, younger and older women, and certain ethnic and religion. Other less important factors mentioned in this study were lack of access to health facility, lower household economic statues, women's low household decision making, unemployed women, women with low level for media exposure and low level of family planning knowledge. On the other hand, the factors mentioned in studies conducted in developed countries were different. A systemic review study in United Kingdom measured the effect of social class and ethnicity in antenatal care inequality and found that although social class was found to be related to late or low attendance of antenatal care, it did not show or could not prove social inequality in that matter. However other studies assessed ethnic relationship with antenatal care found that some ethnic groups were late to attend antenatal care and that might give an indication of inequality (Rowe & Garcia, 2003). Another systematic review study measured the relationship between social inequality and taking pregnancy examinations in the UK had found no association in between, however, it was found there that some ethnic groups use the examination less (Rowe et al, 2003). The two previous mentioned studies in developed countries explained that lack of attendance or lack of pregnancy test taking of some ethnic groups were related to language and cultural barriers that those ethnic group might have which might give an indication of a problem in the health care system that could not appropriately deal with such differences.

Women have been reported worldwide been generally satisfied from the antenatal care received (Langer et al, 2002; Van Teijlingen et al, 2003). However, some studies have measured women's attitude and perception toward number of visits, procedures carried during antenatal care and their satisfaction. One Swedish study measured women's rank of importance in relation to seeking antenatal care found that women had ranked their baby care first followed by their own health care, involving their partners in the care as the most important reasons (Hildingsson et al, 2002). Women who had reported dissatisfaction in

antenatal care in previous studies, their dissatisfaction was associated with an insufficient number of antenatal visits, prolonged waiting time, care content, lack of explanations and information, in addition to the lack of continuity of health care provider (Brown & Lumley, 1994; Sikorski et al, 1996; Williamson & Thomson, 1996; Laslett et al, 1997; Fraser, 1999; Dowswell et al, 2001).

4.7.1.1. Pregnancy and women's reproductive health rights

It is important to provide some information about the importance of antenatal care during pregnancy in terms of reproductive health rights. One part of reproductive health rights is to ensure that all health care during the pregnancy process (antenatal and postnatal period) needs to be to be in a good access, affordable, available and provided in as high quality as possible for women during and the pregnancy period (antenatal and postnatal period) (WHO, 2005).

During pregnancy, women need to be protected from any kind of violence as one of their reproductive health rights. It has been reported that domestic violence during pregnancy in some countries is very high. An example of recent studies is a study in Turkey that shows that about 28.9% of the studied women have had experienced at least one time physical violence from their husbands during their previous or current pregnancy (Deveci et al, 2007). In India, a recent study found that almost half of the surveyed women had reported being kicked or slapped at some time during their current pregnancy (Chhabra, 2007). Empirical studies showed that physical abuse during pregnancy is related to later entry into perinatal care (Gazmararian et al, 1995; Dietz et al, 1997; Goodwin et al, 2000) and miscarriage (Jacoby et al, 1999). Other consequences of violence during pregnancy are a preterm labour and low birth weight as stated by Boy and Salihu (2004). Physical violence during pregnancy can also affect the health of both the mother and the infant indirectly, as it has been found in some studies that pregnant women who experience physical violence are more likely to smoke, drink alcohol or use drugs compared to those who do not experienced violence; where these put their infants into high health risks (Martin et al, 1996).

Another important right of the pregnant women is to live during pregnancy in socially and environmentally favorable conditions. Women around the world face social, race and ethnic inequalities during pregnancy as well as marginalization and discrimination (such as the working conditions and rules during pregnancy) all, which can severely affect the health of the mothers and their infants or child's; these are considered among women's basic rights during pregnancy (WHO, 2005).

4.7.1.2. Antenatal care background information in Palestine

In a household national study (West Bank and Gaza) conducted by Maram project 2003 and the Palestinian Central Bureau of Statistics–Demographic and Health Survey (DHS, 2004), it was found that the majority of the surveyed mothers (95% and 95.5% in Maram and in Palestinian Central Bureau of Statistics -DHS, respectively) received at least four antenatal checkups during their most recent pregnancy, though, these check-ups did not necessarily involve all the internationally recommended components of antenatal care. At least one of these check-ups was provided by trained health personnel; while 62.6% of women were seen by a doctor and 37.3% by a nurse or midwife. The National DHS study conducted by the Palestinian Central Bureau of Statistics (2004) found that mothers who gave birth within the two years preceding the survey made a median of three antenatal visits during that pregnancy. And among mothers who made at least one antenatal visit during their most recent pregnancy, 80-95% received care that included measurements of abdomen, weight, blood pressure, fetal heart rate as well as urine testing, where 69% of mothers who received any antenatal care had their height measured. Barghouthi et al (2003) stated that in Palestine, more than half of the women sough antenatal care from more than one doctor. Moreover, Palestinian Central Bureau of Statistics DHS (2004) reported that the tetanus toxoid immunization coverage was 34.6%. The baseline assessment of Maram (2003) found that 75.1% of pregnant women had reported being suffered from at least one pregnancy complication during their pregnancy where many of them did not seek care despite their worries about these complications. Some of these women gave the reason for not seeking care as they did not regard these complications as a problem.

4.7.2. Delivery and childbirth

The process of delivery starts from the moment women go through labour pain and contractions until the baby born, and then followed by the expelled of full placenta. To give a small introduction to delivery process, it goes into three stages: the first stage starts when the women begin feeling the contractions, which increases until the child goes into the birth canal. During this period, woman needs to be accompanied by a family member and have a good support. The second stage starts when the vagina is fully dilated and the baby safely delivered and gets out from the birth canal. The third stage starts afterbirth, when the full placenta expelled as well (UNFPA-safe motherhood, 2004). During the third stage, the woman might go through unpredictable complications such as that the umbilical cord might be around the infant neck, excessive bleeding and multiple births. Additionally, women might

also go into convulsions and other issues are related to the infant such as low or high heart beats that is related to lack of enough oxygenation and many others (UNFPA safe motherhood, 2004). Although these complications are unpredictable but almost all are treatable in the case of availability of emergency treatment (WHO, 1999; UNFPA safe mother hood, 2004). "…*Even with the best possible antenatal screening, any delivery can become a complicated one requiring emergency intervention*" (UNFPA safe motherhood, 2004). Worth to remember that every minute one woman die in the world as a result of pregnancy and childbirth complications, with high proportions in Asia and Africa (WHO, 2001). Moreover, complications occur to 15% of deliveries and can't be predicted (Maine et al, 1997; Say et al, 2004).

It was recognized in the fifth Millennium Development Goal (2000) that in order to reduce maternal mortality in the world, women need to be delivered under the assistance of skilled birth attendants (SBA). This was defined then as :*"Skilled attendance or care refers to the process by which a pregnant woman and her infant are provided with adequate care during pregnancy, labour, birth and the post-partum and immediate newborn periods, whether the place of delivery is the home, health center, or hospital. In order for this process to take place, the attendant must have the necessary skills and must be supported by an environment that enables her or him at various levels of the health system, including a supportive policy and regulatory framework; adequate supplies, equipment and infrastructure; and an efficient and effective system of communication and referral/transport."*

> *– Adapted from Skilled Care during Childbirth: Information Booklet, published by Family Care International, New York.*

This definition implies that SBA might be a doctor, a nurse, a midwife or sometimes a traditional birth attendant (TBA). The TBA must have the necessary skills and training to follow up on uncomplicated deliveries and to detect early the women with complications and to do proper referring (this is of course in an areas where TBAs are heavily dependant on and where access to doctors and nurses might be difficult) (WHO, 2004). However, based on delivery outcomes it was shown that TBA training might be challenging and face several problems, especially in changing TBAs attitudes and perception of referring the complicated cases particularly when they are too old and been practicing childbirth since quite a long time (Fatim et al, 2005). Previous studies had found that the benefits of TBAs training on improving mother and infant health outcomes were not promising (Goodburn et al, 2000; Smith et al, 2000).

Currently there is a great focus on preparing nurses and midwifes together with other health professionals to take the role as the skilled attendants during the critical period of delivery (Harvey, 2007). But in order to ensure that those health providers are correctly skilled and capable for delivery attendee, they need to have the following: on going training and upgrading as indicated by Harvey (2007); enough and sufficient medication and equipment, enough staff working in the same unit, in addition to self satisfaction by getting good salary and good working conditions (Hassan & Wick, 2007).

4.7.2.1. Where is the best place for delivery?

Delivery can take place in either health care service settings or at home. Home delivery can be well planned like what is taking place in Western countries, for example the Netherlands and many others (Wlegers et al, 1998). Planned home birth is the birthing process that women choose for to satisfy their needs, including: defined medical environment, accompanied with qualified skilful attendants who had special working experience in home delivery and health care system that provides access to equipment, and specialized personnel and back up hospital when necessary. On the other hand, unplanned home birth includes birth without skillful attendant and might lead to precipitous deliveries in route to the hospital and births that occur without an infrastructure or a support of a health care system (Vedam, 2003). Studies had shown that the rate of perinatal mortality is much higher in unplanned home birth compared to the planned one (Burentt et al, 1980; Hind et al, 1985; Mayers et al, 1990; Northern Region Perinatal Mortality Survey Coordinating Group, 1996). In Western societies where planed home birth is available for women as a choice, debates are still going on regarding where it is safer for low risk pregnant women, at home or at hospital (Vedam 2003; Olsen, 1997; Murphy, 1998). In general, low risk pregnant women should have the autonomy to choose the place to deliver that meets their needs. In that, some women may look for more privacy, family surroundings and one midwife support, in addition to being in a familiar environment with less medical stress (such as vaginal examinations, pain killers and many other tests) which can be found in home delivery. Other women might think of the emergency implications that might be happening, more teaching and supportive relationship from the nurses and pain killers in case of the need for it which can be found in the hospital and health institution delivery (Heaman & Gupton, 1998; Wlegers et al, 1998; Zelek et al, 2007).

4.7.2.2. Childbirth and reproductive health rights

Women had the right to have all the necessary high quality services available, accessible and affordable during the process of delivery (Cook, 1993). In Palestine, in 2003 it was reported

that there were about 99 deliveries had been forced to take place at the Israeli checkpoint as these women were not allowed to have an access to reach the hospitals on time (Palestinian Central Bureau of Statistics, 2003). High quality services might be also a serious human rights problem that some women face. For example, an observational study at one of the governmental hospitals in the center of West Bank-Palestine had found that women were mistreated during delivery by shouting and screaming at them while they were in pain, there were no health education after delivery and the immediate postnatal care was not properly done, and that female relative or husband is not allowed to accompany women during delivery (Hassan & Wick, 2007).

Annas (1998 and 2004) has summarized the rights of the child bearing women and clarified many issues related to women's rights. The following are summaries of these related to childbirth rights.

"

1. *Women have the right to health care before, during and after pregnancy and childbirth.*
2. *Every woman and infant has the right to receive care that is consistent with current scientific evidence about benefits and risks.*
3. *Every woman has the right to choose a midwife or a physician as her maternity care provider.*
4. *Every woman has the right to choose her birth setting from the full range of safe options available in her community.*
5. *Every woman has the right to receive all or most of her maternity care from a single health provider or a small group of health providers, with whom she can establish a trusting and confidential professional relationship.*
6. *Every woman has the right to communicate with health care providers by asking any related questions and receive all care in privacy and confidentiality.*
7. *Every woman has the right to receive a respectful maternity care that takes into consideration her social, culture, and religious background.*

8. *Every woman has the right to receive information including benefits, risk, and costs of the procedures and about all interventions that are likely to be offered during labor and birth well before the onset of labor intervention.*

9. *Every woman has the right to accept or refuse procedures, drugs, tests and treatments, and to have her choices honored.*

10. *Every woman has the right to have family member, including husbands and friends of her choice present during all aspects of her maternity care.*

11. *Every woman has the right to receive continuous emotional, social, and physical support during labor and birth from a health care provider who has been trained in labor support.*

12. *Every woman has the right to receive full advanced information about risks and benefits of all reasonably available methods for relieving pain during labor and birth, and to choose which methods will be used and be able to change her mind at any time.*

13. *Every woman has the right to freedom of movement during labour.*

14. *Every woman has the right to maintain a contact with her newborn from the moment of birth.*

15. *Every woman has the right to receive complete information and training about the benefits of breastfeeding well in advance of labor, and to refuse supplemental bottles and other actions that interfere with breastfeeding.*

16. *Every woman has the right to decide collaboratively with the health care provider when she and her baby will leave the birth site for home." (Annas, 1998, 2004)*

4.7.2.3. Background information on childbirth in Palestine

The majority of childbirth in West Bank takes place in hospitals (Maram, 2003; MOH health report, 2003; Palestinian Central Bureau of Statistics -DHS, 2004). According to the MOH (2005), it was reported that 83.9% of deliveries were considered normal, while the rate of cesarean deliveries was 16.1% (17.1 in WB and 15.3% in GS) and about 96.8% of births took place in health institutions and only 3.2% took place at homes in Palestine. In West Bank there are 37 maternity hospitals, eight (22%) run by the government sector, 13 (35%) by the NGO sector, 15 (41%) by the private sector and one in Qalqiliya run by UNRWA (Hanan

Project, 2005; Wick et al, 2005). Close to half of the deliveries took place in Governmental hospitals while only 13.2% of deliveries took place in private hospitals (Wick et al, 2005). Women delivered in governmental hospitals are mainly from poor, government employees or those who are having Alaqsa governmental insurance which is a relatively close to a free of charge insurance (Hanna project, 2005; Wick et al, 2005; Giacamanet al, 2006; Hassan & wick, 2007). In a study conducted by Giacaman et al (2006) assessing women's satisfaction in childbirth, it was found that women felt more satisfied in private hospitals compared to governmental hospitals. This supports the observational study that conducted recently by Hassan and Wick (2007) for one largest referral governmental hospital located in the center of West Bank, where they evaluated the care given as suboptimal. They provided the reason for their evaluation as: shortage of staff (which was also found in the study of Wick et al, 2005), overcrowded labour ward, lack of basic supplies and equipment, poor management and organization of care, outdated knowledge, particularly regarding management of the third stage of labour, forbidden women to have female companions during labour and birth, restricting women to the lithotomy position to give birth, and the routine use of oxytocin to speed up labour and to free up beds for the next women coming in. On the other hand, service provided by the private hospitals are relatively more expensive, give the women more privacy, allow family companion, provide better services by giving the women the allocated time for delivery and health education and with more staff available for care (Giacaman et al, 2006). Moreover, in private hospitals, women were allowed to request for the private specialized physician who was taking care of them during the prenatal period to the private hospital (Wick et al, 2005). Regarding the immediate postnatal care following delivery, Hassan and Wick (2007) reported being insufficient and inappropriate in the observed governmental hospital and among the women observed none were given health education regarding breastfeeding

2.7.3. Postnatal care

The postpartum (postnatal or puerperium) period was defined, as "the period that starts about an hour after the delivery of the placenta and includes the following six weeks" (WHO, 1998). Postpartum period was related to several maternal mortality reasons and morbidity such as: postpartum bleeding which is the first leading cause of death, sepsis, and pregnancy-related hypertension had been identified as major acute morbidities. While, longer-term morbidities include uterine prolapsed, vesicovaginal fistulae (VVF), incontinence, dyspareunia and infertility (Koblinsky, 1994; Ronsmans, 1997; Prual, 1998; WHO, 1998; Chama, 2000; Waterstone, 2003; UNFPA, 2004; Fikree, 2004; Freeman, 2005; Nama et al, 2006,).

Moreover, UNFPA (2004) and Ronsman & Graham (2006) had indicated that up to two thirds of maternal deaths occur after delivery. In Palestine one recent community based study in West Bank- Palestine showed that maternal mortality ratio for the year 2000 and 2001 was 29.2 and 36.7 per 10.000 births respectively, while 55% of these maternal deaths occurred during the postpartum period, and hemorrhage was the main direct reason (Al-Adili et al, 2006). Therefore, postpartum care had been considered as very important in preventing the adverse health out comes for both the mother and the infant (Lomoro, 2002).

The goal of postpartum care is to maintain the physical and psychological well-being of the woman and child. Providers must be particularly sensitive to the needs of the woman during this transitional time, and provide support for a smooth transition back to her family and community (MARAM, 2003). While in practical terms postpartum care should include the prevention and early detection and treatment of complications and disease, and the provision of advice and services on breastfeeding, birth spacing, immunization and maternal nutrition and the psychological status of the mother (WHO, 1998). It also must be collaboration between parents, families, caregivers, health professionals, community groups, and policy makers. The essential components of postpartum care are health education and counseling, and the rapid detection, treatment and referral of any problems for further management (PalMOH, 2004). WHO had recommended that postnatal care needs to be done at 6 hours, 6 days, 6 weeks and 6 months post delivery (WHO, 1998). During the first 6 hours the mother would need basic support on controlling blood loss, pain, observing any warning signs including blood pressure. The first 6 days postnatal care would focus mainly on observing the lochia, women's mood, temperature and providing support on breast care. The 6 weeks care would include women's complete physical checkup, checking anaemia, providing advices on contraceptives use and breast feeding, and checking the psychological status of the mother. Finally the 6 months postnatal care would focus on women's general health, continue assessment of the continuous morbidity and advices on contraception.

Overall among the developing countries, there is low attendance of postnatal care, as an example one study among 30 developing countries representing major regions used the data from Demographic and Health Surveys carried out between 1999 and 2004 found that seven out of ten births mothers do not receive any postpartum care (Alfredo et al, 2006). Another recent study from Nepal showed that 34% of women only have conducted postnatal check up in the first 40 days following delivery (Dhakal et al, 2007). While, regionally, In Jordan about

65% of women who delivered at health care facility received no postnatal check up after delivering their last child (Department of Statistics [Jordan] and ORC Macro. Jordan Population and Family Health Survey, 2002). Furthermore, in Egypt, about 41.7% of women conduct no postnatal care (El- Zanaty & Way, 2005). And in a qualitative study in Lebanon none of the interviewed women from semi-rural villages in the Bekaa and Akkar has conducted postnatal visits (Kabakian-Khasholian et al, 2000).

Low attendance of women at the postpartum visit was related to several factors such as service cost, insensitive staff, feeling well, perceiving the symptoms as not important enough to warrant a consultation, lack of knowledge of the benefits of postnatal care, or prioritizing the heath being of their infants more than their own health (El-Mouelhy et al, 1994; Goodburn et al, 1995; Turan , 2003; Nabukera et al, 2006). While The importance of postnatal care was perceived differently by women between countries, as an example from developed countries, almost all women (95%) from Australia in a community based study ranked postnatal care as very important (Gamble, 2007)**.** On the other hand, and in the regional countries, one qualitative study in Lebanon semi rural villages in the Bekaa and Akkar concluded that postnatal check-ups were considered essential only in case of complications and some women in Beirut doubted its importance in the absence of any complications signs or symptoms (Kabakian-Khasholian et al, 2000):

4.7.3.1. Postnatal care in Palestine

In Palestine (West Bank and Gaza) previous studies reported, that women's attendance of postpartum care was 23.4% in 2003, 34.4% in 2004, 27.4% (West Bank) in 2005, (Maram, 2003, Palestinian Central Bureau of Statistics-DHS, 2004; PalMOH, 2004). The average women's stay in the maternity hospitals post partum is 24 hours, therefore postnatal follow up would take place mainly in the community primary health care clinics (Shaw et al, 2006). The MOH together with many national NGOs had developed the postnatal protocol which had very important elements:

"During the period of postpartum health care providers should do the following:

- *Support the physical, mental, and social health of the woman and baby by supporting the woman and her family in the transition to a new family constellation.*
- *Promote the active participation of the woman, her partner and/or other family members in postpartum care.*

- *Provide early detection and management of problems or complications that may affect the health of the woman and newborn.*
- *Refer the woman and infant to the back-up hospital when necessary.*
- *Assist the woman to breastfeed successfully.*
- *Provide health education and counseling about:*
    - *danger signs for the woman and baby and appropriate responses, including developing a complication readiness plan for the postpartum period*
    - *nutrition*
    - *self-care and hygiene*
    - *physical changes in the woman's body*
    - *breastfeeding*
    - *birth spacing/contraception and sexual life" (PAMOH postnatal protocol, p 7, 2005)*

The protocol also included that at the time of women discharge form the hospital after delivery she needs to be educated about the following important issues**:**

"

- *Infant care, breastfeeding and potential breastfeeding problems.*
- *Self-care and hygiene.*
- *Proper diet and sufficient rest.*
- *Normal changes to expect following childbirth.*
- *Postpartum blues and depression.*
- *Postpartum exercises, including Kegel exercises.*
- *Management of domestic violence situations.*
- *Birth spacing/contraception and sexual life and prevention of STIs /HIV/AIDS.*
- *Danger signs.*
- *Complication readiness plan.*
- *Follow-up care; schedule and location of visits"*

(PAMOH postnatal protocol, p 17, 2005)

"Women's danger signs after delivery (part of the health education after discharge)

- *Signs of sepsis or shock – pale or cool skin, sweating, dizziness, fainting, confusion*
- *Fever more than 38 degrees Celsius*
- *Feeling extremely light-headed when moving from sitting/lying to standing*
- *Edema in the hands or face, severe headaches or blurry vision*
- *Cough, or difficulty breathing (rapid breathing = >30 breaths per minute)*
- *Heavy or sudden increase in vaginal bleeding*
- *Seizures or loss of consciousness*
- *Vomiting*
- *Severe abdominal pain*
- *Excessive tiredness and/or very pale conjunctiva and mucous membranes*
- *Calf pain, tenderness or swelling*
- *Sleeplessness, apathy, verbalization/behavior that indicates the woman may hurt the baby or herself, or other symptoms of depression*
- *Problems with urination – burning, frequency, blood in the urine, severe back pain*
- *Vaginal discharge with an unpleasant odor*
- *Swelling, pain or bleeding from episiotomy or laceration site on perineum*
- *Tenderness, redness and swelling in the breasts*
- *Continuous leakage of urine or stool*
- *Breastfeeding problems"*

(PAMOH postnatal protocol, p 17, 2005)

The protocol also included that women are encouraged to conduct follow up visits to the heath center at one week after delivery, at 6 weeks and 6 months and whenever she has questions or concerns (MOH, 2005).

4.8. Domestic violence and women's attitude's towards wife beating

The United Nations Declaration on the Elimination of Violence against Women (1993) defines violence against women as *"any act of gender-based violence that results in, or is likely to result in, physical, sexual, or psychological harm or suffering to women, including threats of such acts, coercion, or arbitrary deprivation of liberty, whether occurring in public or in private life"* (UN, 1993). This definition refers to the gender-based roots of violence, recognizing that "violence against women is one of the crucial social mechanisms by which women are forced into a subordinate position compared with men." It broadens the definition of violence by including both the physical and psychological harm done towards women, and it includes acts in both private and public life. The Declaration defines violence against women as encompassing, but not limited to, three areas: violence occurring in the family, within the general community, and violence perpetrated or condoned by the State.

Domestic violence includes violence perpetrated by intimate partners and other family members, and manifested through:

Physical abuse such as slapping, beating, arm twisting, stabbing, strangling, burning, choking, kicking, threats with an object or weapon, and murder. It also includes traditional practices harmful to women such as female genital mutilation and wife inheritance (the practice of passing a widow, and her property, to her dead husband's brother).

Sexual abuse such as coerced sex through threats, intimidation or physical force, forcing unwanted sexual acts or forcing sex with others.

Psychological abuse which includes behavior that is intended to intimidate and persecute, and takes the form of threats of abandonment or abuse, confinement to the home, surveillance, threats to take away custody of the children, destruction of objects, isolation, verbal aggression and constant humiliation.

Economic abuse includes acts such as the denial of funds, refusal to contribute financially, denial of food and basic needs, and controlling access to health care, employment, etc"(UNICEF, 2000).

Intimate partner violence (IPV) has been recognized as a widespread public health problem (Campbell, 2002; Dunkle et al, 2004; Klostermann, 2006). It can also have serious consequences for physical and mental health and pregnancy related outcomes such physical out comes as chronic disease: hypertension, allergies, dermatitis and other skin problems, headache, migraine, thyroid related conditions and rheumatic and muscular problem, mental health out comes as depression (Richardson et al, 2002; Ruiz-Pérez, Plazaola-Castaño, 2007). The prevalence of domestic violence had been studied in several countries one recent survey of women conducted in 10 countries including Bangladesh, Brazil, Ethiopia, Japan, Namibia, Peru, Samoa, Serbia and Montenegro, Thailand, and the United Republic of Tanzania showed that the prevalence of ever beating ranged from 15% to 71%, with most sites falling between 29% and 62% (Garcia-Moreno et al, 2006).

In the regional countries the prevalence in Egypt which was reported that one-third of ever-married women were subjected to some form of physical violence at least once by their current or most recent husbands (El-Zanaty & Way, 2005). In a study of low income women in Aleppo, Syria, 26% of married women reported that they had been battered at least 3 times during the last year (Maziak & Asfar, 2003). Among the Palestinians living in Lebanon and Jordan the prevalence of lifetime beating in Palestinian refugee camps was 45% in Jordan (Khawaja & Barazi, 2005) and 59% in Lebanon (Hammoury & Khawaja, 2007).

4.8.1. Domestic violence and reproductive health human rights

The right to be free of violence and torture was recognized first by the United Nation Declarations of Human Rights (1948) (available at: http://www.un.org/Overview/rights.html, accessed on August 2008) as Article 5 provides that "*No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment*. ". Furthermore, The right to be free from all forms of torture and ill treatment which included sexual and domestic violence was recognized by the International Planned Partner hood Federation (IPPF) Article 12 (available at:http://www.ippf.org/en/Resources/Statements/The+Right+to+be+Free+from+Torture+and+Ill+Treatment.htm, accessed on August, 2008) as it provides that women have the right to be protected from violence in relation to their sexuality and reproduction.

4.8.2. Women's acceptance of wife beating

The acceptance of IPV is high in many developing countries, even among women: more than half of all women in Zimbabwe (53%) and about 90% of women in Uganda believed that wife beating was justified in at least one of several scenarios that were described to them (Hindin, 2003; Koenig et al, 2003). In Arab countries, women also share the notion that men have the right to discipline their wives by using force. In recent population-based studies, half of the women in Egypt and 87% in Jordan said that beatings are justified under certain circumstances (El-Zanaty & Way, 2005; Department of Statistics [Jordan] & Orc Macro, 2002).

Previous studies have shown that women's acceptance of wife beating is associated with patriarchic culture, women's low level of education, women's employment, duration of marriage, and their level of involvement in household decision making (Haj-Yahia, 1998; Jewkes et al, 2002; Hindin, 2003; Rani et al, 2004; Oyediran & Isiugo-Abanihe, 2005).

Women's acceptance of wife beating may influence the extent of wife beating reporting and of women's help seeking. According to social psychological theory, the chances of the victims for receiving help or for leaving violent relationships are significantly reduced when victims believe that they caused their own troubles or that they get what they deserve (Lerner, 1970; Weiner, 1980; Gracia, 2004). In addition, studies suggest that women who accept wife beating may be at greater risk for continuous abuse and battering than those who reject this behavior (Muehlenhard & MacNaughton's, 1988). A study in Haiti found that the wife's approval of traditional norms concerning husband's rights to beat his wife was one of the strongest correlates of intimate partner sexual violence (Gage & Hutchinson, 2006).

4.8.3. Domestic violence in Palestine

In Palestine, many social and political changes have taken place in recent years. Women's literacy rate among girls has increased from 77% in 1995 to 87% in 2003 (Palestinian Central Bureau of Statistics, 1998, 2003) and women are increasingly participating in local politics (Elrashidi, 2005). Several non-governmental organizations are now supporting women who are experiencing domestic violence by offering shelters for battered women and by training professionals in the community how to treat victims of violence (Abu-Dayyeh, 2005).

Previous representative studies in Palestine conducted in 1994 and 1995 found that between 52% and 54% of women reported that they had experienced at least one act of physical violence during the past 12 months (Haj-Yahia, 2000). However, the Palestinian Central

Bureau of Statistics reported that only about 25% of women in West Bank and Gaza had experienced at least one act of physical violence from their partners during their marriage, based on a national survey conducted between 2005 and 2006 (Palestinian Central Bureau Of Statistics, 2006).

In relation to women's acceptance of wife beating two studies found that 45 to 50% of Palestinian women believed that wife beating was justified under some conditions (Palestinian Central Bureau of Statistics, 2006; Ha-Yahia, 1998). On the other hand, the national Palestinian survey found that women's acceptance of wife beating was not correlated with reported prevalence of wife beating (Palestinian Central Bureau of Statistics, 2006).

4.9. Age at first marriage and reproductive health rights

Marriage is considered the major context for childbearing in all developing countries. As it is defined by the UNFPA: *"Marriage is a formalized, binding partnership between consenting adults, which sanctions sexual relations and gives legitimacy to any offspring*" (UNFPA, 2006). Throughout the world Marriage is still a respected and a valued social institution and it may takes different forms in different cultures. While in the view of psychotherapist, marriage is considered to be fundamentally social as it is personal (Hawkins, 2002); it implies certain obligations and grants rights and privileges; and it is viewed as substantially beneficial for the society as it is for the individual (Karasu, 2007). Marriage, in fact, the foundation of the family, is also considered as one of the most important women's reproductive health right (Cook, 1992). This right is explained by giving women the right to decide on all issues that involve their health and their life including when, who and how to marry and that marriage should take place only when there is a women's consent (Cook, 1993).

Early marriage or child marriage is defined as "[A]ny marriage carried out below the age of 18 years, before the girl is physically, physiologically and psychologically ready to shoulder the responsibilities of marriage and childbearing" (IAC, 2003). Early marriage is often associated with many health problems such as pregnancy and delivery risks (Cates & McPheeters, 1997; Singh, 1998; UNFPA, 2003; Holme et al, 2007). It has been reported that the leading cause of mortality in 15–19-year-old girls are due to Pregnancy-related risks, as those aged less than 15 years are five times more likely to die than those aged over 20. In addition, infant deaths are also twice as high in babies of very young mothers (UNICEF, 2001). These health related problems are often associated with limited access to health care,

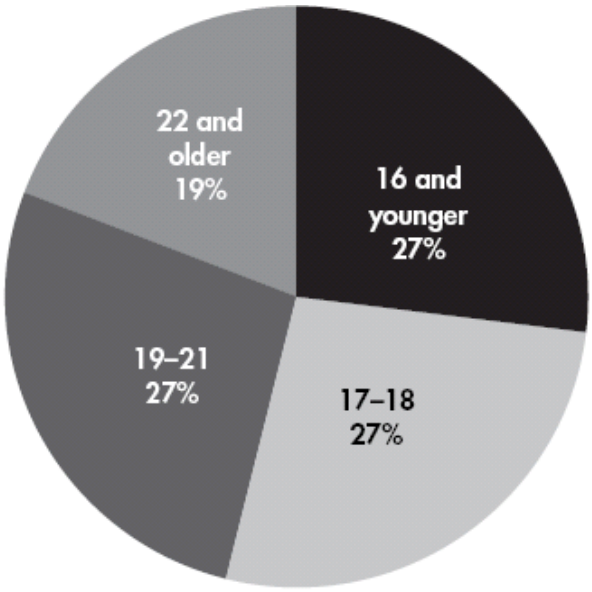
limited use of contraception which is due to younger bride's limited decision making power, economic dependency and fear from Husband and his family (Barua & Kurz, 2001; UNICEF , 2005). Younger women are also lacking proper health information in that being a younger bride will put a woman in a status of low level of education, thus lowering her access to health information (UNFPA, 2003; Barua & Kurz, 2001; World Organization Monitoring, 2003). Early marriage is usually leads to early childbearing (Adhikari, 2003), where younger brides are expected to conceive soon after marriage (Dayson & Moor, 1983; Barrnet, 1998). As reported in a qualitative study in Bangladesh, younger women have a limited use of contraception due to the belief that family planning methods can cause sterility in nulliparous women (Schuler et al, 2006).

Apart from health consequences, early marriage deprives the women from their basic rights for education and to be protected from all forms of physical or mental violence, injury or abuse, including sexual abuse and all forms of sexual exploitation (conventions on the rights of child Article 19 & 34, Bruce, 2002). In a multi-country study on women's health and domestic violence, the world health organization found that younger women, particularly those aged 15-19 years, reported more of being exposed to physical and sexual violence in all studied countries, except Japan and Ethiopia, compared to older age groups (Garcia-Moreno et al, 2006). A study in India found that nearly half of women who experienced unwanted sex, either frequently or occasionally, with their husbands are among the age group of less than 20 years old (Santhya et al, 2007).

According to the Palestinian ministry of health annual report (2004), the mean age of marriage in Palestine is 19 years and 18.6 % of women gave their first child at age under 18 years. Other reports stated that 30% of women have got married at age less than 17 years old (Elrashidi, 2005). It was also reported that Palestine is listed as one of the Arab countries that have the highest level of teenage birth, together with Mauritania and Yemen, in that each year one out of 10 women ages 15-19 gives birth (Ashford, 2005). According to the Palestinian Central Bureau of Statistics (2004) more than 50% of women among age group 15-54 years old have had gotten married at age of less than 18 years (see Figure. 4.2). To compare the age of marriage among the countries in the region, particularly Jordan and Egypt, the median age of marriage among married Jordanian women at age group (25-49) was 21.8 years, where 21% of women were married by age of 18 years and one out of three women was married by age 20. Additionally, the median age at first birth was 23.5 years (Department Of Statistics

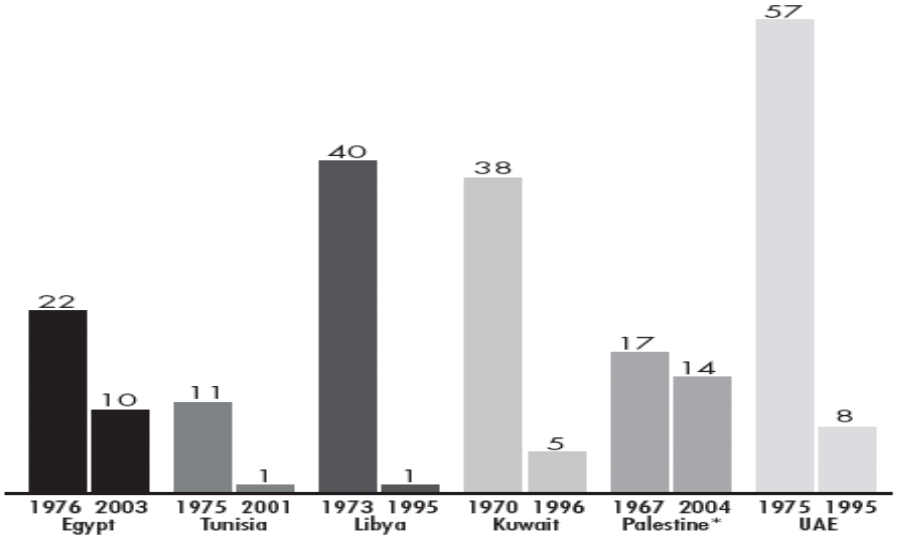
[Jordan] And Orc Macro, 2002). On the other hand, in Egypt, the median age at first marriage among the age group (25-49) was 20 years. Comparing early marriage among several Arab countries, which generally shows a decline over the last years, Palestine have not shown much decline in the percentages of women who marry at early age (see Figure. 4.3).

Figure 4.2. Distribution of married Palestinian women, aged 15 - 54, by age at marriage (2004)



(Note: Includes Palestinians living in Gaza and the West Bank, including East Jerusalem).
(Sources: Palestinian Central Bureau of Statistics, special tabulation, 2004 Palestinian Demographic and Health Survey)
(Figure adopted from Rashad et al, 2005)

Figure 4.3. Decline in percent of women aged 15 to 19 who are married, selected Arab countries



* Refers to the Palestinian population living in Gaza and the West Bank (including East Jerusalem).
(Source: United Nations, *World Fertility Report 2003*, Tables II.9 and II.11; Pan-Arab Project for Family Health Survey (Tunisia 2001); Gulf Family Health Survey (UAE 1995 and Kuwait 1996); and Demographic and Health Surveys (Jordan 2002, Egypt 2003, and Palestine 2004).
(Figure adopted from Rashad et al, 2005)

4.9.1. Marriage in the Palestinian and Arab context

The process of Palestinian marriage is similar to the other Arab countries, in that family is considered the center of Arab people's life and marriage will not take place unless family approves such marriage. In other wards, marriage is more of a family matter than two person's private matter. This would put the two families (the one of the bride and the groom) into great responsibility for such marriage and the consequences in case this marriage had failed to continue (Rashad et al, 2005). The legal obligations of marriage have followed the family law in Palestine, which states that the minimum age of marriage for girls is 15 in West Bank and 9 in Gaza, which is the same as the situation in Jordan and one year less than the situation in Egypt (Islamic family law). Overall Arab countries marriage also puts a great economic burden on the groom and his family as the groom is asked to pay most of the costs such as the dowry, housing, bridal gifts and ceremonies (Rashad, 2005). In Palestine, women have no right to initiate divorce with her husband without meeting certain specified reasons that is listed in the family Islamic Law, http://law.emory.edu/IFL/index2.html). Recently, there were new modifications to the Personal Status Law in some Arab countries in the region, namely Morocco and Egypt, as in 2000, the Egyptian parliament has agreed on the new law named *–Khul-* which gives the women the right to initiate divorce without the consent of their husbands if they would give up some of their financial rights (Singerman, 2005). Moreover, in 2004 the Moroccan government had adopted an entirely new Family Law, which gives the women more rights in terms of minimum age of marriage, which was increased form 15 to 18 years old, as well as the right to initiate divorce and many others) (Advocacy Alert, http://www.learningpartnership.org/advocacy/alerts/morocco0204,).

The present study will explore the age at first marriage among the three regions in West Bank (north, center and south). It will also assess the age at first marriage with specific reproductive health indicators; identify the perception of women in reproductive age toward the age, process, and desired number of children for their future daughters. In addition, this study will check for determinates for the perceived best age of marriage for the next generation.

CHAPTER FIVE
STUDY PURPOSE, OBJECTIVES AND HYPOTHESES

5.1. Study purpose

The main purpose of the study is to assess knowledge, perception, attitude, and practices of reproductive health rights (RHR) among the Palestinian women of reproductive age (15-49).

5.2. Specific objectives

1. Assess the information women in reproductive age have about their reproductive heath rights and reproductive health care.

   the objective will be reached by asking an open ended question to the women regarding their knowledge of reproductive health rights and ask them to mention as many as they know.

   The second part of the objective will be assessed by asking women regarding their knowledge of the reproductive health care such as the use of antenatal care, their knowledge in choosing the place of delivery. It will be assed also by asking women to mention the well known family planning methods.

2. Assess women's perceived importance for each of the specific reproductive health rights.

   The objective will be approached by asking women to rate (1-5) the importance of each of the following reproductive health rights to their health: (1) Right to receive the full care during their pregnancy, during their giving birth and after their pregnancy, (2) Right to choose the place for the health care given to them, (3) Right to choose any family planning method, (4) Right to receive full information concerning their health, (5) Right to make their own decisions concerning their health for example: (operation, family planning etc), (6) Right to be treated without any discrimination (7) To have the right to marry and to found a family and (8) Right to limit the number of children they have.

Mean, median and the mean rank calculated from Kruskal-Wallis test and the p-value (significant <0.05) will be calculated from Kruskal-Wallis test in order to measure the significant differences between regions.

3. Assess women's perceived importance for each of the reproductive health care.

   In order to measure the determinates for use, women were asked to rate the important purpose for using antenatal care, postnatal, the important points in choosing the delivery place, the important purposes in family planning and the important factors in using family planning contraceptives. Here all the reproductive health rights were translated into specific points related to each of the reproductive health care provided. Mean, median and the mean rank calculated from Kruskal-Wallis test and the p-value (significant <0.05) will be calculated from Kruskal-Wallis test in order to measure the significant differences between regions.

4. Assess women's utilization of reproductive health services and the determinants for using the services.

   This objective will be reached by asking women about their current use of the services such as: number and timing of their antenatal visits, whether they attended postnatal care, delivery place and satisfaction from the previous experience, and contraceptives use (ever and current). In order to measure determinates for its use multivariable logistical regression will be applied measuring all the related demographical and social characteristics with the use of each of the reproductive health care.

5. Investigate the associations between pregnancy willingness and fertility decisions in the Palestinian family.

   This objective will be reached by asking women about the fertility decision in each of contraceptive use, contraceptive discontinue and in having another children. Later, investigate the association between willingness of the current pregnancy together with the three fertility decisions. In order to check for differences p-value (significant <0.05) will be calculated from chi-square test.

6. Assess women's attitudes towards wife beating and the factors associated with their attitudes.

Women will be given 6 hypothetical situations (burns the food, argues with her husband, goes out without telling her husband, neglects her children, disobeys her husband, insults her husband) and ask them if they find it justifiable for wife beating. Factors associated with their acceptance will be investigated by applying multivariable logistic regression models.

7. Assess women's attitudes towards early marriage and the associated factors.

   The objective will be reached by asking women about the best marriage age for their daughters, and to investigate their reported answers with their social and demographical characteristics together with their age at first marriage by applying logistical regression models.

5.4. Study hypotheses

The main purpose of this study was to give exploratory information about women's perceived knowledge and attitudes towards reproductive health rights while receiving reproductive health care in Palestine, since the previous studies had focused mainly on the meaning of reproductive health rights and the legislative interpretations from women's rights (WCLAC, 2000, 2004, and 2006). Therefore many of the study objectives will be presented here in this dissertation as descriptive information. However there are three main hypotheses that will be tested as part of this study.

- **Hypothesis one**

There are observable differences in between regions in West Bank, in terms of tradition, culture, life style and living conditions. It is also different in the level of education, economic status, conservativeness and religious affiliation. Women's characteristics are also differing among the three regions (see tables 2.1 and 6.1). Therefore the first important study hypothesis will be:

<u>There is a difference between the studied regions with respect to all of the above objectives</u>.

The existence of these differences will be tested in objectives number 1, 4 and 5 of the study applying chi-square tests through bivariate analysis with a significant $p<0.05$. In regard to the objectives number 6 and 7 will be tested applying Wald test after adjusting for other variables

in multivariable regression models with the significance level $p<0.05$. While, with respect to the objectives number 2 and 3 will be tested applying Kruskal-Wallis test with the significant level $p<0.05$.

- **Hypothesis two**

Previous studies in Palestine (MARAM, 2003; Palestinian Central Bureau of Statistics-DHS, 2004) studied family planning and unmet need, had focused mainly on the use of family planning and accessible services, however none of these studied had focused on the association between women's right to have free of choice in identifying the number and spacing of children as their reproductive health right and the willingness to have children, Therefore the second important hypothesis will be that:

There is a relationship between women's fertility decisions and their pregnancy willingness.

The existence of this relationship will be tested by applying chi-square tests through bivariate analysis with a significant $p<0.05$.

- **Hypothesis three**

Women's status inside the family as women's participation in the household decision making process, women's refusal for wife beating, and women's refusal for making sex with their husbands under certain situations were studied separately in the DHS study (Palestinian Central Bureau of Statistics-DHS, 2004). It has been studied in many other Arab countries as an important independent variable for women's use of reproductive health care such as contraceptives use (Department Of Statistics [Jordan] & ORC Macro, 2002; Al Riyami et al, 2004). But there was no study in Palestine that investigates the relationship between women's statutes inside the family and reproductive health rights particularly contraceptives use. Therefore the third hypothesis will state that:

There is a significant relationship between women's status inside the family with respect to fertility regulations and using family planning methods.

The existence of this relationship will be tested by applying chi-square tests with a significant $p<0.05$.

CHAPTER SIX

METHODOLOGY

6.1. Study design

This study is a descriptive research study using cross sectional, looking to the fact that it's taking the perception of women for their reproductive health rights main purpose.

The research took into consideration the three main areas (North, Middle and south) of West Bank so as to ensure that most areas were assessed and to give an idea about the differences in opinions and perception (comparison purposes).

6.2. Study sites

Looking to the fact that this research is measuring women's perception in reproductive health rights it was more convenient to approach women at the service areas where they tend to receive the services for reproductive health whether that is antenatal, postnatal, self immunization during pregnancy, or child immunization. However, and in order to ensure a valid and representative distribution for women in terms of education, employment and social status the following were the main set of criteria for choosing the districts and the sites for the research:

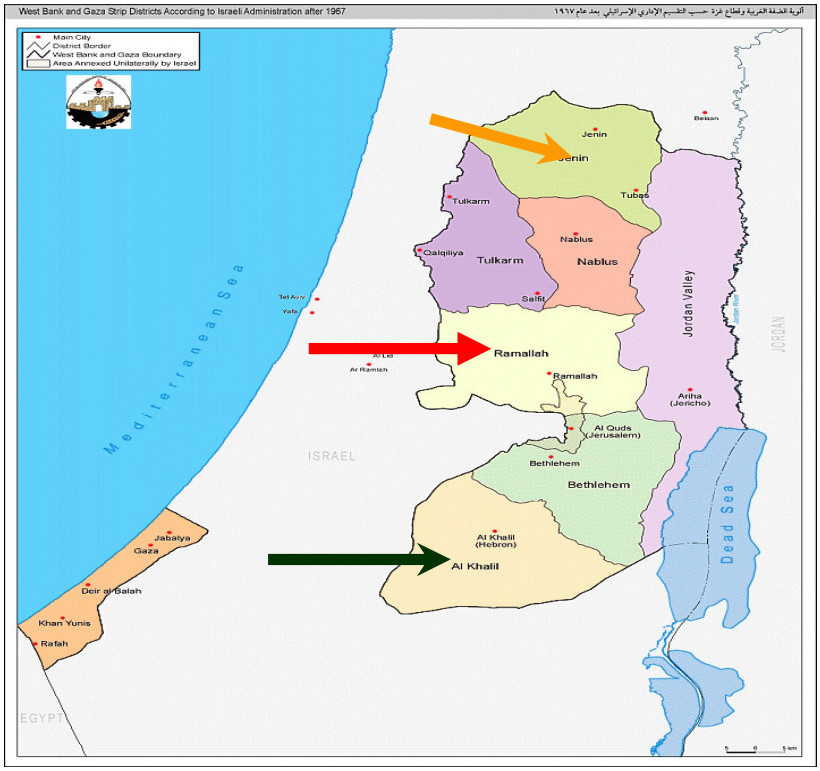
6.2.1. Selection criteria for choosing the districts and choosing the study sites

- The district has to be among the three largest districts in terms of population and area.
- The districts should have large variety of urban, rural and camp distribution.
- Each selected district should have health care services for reproductive health.
- Must have both primary and secondary health care facilities
- The selected sites in the district should represent the whole district in terms of culture and tradition.

- **Choosing districts for the research**

A Stakeholders committee was developed to help in choosing those districts and to help identifying the three main districts to represent the North, middle and south of Palestine. The stakeholders were representing the largest health organization in Palestine as Ministry of Health, UNRWA, the biggest two non-governmental organizations in Palestine. The representatives share the same view of point regarding which districts have to enter the study.

They did took into consideration the study criteria mentioned above, they concluded that Hebron from the south of West Bank has to be chosen, Ramallah from the middle, and Jenin city should represent the North of West Bank (please note the arrows in the West Bank map 6.1 below. They took into consideration the total number of inhabitants and social the cultural factors that represent each of the West Bank regions (north, center, and south).



6.2.2. Background characteristics of the three cities

Hebron city and district is considered to be the largest district in West Bank and in Palestine as a whole in terms of both number of inhabitants and geographical space. According to the last population counting in 1997 as the, the total population of Hebron city was 119,401 inhabitants (estimated district total population in 2006 to be 542,593) out of which 48.6% were females. Hebron city are very family oriented population and the majority are still living in an extended family system. They follow the order of the oldest person in the extended family and they tend to be very connected. Women in Hebron are mainly house makers, not received high education, marry at earlier age and have more than 4 children. About 43.5% of women are in their reproductive age group. Ramallah district is considered the third largest district in West Bank in terms of number of inhabitants and geographical space. While Ramallah city (Ramallah and Al-Biereh) is considered the forth-largest city in terms of number of inhabitant, which was counted as 18017 inhabitants (this number only counted the Ramallah city without Al-Biereh which is one of the largest areas in Ramallah city) out of

which 48.9% are females. It is located in the center of West Bank; the estimated district total population in 2006 was 290,401 inhabitant where and many of the families (counted in 1997 as 179,121 people) were immigrated mainly to the United States. Its is characterized to be very liberal city, all the governmental buildings and the head quarters of the big companies are replaced there; therefore, it attracts all the people in the West Bank for working. Women in Ramallah characterized by being highly educated, working out side their homes, have 2-3 children in average. And their mean age of first marriage is 19.2.

Jenin is the second largest district in the north of West Bank comes after Nablus district, and the forth largest city in West Bank. The total number of inhabitants according to the last population count is 26681 inhabitants and the estimated total district population in 2006 was 261,756, out of total city inhabitants 49.1% are females. It depends mainly on agriculture since it is located at El-Marj valley. Most of the women in Jenin are all working with their husbands in their lands (agriculture). However, 9% of the women are employed in other working facilities. They are socially connected and conservative (although it is less conservative than Hebron area) and depending on their families. (See **Table 5.1**. for more information)

Table 6.1. Social demographic characteristics of the three study cities

Characteristics	Hebron	Ramallah**	Jenin
Total no. of population (1997)*	119401	18017	26681
Total no. of women (all age) percentages	57396 48.6%	8665 48.9%	13111 49.1%
Total no. of women 15-49 Percentages	24975 43.5%	4972 27.5%	6271 23.5%
No. of working women percentages	1923 3.3%	1248 14.4%	915 6.9%
No. of educated women (secondary level) Percentages	3717 6.4%	1974 22.7%	1191 9.0%
No. of higher educated women(>secondary) Percentage	2287 3.9%	1316 15.2%	962 7.3%
Mean of age at first marriage***	18.8	19.2	19
No. of children alive(>4 children) Percentage out of the total live births	10916 10.2%	883 6.3%	2287 10%

*(*Source: Pcbs. Hebron, Jenin and Ramallah city reports- 1997. Ramallah- Palestine. 2000, ** for comparison reason the available data was only for the city of Ramallah excluding Al- Biereh which is the largest part of Ramallah,,*** Source: Pcbs. Marriage and Divorce-2001, Ramallah-Palestine, 2002.)*

5.2.3. Selection criteria for the clinics and choosing the clinics

In order to select the health care service selection criteria were developed as follows:

1. The clinics should be chosen in the center of the cities in terms of its location.
2. The clinics should receive high number of clients per day among the other clinics in the district
3. The clinics should provide type 3 and 4 level for services (based on the MOH classification) which means that the clinics should provide all the reproductive health care service such as antenatal care and high risk pregnancy, postnatal service, self immunization during pregnancy, child immunization, and family planning.
4. The clinic should have clear referral system between both primary and secondary as well as between primary health care clinic in the villages and that clinic.
5. The clinic should be well furnished and with good facilities.
6. The clinic should have enough space for both counseling that ensure clients privacy
7. The staff of these clinics should be exposed for at least one training program in reproductive health
8. The same health care provider must operate the three clinics

- **Choosing clinics for the study**

The same stakeholders committee mentioned above whom help in choosing the study districts discussed also the process of choosing the clinics. They all agreed that the only health care provider that meets these criteria would be the Ministry of health

The Ministry of health then contacted and the clinics were chosen out of the 83 clinics that met the listed above clinics criteria in West Bank. Were one clinic was found in Jenin, 2 in Ramallah, and 4 in Hebron. Three clinics were chosen based on the above selection criteria and the one which have the most flow of patients and located in the center of the city so as to ensure a wide range of women's participation. The involvement of the stakeholders was very important in giving the permission to conduct the study using their facilities as well.

The chosen three clinics were:

1. Jenin central MCH clinic-------Jenin
2. Al-Biereh MCH Clinic----------Ramallah
3. Al- Quarantine MCH clinic-----Hebron

6.3. Target population and sampling

The target population was Palestinian women in reproductive age (15-49) whom are using the reproductive health care service (antenatal care, postnatal care, family planning, Tetanus immunization during pregnancy, and baby immunization) at the MOH three mentioned above clinics. The number of women participated in the study was 450 women, 150 women in each clinic.

It was initially planned to invite 450 women and assuming a 75% response rate I would obtain over 100 responses for each site which is a reasonable number for this exploratory study. The whole sample of 300 respondents would allow us to estimate proportions with +/- 5.7% uncertainty on each side of the 95% confidence interval. In the preparation process 150 questionnaires were printed for each site and since the response rate and women showed an excellent response to participate in the study the whole 150 questionnaires in each site were filled which allowed us to have a sample of 450 women.

This sample size of 450 women provides 80% power to detect differences of 16% or more between sites would allow us to estimate proportions with +/- 4.6% uncertainty on each side of the 95% confidence interval

6.4. Study tool

This study used both quantitative and qualitative approaches, given the fact that attitudes and practices are hard to be measured with quantitative methods only. Quantitative data includes social, demographical, and political characteristic, such as the population characteristics as age, education, occupation, employment. While, the qualitative data was included in the form of open-ended questions that measure the attitudes of women toward their reproductive health rights

6.4.1. The process of preparing the study tool (questionnaire)

A structured questionnaire was prepared for the study and here is the process of preparation:

1. Intensive reviews of literature written in preparing similar questionnaires were first done (Beker, 1991; Zikmund, 1991; Oppenhein, 1992; Neuman, 1994; Frazer, 2001).
2. Literature review for all the previous study's objectives and questionnaire design were done such as demographic health surveys and some of them were in Arabic such as DHS in Egypt and in Jordan and the national health survey in Oman (Al-Riyami et al, 2000; Department of Statistics [Jordan] & ORC Macro, 2002; El-Zanaty & Way, 2005).

3. Then study matrix was set, that included each study objective, number of questions meeting that objective, level of data, and proposed analysis plan as the following example :

Research Objectives	Relevant Questions from Questionnaire	Level of data	Proposed analysis techniques
1. Find out the amount of information that women in Reproductive health age know about their RH rights	B13 B14 B.15 B.16 B.22 B.23 B.24 B.25 B.26 B.27 B.28 B.29 B.30 B.31 B.32 B.33 B.34 C.3 C.4 C.6 C.7	Ordinal Nominal Nominal Nominal Nominal Nominal Nominal Nominal ordinal Ratio Ratio Nominal Ratio Nominal Ordinal Nominal Ordinal Nominal Nominal Nominal Nominal	Frequencies and Percentages, then appropriate measures of central tendency

4. In the process of designing the questionnaire intensive literature review was done especially marketing research's questionnaire design (Beker, 1991; Zikmund, 1991; Oppenhein, 1992; Neuman, 1994; Frazer, 2001).
5. Lay out each study objectives and drafting the questions that will meet that study objective.
6. Setting an analysis plan for each single question was another important step in preparing the questionnaire as it can help to asses the relevancy for each question in the questionnaire as the following example:

Analysis Plan

QUESTION	KAP	LEVEL OF DATA	ANALYSIS	CORRELATIONS AND COMMENTS
A.1	P	Nominal	%	
A.2.1	D	Nominal	Nominal	
A.2.2	D	Ratio	Average	
A.3	P	Ratio	Average	
A.4	P	Ratio	Average	
A.5	P	Nominal	Frequency & %	
A.6.1	K	Nominal	%	
A.6.2	K	Nominal	%	
A.7	A	Nominal	%	
A.8	A	Interval	Mean, variance, Standard deviation	
A.9.1	P	Nominal	%	Combine with B.12 & B.22
A.9.2	P	Ratio	Average	

K= Knowledge, A= Attitude, P= Practice, D= Demography & Background

7. Cards were prepared and developed to help the participants in choosing there answers especially from questions that have more than one answer choice (All study cards will be available in Appendix III).

8. Reviewing and finalizing the English version of the questionnaire (English version is available in APPENDIX I).

9. Translating the questionnaire into Arabic Language, as two independent translators were contacted from Palestine whom had a health background and good experience in translating similar health terminology and questionnaires. Later it was reviewed by another independent translator, then I reviewed the translation looking to the fact that the researcher had the best understating for what each question means and what is the expected reply for each question. Later it has been distributed to many health professionals and research stakeholders (who did participate in choosing the sites and the clinics earlier) for review and comments. Finally the final version in Arabic was set and finalized.

10. A study brochure were developed explaining the research objectives and it's main out come so as to be distributed for the women in the clinics. The main purpose of this brochure was to give the women an idea about the research and to be familiar with the terminology of reproductive health rights and to disseminate the rights themselves. The brochure was distributed after conducting the interview in each clinic. (The study brochure is available at Appendix IV).

11. A special form for women's refusal for participation was prepared (refusal to participate form is available in Appendix VII.

6.5. Pilot study

The pre testing and pilot study period took about one month between pre-testing, reviewing and modifying the questionnaire and the data collection plan.

The pilot study was very important for the three following aspects:

1. Clinic assessment
2. Questionnaire and interview pilot testing
3. Women participation rate.

6.5.1. Clinic assessment

Clinic assessment tool were developed while its main purpose was to measure the main activities for each clinic, dates and schedules for their services, and to check the clients average daily flow together with the average waiting time.

This information were very much important in terms of identifying the week dates were its possible to meet women from different categories, check whether the clinic provides all reproductive health care services, and identify the sample size each day from the clinic.

The clinics were visited by me and this tool was filled according to the clinic's daily and monthly reports.

- **Clinic assessment main results**

  The daily number of women attending the clinics varies from one clinic to another, but women comes most for the purpose for baby immunization which was similar among the three clinics., followed by antenatal care, then least for the purpose of postnatal are and self immunization.

  Waiting time depends on the number of women visiting the clinic and the flow rate, but Hebron has the maximum waiting time among the average monthly working days (60 minutes) followed by Jenin (10-35 minutes) then Ramallah (5-10 minutes).

  All clinics have a private room that could be used for conducting private interviews.

  (Clinic assessment form is available in Appendix VI)

6.5.2. Questionnaires and interview pre-testing

- Thirty copies for the questionnaire were prepared for the pre-testing.
- Pre-testing was done at Ramallah clinic and was conducted by the researcher.
- Women were asked randomly for their participation while they were sitting in the waiting room.
- The questions were asked systematically.
- Women were not answered for any medical questions and referred to the nurses or midwife on duty.
- Thirty women were interviewed in a rate of five women per day.

6.5.3. Women participation rate in the pilot study

Counting the women who refused to participate and indicate the reason for refusal was one of the pre testing purposes. Response rate was very low in the pre-testing period as one out of

five women had accepted to participate and their main reason was having no time to wait in the clinic.

6.5.4. Pilot study main results and limitations

- Women participation rate was very low, as women were asked in both the waiting room and after they are done from the service.
- The pre-testing done in Ramallah which have the least waiting time among the three other clinics, which made it difficult to meet women in the waiting time.
- Most questions were understood clearly and answered directly and at ease by women.
- The interview took about 25-30 minutes
- Women visited the clinic normally between 8am and 11:30am which makes it difficult to make more than 5 interviews a day.

6.5.5. Data collection modified strategy based on the results of the pilot study

1. In order to increase the response rate, the following strategies were set and planned together with many people whom having good experience with surveys in Palestine:
    a) Women should be asked to participate in the research after they were done from the service and in the private room having two minutes explaining the research and give the women enough space to think about her willingness to participate, also this would help her not to worry about her turn in the raw waiting for the health care. Then women would be asked to sign a consent form for their participation.
    b) There will be no names or any specific personal information written in the questionnaire.
    c) Giving women praise for her participation was very important, so the most feasible praise that could be given was breast self examination health education and advising and answering all women's family planning related concerns after finishing the interview.
    d) The nurses will be asked to inform the women as well as a written poster will be hanged in the clinic informing the women about that praise, which should made the women talk to each other about it. In addition to women's expected reported positive experience after finishing the interview to the other women sitting in the waiting room.
    e) Women should be selected randomly as the average duration of the clinic service lasts between 5-7 minutes and the interview took about 30 minutes. So

women were asked to participate after finishing their service, during the interview time, no women were asked for participation, which gives around 5 women not having the chance for participation and then asking the next woman who had just finished from the service for participation and in case of women's refusal to participate the next women in the raw will be asked after receiving her health care.

f) Plan to conduct between 6-7 interviews per day. Which should be randomly selected as described above and not according to the purpose of the visit.

6.6. Data Collection

6.6.1. Data collection preparation

1. Two data collectors were selected form each of Jenin and Hebron; they were selected on the basis of their experience in conducting similar researches, having health or social workers background, committed to one organization.

2. Three days training workshop were given for those data collectors at the Women's Center for legal Aid and Counseling in Ramallah (WCLAC) so as to ensure common methodology, the following are the objectives of the training and training out line:

- **Data collectors training objectives**

By the end of the training the data collectors should be able to:

1- Know the basic principles and information about the research.
2- Understand the main research objectives.
3- Be familiar with the process of choosing women in the clinic.
4- Be familiar with the questionnaire as question-by-question.
5- Be able to collect the data and use the questionnaire at easy and smooth way.
6- Demonstrate conducting the interviews with the selected women.

And

Being familiar in demonstrating health education around breast ***self examination and providing counseling in family planning as a praise for women's research participation***

- **Training methodology**

1. Presentation: for each of the basic principle of the research, research objectives and methodology.

2. Review: all the questionnaire questions were reviewed, by reading and explaining each question of the questionnaire and answering all the possible questions
3. Role-play: each of the data collectors supposed to make several role-plays with each other demonstrating interview and filling the questionnaire taking hypothetical cases and answers until they show mastering the questionnaire and handling all possible questions.

- **Training evaluation**

Demonstration of the data collection and observation for their performance while conducting the interview.

- **Training follow-up**

1. One visit for each clinic center and data collection control was done during the process of data collection.

Parts of the training

2. Training for the two head nurses working at the Ministry of health-primary health care department in order to ensure the quality of data collection.

The 450 questionnaires were copied and coded as well as sent to the districts.

6.6.2. Data collection process and duration

Data collection took about 12 weeks were the data from the three sits filled at the same time. Women were asked for their participation after they are done from the service, there were a private room for the interview and the process went smooth and without any problems. The Ministry of health was very cooperative in terms of facilitating the process and supporting the data collectors.

Jenin data collection

Ramallah data collection

6.7. Successes for increasing the participation rate

The total number of interviewed women was 450 woman and only 4 women refused to participate (one in Jenin and 3 in Hebron) and not counted in these 450 women, response rate was 99.3% which was a tremendous success for the data collection. Each site had 150 questionnaires prepared and printed earlier in the data collection preparation process and since the data collectors had seen (while they invite women to participate in the study) a very high response rate they did filled the whole 150 questionnaires in each site which allowed us to have 450 questionnaires at the end. The main reason for such a result was the praise described above as well as the timing for asking the women and the privacy in asking women for their participation, as it was noticed that when I ask the woman in front of the person who is joining her she might be hesitant to take the decision of acceptance while she can take it much faster and more confident when that is alone in the private room. It was also noticed that women talk about the research and the praise as they all thanked us after they are done from the interview, they appreciate the information they got from the interviewer and they felt it was worth it to sit and give their opinions. Educated women find it very good opportunity for them to give there opinions and to be able to share ideas with the interviewers through the questionnaire questions as well as get a health benefits from the interviewer. Women were egger to participate, in that many women came to the clinic and ask about the research and show their willingness to participate although only those who comes in the time of the random selection they did participate and not all those women. It was very much important to modify the plan after the pre-testing so as to get such a result, pre-testing helped a lot in both facilitating the data collection process and increasing the participation rate.

6.8. Partnership with Juzoor Foundation for Health and Social Development organization and Women's Center for Legal Aid and Counseling' (WCLAC) in the process of research

It was important to connect with one or two local organizations so as to facilitate the research process and to give the research future national impact in order to ensure the use of the research results in building up a new national strategy, plans, and in planning new programs for women's health in the future.

The first organization was (Juzoor Foundation for Health and Social Development) since this research reflects a health issues as reproductive health and looking to the fact that this local organization has a tremendous national health experience particularly in women's health as well as having highly qualified health candidates that participate in establishing national health policies as well as most of the health related programs and policies in Palestine.

6.8.1. Background information about Juzoor Foundation for Health and Social Development Organization and their contribution in this study

Juzoor Foundation for Health and Social Development is a professional Palestinian organization based in Jerusalem. In 1996, a group of multi-disciplinary professionals, with strong health backgrounds, get together and established Juzoor Foundation for Health and Social Development. They gave it the name Juzoor Foundation for Health and Social Development meaning "Roots" in Arabic as they had long histories and experiences in their related fields and in establishing some of the grass roots of health organizations in Palestine.

- **Mission**

Juzoor Foundation for Health and Social Development is committed to promoting the well-being of the Palestinian people through its work with community based organizations, the development of human capacities and by working towards affecting health and social policies.

- **Objectives of Juzoor Foundation for Health and Social Development**
    - To build the institutional capacity of health and social organizations through the development of human resources and to promote and support sustainable systems. As well as enhance networking and partnership among these organizations.

    - To provide a platform for discussions and dialogue and enable a conducive environment for policy formulation and developmental interventions in the

health and social sectors that support the deprived and marginalized communities.

- To promote an interdisciplinary, cross-sectional approach in the health and social sector in order to improve the health status and the well being of the individual, family and community.

- To raise public awareness and encourage communities' participation regarding health and socio-economic issues that affect their overall well-being.

- To promote and develop regional and international cooperation to provide a facilitating environment for policy dialogue, participatory planning, information and technology transfer among local and international organizations.

- **Juzoor Foundation for Health and Social Development contributions in the current research**

The organization has an important role in the process of the current research through the following important key issues:

- Connect with all the health stakeholders in Palestine so as ensure cooperation and involvement of the research process and results.
- Help in getting the permission from the MOH clinics for the data collection.
- Provide all the logistical and management supports during the process of preparation for the data collection as well as the process it self such as fax use, telephone, copying .etc.
- Provide technical support through their technically highly qualified consulting group especially in Reproductive health.
- Help in connecting with a woman organization (Women's Center for Legal Aid and Counseling' (WCLAC), as it was important to give the research a women perspective in addition to the health perspective.

(The following are some photos from Juzoor organization. The first photo at the right side is the entrance building for Juzoor Foundation for Health and Social Development, the second photo is the office manager helping in the questionnaires copying, while the last photo is the office where I used while preparing for the data collection at Juzoor Foundation for Health and Social Development.

6.8.2. Women's Center for legal Aid and Counseling' (WCLAC)

Through Juzoor Foundation for Health and Social Development organization, it was important to connect with other important national organizations that worked tremendously with Palestinian women issues and their rights. They actually look at the perspectives of gender equality but it was important to connect with such organization so as to give the research women perspective in terms of gender and equality as well as health perspective to ensure effective use of the research result at the national level.

- **Background Information about Women's Center for Legal Aid and Counseling' (WCLAC)**

WCLAC was established in Jerusalem in 1991 as a Palestinian independent non-governmental non-profit organization with the aim of contributing to the building of a democratic Palestinian society based on the principles of gender equality and social justice. In order to achieve this aim, WCLAC develops programs and projects with clear Palestinian women's agenda based on international human rights standards.

- **Vision**

Palestinian women can exercise their right to self-determination in a social, legal, and institutional environment within a sovereign Palestinian state guided by the rule of law that does not discriminate against them or hinder their social, economic, and political progress.

WCLAC aims to realize this vision by:

- Contributing to the development of legislation and institutional policies which support women and their rights;
- developing local cultural and moral attitudes and resources in order to eradicate negative social attitudes/practices against women;
- contributing to build the capacity of official and grass-root organizations influentially involved in women's issues;
- monitoring and disseminating the effects of militarization on the status of women, including Israel's violations of international human rights law;
- developing the Centre's own capacity, performance and continuity.

- **WCLAC contribution in the research process**

The organization helped in the following important issues:

1. The organization find that the research of measuring women's reproductive health rights an extension for the three other researches that they did conduct previously and they find that they can get use of the results at the national level by combining the results from the four researches and then building a new strategic programs and policy development in that matter. In that the organization helped the research in using the same data collectors that have worked previously in the same topic and researches and help in giving these data collectors enough space and time to work in this research.
2. The organization hosted the data collectors training workshop
3. The organization connected with their offices in both Jerusalem and Hebron as well as their key important networks in Jenin so as to facilitate both the movement of the data collectors as well as controlling the process of data collection, that was also important in transporting the filled questionnaires from the data collectors to Ramallah where the researcher did the data entry.
4. The organization had planed to conduct three dissemination workshops for the research results in Jenin, Ramallah and Hebron, while the main purpose of the national workshops is to get use of the four researches and set a new programs and strategies for women's reproductive health as well as review for the other three researches that had been conducted previously. WCLAC also plan to invite all the interested national and international organization for this workshop in order to attract attention for this important issue in women's health as well as building a new health and women's programs for supporting and helping women in their reproductive health rights.

The photo aside is in the WCLAC organization with the head of the health and research department
Mrs. Soriedeh Hussein

6.9. Data entry and data editing

The statistical program SPSS version 12 was used in the data entry. All data were collected and sent to Ramallah were the researcher did the data entry, it took about two month to finalize all the data entry.
In order to control the data entry **90** questionnaires randomly selected from each site (out of 150 questionnaires) were rechecked and controlled.
The open ended questions were also grouped and categorized.

6.10. Data analysis

6.10.1. General statistical analysis for the overall study themes

The SPSS software 12 was used to analyze the data. Cross tabulation and Pearson chi-square test were used for descriptive and multivariable analysis. Multivariable regression models were used to check association between dependent and independent variables. Kruskal-Wallis Test was used to test the mean level of importance among the questions that have rank order. Open-ended questions analyzed by grouping similar answers.

The main independent variables used in the analysis were: region, age of women, duration of marriage years, age at first marriage, and number of living children, Women's status inside the family as the variables of the total number of household decision done solely by the women, women's refusal for sexual relationship with their husbands, and women's refusal for wife beating.

The total number of women used for the analysis for each theme was: 450 women for family planning section, 186 women for antenatal care, 264 women for postnatal care, 264 for delivery care, 450 women for each of domestic violence, age at first marriage, while some variables had missing values and will be presented in each of the study themes.
Dependent and independent variables will be presented for each study theme following:

6.10.2 Reproductive health rights statistical analysis (dependent and independent variables)

Statistical analysis that was mainly used for Reproductive health rights was grouping the open ended question similar answers into categories. Kruskal-Wallis Test was used for measuring the mean rank for checking the level of importance on reproductive health rights.

- **Dependent variables**

Two dependent variables were used to measure the reproductive health rights knowledge and attitudes:

The first variable was measuring the knowledge of reproductive health rights by asking the women an open-ended question about the three important reproductive health rights that women were considered important for them. These answered were grouped similar categories. Only 367 women answered this question and the rest were missing values.

While the second dependent variable was measuring women's attitudes towards the importance of reproductive health rights as women were asked "*I would like to ask you in more details about the importance of your health rights even if you have to repeat your priorities that you have just mentioned in the previous question: Your right to receive the full care during your pregnancy, during your giving birth and after your pregnancy, Your right to choose the place for the health care given to you, . Your right to choose any family planning method, Your right to receive full information concerning your health, Your right to make your own decisions concerning your health for example: (operation, family planning etc), your right to be treated without any discrimination, to have the right to marry and to found a family, and your right to limit the number of children you have.* Women were given a rank of importance (1-5) as 1 is very important and 5 is not important for each statement as detailed as: 1 = very important, 2 = important, 3 = some what important, 4= less important, 5= not important. Mean rank was calculated per region first using descriptive statistics and then using Kruskal-Wallis Test, then the significant correlations between the three regions was measured using Kruskal-Wallis Test as $p = <0.05$. Median was also calculated to see the median point of importance.

- **Independent variables**

Region was the only independent variable used in this part of the study (three categories: Hebron south of West Bank, Ramallah, center of West Bank, Jenin north of West Bank) in order to compare women's attitudes and knowledge among the three regions in West Bank.

6.10.2. Family planning statistical analysis (dependent and independent variables)

The general statistical analysis used for family planning section were univariate analysis to assess some variables in terms of frequency distribution and percentages, bivariate association, Chi-square significant (p value), multivariable analysis for the selected significant variables, and Kruskal-Wallis Test to measure the rank of questions measuring the received level of importance.

- **Family planning knowledge**

In order to assess women's knowledge for family planning (contraceptives and methods), women were asked to mention the methods that they just remember spontaneously. The second step of assessment was through reading each of the contraceptive methods definition for the woman and ask her whether she have heard about that method before or not. All women (450) answered this question and there were no missing values.

- **Family planning Practices**
  - Women were asked next to each method of family planning whether they had ever used this contraceptive before or not. One variable at the end was measured as those who mentioned not being using ever any of the contraceptives and those women who had been using contraceptives before as dependent variable. No missing values were reported. The Independent variables used here were region (three categories: Hebron, Ramallah, Jenin), age of women (three categories: ≤24, 25-29, ≥ 30), duration of marriage years (two categories: <10 and ≥ 10), number of children (three categories: 0-1, 2-3, +4), and total number of household decision done solely by the women (three categories: 0, 1-2, +3). Bivariate analysis and p value was calculated.

  - Another dependent variable is contraceptive method ever used and was measured using bivariate analysis for any association with one independent variable which is women's age (six categories: 15-19, 20-24, 25-29, 30-34, 35-39, >40) the purpose of giving many age groups categories was to check for the women's preference of contraceptive methods and any relation with specific age group.

  - Current contraceptive methods used as dependent variable, while the independent variable used were age specified categories as above, region, women's education, and parity. Women's status inside the family as an independent variable was also assessed through the following three variables as follows:

- Women were asked about the responsibility of making decisions inside the household as "*Who in your family usually has the final say on the following decisions?"*

    1. *Your own health care?*
    2. *Your children health care?*
    3. *Making large household purchases?*
    4. *Making household purchases for daily needs?*
    5. *Visits to family or relatives?*
    6. *What food should be cooked each day?*

Women were given the options to choose between Respondent, Husband, Respondent and husband Jointly, Someone else, Respondent and someone else jointly, and Decisions not made/ not applicable.

for the purpose of analysis a three dichotomies variable was created counting the number of decisions woman only has the final say as categorized into (0, 1-2, and +3).

- The second question was women's beliefs towards husband right for wife beating as Women were asked:

"Sometimes, a husband is annoyed or angered by things that his wife does. In your opinion, is a husband justified in hitting or beating his wife in the following situations?"

1. *If she goes out without telling him*
2. *If she neglects the children*
3. *If she argues with him*
4. *If she burns the food*
5. *If she disobeys him*
6. *If she insults him*

For each reason women were given three option (Yes/No, and don't know).

Here also another three dichotomies variable was created, as calculating the number of reasons wife beating is justified into three categories (0,1-2, and +3 reasons)

- The third variable assessed was women's attitudes of refusing sex with their husbands under certain conditions as women were asked*:*

"Couples sometimes do not agree in everything, please tell me if you think that the wife has the right to refuse having sex with her husband

1. *If your husband has any sexual transmitted diseases*
2. *You have newly delivered baby (first 40 days after delivery)*
3. *Tired and not in the mood*
4. *during the menstrual period*
5. *if you have lack of privacy (such as having children around)*
6. *if your husband assaults you physically or psychologically*

For each reason women were given three option (Yes/No, and do not know).
Here also another three dichotomies variable was created, as calculating the number of reasons women tend not to refuse sex with her husband into three categories (0,1-2, and +3 reasons.

- Another variable assessed under women's family planning practices was the timing of the first use of contraceptives for that women were asked:

"When you first used family planning methods, how many children did you have? Were they were asked to mention the total number as well as the number of boys and the number of girls.

As independent variables were women's age and region were assessed through bivariate analysis.

- **Attitudes towards the use of family planning**

In order to assess women's attitudes towards the importance of using family planning and to get an idea about their knowledge regarding the use of family planning as well women were asked:

"How important is family planning for you for…

- *delaying the first child*
- *spacing the birth*
- *Limiting the number of the family members*
- *Economic reasons*
- *the mother health*
- *the children health and good raising up"*

Women were given the rank of importance 1-5. Kruskal-Wallis Test, mean rank, mean and median was used for the analysis. No missing values were reported.

- **Determinants for contraceptive use**

In order to assess women understanding of their family planning rights while receiving family planning service. Family planning rights that are stated for providing the health services together with other important determinants for seeking the maternal health services were spelled out as the determinants for using family planning. Women were asked to rank each determinant importance for using contraceptives as women were asked:

In your opinion how important are the following factors for you to use family planning methods:

1. *Number of children you have*
2. *Accessibility to FP methods & clinics*
3. *Privacy in the health center*
4. *Confidentiality in Health care center*
5. *Cost of the FP methods*
6. *Information about FP methods*
7. *Husband participation*
8. *Free in choosing the method*
9. *Your opinion in using the methods*
10. *The continuity in having FP methods*
11. *Being relax , comfort and satisfied in family planning methods use*
12. *Free of discrimination*

Women were given the rank of importance 1-5. Kruskal-Wallis Test mean rank, mean and median were used for the analysis. Here there were no missing values reported.

- **Decisions for family planning use, family planning discontinue, and planning for having a new child**
  - In order to assess the decision inside the family for using family planning or stop using or having another child, one new dependent variable was created with three dichotomous (woman, husband and wife together and others). Husband only was added to the others for checking the factors that may affect women's decisions rather than focusing on the husband's decisions. While the independent variables assessed by bivariate association were women's age, region, level of education, total number of children and women's status inside the family (which was explained earlier in the method chapter). No missing values were reported in the 3 dependent variable.

- In order to assess women's ability to make self-decision in terms of using family planning and to make sure that the first three variables discussed above were fully understood and correctly answered by the women. Women were asked directly:

  "Can you use family planning based on your own opinion alone?

  Women were given yes/ no answer choice, when they answered no then the following question was:

  With whom you think you should consult? Here the interviewer does not read the answer, only probe and here is the list of expected answers: Husband, mother, and mother in law, neighbors / friend/relatives, health care provider, or others.

The independent variables assessed by bivariate association were women's age, region, level of education, total number of children and women's status inside the family (which was explained earlier in the method chapter).

- **Fertility decisions and wanting the current pregnancy**

in order to asses women's wanting the current pregnancy, all currently pregnant women (187) were asked whether they want this pregnancy at this time, later or they do not want it at all. This was measured for association as dependent variable with the three fertility decisions (decisions for using contraceptives, stop using contraceptives and for having another child) as an independent variables. Chi-square p-value was calculated.

6.10.3 Reproductive health care statistical analysis (dependent and independent variables)

6.10.3.1. Antenatal Care

From the total sample of 450 women, there were 187 women who have visited the clinic for the purpose of antenatal care those women were asked several questions in order to assess their knowledge, attitudes, and practices toward antenatal care.

- **Knowledge of the importance of antenatal care**

In order to assess women's knowledge of the use of antenatal care, women were asked: *What is the main reason for you to conduct antenatal care, "my mother and my mother in law advised me to do so, my husband wants me to do it, I think its very important for my health, I think its very important for the health of baby, every body does it".* Answers were not

presented for the woman and she was allowed to mention more than one reason, descriptive lay out of percentages was then developed.

- **Received antenatal care**

Descriptive percentages were calculated from the kind of services women's received during antenatal care visits as an example health education regarding complications during pregnancy and the appropriate measures women need to take in case of the occurrence of these complications**.**

- **Antenatal care practices**

For assessing women's antenatal practices among the three regions, women who visited the clinic for the purpose of antenatal care (186 women) were asked: "*How many months pregnant were you when you first received antenatal care for this pregnancy*", one woman replied as do not know and calculated as missing value.

Women who came for baby immunization or postnatal care (264 women) were asked about their antenatal care visits during their recent birth: "*During your last pregnancy how many times did you receive antenatal care", 14* women replied as do not remember calculated as missing 3.1%. Postnatal women and antenatal women antenatal care practices were assessed dependably by region as an independent variable.

- **Attitudes towards the importance of attending antenatal care**

Attitudes towards the importance of antennal care were assessed for both antenatal women as well as postnatal (450 women in total) through asking women about the importance of conducting antenatal care as follows:

Why do you think you should conduct antenatal care visits, what was the most important to you : Knowing the sex of the baby, follow up on my health during my pregnancy, follow up on the health of my baby during my pregnancy, being safe and free from complications during my pregnancy, having a healthy baby.

Women were given the rank of importance 1-5, Kruskal-Wallis Test mean rank, mean and median were calculated for the analysis.

- **Determinants of antennal care use**

In order to assess women's perceived importance of their antenatal reproductive health rights all women (450) were asked about the important determinants for them to attend antenatal care as follows:

In your opinion what is important in a place where a woman can conduct an antenatal visits?

1) *Not far from where I live-* ***measures distance***

2) *Cost is not high- measures cost -**accessibility of care***
3) feel assured and secure in that place- **assurance**
4) *have every and all equipment necessary for the examination- **availability of equipment***
5) *be comfortable in receiving the care- **measures safety and assurance***
6) *have full privacy- **measures privacy in providing care***
7) *have someone who can answer all my questions and concerns**- measures counseling service***

Women were given the rank of importance 1-5, Kruskal-Wallis Test mean rank, mean and median were calculated for the analysis.

6.10.3.2. Delivery Care

- **Practice of delivery**

Only postpartum women had been assessed in this matter regarding their most recent birth (264 women). Place of delivery was assessed as dependent variable for any association with women characteristics as region, residency (Two categories: city, others), level of education, number of children, problems during delivery (two categories: with problems, without problems) as independent variables.

- **Delivery satisfaction**

Satisfaction from last delivery was assessed by asking the women: *How satisfied were you with the services you received during your last delivery? And women were given a rank of satisfaction 1-5 as 1 = very satisfied, 2 = somewhat satisfied, 3=neutral, 4=somewhat dissatisfied, 5= very dissatisfied*

Mean rank was calculated per place of delivery first using descriptive statistics and then using Kruskal-Wallis Test for the rank itself, then the significant correlations between the four places of delivery was measured using Kruskal-Wallis Test and p value was calculated, mean rank, mean and median was also calculated to check the level of satisfaction between different delivery places.

- **Health education received before leaving the place of delivery**

Women were asked about the danger signs mentoring information as: as women were asked: *before you leave the place of delivery did any one told you about the danger signs that you need to monitor in your health?* Women has the choice to answer yes, no or don't remember

And they were asked: Women were also asked: *before you leave, the place of delivery did any one told you about the danger signs that you need to monitor at your baby? Women were given the chance to choose, yes, no or do not remember.* Descriptive lay out of percentages was then presented.

- **Determinates for choosing the place of delivery**

Perceived attitudes of the importance key points in choosing the place of delivery (as reproductive health rights) were assessed through asking women about the importance of choosing the delivery place based on the availability of these rights as women were asked: *When you think of choosing the place where you can give birth for your coming baby, what is most important for you to have?*

1. *How far is the place of delivery from where you live*
2. *Cost of delivery*
3. *Being safe, and secure in that place*
4. *The equipment that that place has*
5. *having your privacy while you deliver*
6. *Having all the necessary information during the process of delivery*
7. *Being informed before administering any medical procedure to you*
8. *Being comfortable in receiving the care*
9. *Having your husband with you during your delivery*
10. *Having kind , welcoming staff working with you*
11. *Having good care of your baby after your delivery*
12. *Having all the necessary emergency care in case of emergency*
13. *Having your baby around you from the moment you deliver until you leave the place of delivery*

Women were given the rank of importance 1-5. Kruskal-Wallis Test mean ranks, mean and median were calculated for the analysis.

6.10.3.3. Postnatal care

- **Received postnatal care**

Receiving postnatal care was calculated as an dependent variable by asking postpartum women who had delivered a baby within the past 15 months (N=264) whether they had obtained postnatal care any time during the first 42 days after delivery.

The independent variables were women's employment status, women and husbands highest level of education (< secondary or ≥ secondary school), woman's age and age at first marriage, total number of living children and the self-assessed economic situation (in three categories: high, middle, low). Education of both partners was recoded into a single variable with four categories: both < secondary, wife ≥ secondary + husband < secondary, wife < secondary + husband ≥ secondary, both ≥ secondary schools. Several additional variables related to medical care were collected: delivery place, having problems during last delivery, number of antenatal visits during the last pregnancy, and whether the woman was informed about danger signs to be monitored after delivery related to her and her baby's health before discharge from the hospital. Women who had received postnatal care were asked whether they had received counseling on family planning and breast feeding.

Cross tabulation and Pearson chi-square test were used for descriptive and bivariate analysis were first calculated to check for associated variables of women's lack of attendance and then choosing those significant variables for running the multivariable regression model. the variables that chosen were: location of the clinic, woman's age (in years), woman's and her partner level of education as a joint variable, number of living children, number of antenatal visits during the most recent pregnancy (to assess general use of medical care), woman's age at first marriage (below or above 20 years, as a marker of more traditional upbringing), problems during delivery, and delivery place, public versus private hospital and whether woman was informed about danger signs for herself before discharge.

- **Reasons for not attending postnatal care**

Those women who answered that they did not attend postnatal care (166 women) were asked about the reasons for that. The question was open-ended and women were able to provide multiple reasons. Reasons for not obtaining postnatal care were analyzed by grouping similar answers later a descriptive figure was laid out for women's answers.

- **Women's attitudes towards the importance of postnatal care**

Women were also asked about their attitudes toward the necessity of postnatal care: "*In your opinion is postnatal care necessary for a woman's health? "*. Women who answered *"yes"* were considered to have positive attitudes about the importance of postnatal care, those who answered *"no"* were considered to have negative attitudes, while "*don't know"* answers were considered missing in the analysis (13 women, 4.9%).

6.10.4. Domestic violence, women's attitudes toward wife beating

- **Attitudes towards wife beating**

An attitude towards wife beating was the main study our come in this theme and was assessed as in other surveys (Department of Statistics [Jordan] and ORC Macro, 2002; Hindin, 2003; El-Zanaty & Way, 2005) asking women about their attitude in 6 situations that varied in severity as: "*Sometimes a husband is annoyed or angered by things which his wife does. In your opinion, is a husband justified in beating his wife in the following situations:*

- *If she goes out without telling him?*
- *If she neglects the children?*
- *If she argues with him?*
- *If she burns the food?*
- *If she disobeys him?*
- *If she insults him?"*

Women who answered "yes" to any of the situations were classified as accepting violence. Women who answered "no" to all situations were classified as rejecting violence. *"Do not know" responses were treated as missing values and women were classified according to the remaining responses. Between 0% of responses (If she burns the food) and 7% (If she disobeys him and if she insults him) were missing.*

A descriptive lay put of the results were calculated and drown in a figure.

- **Factors associated with women's attitudes**

In order to check for the factors that are associated with women's attitudes towards wife beating, the following independent variables were checked first in a cross tabulations and person's chi square then multiple logistical model was late calculated.

Here are the independent factors that were checked*:* woman's current employment status (unemployed or employed), woman's highest level of education obtained (< secondary or ≥secondary school), women's age (in three categories: ≤24, 25-29, ≥30 years), the total number of living children (in three categories: 0-1, 2-3, >3), number of years being married (in two categories: <10 or ≥10), and age at first marriage (in two categories: <20 or ≥20 years).

Other important independent variables that were assessed were related to women's status inside the family, which was assessed through two main variables: The first was women's participation in household decision-making and the second one was women's ability to refuse sex with their husbands (both variables have been explained in the family planning section at 6.10.2.)

6.10.5. Age at first marriage (early marriage) statistical analysis (dependent and independent variables)

The main statistical analysis used this section was descriptive analysis of frequencies, percentages, median and mean of best age of marriage. Bivariate analysis to check for association between variables and person's chi-square were calculated then. Multivariable logistic regression model was developed for checking the associations between dependent variable and selected independent variables.

- **Women's age at first marriage**

The first study out come was women's age at first marriage (three categories: <16, 17-20, >21). As women's age at first marriage were categorized into three categories. Descriptive calculation was created.

In order to check women's characteristics by the first age of marriage several independent factors were checked for association as: region, employment, education, number of living children, attitudes towards wife beating, refusal sex with husbands, number of household decision making. And other health related variables were included as number for antenatal visits, attendance for postnatal care, ever use of contraceptives. Cross tabulations and person's chi square was calculated.

- **Women's perception of the best age of marriage**

The second study out comes was women's perception towards their daughter's best marriage age as women were asked an open ended question " *If you have a daughter and she wants to get married, in your opinion what is the best age for her to get married?*. From the women's answers, two age groups were created: 16-20 and >21.

Cross tabulation and person's chi square was calculated to check the factors associated with women's perception, later multivariable logistic regression model was created taking the association between women perceived the best age of marriage to be between 16 and 20 (228 women) and the following independent variables: education, women's age, employment, region, number of living children, number of living daughters, justifying wife beating and women's age at first marriage.

- **Women's perception towards the marriage process**

The third study out come in this theme was women's perception towards giving opinion in choosing their daughters future husbands as women were asked an open-ended question "*If you have daughters, do you expect to have an opinion in choosing their future husbands? Then the answers were grouped into four categories (yes, no, whom she accepts I will accept, or do not know).* Descriptive lay out of the results were calculated.

6.11. Ethical considerations

A steering committee comprised of representatives from the Palestine Ministry of Health, the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA), and Juzoor Foundation as one of the largest local health non-governmental organizations, reviewed and approved the study protocol and questionnaire prior to data collection. Permission for data collection at each site was given by the Ministry of Health. Prior to the interview, each woman was asked to read and sign a consent form, which stated the purpose of the study, that participation was voluntary, and that women's responses were kept confidential.

CHAPTER SEVEN

RESULTS OF THE STUDY

7.1 Introduction

The results of this study are presented in this chapter in six major parts; the first part presents the women's and their husbands demographic characteristics. The second part shows the results of women's reproductive health rights assessment. The third part presents women's assessment on family planning knowledge, attitudes towards its use and their family planning practices. The forth one presents the detailed results of the reproductive health care assessment which included the results from antenatal care, delivery and postnatal care. The fifth part presents all the results related to domestic violence and women's attitudes towards wife beating. The final part presents women's perception towards early marriage and their perception regarding their daughters best age of marriage.

7.2 Demographic characteristics of the sample

Table 7.1 presents women's demographic characteristics by region. It shows that the majority of women were below the age of 30 years old, and that the majority of husbands were also of the middle age group below 40 years old. Most women were living in the cities with a regional difference. Women and husband with higher than secondary education were mostly from Ramallah, followed by Jenin and least from Hebron. Most women were married for less than 10 years. The majority of women rated their social economic status as middle class. Only 19 % of women were employed and mostly were from Ramallah. However, only 4.5% of husbands were unemployed. Most women have 1-3 children, with a regional difference as women from Hebron were the most to have more than four children compared to the other two regions.

Table 7.1: Demographic characteristics of the sample (450 women) by region

Characteristics	Total (n=450)	Jenin (North) (n=150)	Ramallah (Middle) (n=150)	Hebron (South) (n=150)	*p-value
Age					0.49
≤24	29.2	26.0	26.0	32.7	
25-29	32.2	32.0	37.4	31.3	
≥30	38.6	42.0	36.7	36.0	
Husband's age					0.10
20-29	30.4	28.0	26.0	37.3	
30-39	47.8	50.0	54.0	39.3	
≥40	21.8	22.0	20.0	23.3	
Residency now					<0.001
City	82.2	70.7	78.0	98.0	
Others	17.8	29.3	22.0	2.0	
Women's education					<0.001
<secondary	42.0	48.7	18.7	58.7	
≥secondary	58.0	51.3	81.3	41.3	
Husband education					<0.001
<secondary	44.7	42.7	21.3	70.0	
≥secondary	55.3	57.3	78.7	30.0	
Duration of marriage					0.17
<10 years	69.7	67.8	75.3	66.0	
≥10 years	30.3	32.2	24.7	34.0	
Age at first marriage					<0.001
<20	65.8	62.7	53.3	81.3	
≥21	34.2	37.3	46.7	18.7	
Economic status (subjective)					0.019
High	8.4	11.3	6.4	7.8	
Middle	73.3	78.3	73.4	70.3	
Low	18.2	10.4	20.2	21.9	
Women's Employment status					<0.001
Yes	19.3	12.7	40.0	5.3	
No	80.7	87.3	60.0	94.7	
Husband's employment status					0.26
Yes					
No	95.3	95.3	97.3	93.3	
	4.7	4.7	4.7	2.7	
Number of living children					0.005
0-1	29.3	30.7	37.3	20.0	
2-3	40.7	41.3	40.0	40.7	
4+	30.0	28.0	22.7	39.3	

* calculated from Chi –square for measuring differences, significant p<0.05

Table 7.2 presents women's demographic characteristics by reason of visiting the clinic. In that all women who came for the purpose of follow up during pregnancy, or in order to obtain tetanus immunization were grouped into one category as antenatal women (n=186). While all women who came within the time window of postnatal as well as for children immunization, or postnatal care were grouped into postnatal women (n=264). The table shows that there were significant differences between the antenatal group of women and the postnatal group of women in terms of number of living children, employment status and the perception of the importance of postnatal.

Table 7.2: Demographic characteristics by reason of visiting the clinic (postnatal women and women in the antenatal period)

Characteristics	Total (n=450) %	Antenatal (n= 186) %	postnatal (n=264) %	*p-value
Age				0.74
≤24	29.2	26.9	29.2	
25-29	32.2	35.5	32.2	
≥30	38.6	37.6	38.6	
Women's education				0.69
<secondary	42.0	40.9	42.8	
≥secondary	58.0	59.1	57.2	
Husband education				0.44
<secondary	44.7	42.5	46.2	
≥secondary	45.3	57.5	43.8	
Duration of marriage				0.53
<10 years	69.7	71.5	68.4	
≥10 years	30.3	28.5	31.6	
Age at first marriage				0.10
<20	65.2	61.3	68.9	
≥21	34.8	38.7	31.1	
Women's Employment status				0.030
Yes	19.3	24.2	15.9	
No	80.8	75.8	84.1	
Number of living children				<0.001
0-1	29.3	40.3	21.6	
2-3	40.7	37.6	42.8	
4+	30.0	22.0	35.6	
Postnatal care is necessary				0.002
Yes	78.7	76.9	62.9	
No	31.3	23.1	27.1	

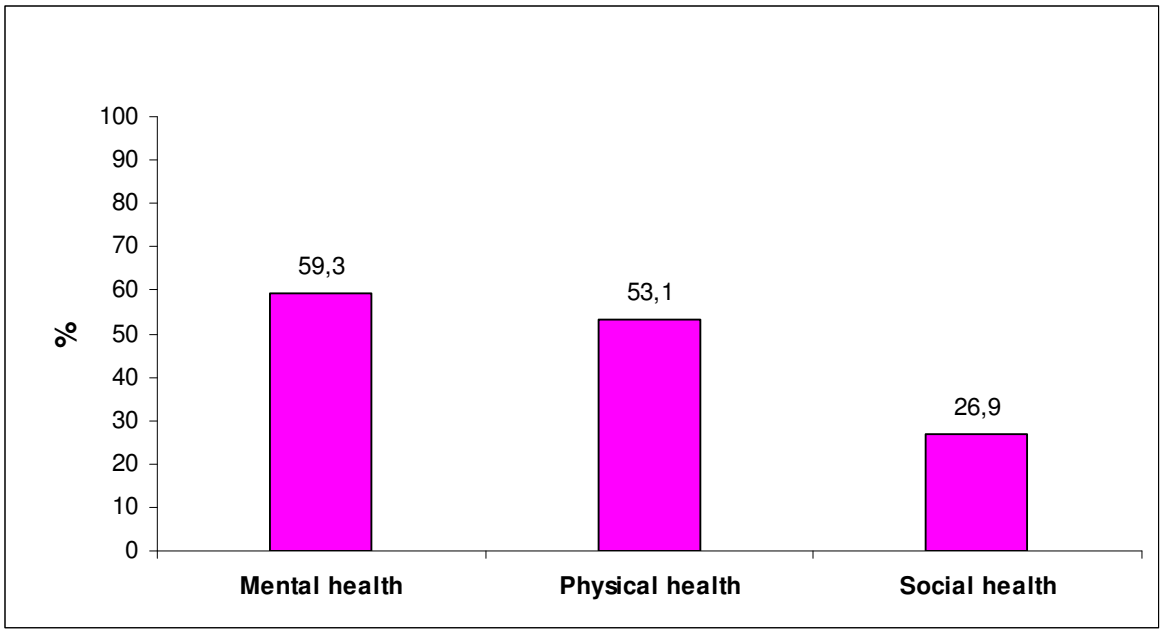
*calculated from Chi –square test for measuring differences, significant p<0.05

7.3. Reproductive health rights

Women's perceived importance of health according to WHO definition

Women were asked to rate the importance of each aspect of health according to the definition of WHO as it was read by the interviewer for each woman before she asked to fill in the rate. Figure 7.1 shows that women ranked, as the very important aspect of health, first the mental health, then physical health and least the social health.

Figure 7.1: Percentages of women's perceived importance (as very important) of the three aspects of health (according to the WHO definition) (n=450)



Women's knowledge of their reproductive health rights

Table 7.3 presents the most important reproductive health rights mentioned by the women (n=367) in response to an open ended-question: The right to receive full health care services during pregnancy, delivery and after birth (40%). The right to receive good, respectful, and caring treat from the health care providers while receiving the health care services (30.7%). The right to find all the necessary drugs, medical treatment, medical instruments and health insurance available and accessible (23.1%). The right to receive all necessary and full health information and health education needed for the women during the birth cycle (5.9%), and others (28.6%). There were regional differences in terms of the points mentioned. Women in Hebron had limited knowledge of reproductive health rights compared to women in both Jenin and Ramallah. Women were allowed to mention more than one right; therefore these percentages were not cumulative.

Table 7.3: Frequency and percentages of women's responses for the most important reproductive health rights they do perceive by study sites.

Mentioned reproductive health rights	Jenin n (%)	Ramallah n (%)	Hebron n (%)	Total n (%)
1. The right to receive full health care services during pregnancy , delivery and after birth	69 (18.8)	52 (14.1)	26 (7.0)	147 (40.0)
2. The right to receive all necessary and full health information and health education needed for the women during the birth cycle	4 (1.8)	18 (4.9)	0 (0.0)	22 (5.9)
3. The right to have available and accessible medical treatment (including medicine and modern medical instruments) and health insurance for all	38 (10.8)	36 (9.8)	11 (2.9)	85 (23.1)
4. The right to receive good , respectful and caring treatment from the health care providers while receiving the health care services	42 (11.4)	38 (10.35)	33 (8.9)	113 (30.7)
Total	153	144	70	367

*** These percentages are not cumulative as women may give more than one point or don't answer at all*

- Women expressed several important points categorized as others as follows:

1. Clear referral system between clinics and hospitals (5 women in Ramallah)
2. Right to receive full and regular medical check up (one woman in each of Ramallah & Jenin)
3. The right to limit the number of children (one in Ramallah)
4. Right to have full privacy while receiving the health care (one woman in Ramallah and 5 in Jenin)
5. The right to have clean and safe health care centers (3 women in Ramallah, 27 in Jenin),
6. The right to have all family planning methods available (1 in Ramallah, 1 in Jenin , and 10 in Hebron
7. Healthy nutrition (13 women in Hebron)
8. The right to have long maternity leave for working women (one woman in Ramallah)
9. The right to have easier and less complicated process in providing the health care (one woman in Ramallah)
10. The right to have health care law and legislatives aiming to protecting women from medical mistakes (10 women in Ramallah)
11. The right to have the freedom for making self- decisions necessary for the women's own health (3 women in Ramallah)

12. The right to have follow up health care services after delivery (one woman in Ramallah, 4 in Jenin, and 4 in Hebron)
13. The right to find well trained, experienced and professional health care providers in the public health care centers (one in Ramallah, 5 in Hebron and 7 in Jenin)
14. The right to Breast-feed their babies during working hours (one in Ramallah)
15. The right to have female health care providers in the health care centers (5 in Ramallah)
16. The right for birth spacing (one in Jenin and 4 in Hebron)

Attitudes towards the importance of reproductive health rights

Table 7.4 presents women's perception regarding reproductive health rights. In general, women had positive perception towards their reproductive health rights, and believed that these rights were very important to them with significant regional differences. The most important right that women have perceived was the right to receive full information concerning their health (mean =1.54), and the least important was the right to limit the number of children (mean = 2.00). The results presented in table 7.4 show that in general women in Hebron were the least to recognize the importance of the women's rights concerning most of the listed rights except for the right to choose the place for the health care given. The right to limit the number of children was not recognized as very important by all women among the three regions compared to the other rights. (See table 7.4 for more information)

Table 7.4: Women's perceived level of importance for each one of the reproductive health rights by study sites

Important reproductive health rights*	Hebron (South) (n=150)	Ramallah (Middle) (n=150)	Jenin (North) (n=150)	Total (n=450)	p-value
Right to receive the full care during their pregnancy, during their giving birth and after their pregnancy					
Mean	1.67	1.36	1.35	1.64	
Median	2	1	1	1	
Mean rank (Kruskal-Wallis Test)	274.33	199.54	202.63		<0.001
% very important	33.3	68.0	66.0	55.8	
Right to choose the place for the health care given to them					
Mean	1.82	1.91	1.74	1.82	
Median	2	2	2	2	
Mean rank (Kruskal-Wallis Test)	234.34	328.88	213.28		0.23
% very important	22.0	32.7	36.0	30.2	
Right to choose any family planning method					
Mean	1.81	1.68	1.69	1.72	
Median	2	2	2	2	
Mean rank(Kruskal-Wallis Test)	239.44	209.05	218.08		0.005
% very important	23.3	44.7	38.7	35.6	
Right to receive full information concerning their health					
Mean	1.76	1.45	1.42	1.54	
Median	2	1	1	2	
Mean rank (Kruskal-Wallis Test)	273.72	201.28	198.17		<0.001
% very important	24.0	57.7	58.4	46.7	
Right to make their own decisions concerning their health for example: (operation, family planning etc)					
Mean	1.78	1.76	1.74	1.76	
Median	2	2	2	2	
Mean rank(Kruskal-Wallis Test)	246.82	209.29	218.79		0.014
% very important	25.3	49.7	44.7	39.9	
Right to be treated without any discrimination					
Mean	1.77	1.45	1.42	1.59	
Median	2	1	1	2	
Mean rank(Kruskal-Wallis Test)	278.83	202.50	195.17		<0.001
% very important	24.0	59.3	63.3	48.8	
To have the right to marry and to found a family					
Mean	1.85	1.53	1.40	1.59	
Median	2	2	1	2	
Mean rank(Kruskal-Wallis Test)	284.15	209.75	182.60		<0.001
% very important	14.7	48.7	60.0	41.0	
Right to limit the number of children they have					
Mean	2.04	2.16	1.82	2.00	
Median	2	2	2	2	
Mean rank(Kruskal-Wallis Test)	243.61	226.26	206.64		0.028
% very important	22.7	40.0	42.7	35.1	

* Mean of Importance of selected reproductive health rights by region, Mean = the mean of the rate between 1-5 as 1 = very important, 2 =important, 3=some what important, 4=less important, 5= not important; Median of the importance rate, Mean rank using the Kruskal-Wallis; % of women rate the point as very important; significance P value calculated from Kruskal-Wallis test, p significant= 0<0.05

7.4. Family Planning

7.4.1. Family planning knowledge

The women were asked to motion the family planning methods they do know spontaneously, and later the interviewer did read all the contraceptives with an explanation about each one of them then asked the women whether they knew these methods.

Table 7.5 presents women's knowledge of family planning methods. It shows that among the whole sample and in the three regions, most women knew IUDs, pills, then male condom spontaneously. Comparing what women had identified spontaneously by themselves and after reading the explanations, women seemed to know most of the contraceptive methods, except some of the modern methods such as Implants, Diaphragm, and Female condom as shown in table 7.5. The most well known contraceptive methods was Pills, as almost all women (99.1%) knew pills after reading the definition, followed by IUDs then male condom and LAM. In relation to the traditional methods, more than 50% of women identified withdrawal as a family planning method after reading the definition. In general, the results showed that women have good knowledge about family planning methods.

Table 7.5: Women's knowledge of family planning methods: the number and percentage of all women that reported specific contraceptives to be known spontaneously and the number and percentages of women who reported contraceptives to be known after reading the definition.

Family planning methods	Spontaneously reported to be known n (%)	Reported as known after reading the definitions n (%)
Modern methods		
Female sterilization	30(6.7)	418 (92.9)
Male sterilization	6 (1.3)	99 (22.0)
IUD	437 (92.2)	442 (98.2)
Injections	98 (21.8)	290 (64.4)
Implants	9 (2.0)	39 (8.7)
Female condom	6 (1.3)	39 (8.7)
Male condom	191 (42.4)	389 (86.4)
Diaphragm	3 (0.7)	37 (8.2)
Foam and Jell	32 (7.1)	147 (32.4)
Pill	415 (92.2)	446 (99.1)
LAM	11 (2.4)	398 (88.4)
Emergency contraceptives	3 (0.7)	64 (14.2)
Others	0 (0.0)	21 (4.7)
Traditional methods		
Rhythm of periodic abstinence	**145 (32.2)**	**403 (89.6)**
Withdrawal	**136 (30.2)**	**400 (88.9)**

7.4.2. Family Planning Practices

Contraceptives use and never use

Table 7.6 presents the percentages of women who had been ever used and those who had been never used family planning methods by women's selected demographic characteristics. The results showed that there was no significant difference among the regions, however, there was a trend to use contraceptive more when women are older. High parity women and longer marriage years showed significant association with more use of contraceptive methods.

In relation to women's status inside the family, women who made more sole household decisions have used contraceptives more compared to those who made less sole household decisions. (p-value = 0.003).

Table 7.6: Family planning practices in terms of ever used and never used contraceptives by women's selected characteristics

Characteristics	Ever Used (n=348)	Never used (n=102)	Total (n=450)	p-value
Region				0.54
Hebron (South)	76.7	23.3	150	
Ramallah (Middle)	80.0	20.0	150	
Jenin (North)	74.7	25.3	150	
Number of decisions made by the woman				0.003
0	64.3	35.7	84	
1-2	77.5	22.5	231	
+3	84.3	15.7		
Total number of children				<0.001
0-1	44.7	55.3	132	
2-3	85.2	14.8	183	
+4	97.7	2.3	133	
Age				<0.001
≤24	57.5	42.5	127	
25-29	78.7	21.3	150	
≥ 30	90.1	9.9	171	
Marriage Years				<0.001
<10	69.3	30.7	313	
≥10	94.8	5.2	134	

*calculated from Chi –square test for measuring differences, significant p<0.05

Ever use contraceptives

Women who had been ever used contraceptives were asked about all the methods they had been using through their previous reproductive life. Women mentioned as many methods as they have ever used.

Table 7.7 presents the contraceptives that women were using by age group. It shows that withdrawal was the most family planning method that had been used among women from all different age groups with (47.8%), followed by IUD (36.7%), then Pills (29.8). Traditional methods as rhythm abstinence as well as lactational amenorrhea were used in relatively high percentages. Older women had used more IUD and pills than those in younger age group.

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Table 7.7: Percentages of family planning methods that had ever been used by women classified as modern and traditional methods as reported by women by specific age groups.

	Modern Methods							Traditional methods			
Age	**Female sterilization**	**Pills**	**IUD**	**Injectables**	**implants**	**Male condom**	**Foam / jell**	**LAM**	**Rhythm abstinence**	**withdrawal**	**Total**
15-19	0.0	9.1	9.1	0.0	4.5	13.6	4.5	18.2	4.5	22.7	8
20-24	0.0	21.3	14.8	1.9	0.0	17.6	0.9	20.4	19.4	42.6	68
25-29	0.0	20.3	31.8	0.7	0.0	29.7	0.7	30.4	30.4	52.7	117
30-34	2.2	47.8	47.8	1.1	0.0	37.0	4.3	32.6	37.0	50.0	82
35-39	0.0	42.9	65.1	7.9	0.0	39.7	11.1	33.3	33.3	54.0	56
>40	0.0	47.1	88.2	5.9	5.9	29.4	11.8	41.2	35.3	35.3	17
Total	1.1	29.8	36.7	2.2	0.4	28.9	3.8	28.7	28.4	47.8	348

The total percentage is not accumulative since women mentioned all the contraceptives that they had ever used.

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Current use of contraceptives

Table 7.8 shows that 38.8 % of women were currently contraceptive users. Excluding pregnant women (186 women), 135 (51.1%) women out of the 264 postnatal women were current users of contraceptives. The IUD was the most widely adopted modern method (9.8%), followed by LAM (5.1%), male condom (3.6%), Pills (3.3%), female sterilization and Injectables (used by less than 1%), respectively.

Among traditional, which were used mostly by younger aged women (15-24 years old), higher educated, and more in both regions of Hebron and Ramallah, withdrawal (5.8%) and periodic abstinence (1.3%) was the most frequently employed traditional methods.

Women with higher parity (43.7%) were currently using more contraceptive methods than those with low parity women. There was regional difference in terms of currently using contraceptives, where more women were currently using contraceptives in Ramallah compared to Jenin and Hebron.

Women's status and current use of contraceptive

Table 7.9 presents women's status and the associations with current use of contraceptives. It shows that neither women's final household decision nor women's beliefs towards husband's right for wife beating was significantly associated with the current method used by women or by the contraceptive method chosen. However, the right to refuse sex was significantly associated with women's current use of contraceptives and with the methods used. In that women who were not refusing sex with their husbands under more than three reasons tend to use more contraceptive method (42.9 %), but there was no clear trend of which contraceptives mostly used. Although the results show that women who tend not to refuse sex under more than three reasons with their husbands, have used male condom as well as withdrawal more than those who refused sex under all the questioned reasons (5.8%, 3.6% respectively). More details are presented in table 7.9.

Table 7.8: Current family planning methods used: Percentage of women who are currently using contraceptives by specific method, age, demographic characteristics and total number of children

	Modern methods							Traditional methods				
Characteristics	**Use any method**	**Female sterilization**	**Pills**	**IUD**	**Injectables**	**Male condom**	**LAM***	**Rhythm abstinence**	**Withdrawal**	**Percentage of women who currently not using**	**Total number of current users**	**Total number of women**
15-19	25.0	.0	.0	.0	.0	.0	.0	.0	9.1	75.0	2	8
20-24	52.9	.0	5.6	9.3	.9	4.6	3.7	.9	8.3	47.1	36	68
25-29	31.6	.0	3.4	7.4	.0	3.4	5.4	.7	4.7	68.4	37	117
30-34	43.9	2.2	4.3	14.1	1.1	2.2	8.7	1.1	5.4	56.1	36	82
35-39	30.4	.0	.0	9.5	.0	4.8	3.3	3.2	4.8	69.6	17	56
>40	41.2	.0	.0	23.5	.0	5.9	5.9	5.9	.0	58.8	7	17
Total	38.8	.4	3.3	9.8	.7	3.6	5.1	1.3	5.8	61.2	135	348
Region												
South (Hebron)	38.3	.0	4.7	9.3	.7	1.3	7.3	.7	6.0	61.2	45	116
Middle(Ramallah)	44.2	.7	2.0	14.0	.7	8.0	.7	2.7	6.7	55.8	71	120
Jenin (North)	33.0	.7	3.3	6.0	.7	1.3	7.3	.7	4.7	67.0	116	112
Education												
<Secondary	32.8	1.1	3.7	10.1	1.1	2.6	7.9	1.6	4.8	67.2	62	189
≥Secondary school	28.0	0.0	3.1	9.6	.4	4.2	3.1	1.1	6.5	59.0	73	261
Total number of children												
0-1	14.4	.0	1.5	1.5	.0	4.5	.0	1.5	5.3	85.6	19	132
2-3	31.1	.0	4.9	12.6	.0	1.6	4.9	1.1	6.0	68.9	57	183
+4	43.7	1.5	3.0	14.1	2.2	5.2	10.4	1.5	5.9	56.3	59	135
Total	38.8	.4	3.3	9.8	.7	3.6	5.1	1.3	5.8	61.2	135	348

Note: If more than one method is used, only the most effective method (all modern methods except LAM and traditional methods) is considered in the tabulation.

* =LAM = Lactational amenorrhea method

Table 7.9: Current use of contraceptive methods by women's status

Characteristics	Use any method	Pills	IUD	Male condom	LAM	Rhythm abstinence	withdrawal	Percentage of women who currently not using	Total number of current users	Total number of women	*p-value
Number of decisions women has the final say											
0	28.6	2.4	6.0	3.6	8.3	2.4	6.0	71.4	24	84	
1-2	29.5	3.0	11.3	3.9	4.3	.9	6.1	70.5	69	231	
3+	28.1	4.4	9.6	3.0	4.4	1.5	5.2	71.9	42	135	
											0.68
Number of reasons wife beating is justified											
0	27.9	4.4	9.5	4.4	5.1	.6	3.8	72.1	46	158	
1-2	30.0	4.3	12.1	2.9	2.9	2.1	5.7	70.0	43	140	
3+	29.0	1.3	7.9	3.3	7.2	1.3	7.9	71.0	46	315	
											0.60
Number of not to refuse sex with husbands											
0	30.4	4.2	11.5	2.2	6.1	1.9	4.2	69.6	98	312	
1-2	25.2	1.5	5.3	6.1	2.3	.0	9.9	74.8	34	131	
3+	42.9	3.3	9.8	3.6	5.1	.0	5.8	57.1	3	7	
											**.047
Total	38.8	3.3	9.8	3.6	5.1	1.3	5.8	61.2	135	450	

Percent distribution of currently married women by contraceptives that were currently used, according to selected indicators of women's status

* p-value calculate from Chi-square tests and significant p =<0.05

Number of children at the onset of contraceptive use

Table 7.10 shows the percent distribution of women who had been ever used contraceptives by number of living children at the time of the first use of any family planning method, according to the current age and region. In general, around half of women started using contraceptives after the first child (53.3%).

The table also shows that women younger than 20 years and between 20 and 24 years old started using contraceptives after having their first child, while 42.9% of women of age 40 started using contraceptives after the third child. Only 4.4% of women used contraceptives before having children. There was regional difference in this regard. In that, women from Jenin used contraceptives for delaying the first child more compared to women from Ramallah and Hebron (10.8%, 1.9%, and 2.2% respectively). Women in Hebron seemed to use contraceptives at later stage after having the second and the third child compared to both of Ramallah and Jenin.

Table 7.10: Percent distribution of women "who have ever used contraceptives" distributed by their number of living children at the time of their first use of contraceptives by current age, and region

Age	0	1	2	3	4+	Total (ever used)
15-19	0.0	100.0	.0	.0	.0	8
20-24	2.8	63.9	19.4	3.9	.0	68
25-29	2.7	64.9	29.7	2.7	.0	116
30-34	5.6	38.9	36.1	16.7	2.8	82
35-39	11.8	41.2	17.6	11.8	17.6	56
>40	0.0	28.6	.0	42.9	28.6	16
Region						
South (Hebron)	2.2	48.9	26.7	15.9	6.7	115
Middle(Ramallah)	1.9	54.7	26.4	13.2	3.8	120
Jenin (North)	10.8	56.8	21.6	8.1	2.7	111
Total	4.4	53.3	25.2	12.6	4.4	346

7.4.3. Attitudes towards the importance of family planning

Table 7.11 shows women's attitudes towards the importance of contraceptives use and family planning by region. Among the three regions, women ranked the importance of using family planning in the following order:

1. The children health and good raising up
2. The mother health
3. Birth spacing
4. Economic reasons
5. limiting the number of the family
6. Delaying the first child

Regional differences were found among all the 6 purposes of family planning.

Delaying the first child contraceptive use purpose was ranked differently between the three regions, as women in Ramallah were more to support this purpose with a mean of (3.93) compared to women in both Jenin and Hebron (4.16, and 4.56 respectively). Women in Jenin were the most to support birth spacing (mean 1.48, median 1), as one of the important use of family planning. Limiting the number of children was much more accepted in both Jenin and Ramallah (percent of very important 26% and 34% respectively) compared to women in Hebron (6.7%). More women in Jenin found the economic reasons as very important purpose of family planning use (60%) compared to women in both Ramallah and Hebron (33%, 15% respectively). In general, women gave the purposes of family planning as delaying the first child and limiting the number of children as the least important.

Table 7.11: Women's perceived rate of importance regarding the main purposes of using family planning methods by region

Purposes for using family planning methods*	Hebron (South) (n=150)	Ramallah (Middle) (n=150)	Jenin (North) (n=150)	Total (n=450)	p-value
First child delay					
Mean	4.56	3.93	4.16	4.22	
Median	5	5	5	5	
Mean rank(Kruskal-Wallis Test)	259.15	203.10	214.25		<0.001
% very important	1.3	8.7	5.3	5.1	
Birth spacing					
Mean	1.92	1.89	1.48	1.76	
Median	2	2	1	2	
Mean rank(Kruskal-Wallis Test)	258.79	240.54	177.17		<0.001
% very important	19.3	28.7	54.7	34.2	
Limits the number of children					
Mean	2.92	2.43	2.10	2.48	
Median	2	2	2	2	
Mean rank(Kruskal-Wallis Test)	265.48	216.24	193.24		<0.001
% very important	6.7	24.0	26.0	18.9	
Economic reasons					
Mean	2.14	2.12	1.49	1.92	
Median	2	2	1	2	
Mean rank(Kruskal-Wallis Test)	267.56	242.49	166.44		<0.001
% very important	15.3	33.3	60.0	36.2	
For the health of the mother					
Mean	1.44	1.37	1.09	1.30	
Median	1	1	1	1	
Mean rank(Kruskal-Wallis Test)	256.01	241.08	179.41		<0.001
% very important	56.7	63.3	90.7	70.2	
For the health of the children					
Mean	1.41	1.32	1.06	1.23	
Median	1	1	1	1	
Mean rank(Kruskal-Wallis Test)	264.94	223.12	188.44		<0.001
% very important	60.0	78.7	94.0	77.6	

*Mean of Importance for the purposes of using family planning methods, Mean = the mean of the rate between 1-5 as 1 = very important, 2 =important, 3=some what important, 4=less important, 5= not important;
Median of the importance rate; Mean rank using the Kruskal-Wallis; % of women rank the point as very important; significance p- value calculated from Kruskal-Wallis test. P significant= 0<.05

7.4.4. Determinants for women's use of contraceptives

Table 7.12 shows women's ranking for the most important determinants that they do perceive while using family planning contraceptives in the following order:

1. Free in choosing the method
2. Being relax , comfortable and satisfied in family planning methods use
3. The continuity in having FP methods
4. Information about FP methods
5. Women's opinion in using the methods
6. Husband participation
7. Free of discrimination
8. Privacy in the health center, and confidentiality in health care center
9. Accessibility to FP methods & clinics
10. Cost of the FP methods

The results showed that women put reproductive health right among the most important factors to use family planning, which was the freedom in choosing family planning method (64.2% of very important, mean 1.33, median 1). The availability of family planning was also ranked as an important family planning determinant for the use of contraceptives. The results showed that the free of choose, availability, and information were the most important points for the women when using family planning contraceptives.

Regional differences were found among each of the following determinants: cost, information, husband participation free of discrimination, choosing methods freely, giving opinion in using the service, continuity in having the method, number of children and being comfortable in receiving the service. Husband participation was more important for women in Jenin compared to women in Hebron where it was ranked as the least important (68.7%, 37.3% respectively).

Table 7.12: Perception of women's important determinants for using family planning methods by region

Determinants for using contraceptives*	Hebron (South) (n=150)	Ramallah (Middle) (n=150)	Jenin (North) (n=150)	Total (n=450)	p-value
Number of living children					
Mean	1.77	1.67	1.62	1.69	
Median	2	1	2	2	
Mean rank (Kruskal-Wallis Test)	245.35	210.41	220.7		0.027
% very important	33.3	52.0	43.3	42.9	
Accessibility of family planning services					
Mean	1.76	1.89	1.87	1.84	
Median	2	2	2	2	
Mean rank (Kruskal-Wallis Test)	214.24	229.80	223.45		0.29
% very important	30.0	27.3	25.3	27.6	
Privacy					
Mean	1.68	1.81	1.88	1.79	
Median	2	2	2	2	
Mean rank(Kruskal-Wallis Test)	218.19	220.27	236.51		0.33
% very important	35.3	40.3	38.7	38.1	
Confidentiality					
Mean	1.69	1.64	1.81	1.79	
Median	2	2	2	2	
Mean rank (Kruskal-Wallis Test)	229.50	210.85	236.15		0.15
% very important	35.3	48.7	42.0	42.0	
Cost					
Mean	2.03	2.80	2.11	2.31	
Median	2	2	2	2	
Mean rank (Kruskal-Wallis Test)	201.31	268.80	206.38		<0.001
% very important	26.0	16.7	28.7	23.8	
Information					
Mean	1.63	1.68	1.40	1.57	
Median	2	2	1	2	
Mean rank (Kruskal-Wallis Test)	242.26	242.85	191.39		<0.001
% very important	38.0	40.7	62.0	46.8	
Husband participation					
Mean	1.82	1.72	1.38	1.64	
Median	2	2	1	1	
Mean rank(Kruskal-Wallis Test)	257.20	236.16	183.14		<0.001
% very important	37.3	46.0	68.7	50.7	
Free of discrimination					
Mean	1.73	1.79	1.57	1.70	
Median	2	2	1	2	
Mean rank (Kruskal-Wallis Test)	238.24	235.11	203.15		0.015
% very important	36.0	38.0	52.7	42.2	
Choosing methods freely					
Mean	1.55	1.40	1.10	1.36	
Median	2	1	1	1	
Mean rank (Kruskal-Wallis Test)	269.22	229.35	177.93		<0.001
% very important	44.7	62.7	85.3	64.2	
Giving opinion in methods and services					
Mean	1.62	1.66	1.45	1.58	
Median	2	2	1	2	
Mean rank (Kruskal-Wallis Test)	241.55	239.18	195.77		0.001
% very important	38.7	42.7	62.0	47.8	

Determinants for using contraceptives Table 7.12 continues.	Hebron (South) (n=150)	Ramallah (Middle) (n=150)	Jenin (North) (n=150)	Total (n=450)	p-value
Continuity in having the methods					
Mean	1.58	1.73	1.35	1.55	
Median	2	2	1	2	
Mean rank(Kruskal-Wallis Test)	239.23	251.90	185.37		<0.001
% very important	42.0	40.0	67.3	49.8	
Comfort and satisfaction from the service					
Mean					
Median	1.57	1.49	1.24	1.43	
Mean rank(Kruskal-Wallis Test)	2	1	1	1	
% very important	256.00	238.00	182.50		<0.001
	43.3	51.3	76.0	56.9	

[1]: Mean of determinants for using contraceptive; Mean = the mean of the rate between 1-5 as 1 = very important, 2 =important, 3=some what important, 4=less important, 5= not important; Median of the importance rate; Mean rank using the Kruskal-Wallis; % of women rate the point as very important; significance p-value calculated from Kruskal-Wallis test. p significant= 0<.05

7.4.5. Decisions making and family planning (using and discontinue using of contraceptives and having a new child)

Decision for using contraceptives

Figure 7.2 shows the results of a question measuring whom responsible for making the decision for using contraceptives by the three regions. It shows that most women reported that they made the decision together with their husbands; however, it differs between regions to be 76% in Jenin and 53.3% in Hebron. Women who have alone decided the contraceptive use were most in Hebron and least in Jenin (23.3%, 6.7% respectively). Husband alone decision was least in Ramallah (14.7%).The figure shows significant regional difference in terms of women's ability to make decisions as well.

Figure 7.2: Percent distribution of the decision makers inside the family for using contraceptives by region

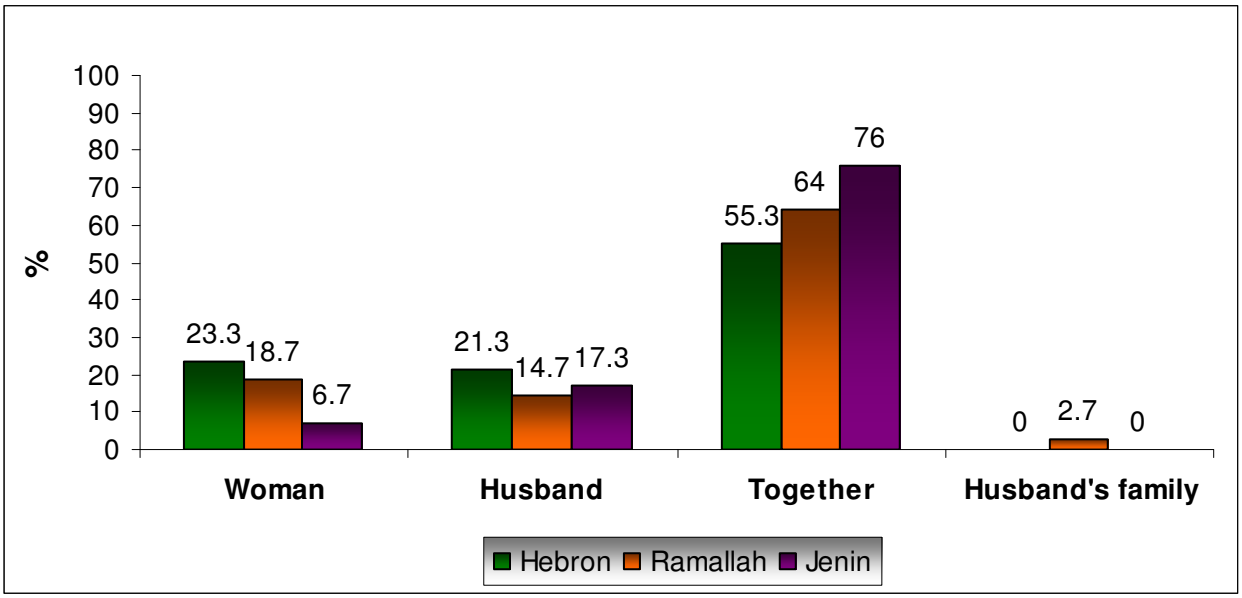


Table 7.13 presents the associated factors for the women's sole decision making for using contraceptives (based on the cross tabulation). It shows that there was a significant association between women's age and women's decision of using contraceptives, as the older the women was the more they tend to made sole decisions for using contraceptives (p=<0.001).

Highly educated women tend to make decisions more sharing with their partners compared to less educated women (p=<0.001). However, lower educated women made more self decisions for using contraceptives.

High parity plays a significant role; as the women with more children made much more decisions for using contraceptives (p=.003). Women's status had a strong association with women's ability to make sole decision in terms of using contraceptives. In that women who were working for money, women who tended to refuse husband beating, women who made more sole household decisions, and women who refused making sex with their husbands under the six questioned situations, have more ability and power to make sole decisions in terms of using contraceptives. It shows also that the influence of others to interfere with their decisions became less. There was also a regional difference, as women in Hebron tended to make sole decision more comparing to the other two regions and the interference of others were much stronger in Hebron as well.

Employed women reported being doing more joint decision with their husbands while the interference of others is less compared to the unemployed**.**

Table 7.13: Decisions on using contraceptives : Percent of women who reported being responsible for **using** family planning methods by demographic characteristics, number of children and women's status such as working status and level household decisions, number of justified reasons for wife beating and number of reasons not to refuse sex with husbands.

Characteristics	Woman (n=73)	Together (n=293)	Others (n=84)	Total (n=450)	p-value*
Age					0.06
≤24	10.2	71.7	18.1	127	
25-29	14.6	66.9	18.5	151	
≥30	22.0	58.7	19.2	172	
Region					0.001
South (Hebron)	23.3	55.3	21.3	150	
Middle(Ramallah)	18.7	64.0	17.3	150	
Jenin (North)	6.7	76.0	17.3	150	
Education					<0.001
No education & primary school	20.1	52.4	27.5	189	
Secondary school & High education	13.4	74.3	12.3	261	
Total number of children					0.003
0	10.4	79.2	10.4	48	
1-3	13.1	68.5	18.4	267	
≥4	24.4	53.3	22.2	135	
Working status					0.03
Yes	20.7	70.1	9.2	87	
no	15.2	63.9	20.9	363	
Number of reasons wife beating is justified					<0.001
0					
1-2	22.8	62.0	15.2	158	
3+	14.3	75.7	10.0	140	
	11.2	58.6	30.3	152	
Number of decisions women has the final say					<0.001
0	6.0	71.4	22.6	84	
1-2	12.1	69.7	18.2	231	
3+	29.6	53.3	17.0	135	
Number of reasons not to refuse sex with husbands					0.041
0	17.9	66.7	15.4	312	
1-2	13.0	61.8	25.2	131	
3+	.0	57.1	42.9	7	
Total	**16.2**	**65.1**	**18.7**	**100.0**	

*Calculated from Chi –square for measuring differences, significant p<0.05

Decisions on the discontinue use of contraceptives

Figure 7.3 shows the results of decisions to stop using contraceptives by region. It shows that most women made this decision together with their husbands. However it differs between regions; as joint decision is mostly made by women in Jenin and least by women in Hebron (72%, 46% respectively). Women sole decision to stop using contraceptives is more done by women in Hebron (25.3%) and least in Jenin (10.7%). However, husbands alone made the decision least in Ramallah (12%). Husband's family interference with the decision to stop using contraceptives was found in both Ramallah and Hebron (6%, and 2% respectively), but none of the women from Jenin reported so.

Figure 7.3: Percentage distribution of the decision makers inside the family in regard to discontinue use of contraceptives by region

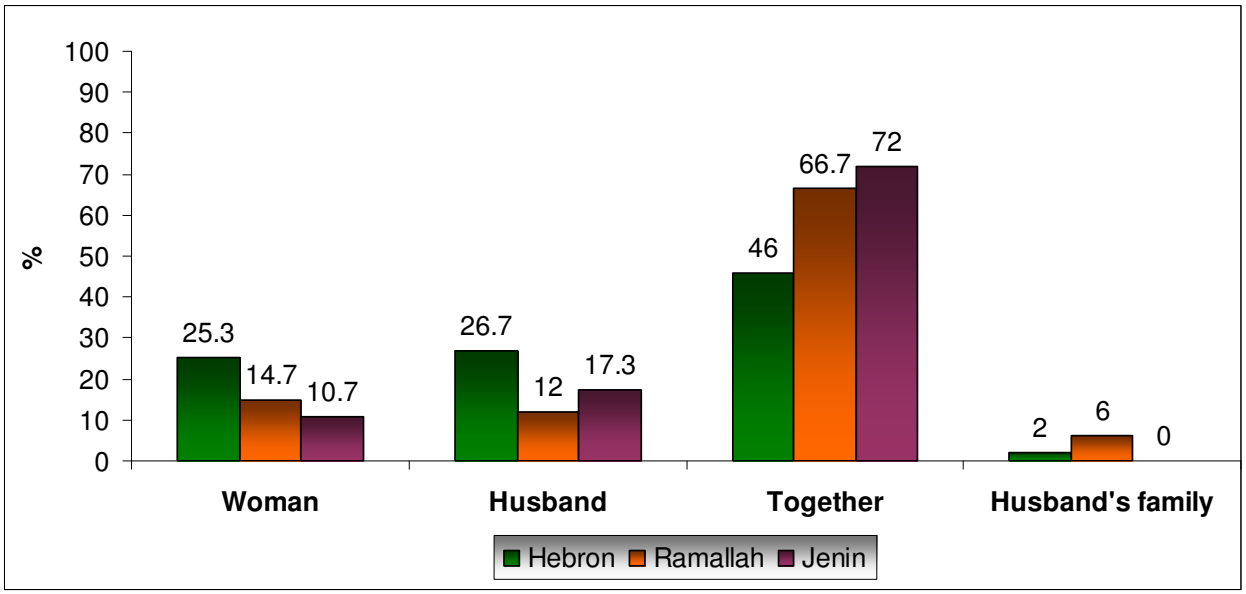


Table 7.14 presents the factors that influenced women's decision to stop using contraceptives. Overall the three regions, 61.6% of women made the decision to stop using contraceptives together with their husbands, while only 16.9% of women made this decision alone.

Age was a significant factor as women older than 30 made more sole decision regarding stopping the use of contraceptives. Regional difference was found among the three regions as women from Hebron made more sole decision compared to those in Jenin (2.3%, 10.2% respectively). Women who received higher education tended to make this decision jointly with their husbands more than those who received lower education. The more the number of children the women had, the more she got the initiatives to make sole decision to stop using contraceptives (p=<0.001). Economic status was a significant factor (p=.050) as women from higher economic status made this decision much more than those form lower economic status. Women who were working for money made this decision more jointly (together decision) with their partners than those who are not working (p=0.003).

Women's household status had a strong association with women's ability to make self-decision in terms of stop using contraceptives. In that, women who tended to refuse husband's beating, women who made more sole household decisions and women who refused sex with their husbands under certain conditions made their sole decisions in terms of stop using contraceptives (p= .001, <.001 and 0.003, respectively).

The results show that the influence of others in making the decision was more among women in Hebron compared to Jenin (28.7%, 17.3% respectively), and among women who received lower education compared to those women who received higher education (33.3%, 13.3% respectively).

Table 7.14: Determinants for women's decision to stop using contraceptives: Percent of women who reported being responsible for **stop** using contraceptives by demographic characteristics, number of children and women's status such as working status and level household decisions, number of reasons wife beating is justified and number of reasons not to refuse sex

Characteristics	Woman (n=76)	Together (n=277)	Others (n=97)	Total (n=450)	p-value*
Age					0.07
≤24	10.2	65.4	24.4	127	
25-29	15.9	63.6	20.5	151	
≥30	22.7	57.0	23.3	172	
Region					<0.001
South (Hebron)	25.3	46.0	28.7	150	
Middle(Ramallah)	14.7	66.7	18.7	150	
Jenin (North)	10.7	72.0	17.3	150	
Education					<0.001
No education & primary school	22.2	44.4	33.3	189	
Secondary school & High education	13.0	73.9	13.0	261	
Total number of children					<0.001
0	8.3	81.3	10.4	48	
1-3	12.0	65.9	22.1	267	
≥4	29.6	45.9	24.4	135	
Working status					0.003
Yes	12.6	77.0	10.3	87	
no	17.9	57.9	24.2	363	
Economic status					0.050
High	28.9	60.5	10.5	38	
Middle	17.0	62.1	20.9	338	
low	11.0	59.8	29.3	82	
Number of reasons wife beating is justified					0.001
0	21.5	63.3	15.2	158	
1-2	15.7	67.1	17.1	140	
3+	13.2	54.6	32.2	152	
Number of decisions women has the final say					<0.001
0	9.1	65.5	25.0	84	
1-2	11.7	66.7	21.6	231	
3+	30.4	50.4	19.3	135	
Number of reasons not to refuse sex with husbands					0.003
0	20.2	60.9	18.9	312	
1-2	7.6	64.1	28.2	131	
3+	42.9	61.6	14.3	7	
Total	**16.9**	**61.6**	**21.6**	**100%**	

Calculated from Chi –square for measuring differences, significant p<0.05

Decision for having another child

Figure 7.4 shows the results of women's decision making for having a new child in the family. It shows that most women made this decision together with their husband, which varies between regions to be mostly done among women in Jenin (72%), compared to women in Hebron (46%). Husbands alone made this decision more in Hebron compared to Ramallah and Jenin (26.7%, 17.3%, 12%, respectively). In this regard, overall the three regions, 16.9% of women made sole decisions with a similar percent for women in Hebron and Ramallah (data not shown).

Figure 7.4: Percent distribution of the decision makers inside the family on having another child

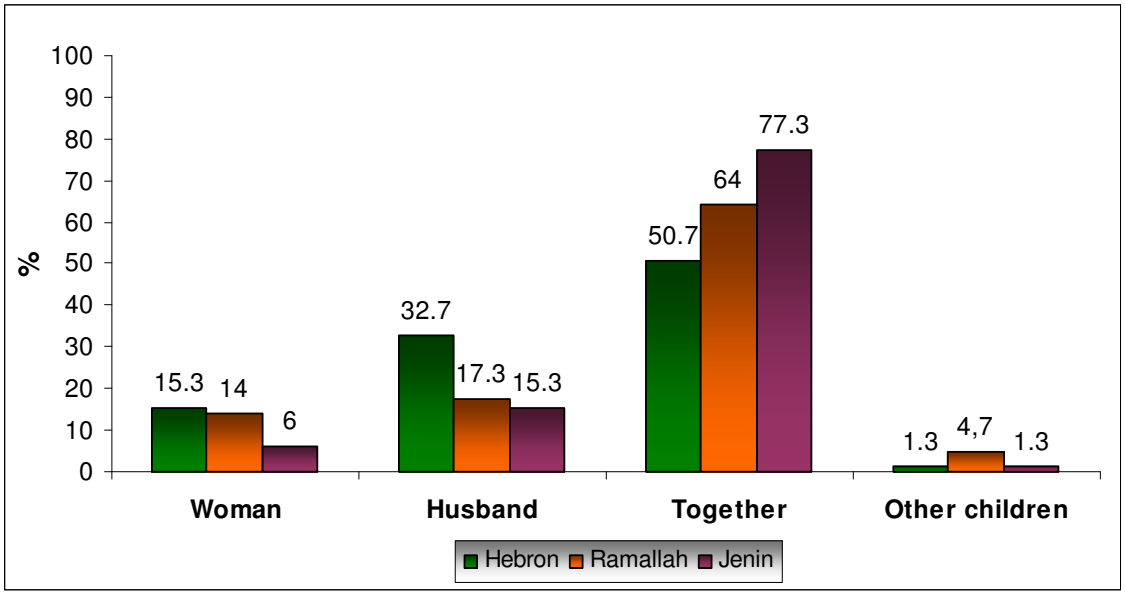


Table 7.15 presents the percentages of women who were responsible for making the decision for having another child by demographic characteristics. Overall 64% of women reported being making this decision together with their husband. 24.2% of women reported that others such as other children or husband's family made this decision and 11.8% of women reported being responsible for making sole decision.

Age and economic status were not significantly associated with women's ability to make their sole decision in terms of having another child. However, regional differences were highly significant (p=<.001). It shows that women in Hebron were the least to make this decision

together with their husbands (50.7%), but they were the most who reported making a sole decision in this regard (15.3%) and the most where others interfered for the process of making same decision (34%), compared to women in both Ramallah and Jenin.

Education had a highly significant association (p=<0.001). In that women who received higher education (secondary school & high education) reported being making this decision together with their husband (74%), the interference of others was least (12.3), and least to made sole decision (13.4%) compared to the women who received less education (no education & primary school).

Women's status had a strong association with women's ability to make sole decision in having another child. In that, women who worked for money, women who refused husband beating, women who made more household decisions, and women who refused making sex with their husbands under the six questioned situations tended to have more initiatives to make their sole decisions in terms of having another child (p= .031,<.001, .033, and .050, respectively).

High parity is a highly significant factor influencing women's decision to have another child. In that women who were having more than four children tended to make more sole decision (18.5%). Others also tended to have more influence in making the decision when there were more children (31.4%).

Table 7.15: Decisions for having another child: Percent of women who reported being responsible for **having another child** by demographic characteristics, number of children and women's status such as working status and level of household decisions, number of reasons wife beating is justified and number of reasons not to refuse sex with husbands.

Characteristics	Woman (n=53)	Together (n=288)	Others (n=109)	Total (n=450)	p-value*
Age					0.10
≤24	5.5	67.7	26.8	127	
25-29	12.6	64.9	22.5	151	
≥30	15.7	60.5	23.8	172	
Region					<0.001
South (Hebron)	15.3	50.7	34.0	150	
Middle(Ramallah)	14.0	64.0	22.0	150	
Jenin (North)	6.0	77.6	16.7	150	
Education					<0.001
No education & primary school	20.1	52.1	27.5	189	
Secondary school & High education	13.4	74.3	12.3	261	
Total number of children					<0.001
0	16.8	75.0	8.3	48	
1-3	7.5	68.9	23.6	267	
≥4	18.5	50.4	31.4	135	
Working status					0.031
Yes	20.7	70.1	9.2	87	
no	15.2	63.9	20.9	363	
Economic status					0.31
High	21.1	57.9	21.1	38	
Middle	10.9	65.8	23.3	338	
low	11.0	59.8	29.3	82	
Number of reasons wife beating is justified					<0.001
0	17.1	62.7	20.3	158	
1-2	10.7	74.3	15.0	140	
3+	7.2	55.9	36.8	152	
Number of decisions women has the final say					0.033
0	7.1	66.7	26.2	84	
1-2	9.5	68.0	25.5	231	
3+	18.5	55.6	25.9	135	
Number of reasons not to refuse sex with husbands					0.050
0	14.4	64.1	21.5	312	
1-2	6.1	63.4	30.5	131	
3+	.0	71.4	28.6	7	
Total	**11.8**	**64.0**	**24.2**	**100%**	

*Calculated from Chi –square for measuring differences, significant p<0.05

Using family planning based on women's sole decision

Table 7.16 shows the results from women's reporting of sole decision making in terms of using family planning methods. It shows that 16.2 % of women mentioned that they could use contraceptives based on their self opinion only. It also shows the determinants supported women's ability to make sole decision and to use family planning methods based on their own opinion only. Age, education and working status were not significantly associated with

women's ability to use family planning based on their self opinion. However, there were high significant regional differences. In that most of women who answered that they could use family planning method based on their sole decisions were from Hebron (30.1%) compared to those from Jenin (6%).

High parity was an associated factor with women's sole decision on using contraceptives. In that women with more children tend to use family planning based on their own opinion. Women's status inside the family was highly significant factor (p=<.001). In that, women who were making more than three sole household decisions mentioned more that they could use family planning based only on their self-opinion.

Figure 7.5 shows the persons whom the women would ask and consider when they decided to use contraceptives. Almost all women mentioned considering their husbands either alone or together with someone else. 48.3% mentioned husband only, 23.2% mentioned husband and health care provider, 13.5% mentioned husband together with others and health care provider, 4.8% mentioned husband and mother in law, 4% mentioned husband and other and only 1.9 mentioned consulting other alone.

Figure 7.5: Percent of women's reported considering persons when they decided using contraceptives

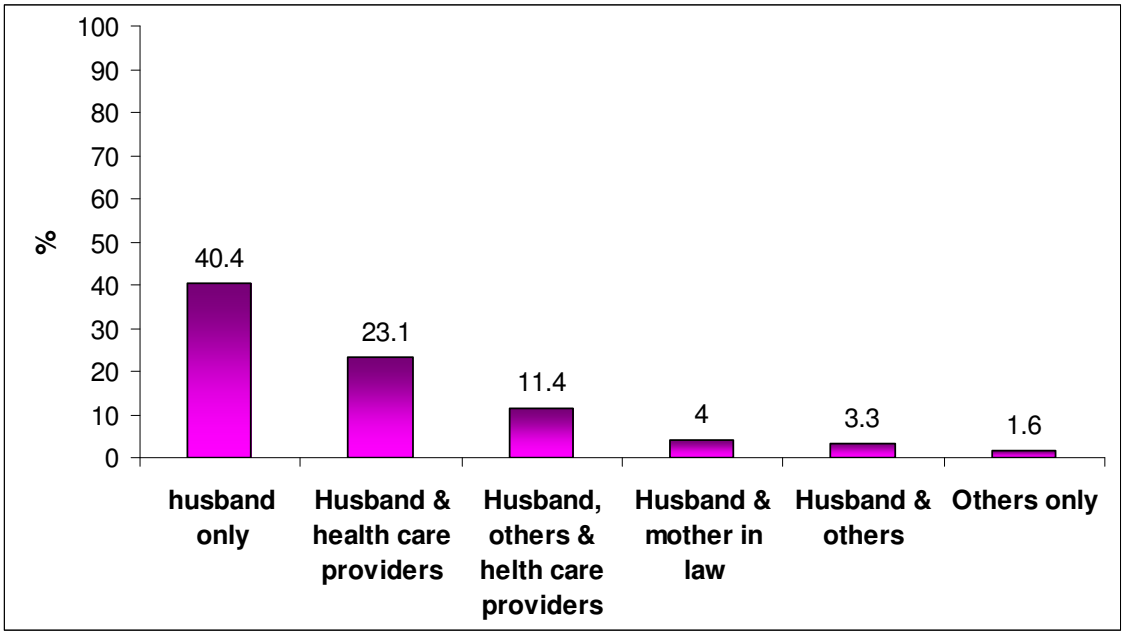


Table 7.16: Using family planning methods based on women's self-opinion only: Percentage of women who replied that they could use family planning based on their self-opinion only by demographic characteristics and women's status

Characteristics	Yes (n=73)	No (n=377)	Total (n=450)	p-value*
Age				0.74
≤24	15.7	84.3	127	
25-29	15.2	84.8	151	
≥30	17.4	82.6	172	
Education				0.33
No education & primary school	18.0	82.0	189	
Secondary school & High education	14.9	85.1	261	
Working status				0.67
Yes	13.8	86.2	87	
no	16.8	83.2	363	
Region				<0.001
South (Hebron)	30.7	69.3	150	
Middle(Ramallah)	12.0	88.0	150	
Jenin (North)	6.0	94.0	150	
Total number of children				0.023
0	8.3	91.7	48	
1-3	13.9	86.1	247	
≥4	23.7	76.3	135	
Number of decisions women has the final say				<0.001
0	11.9	88.1	84	
1-2	8.7	91.3	231	
3+	31.9	68.1	135	
Number of reasons not to refuse sex with husbands				0.013
0	19.6	80.4	312	
1-2	7.6	92.4	131	
3+	28.6	71.4	7	
Number of reasons wife beating is justified				0. 08
0	21.5	78.5	158	
1-2	15.7	84.3	140	
3+	11.2	88.8	152	

* Calculated from Chi –square for measuring differences, significant p<0.05

Fertility decisions and wanting the current pregnancy

in order to check the relationship between women's pregnancy intention and fertility decisions, pregnant women (187) were asked whether they wanted that current pregnancy by the time of being pregnant and they gave the options of *" they wanted that then, later, they does not want it at all"*.

Table 7.17 presents the association between women's fertility decisions and the reported answer of wanting the current pregnancy. The table shows that there was no significant association between wanting the current pregnancy and the decisions for using contraceptives and the majority of women reported making this decision together with their husbands. While

on the other hand there were significant association between both the decisions for stop using contraceptives, having another child and wanting the current pregnancy (p=0.03, p= <0.001 respectively). In that the interference of others when women does not want children or wanting children later was relatively high in case of making the decisions for having another child (42.4%, 38.5%).

Table 7.17: Fertility decisions and wanting the current pregnancy: Number and percentages of women who reported wanting the current pregnancy by their fertility decisions (responsibility for using contraceptives, stop using contraceptives and having another child)
* Calculated from Chi –square for measuring differences, significant p<0.05

Fertility decisions	Wanting pregnancy (n=102)	Wanting later (n=53)	Not at all (n=33)	Total (n=187)	p-value*
Responsibility for using contraceptives					0.15
Woman	12 (11.8)	4 (7.7)	4 (12.1)	20 (10.7)	
Together	78 (76.5)	34 (65.4)	21 (63.6)	133 (71.1)	
Others	12 (11.8)	14 (26.9)	8 (24.2)	34 (18.3)	
Responsibility for stop using contraceptives					0.033
Woman	9 (8.8)	3 (5.8)	6 (18.2)	18 (9.6)	
Together	78 (76.5)	34 (65.4)	17 (51.5)	129 (69.0)	
Others	15 (14.7)	15 (28.8)	10 (30.3)	40 (21.4)	
Responsibility for having another child					<0.001
Woman	12 (11.8)	2 (3.8)	1 (3.0)	15 (8.0)	
Together	79 (77.5)	30 (57.7)	18 (54.5)	127 (67.9)	
Others	11 (10.8)	20 (38.5)	14 (42.4)	45 (24.1)	

7.4.6. Family planning results summary

Family planning knowledge

- Among the whole sample and in the three regions, most women mentioned spontaneously IUDs, pills, then male condom.
- After reading the definitions, women seemed to identify most of the contraceptive methods except some of the modern methods such as implants, diaphragm, and female condom.
- Pills (99.1%) and IUDs (98.2%) were the most well-known contraceptives.

Family planning practices

- From the total sample, 77% of women have ever used contraceptives.
- The results show that there was no significant difference among the regions. However, common use of contraceptives was among older women, women who have children and those with longer marriage years.
- Withdrawal was the most contraceptive method which had been used among women from all different age groups with (47.8%), followed by IUD (36.7%), then Pills (29.8).
- Only 38.8% of married women were currently using any contraceptive method.
- The most common currently used contraceptives were IUD (9.8%), the male condom (3.6%) then Pills (3.3%).
- There was regional difference in terms of currently using contraceptives to be higher by women in Ramallah compared to women in both Jenin and Hebron (44.2%, 38.3%, 33%, respectively).
- Women's status inside the family in terms of the number of household decisions or refusal for the husband's beating had shown no significant association with women's current use of contraceptives.
- Most women of age group 20-24 used contraceptives after the first child.
- The majority of women of age 40 started using contraceptives after the third child (42.9%).

Attitudes around family planning (importance, family planning rights, and family planning services)

- Among the three regions women ranked the use of family planning importance in the following order:

(1) The children health and good raising up
(2) The mother health
(3) Birth spacing
(4) Economic reasons
(5) limiting the number of the family
(6) Delaying the first child

- A regional difference was noted among all the six purposes of family planning.
- In delaying the first child the result shows that women in Ramallah was more to consider it with a mean (3.93) compared to both Jenin and Hebron (4.16, and 4.56, respectively).
- Women in Jenin were the most to support birth spacing (mean 1.48, median 1) as one of the important use of family planning. Limiting the number of children was much more accepted among women in both Jenin and Ramallah (percent of very important 26% and 34%, respectively) compared to women in Hebron (6.7%). Women in Jenin found the economic reason as very important purpose of family planning use (60%) compared to those in both Ramallah and Hebron (33%, 15%, respectively).
- Women ranked the most important determinants for using family planning services in following order:
    (1) Free in choosing the method
    (2) Being relax , comfort and satisfied in family planning methods use
    (3) Continuity in having the methods
    (4) Information about FP methods
    (5) The continuity in having FP methods
    (6) Your opinion in using the methods
    (7) Husband participation
    (8) Free of discrimination
    (9) Privacy in the health center, and confidentiality in health care center
    (10) Accessibility to FP methods & clinics
    (11) Cost of the FP methods
- Husband participation was more important for women in Jenin and least for those in Hebron (68.7%, 37.3%, respectively).

Decisions to use contraceptives

- Most women mentioned that they made the decision together with their husbands; however, it differs between regions to be 76% in Jenin and 53.3% in Hebron. Women alone decided contraceptive use most in Hebron and least in Jenin (23.3%, 6.7% respectively). Husband alone made least decision in Ramallah (14.7%).
- The results show that there was a significant association between age and women's sole decision for using contraceptives, as the older the women were the more they were able to make the decision to use the contraceptives by their own (p=<.001).
- Highly educated women tend to made decisions more sharing with their husbands compared to those with less educated women (p=<.001). However, lower educated women made more sole decision for contraceptives use.
- High parity played a significant role; the women with more children made much more decisions for using contraceptives (p=.003).
- Women's status had a strong association with women's ability to make sole decision in terms of using contraceptives. In that women who were working for money, women who refused husband beating, women who had more household decisions, and women who refused making sex with their husbands under the six questioned situations, tended to have more power for making their sole decisions in terms of using contraceptives.

Decisions to discontinue use of contraceptives

- Most women made that decision together with their husbands (61.6%); however, it differs between regions to be most among women in Jenin and least for those in Hebron (72%, 46%, respectively). Women's self decision to stop using contraceptives were most among women in Hebron (25.3%) and least for those in Jenin (10.7%). Husbands alone made this decision least in Ramallah (12%). Husband's family interference with the decision to stop using contraceptives was mostly recognized by women in Ramallah and Hebron (6%, and 2%, respectively).
- Women who received higher education were able to make this decision jointly with their husbands compared to those who received lower education.
- The more the women have children the more they got the authority and power to make the sole decision to stop using contraceptives (p=<.001).

- Economic status was a significant factor (p=.050), as women from higher socioeconomic class reported being able to make sole decision much higher than those form lower class.
- Women who were working for money tended to do this decision more in sharing (together decision) with their partners compared to those who are not working (p= .003).
- Women's status played a strong association with women's ability to make sole decision in terms of stop using contraceptives. In that women who refused husband beating, women who made more household decisions, and women who refused making sex with their husbands under the six questioned situations tend to have more ability and power to make their sole decisions in terms of stop using contraceptives (p= .001,<.001, and .003, respectively).

Decisions on having another child

- The results show that most women made this decision together with their husband (64%) but also vary between regions to be the highest among women in Jenin (72%) and lowest among those in Hebron (46%). Husbands alone made the decision more in Hebron compared to Ramallah and Jenin (26.7%, 17.3%, and 12%, respectively). However, 16.9% of women made alone this decision with a similar percent between Hebron and Ramallah.
- Neither age nor economic status showed significant association with women's ability to make their sole decision in terms of having another child.
- Education played a highly significant role (p=<.001), in that women who received higher education made this decision together with their husband (74%) and that the interference of others was least reported in making this decision (12.3%).
- Women's status had a strong association with women's ability to make sole decision in having another child. In that women who worked for money, women who refused husband beating, women who made more household decisions, and women who refused making sex with their husbands under the six questioned situations tended to have more ability and power to make their sole decisions in terms of having another child (p= .031,<.001, .033, and .050, respectively).

Using contraceptives based on women's opinion only

- The results showed that 16.2% of women mentioned that they could use contraceptives based on their sole opinion only.
- Among the rest of the women, almost all women mentioned that in order to use a contraceptive, they consider asking the opinion of their husbands either alone or together with someone else. 48.3% mentioned husband only, 23.2% mentioned husband and health care provider, 13.5% mentioned husband together with others and health care provider, 4.8% mentioned husband and mother in law, 4% mentioned husband and others and only 1.9% mentioned others alone.

Wanting the current pregnancy and fertility decisions

- The results showed that there was no significant association between decisions for using family planning methods and wanting the current pregnancy, however there were significant associations between the decisions for stop using contraceptives, having another child and wanting the current pregnancy ($p=0.033$, <0.001 respectively).
- The interference of others in making the decision of having another child was relatively high when women did not want the current pregnancy at all or at another time.

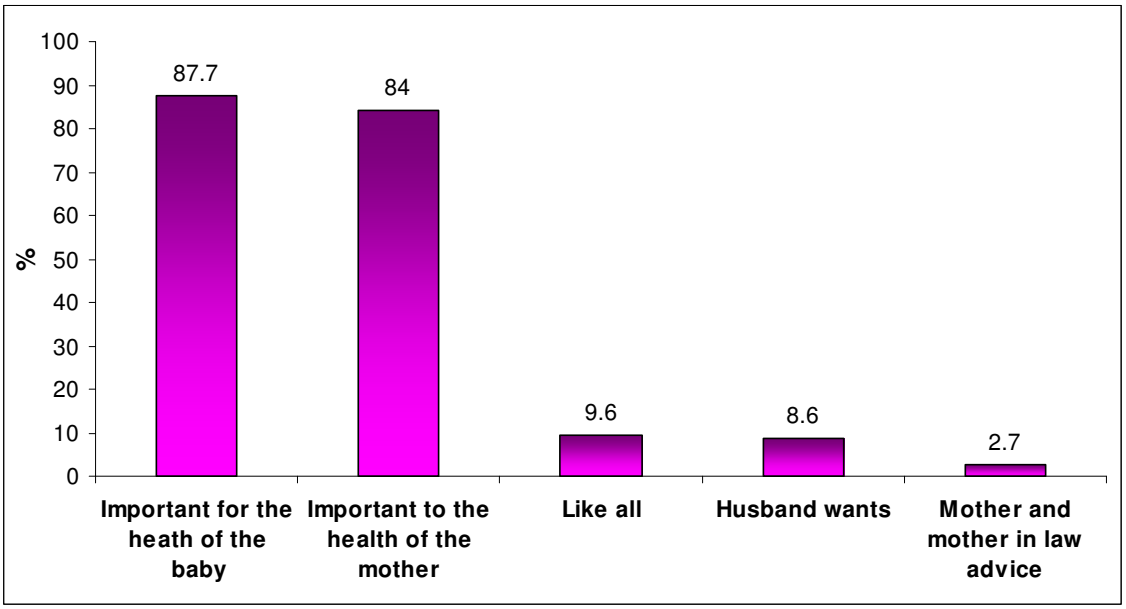
7.5. Results of reproductive health care

7.5.1. Antenatal care

Antenatal care importance (knowledge)

Among the total number of women there were 186 women who visited the clinic for the purpose of antenatal care. In general, women had positive understanding of the reasons to conduct antenatal care as almost all women reported its importance for the health of the baby, and 84.0% mentioned its importance for the health of the mother as shown in figure 7.6

Figure 7.6: Percent of women's report on the main reasons for conducting antenatal care



Note: the percent is not cumulative as women were allowed to mention more than one reason

Antenatal care services

In order to assess women's received care during their antenatal visits; some of the antenatal care services were assessed. With regards to the health advices during pregnancy, women were asked: "*Were you told about any signs of pregnancy complications? And the interviewer probe (for example; back pain; vomiting; nausea; edema and etc).*

Table 7.18 presents the women's reported receiving health information regarding pregnancy complications. It shows that 44.9% of mothers who received antenatal care reported that they were informed about pregnancy-related complications during their visits. Women with secondary or higher education and living in the cities were more likely to have received information regarding pregnancy related complication than less educated women and women living outside cities. Those who answered positively regarding received health information were asked later: "*Were you told what to do if you had had complications"*. 75.9% of women reported that they have received detailed information of what to do in case of complications. Among the 186 women, 75.4% of women reported having the tetanus toxiods immunization at least once during their lives (data not shown), see table 7.18**.**

Table 7.18: Antenatal health care received services: Percentages and number of women reported receiving information regarding pregnancy complications and percentages of women who received health educations regarding possible action in case of complication occur by level of education and residency.

Characteristics	**Told about pregnancy complications (n=186)**		**Told what to do in case of complications (n=84)**	
	Yes (n=84) n (%)	**No (n=103) n (%)**	**Yes (n=63) n (%)**	**N0 (n=20) n (%)**
Education				
No education & primary school	31(40.3)	46 (59.7)	25(78.1)	7 (21.9)
Secondary school & High education	53 (48.2)	53 (51.8)	38 (74.5)	13 (25.5)
Residency				
City	50 (39.7)	76(60.3)	37 (75.5)	12 (24.5)
others	34 (55.7)	26 (44.3)	26 (76.4)	8 (23.5)

Antenatal care practices

Table 7.19 presents the timing and number of antenatal visits among both antenatal and postnatal women by region. It shows that among women who were currently pregnant (n=186), in general, women started early for antenatal checkups as 90.7% of women started their first antenatal visit either before or at 3 months (12 weeks) pregnancy. The median duration of pregnancy for the first antenatal check ups was at 2 months of pregnancy. ***(One woman has answered as not being sure and was calculated as missing).*** The majority of post

partum women (n=264) made more than six visits during the entire previous pregnancy with regional differences.

Table 7.19: Antenatal care practices: Percent distribution of women who came to the clinic for the reason ANC by the timing of the first ANC visits and those who came for baby immunization and postnatal care by the number of ANC visits for the most recent birth, by region.

Number and timing of antenatal care visit	Hebron (South)	Ramallah (Middle)	Jenin (North)	Total
Timing of the first antenatal visit (months) (antenatal women)	**(n=43)**	**(n=56)**	**(n=86)**	**(n=185)**
≤3	81.4	96.4	90.7	90.3
4+	18.6	3.6	9.3	9.7
Mean =3.6, Median=2				
Number of ANC visits for the most recent birth (postnatal women)	**(n=98)**	**(n=93)**	**(n=59)**	**(*n=250)**
≥5	30.6	30.6	16.9	17.6
6-10	59.2	59.2	47.5	53.6
>10	10.2	10.2	35.6	28.8
Mean= 14.20, median=9				

** 14 women replied as do not remember calculated as missing 3.1%*

Attitudes towards the importance of antenatal care

The results showed that women had in general positive understanding and attitudes towards the importance of antenatal care among the three regions. While, there was a significant difference between regions in all of the mentioned important points.

Women ranked the importance of antenatal care as the following order:

1. Having a healthy baby (mean 1.14)
2. Follow up on the baby's health (mean 1.22)
3. Follow up on mother's health (mean 1.32)
4. Being safe and free of complications (mean 1.34)
5. Know the sex of the baby (mean 3.14)

From the results, women ranked baby's health at the top priorities and then their own health. Although knowing the sex of the baby considered to be important, but was not more important than the health of both the baby and the mother.

Women from the Jenin (north of West Bank) rated the highest mean among the other three regions which can be interpreted as women in Jenin had the most positive attitudes towards the importance of antenatal care in all the 5 points.

(See table 7.20 for more information)

Table 7.20: Women's perceived importance of antenatal care visits

Importance in conducting antenatal visits*	Hebron (South) n=150	Ramallah (Middle) n=150	Jenin (North) n=150	Total n=450	p-value
Know the sex of the baby					
Mean	3.53	3.10	2.79	3.14	
Median	4	3	2	3	
Mean rank(Kruskal-Wallis Test)	259.89	221.84	194.7		0.020
% very important	10.0	20.0	18.7	16.2	
Follow up on the mother health					
Mean	1.37	1.37	1.23	1.32	
Median	4	3	2	1	
Mean rank(Kruskal-Wallis Test)	239.63	231.15	205.72		0.012
Percent of very important	64.0	68.7	80.0	70.9	
Follow up on baby's health					
Mean	1.31	1.20	1.15	1.22	
Median	1	1	1	1	
Mean rank(Kruskal-Wallis Test)	247.69	219.64	209.18		0.001
% very important	78.7	81.3	86.0	78.7	
Safe and free of complications					
Mean	1.38	1.46	1.17	1.34	
Median	1	1	1	1	
Mean rank(Kruskal-Wallis Test)	241.06	241.29	194.15		<0.001
% very important	62.7	64.0	84.0	70.2	
Having healthy baby					
Mean	1.27	1.09	1.07	1.14	
Median	1	1	1	1	
Mean rank(Kruskal-Wallis Test)	254.50	214.00	208.00		<0.001
% very important	72.7	90.7	93.3	85.6	

* Mean of Importance reason for conducting antenatal care visits by region; Mean = the mean rate between 1-5 as 1 = very important, 2 =important, 3=some what important, 4=less important, 5= not important; Median of the importance rate; Mean rank using the Kruskal-Wallis; % of women rank the point as very important; significance p-value calculated from Kruskal-Wallis test. p significant= 0<.05

Antenatal care versus reproductive rights

In order to assess women's perceived importance of their reproductive health rights while receiving antenatal care, women were asked to rank the importance of 7 important points in women's reproductive health rights in antenatal health care services: distance of the health care service, heath education, cost of the service, safety and assurance in health care

provision, availability and affordability of health examination equipment, women's feeling of being comfortable while receiving the health care, assuring privacy while providing the health care.

The results are shown in table 7.21**.** Women perceived health counseling as the most important point in antenatal health care services, and then they put the other concerns later in the following order:

1. Counseling service (mean=1.43)
2. Being comfortable (mean=1.53)
3. Examinations and equipment (mean=1.54)
4. Safety and assurance (mean=1.56)
5. Privacy (mean=1.60)
6. Cost (mean=2.31)
7. Distance (mean=2.33)

There were regional differences among all the seven points except among the point that measured the cost and the point that measured the distance as all regions had similar attitudes in these regards. See table 7.21 for more details.

Table 7.21: Perceived determinates for antenatal services by region

Importance in conducting antenatal visits*	Hebron (South) (n=150)	Ramallah (Middle) (n=150)	Jenin (North) (n=150)	Total (n=450)	p-value
Distance					
Mean [1]	2.25	2.39	2.35	2.33	
Median [2]	2	2	2	2	
Mean rank(Kruskal-Wallis Test)[3]	217.87	224.70	233.93		0.49
% very important [4]	34.1	46.3	19.5	18.2	
Cost					
Mean	2.18	2.45	2.29	2.31	
Median	2	2	2	2	
Mean rank(Kruskal-Wallis Test)	215.69	231.50	229.31		0.44
% very important	33.8	35.2	31.0	15.8	
Safety and Assurance					
Mean	1.80	1.48	1.39	1.56	
Median	2	1	1	2	
Mean rank(Kruskal-Wallis Test)	279.75	207.41	189.34		<0.001
% very important	15.5	39.8	44.7	45.8	
Examination Equipment					
Mean	1.78	1.50	1.33	1.54	
Median	2	1	1	2	
Mean rank(Kruskal-Wallis Test)	279.38	217.84	179.28		<0.001
% very important	16.3	35.8	47.9	47.8	
Being Comfortable					
Mean	1.74	1.52	132	1.53	
Median	2	1	1	2	
Mean rank(Kruskal-Wallis Test)	274.30	221.56	180.64		<0.001
% very important	18.3	34.7	47.0	48.7	

Importance in conducting antenatal visits* Table 7.20 continues	Hebron (South) (n=150)	Ramallah (Middle) (n=150)	Jenin (North) (n=150)	Total (n=450)	p-value
Privacy					
Mean	1.79	1.55	1.47	1.60	
Median	2	1	1	2	
Mean rank(Kruskal-Wallis Test)	268.96	221.81	194.73		<0.001
% very important	18.1	37.0	44.9	48.0	
Counseling Service					
Mean	1.41	1.55	1.33	1.43	
Median	1	1	1	1	
Mean rank(Kruskal-Wallis Test)	227.47	246.18	202.86		0.003
% very important	32.4	28.7	38.9	61.1	

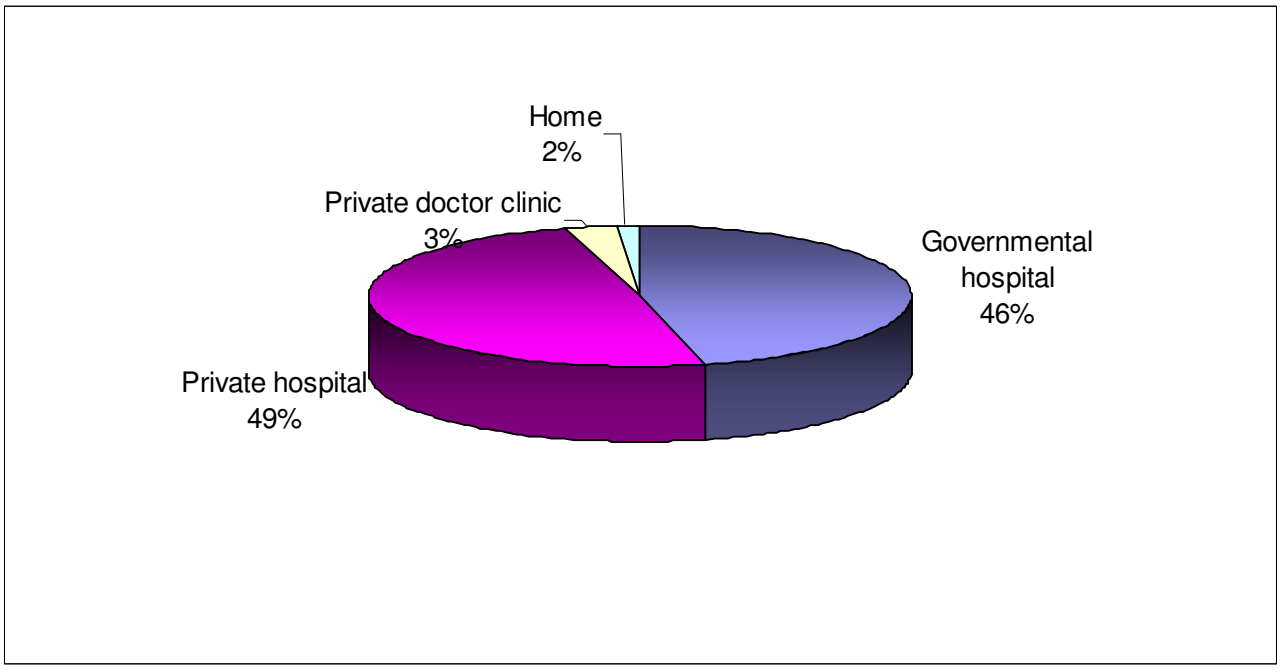
* Mean of Importance of important determinates for antenatal services by region; Mean = the mean rate between 1-5 as 1 = very important, 2 =important, 3=some what important, 4=less important, 5= not important; Median of the importance rate; Mean rank using the Kruskal-Wallis; % of women rank the point as very important; significance p-value calculated from Kruskal-Wallis test. p significant= 0<.05

7.5.2. Delivery care

Delivery practice

Women who attended the clinics for the purpose of postnatal care or baby immunization (n=264) were asked about their places of delivery for their last birth. An overwhelming majority (98%) of last childbirth took place in medical institutions and under medical supervision and only 2% of women delivered at home. (See figure 7.7)

Figure 7.7: Place of last birth delivery



The proportion of births delivered in governmental hospitals was higher (54.5%) for uneducated mothers, compared with 39.7% of births to mothers with higher education.

There was no significant association between delivery problems and complications with the delivery place as seen in table 22.

Table 7.22: Percentages of delivery place of the recently delivered child by region, total number of children, level of education and experiencing problems during delivery.

Characteristics	Governmental hospital (n=122)	Private hospital (n=130)	Private doctor clinic (n=8)	Home (n=4)	Total (n=264)
Region					***P=0.001**
South (Hebron)	62.3	36.8	. 0	.9	106
Middle (Ramallah)	25.5	66.0	8.5	.0	94
North (Jenin)	50.0	45.3	.0	4.7	64
Total number of children					**p=0.52**
1	38.6	56.1	3.5	1.8	57
2	41.7	56.7	.0	1.7	60
3	51.9	42.6	5.6	.0	54
>4	50.5	44.1	3.2	2.2	93
Level of education					**p=0.017**
<Secondary	54.9	41.6	0.9	2.7	113
≥Secondary	39.7	55.0	4.6	.7	151
Problems during delivery					**p=0.48**
With problems	42.1	56.1	1.8	.0	57
No problems	47.0	47.5	3.5	2.0	200

*Calculated from Chi –square for measuring differences, significant p<0.05

Delivery satisfaction and received health information after delivery

Table 7.23 presents women delivery satisfaction and the information given upon discharge. It shows that most women were satisfied from private doctor clinics followed by private hospitals and least from governmental hospital with means of 1.50, 1.61, and 2.40, respectively. It shows also that there is a significant difference (p= <0.001) between the place of delivery and the satisfaction.

The second component of table 7.23 is women's health education after delivery. Only 11.6% of women were given the information regarding the danger signs that they need to monitor in their health status after delivery in governmental hospitals compared to 37.5% in private hospital clinics and 21.7% in private hospitals. In general, this information was not given in high percentages overall the places of delivery (18.7%), although this varies among them.

Table 7.23 shows that in general, only 16.8% of women mentioned that they were given the information regarding danger signs monitoring on their baby before leaving the place of delivery among all the selected places. Home delivery and private doctor clinics were the most to give this information followed by the private hospitals and it was least to be given in the governmental hospitals (9.1%).

Table 7.23: Place of delivery: Women's level of satisfaction and information given for mothers at the time of discharge by delivery place.

Characteristics	Governmental hospital (n=122)	Private hospital (n=130)	Private doctor clinic (n=8)	Home (n=4)	Total (n=264)
Satisfaction from delivery *					
Mean	2.40	1.61	1.50	2	1.98
Median	2	1	1	1	2
Mean rank(Kruskal-Wallis Test)	158.42	106.88	100.38	109.13	p=0.001
% of women mentioned very satisfied	28.1	62.0	75.0	75.0	46.9
Mother danger signs informing	%	%	%	%	%
Yes	11.5	21.5	37.5	100.0	18.7%
No	88.5	78.5	62.5	0.0	81.4%
					**p=<0.001
Baby danger signs informing	%	%	%		%
Yes	9.1	21.5	28.6	75.0	16.8
No	90.9	78.5	71.4	25.0	83.2
		.			**p=0.001

* Mean of satisfaction from last delivery by place of delivery Mean = the mean of the rate between "1-5" as 1 = very satisfied, 2 =somewhat satisfied, 3=neutral, 4=somewhat dissatisfied, 5= very dissatisfied. ; Median of the satisfaction rank; Mean rank using the Kruskal-Wallis; % of women rate the point as very satisfied.; significance p-value calculated from Kruskal-Wallis test. p significant= 0<.05.

** Comparison between places of delivery, calculated from Chi-square test, significant at p=<0.05

Determinants for choosing the place of delivery

Women had perceived the most important determinants in choosing the place of delivery in the following rank of importance: (as shown in table 7.24)

1. Good and proper baby care (mean=1.20)
2. Emergency care available (mean=1.26)
3. Well equipped, husband presence, welcoming staff (mean=1.29)
4. Safety and security (mean=1.33)
5. Information (mean=1.37)
6. Being comfortable (mean=1.43)
7. Privacy (mean=1.44)
8. Being informed for any medical action (mean=1.47)
9. In room baby care (mean=1.74)

10. Cost (mean=2.41)
11. Distance (mean=2.58)

There were significant regional differences in relation to the most important determinants women were looking for and need to be present in the place of delivery. The most positive attitudes was found among women in Jenin in that most of the points were given the highest importance mean especially in terms of the availability of information and health education necessary for delivery.

Women mentioned that welcoming staff was very important among the three regions; Hebron, Ramallah and Jenin (53.3, 61.3, and 84.7, respectively).

Table 7.24: Women's perceived importance for the most important determinants in choosing the place of delivery

Determinants for choosing the place of delivery*	Hebron (South) (n=150)	Ramallah (Middle) (n=150)	Jenin (North) (n=150)	Total (n=450)	p-value
Distance					
Mean	2.82	2.42	2.57	2.58	
Median	2	2	2	2	
Mean rank(Kruskal-Wallis Test)[3]	254.11	197.21	225.18		<0.001
% very important	11.3	32.0	7.3	16.9	
Cost					
Mean	2.36	2.49	2.38	2.41	
Median	2	2	2	2	
Mean rank(Kruskal-Wallis Test)	204.60	247.29	224.62		0.010
% very important	17.3	18.7	13.3	16.4	
Safety and security					
Mean	1.52	1.21	1.31	1.33	
Median	1.50	1	1	1	
Mean rank(Kruskal-Wallis Test)	274.37	216.24	185.79		<0.001
% very important	40.0	74.7	71.3	62.0	
Well equipped					
Mean	1.48	1.26	1.22	1.29	
Median	1	1	1	1	
Mean rank(Kruskal-Wallis Test)	274.47	216.24	185.76		<0.001
% very important	40.0	66.0	79.3	61.8	
Privacy					
Mean	1.45	1.60	1.34	1.44	
Median	1	1	1	1	
Mean rank(Kruskal-Wallis Test)	263.53	227.17	185.80		<0.001
% very important	40.0	59.3	77.3	58.9	
Information					
Mean	1.59	1.47	1.19	1.37	
Median	2	1	1	1	
Mean rank(Kruskal-Wallis Test)	277.24	236.60	162.66		<0.001
% very important	30.0	50.0	81.3	53.8	
Being informed for any medical action					
Mean	1.64	1.58	1.29	1.46	
Median	2	2	1	1	
Mean rank(Kruskal-Wallis Test)	276.04	227.44	173.02		<0.001
% very important	27.3	52.0	75.3	51.6	

Determinants for choosing the place of delivery Table 7.23 continues…	Hebron (South) (n=150)	Ramallah (Middle) (n=150)	Jenin (North) (n=150)	Total (n=450)	p-value
Being comfortable					
Mean	1.50	1.66	1.28	1.43	
Median	1.50	2	1	1	
Mean rank(Kruskal-Wallis Test)	243.37	246.13	187.00		<0.001
% very important	49.3	48.7	74.7	57.6	
Husband presence					
Mean	2.11	3.16	2.07	1.29	
Median	2	3	2	1	
Mean rank(Kruskal-Wallis Test)	221.05	264.05	191.10		<0.001
% very important	36.7	34.7	54.7	42.0	
Welcoming staff					
Mean	1.45	1.39	1.14	1.29	
Median	1	1	1	1	
Mean rank(Kruskal-Wallis Test	254.85	237.03	184.64		
% very important	53.3	61.3	84.7	66.4	<0.001
Good and proper baby care					
Mean	1.43	1.14	1.13	1.20	
Median	1	1	1	1	
Mean rank(Kruskal-Wallis Test)	281.00	212.00	183.50		
% very important	44.0	74.7	87.3	68.6	<0.001
Emergency care availability					
Mean	1.34	1.28	1.16	1.26	
Median	1	1	1	1	
Mean rank(Kruskal-Wallis Test)	281.89	215.77	78.85		<0.001
% very important	38.7	68.7	84.7	64.0	
In room baby care					
Mean	2.39	1.72	1.48	1.76	
Median	2	1	1	1	
Mean rank(Kruskal-Wallis Test)	291.76	205.63	179.10		<0.001
% very important	14.0	50.7	62.7	42.4	

* Mean of Importance of important determinates for choosing the place of delivery by region; Mean = the mean rate between 1-5 as 1 = very important, 2 =important, 3=some what important, 4=less important, 5= not important; Median of the importance rate; Mean rank using the Kruskal-Wallis; % of women rank the point as very important; significance p-value calculated from Kruskal-Wallis test. p significant= 0<.05

7.5.3. Postnatal care

Postnatal women

Table 7.25 presents a general description of the sample (postnatal women=264). The majority of women in the sample had married at less than 20 years of age, had more than 1 child, was not employed outside the home and rated their economic status as “middle class”. Most women reported more than 6 antenatal visits for their last pregnancy and a normal delivery without problems. Of interest is that only 17-19% of the women reported being informed about danger signs related to the mother’s or the baby’s health before hospital discharge. Almost two-thirds of the women considered postnatal care necessary.

Table 7.25 also shows the associated factors with not obtaining postnatal care based on univariate analysis. Among the 264 postpartum women, 97 (36.7%) obtained postnatal care. This proportion was significantly higher in the site of Jenin than both sites of Ramallah and Hebron. Women who were ≥ 21 years of age at the time of their first marriage and experienced complications during delivery were informed about danger signs for their own health or the health of their baby before discharge from the hospital and considered postnatal care necessary. Women who had delivered in private hospitals were more likely to obtain postnatal care than women who had delivered in public hospitals (41% versus 31%), but this association was not statistically significant. Women who delivered in private hospitals reported significantly more frequently that they were informed about the danger signs for their own health or the health of their baby before discharge than women who delivered in a public hospital (table 7.25).

Table 7.25: Characteristics of postnatal women and their use of postnatal care

Characteristics	Total (n=264)	Total %	Postnatal care		*p-value
			Used (n=97)	Not used (n=167)	
Age group					0.64
≤24	77	29.2	33.8	66.2	
25-29	85	32.2	35.3	64.7	
≥30	102	38.6	40.2	59.8	
Study site/region					0.007
Jenin (North of West Bank)	64	24.2	53.1	46.9	
Ramallah (Center of West Bank)	94	35.6	30.9	69.1	
Hebron (South of West Bank)	106	40.2	32.1	67.9	
Wife and husband educational level					0.21
Both<secondary (sec.)	72	27.3	27.8	72.2	
Wife≥sec.+ husband<sec.	50	18.9	34.0	66.0	
Wife<sec+ husband ≥ sec.	41	15.5	41.5	58.5	
Both≥sec.	101	38.3	42.6	57.4	
Number of living children					0.47
1	57	21.6	40.4	59.6	
2-3	113	42.8	38.9	61.1	
4+	94	35.6	30.9	68.1	
Age at first marriage					0.019
<20	182	68.9	31.9	68.1	
≥21	82	31.1	47.6	52.4	
Woman's working status					0.38
Employed	42	15.5	42.9	57.1	
Not employed	222	84.1	35.6	64.4	
No. of antenatal visits in the last pregnancy					0.46
1-5					
6-10	45	18.0	28.9	71.1	
>10	133	53.2	39.1	60.9	
	72	28.8	36.1	63.9	
Economic status (subjective)					0.07
High	23	8.7	47.8	52.4	
Middle	197	74.6	38.6	61.4	
Low	44	16.7	22.7	77.3	

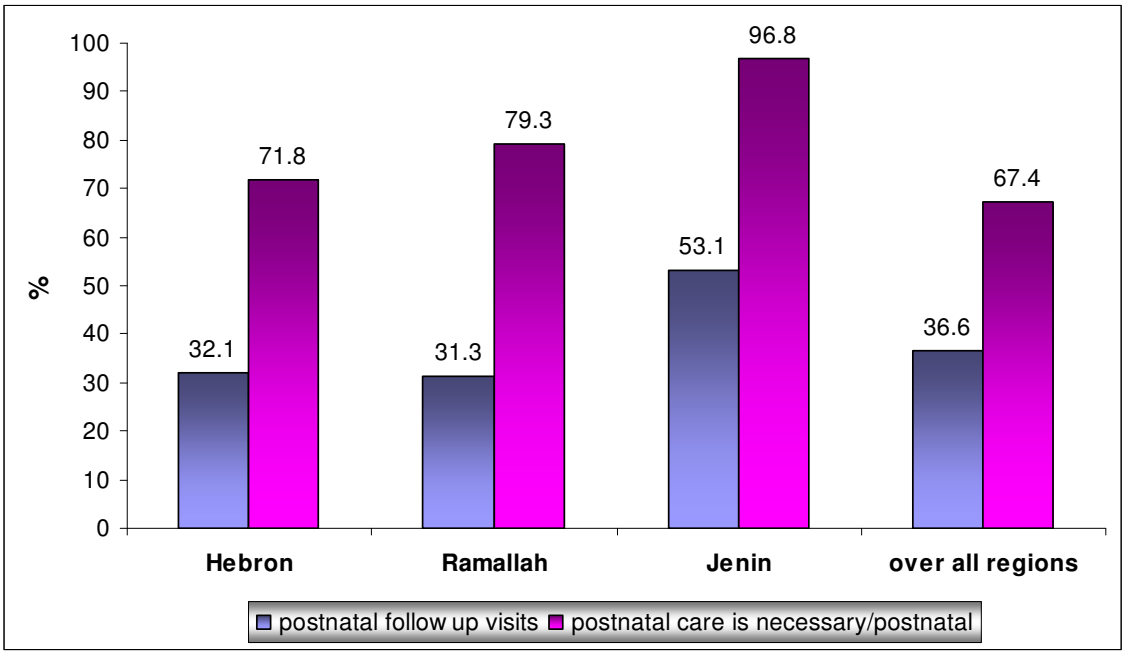
Characteristics Table 7.25 continues…	Total (n=264)	Total %	Postnatal care Used (n=97)	Postnatal care Not used (n=167)	*p-value
Delivery					<0.001
Normal delivery	221	83.7	29.5	70.5	
Other **	43	16.3	74.4	25.6	
Delivery problems					<0.001
Yes	57	22.2	59.6	40.4	
No	200	77.8	28.5	71.5	
Informed about danger signs for the mother's health before discharge					0.001
Yes	49	18.6	57.1	42.9	
No	215	81.4	32.1	67.9	
Informed about danger signs for the baby's health before discharge					0.006
Yes	44	16.7	56.8	43.2	
No	218	82.6	33.0	67.0	
Delivery place of the last child					0.15
Public hospital	121	46.7	31.4	68.6	
Private hospital	138	53.3	40.6	59.4	
Considering postnatal care necessary					<0.001
Yes	166	62.7	46.7	53.3	
No	98	37.3	20.4	79.6	

* Chi-square p-value for comparison between postnatal care use and non-use significant p=<0.05
** Other: cesarean section or instrument-assisted delivery

Obtaining postnatal care

Figure 7.8 shows the percentages of women who obtained postnatal care by region and those who perceived postnatal care as necessary among them. It shows that women who find postnatal care as necessary are much higher than those who obtained it.

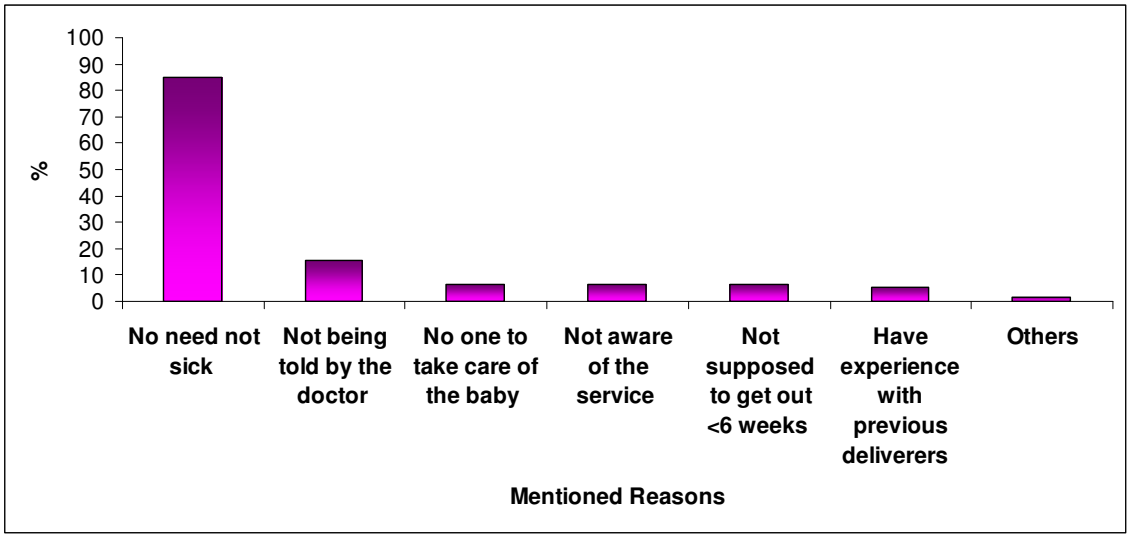
Figure 7.8: Percentages of women who obtained postnatal care and their attitudes towards the necessity of postnatal care (N=264) by region



Reasons for not obtaining postnatal care

Figure 7.9 shows the main reasons the women have given for not obtaining postnatal care. most women have mentioned that because they felt that there was not in need and that there were not sick (85%) followed by being not informed by their doctor (15%).

Figure 7.9: Reasons for not obtaining postnatal care (N=166 women who did not obtain postnatal care) *(women were allowed to mention more than one reason)*



Factors associated with not obtaining postnatal care

Table 7.26 presents the results from multivariable logistic regression analysis for the factors associated with not obtaining postnatal care. The results revealed that three factors were associated with lack of postpartum care after controlling for demographic and pregnancy-related variables: Women sampled in Ramallah (center of West Bank) were significantly more likely to lack postpartum care than women sampled in Jenin (north of West Bank). In addition, women who delivered in public hospitals, and women who delivered without experiencing any problems or complications were also significantly more likely to lack postpartum care as compared to women who delivered in private hospitals and women who had problems during delivery. Woman's age and age at first marriage, woman's and husband's level of education, number of children and number of antenatal visits during the last pregnancy were not significantly associated with obtaining postpartum care.

Table 7.26: Association of socio-economic and demographic factors with non-use of postnatal care

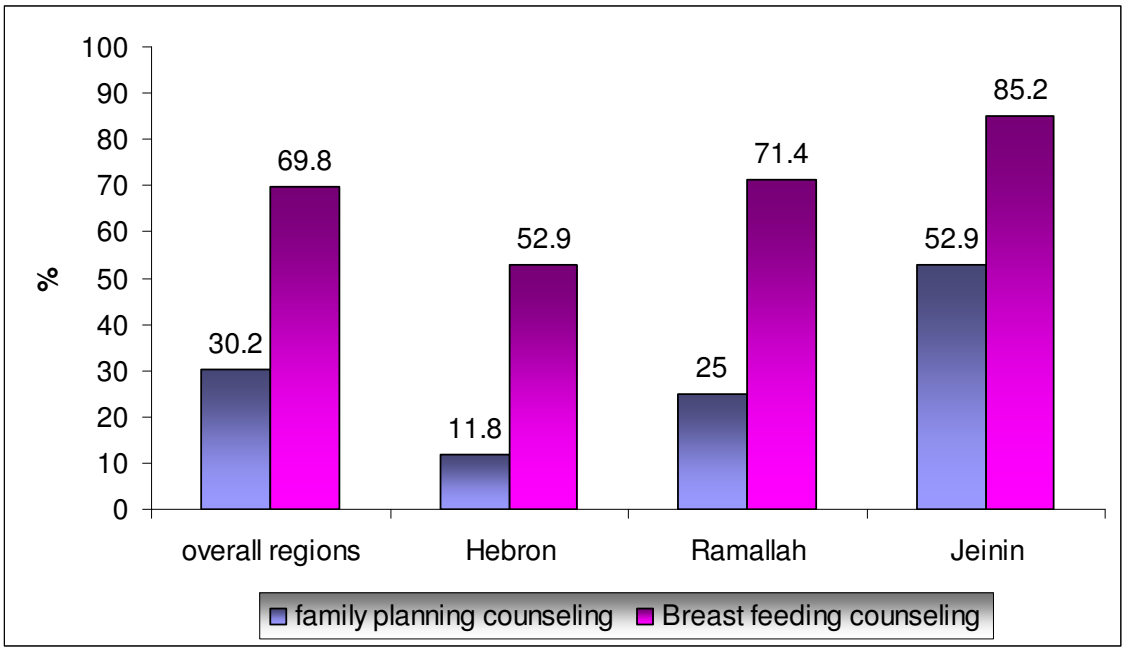
Characteristics	OR (95% CI)[a]	p-value
Study site		
Hebron (South of West Bank)	1.7 (0.8-3.6)	0.14
Ramallah (Center of West Bank)	3.6 (1.6-7.9)	0.001
Jenin (North of West Bank)	Reference	
Woman's Age [per year]	0.9 (0.9-1.0)	0.88
Both husband & wife level of education		
Both<secondary	1.9 (0.8-4.5)	0.10
wife ≥Secondary+ husband<secondary	1.5 (0.6-3.4)	0.33
Husband ≥Secondary + wife < secondary	0.9 (0.3-2.2)	0.87
Both ≥Secondary	Reference	
No. of living children [per child]	1.0 (0.8-1.2)	0.84
No. of antenatal visits in last pregnancy [per visit]	0.9 (0.9-1.0)	0.72
Woman's age at first marriage		
< 20	1.6 (0.8-3.3)	0.14
≥ 20	Reference	
Delivery problems		
No	3.9 (2.0-7.5)	<0.001
Yes	Reference	
Delivery place		
Public hospital	1.8 (1.0-3.4)	0.045
Private hospital	Reference	

OR = odds ratio; CI = confidence interval.
[a] adjusted for all variables in the table

Health care obtained during the postnatal follow up visit

Among the 97 women who obtained postnatal care, only 30.2% received counseling regarding family planning, while about two-thirds received counseling regarding breast feeding. There was regional difference as the counseling was given more for women in Jenin compared to those of the other two regions. As seen in figure 7.10.

Figure 7.10: Percentages of both family planning and breast feeding counseling provided to the women during the postnatal care by regions



7.5.4. Reproductive health care results summary

Antenatal care

- Women had positive understanding of the reasons to conduct antenatal care.
- Less than half of the women were given proper antenatal health education during their antenatal visits.
- Women started antenatal care at a relatively early stage of their pregnancy (before 4-month pregnancy) with relative regional differences.
- 78.2 % of women made six or more antenatal care visits during their entire pregnancy with regional differences as it was found to be most in Ramallah and least in Hebron (94.6 and 65.4 respectively).
- Women gave the first rank for the importance of antenatal care purposes of visits for their baby's health then their own health.
- In general women had positive attitudes toward the importance of antenatal care and antenatal rights.
- There were regional differences among each of the knowledge, attitudes and practices of antenatal health care rights.

Delivery care

- Almost all women delivered their last child in medical institutions and under medical supervision.
- Women were more likely to have their first birth at a private health facility than subsequent births.
- Women from Ramallah delivered their last child most in private health facilities compared to those from Jenin or Hebron.
- Women who were working and received higher education were most likely prefer to deliver in private health sectors than unemployed and least educated women.
- Women were most likely more satisfied from the private health facilities than from the governmental facilities.
- Health education after delivery regarding both women's health and baby's health were most likely not well provided, neither in the private nor in the governmental facilities of delivery. However, it was more provided in the private settings.
- Husband presence during delivery was the third important determinants women had ranked when choosing the place of delivery.

Postnatal care

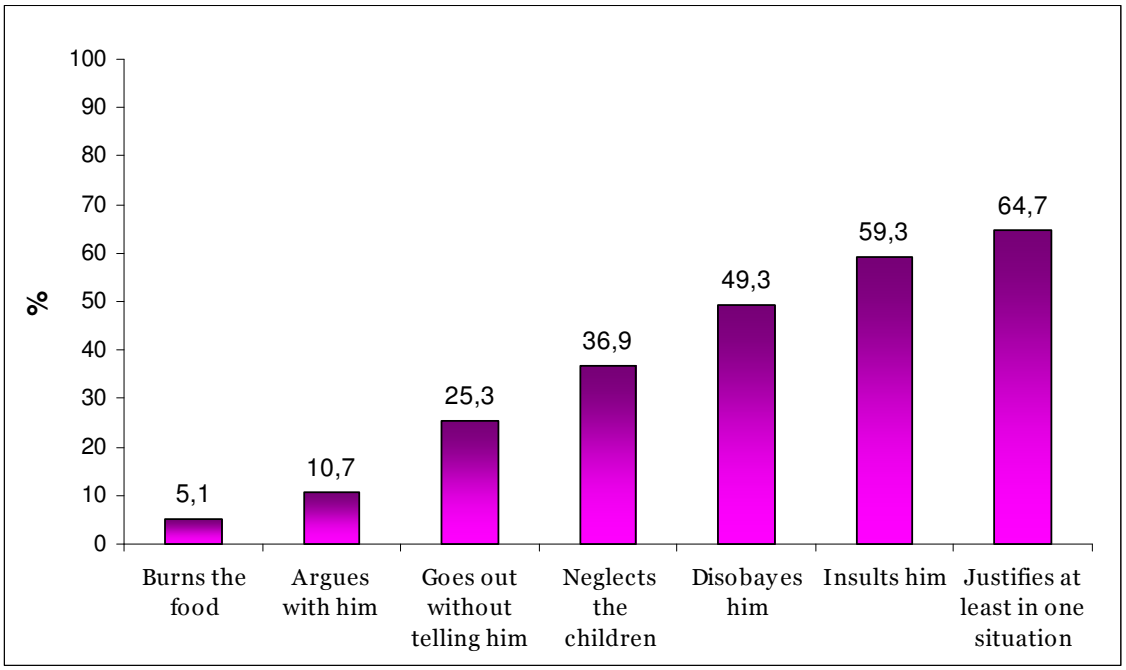
- Among the 264 postnatal women, only 97 (36.9%) women obtained postnatal care after delivery.
- There were regional differences in terms of obtaining postnatal care to be most in Jenin and less in Ramallah.
- Women gave the main reason for not obtaining postnatal care as there was no need and not being sick followed by not being informed by their doctor.
- In general, women had positive attitudes towards the importance of postnatal care. However, not all of them had obtained this care.
- Close to one third of women from those who obtained postnatal care had received family planning counseling (30.2%) and more than half received counseling in terms of breast feeding (69%). However, there were differences between the three regions to be higher received by women in Jenin compared to those in the other two regions.
- Factors that were found to be associated with women's practices of obtaining postnatal care were: woman's experience delivery complications, women's deliver at private settings, and women form Jenin.

7.6. Domestic violence and women's status inside the family (right to refuse sex and household decision making)

Women's attitudes towards intimate partner violence

Figure 7.11 shows that, overall, women perceived wife beating to be justified if a wife insults her husband (59.3%), if she disobeys her husband (49.3%), if she neglects her children (36.9%), if she goes out without telling her husband (25.3%), if she argues with her husband (10.7%), and if she burns the food (5.1%, see Table 2). A total of 64.7% of women agreed with at least one reason for wife beating, but there were statistically significant regional differences: Wife beating was most accepted in Jenin (73.3%) and least accepted in Hebron (55.3%) as shown in table 7.26 first sections and in figure 7.11.

Figure 7.11: Percentages of women's justification of wife beating by situation

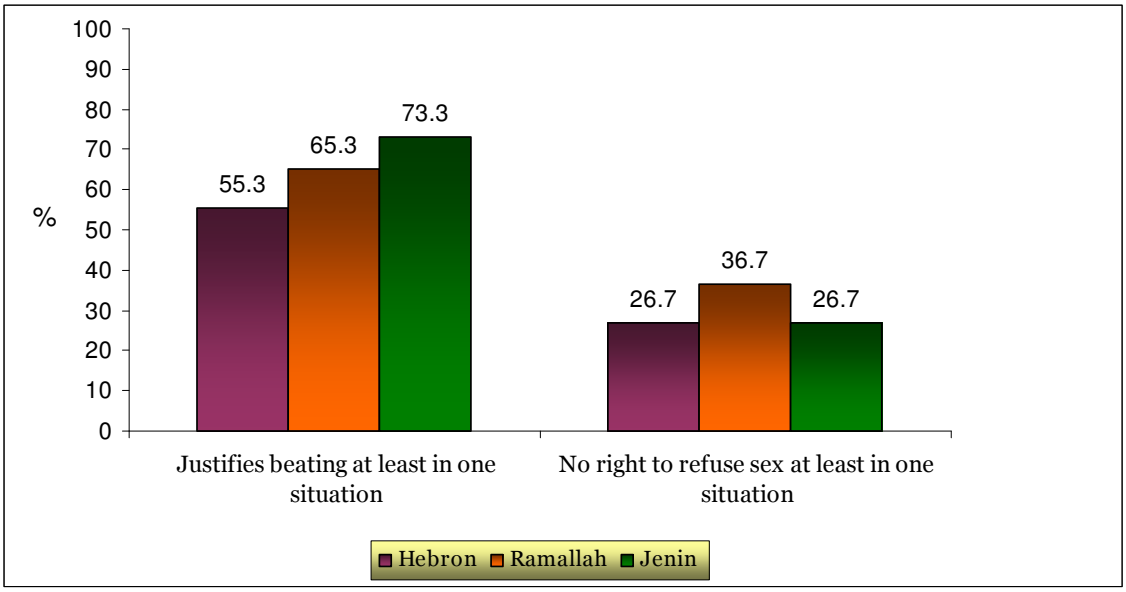


Women's attitudes towards the right to refuse sex

Table 7.27 (second section) presents women's attitudes towards the right to refuse sex by region. The vast majority of women believed in the right to refuse sex during menstruation (99.3%), after childbirth (98.6%), if the husband has a sexually transmitted disease (98.2%), in case of husband's assault (92.4%), when lacking privacy (92%) and when the woman is tired and not in the mood for sex (76.9%). Overall, 69.6% of women stated that a woman has the right to refuse sex with her husband in each of these situations. This percentage ranged

from 63.3% in Ramallah to 73.3% in Hebron, but was not statistically different between the sites. After excluding the responses to the statement "If she is tired and not in the mood for sex", 83.3% stated that a woman has the right to refuse sex with her husband in each of these situation (as shown in Figure 7.12)

Figure 7.12: Women's justification of wife beating in at least one situation and attitudes of not giving the women right to refuse sex with their husbands by region



Women's participation in household decision-making

Table 7.27 (last section) shows that, overall, women made more final decisions with respect to daily cooking (62.9%), their own health care (44.4%) and their children's health care (28.8%) as compared to decisions regarding daily and large household purchasing (24.6% and 12.9%, respectively) and visiting friends and relatives (17.3%). Overall, most women made between 1-2 final household decisions (as shown in table 7.28). Women residing in Jenin tended to make significantly fewer decisions than women in Hebron and Ramallah, who were very similar with respect to number of decisions made. Closer examination of the decision making pattern in the 3 sites revealed that women in Hebron tended to be more likely to be the sole decision maker with respect to children's health care, large household purchases and visiting friends and relatives than women at the other two sites.

Table 7.27: Women's attitudes towards wife beating, having the right to refuse sex with a husband, and women's participation in household decision-making by region

Characteristics	Total (n=450) %	(Hebron) South (n=150) %	(Ramallah) Middle (n=150) %	(Jenin) North (n=150) %	p-value*
Beating is justified when a woman:					
Burns the food	5.1	6.0	4.0	5.4	
Argues with her husband	10.7	9.5	10	13.5	
Goes out without telling her husband	25.3	31.8	15.5	30.6	
Neglects her children	36.9	29.3	33.3	50.7	
Disobeys her husband	49.3	49.6	44.9	60.6	
Insults her husband	59.3	51.1	62.8	72.7	
Justified in at least one situation	**64.7**	**55.3**	**65.3**	**73.3**	0.005
A woman has the right to refuse sex…					
During menstrual period	99.3	99.3	99.3	99.3	
After childbirth	98.6	98.6	98.6	98.0	
If husband has STDs	98.2	98.7	99.3	96.6	
If husband assaults her	92.4	90.0	92.6	94.9	
If there is lack of privacy	92.0	98.0	86.6	91.4	
If she is tired and not in the mood for sex	76.9	74.8	76.2	80.0	
In each of these situations	**69.6**	**73.3**	**63.3**	**72.0**	0.12
Woman is the sole decision maker regarding	44.4	48.0	48.0	29.3	
Woman's own health care	28.8	40.7	20.7	24.0	
Children's health care	12.9	20.0	6.7	12.0	
Large household purchases	24.6	34.7	34.7	20.7	
Daily household purchases	17.3	27.3	14.0	10.7	
Visiting friends and relatives	62.9	66.7	65.3	56.7	
Daily cooking					
Number of decisions women make					
0	18.7	14.7	12.7	18.7	
1-2	51.3	45.3	45.3	51.3	
3+	30.0	40.0	40.0	20.0	
					<0.001

* Calculated from Chi –square for measuring differences, significant p<0.05

Factors associated with women's acceptance of intimate partner violence (IPV)

Table 7.28 presents the associations between women's acceptance of wife beating (at least in one situation) and socio-demographic factors as well as women's status based on a logistic regression model. Women in Hebron were significantly less likely to accept wife beating than those in Jenin (OR= 0.39). Women with low educational level (less than secondary school) were more likely to accept wife beating compared to those with a higher educational level (OR=1.83). Women who were employed were less likely to accept wife beating compared to those who were unemployed (OR=0.47). Women who were married for less than 10 years were more likely to accept wife beating (OR=2.42) than those who were married for 10 years or longer. Women with more than one child were more likely to accept wife beating

compared to women with no children or only 1 child. Compared to the reference group of women who had the final say on three or more decisions, women who made fewer decisions were more likely to accept IPV. Women's age, their age at first marriage and their attitudes towards women's right to refuse sex were not associated with their acceptance of wife beating.

Table 7.28: Factors associated with women's acceptance of intimate partner violence (multivariable analysis)

characteristics	n[a]	% accepting IPV[b]	Adjusted[c] OR (95% CI)	p-value[d]
Region				
Hebron	150	55.3	0.39(0.23-0.67)	0.001
Ramallah	150	65.3	1.01(0.57-1.79)	0.96
Jenin	150	73.3	Reference	
Woman's age				
≤24 years	127	71.7	1.44(0.65-3.18)	0.362
25-29 years	151	62.9	0.85(0.47-1.56)	0.618
≥30 years	172	61.0	Reference	
Woman's employment status				
Employed	87	50.6	0.47(0.25-0.89)	0.021
Unemployed	363	68.0	Reference	
Duration of marriage	313	67.4	2.42(1.19-4.92)	0.014
< 10 years	136	58.1	Reference	
≥ 10 years				
No. of living children				
>3	132	60.6	2.01(1.14-3.55)	0.015
2-3	183	68.9	2.39(1.02-5.61)	0.044
0-1	135	63.0	Reference	
Woman's level of education				
< Secondary school	189	70.9	1.83(1.13-2.97)	0.013
≥ Secondary school	261	60.2	Reference	
Age at First marriage	296	66.6	0.92(0.52-1.61)	0.771
<20	154	61.0	Reference	
≥20				
Right to refuse sex				
Has right in each situation	313	62.3	1.36(0.85-2.17)	0.187
No right in at least one situation	137	70.1	Reference	
Number of decisions women make				
0	84	66.7	1.70(0.91-3.17)	0.091
1-2	231	72.3	2.35(1.46-3.78)	<0.001
+3	135	50.4	Reference	

IPV = intimate partner violence; OR = odds ratio; CI = confidence interval.
[a] Number of women in each stratum. [b] Percentages of women who justified IPV within each stratum. [c] Final logistic regression model included only those variables listed in column. [d] significant p=<.05

7.6.1. Domestic violence and women's status inside the family (refusal sex, and household decision making) results summary

- 64.6% of women justified at least one situation for wife beating. However, it varies by situations to be mostly justified in case of husband insulting and least in case of burning the food.
- There was regional difference in terms of justification for wife beating to be least justified in Hebron and mostly justified in Jenin.
- In general, the majority of women found it a right for the women to refuse sex with her husband in most of the situations.
- Women made solely 1-2 household decisions in the three regions.
- Factors that found to be associated with women's justification of wife beating were :
  - Region: women in Hebron were significantly less likely to accept wife beating than those in Jenin (OR= 0.39).
  - Working status: women who were employed were less likely to accept wife beating compared to those who were unemployed (OR=0.47).
  - Marriage years: women who were married for less than 10 years were more likely to accept wife beating (OR=2.42) than those who were married for 10 years or longer.
  - Number of living children: women with more than 1 child were more likely to accept wife beating compared to women with no children or only 1 child.
  - Decision making: women who made fewer decisions were more likely to accept wife beating.

7.7. Age at First Marriage

Age at first marriage among women in the three regions

Figure 7.13 shows for the whole sample (450 women) the frequency distribution of age at first marriage, the mean age of marriage for those women was 20 years old, while the median was 19 years old. While table 7.28 shows the frequency distribution of marriage age by region. Younger age was most in Hebron with a mean age of 18.9 and the median was 18 years old as shown in table 7.29. The range of marriage age was between 14-36 years old; most women had got married at the age between 15 and 27 years old; while women in Hebron had got married mostly at the age between of 15 and 19 years old.

Figure 7.13. Frequency of age at first marriage among the total sample (450 women)

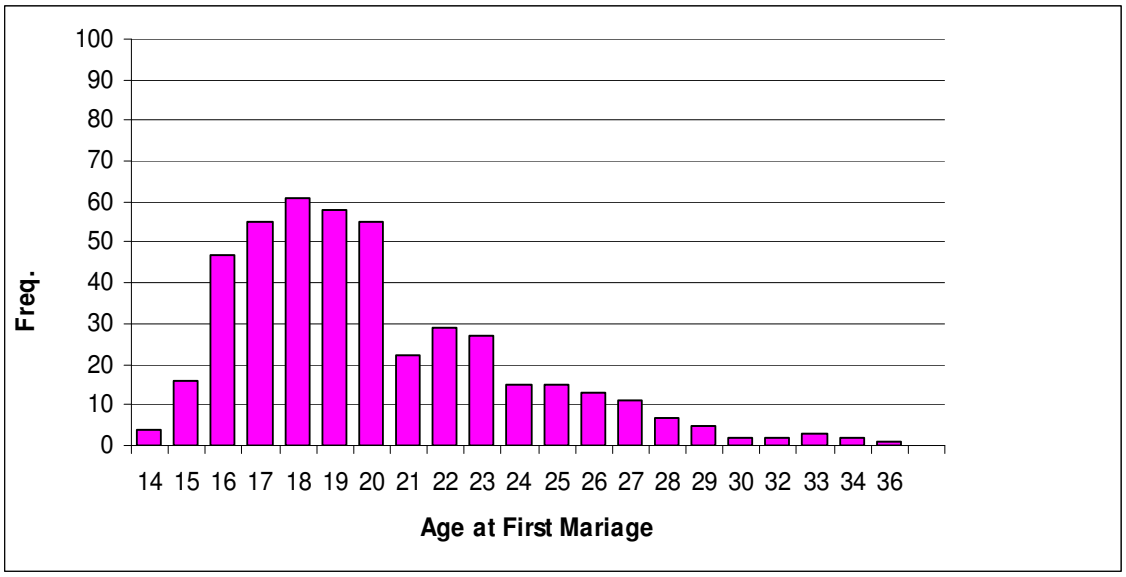


Table 7.29: Age distribution at first marriage and median by region

Characteristics	Total (n=450)	(Hebron) South (n=150)	(Ramallah) Middle (n=150)	(Jenin) North (n=150)
Age at first marriage				
14	4	1	0	3
15	16	8	2	6
16	47	21	11	15
17	55	22	15	18
18	61	29	18	19
19	58	17	21	20
20	55	24	18	13
21	22	4	8	10
22	29	7	12	10
23	27	4	17	6
24	15	3	6	6
25	15	0	10	5
26	13	2	4	7
27	11	3	6	2
28	7	4	2	1
29	5	0	3	2
30	2	0	0	2
31	0	0	0	0
32	2	0	0	2
33	3	1	1	1
34	2	0	1	1
35	0	0	0	0
36	1	0	0	1
median	**18**	**20**	**19**	**19**

Women's age at first marriage and their perceived best marriage age for their daughters

Figure 7.14 shows the descriptive percentages of women by their age at first marriage and their attitudes toward the best age of marriage for their daughters. The figure shows that most women have had gotten married at the age between 17 and 20 years old. Only about one third of women got married at the age of 20 and more.

Regarding women's attitudes towards the best age of marriage for their daughters, about half of the women reported the best age to be between 16 and 20 years old.

Figure 7.14: Percentages of women by age at first marriage and by their responses of best marriage age for their daughter in the future.

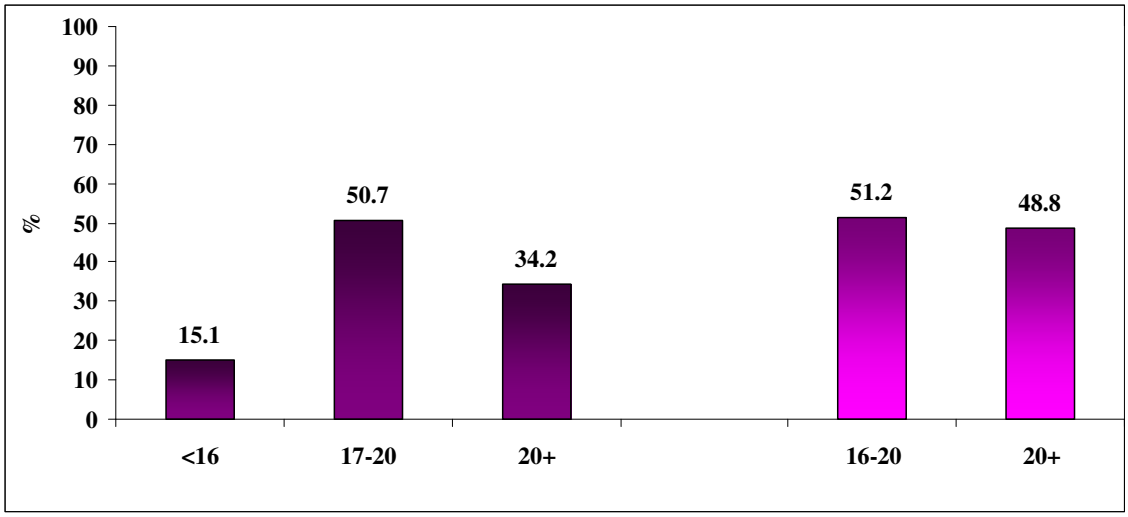


Figure 7.15 shows the percentages of women's age at first marriage by region. It shows that women from Hebron were the most to marry at the age of 16 and less compared to the other two regions. Moreover, women form Hebron was also the most to marry at the age of (17-20) compared to both Ramallah and Jenin. On the other hand, women from Ramallah were the most to be married at the age of 21 and more followed by Jenin.

Figure 7.15: Women's age at first marriage by region

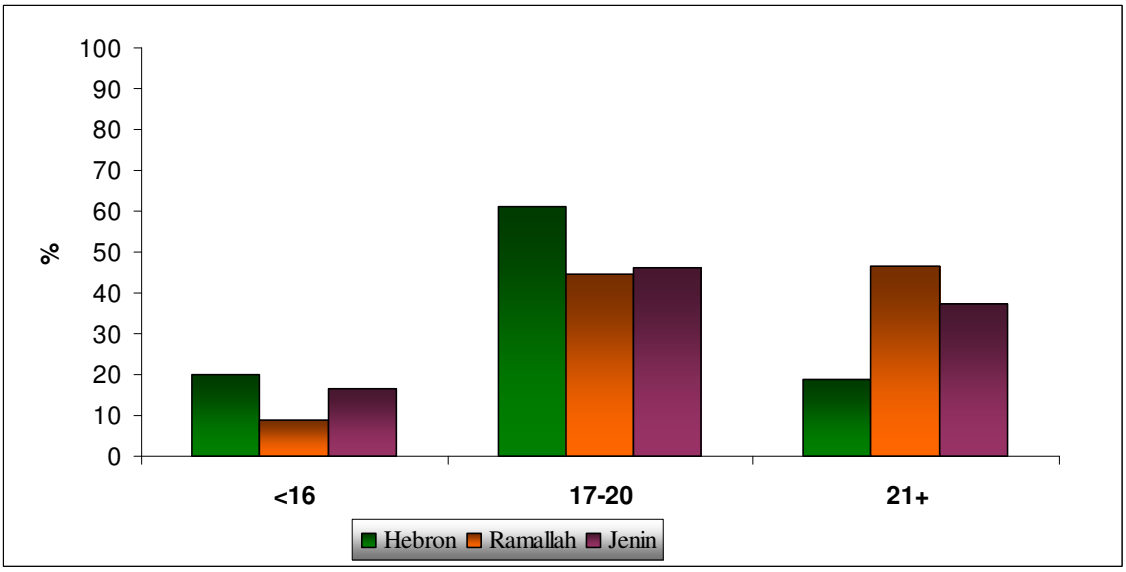
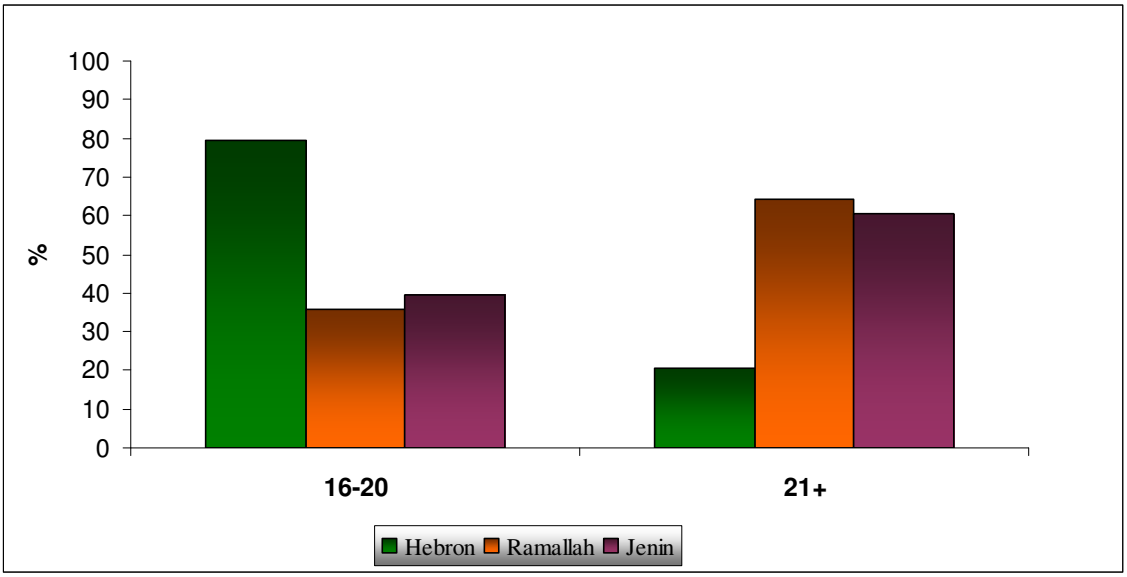


Figure 7.16 shows the results of asking women about their opinion regarding the best marriage age for their future daughters by region. Women were asked an open-ended question regarding the best marriage time for their future daughters. Women who thought that the best marriage age for their future daughter's marriage was between 16 and 20 were most in Hebron and least in Ramallah. While best marriage age of 20 and more were given most in Ramallah, followed by Jenin and least in Hebron.

Figure 7.16: Percentages of women's opinion of the best marriage age for their daughters by region



Desired number of children for the women's daughters

Table 7.30 shows the opinion of women who answered the question regarding the desired number of children that women wish for their daughters (the rest have answered "don't know"). The total mean number of children was 3.70 and the median was 4 children.

Table 7.30: Desired number of children for the women's daughters: mean and median number of children women wish for their daughters to have in the future by region

Region	Mean	Median	Range (max-min)	Total no. of women
Hebron	3.48	4	(7-1) 6	114
Ramallah	4.9	4	(7-1) 6	106
Jenin	3.53	4	(6-1) 5	106
Total	3.70	4	(7-1) 6	326

Demographic characteristics of women by age at first marriage

Table 7.31 presents the socio-demographic characteristics of women by their age at first marriage. It shows that most women who had gotten married at the age of 16 and less and at the age of 17-20 (21% and 64.6%, respectively) were currently the youngest women (≤24 years). Close to half of women of the oldest age group have had gotten married at the age of 21 and more. There were significant differences between age groups and the age at first marriage. Table 7.30 also shows a significant association between age at first marriage and education received, in that most women who have gotten married at the age of 16 and less and between 17 and 19 received less than secondary school education compared to those who got married in an older age (29.6% and 50.8%, respectively). The table 7.31 also presents the results of working status by age at first marriage. It shows that women who got married at later age were most likely working. There were regional differences in terms of age at first marriage, in that women married at younger age were mostly living in Hebron compared to the other two regions. Women who got married at a younger age reported having more living children compared to those who got married at later age. Marriage years also showed a significant association with women's age at first marriage, as women who got married at later age is mostly married for a shorter marriage years (<10 yrs). The table 7.31 shows also that there was no significant association between women's age at first marriage and women's status inside the family in terms of women's right to refuse sex with their husbands and women's number of final household decisions. In addition, there was no significant association between women's acceptability of wife beating and their age at first marriage.

In relation to women's health care and age at first marriage, table 7.30 presents a bivariate association between women's age at first marriage and women's health. It shows that there was a trend in terms of the number of antenatal visits women have had conducted and women's age at first marriage, as the older the age of marriage the more visits for the purpose of antenatal care, though the association was not statistically significant (p= 0.07). However, there was a significant association between women's age at first marriage and attending postnatal follow up visits (p=.053). In that, women who got married at age older than 21 years old had conducted more postnatal follow up visits compared to those who got married at younger age groups. While in relations to contraceptives use, the trend of use shows different direction, as the younger the age were of marriage the more use of contraceptives. (See table 7.30 for more information). There was also more tolerance of wife beating among those who married at younger age; however it shows no significant association.

Table 7.31: Percent of women's age at first marriage by women's characteristics

Characteristics	<16 (n=6)	17-20 (n=228)	21+ (n=154)	Total n. (n=450)	*p- value
Age					<0.001*
≤24	21.3	64.6	14.2	127	
25-29	10.6	48.3	41.1	151	
≥30	14.5	42.4	43.0	172	
Education					<0.001*
< Secondary school	29.6	50.8	19.6	189	
≥ Secondary school	4.6	50.6	44.8	261	
Working status					<0.001*
Yes	3.4	19.5	77.0	87	
No	17.9	58.1	24.0	363	
Region					<0.001*
South (Hebron)	20.0	61.3	18.7	150	
Middle (Ramallah)	8.7	44.7	46.7	150	
Jenin (North)	16.7	46.0	37.3	150	
Total number of children					<0.001*
0	13.2	23.7	44.8	132	
1-2	36.8	42.5	39.6	183	
4+	50.0	33.8	15.6	135	
Marriage years					<0.001*
<10	49.3	66.2	83.8	313	
≥10	50.7	33.8	16.2	136	
Right to refuse sex					0.78
Has right in all situations	66.2	70.6	69.5	313	
No right at least once	33.8	29.4	30.5	137	
Number of final household decisions					0.76
0	22.1	19.3	16.2	84	
1-2	47.1	52.6	51.3	231	
+3	30.9	28.1	32.5	135	
Justified wife beating (at least once)					0.28
Yes	72.1	64.9	61.0	291	
no	27.9	35.1	39.0	159	
Number of antenatal visits conducted during the last pregnancy					0.070
0-5	20.5	21.1	10.4	44	
6-10	56.4	54.9	49.4	133	
>10	23.1	24.1	40.3	72	
Conducting postnatal checkups any time during or after the first 40 days following delivery					0.053
Yes	31.0	32.4	47.6	97	
No	69.0	67.6	52.4	166	
Using contraceptives					0.005
Ever used	88.2	78.9	69.3	345	
Never used	11.8	21.1	30.7	103	

*Calculated from Chi –square for measuring differences, significant p<0.05

Perceived best marriage age for women's daughters and marriage process

In order to check women's attitude toward their future daughter marriage's process, women were asked if they thought they would have opinion in choosing their future daughter's husband. The results are shown in figure 7.17. Almost all women thought that they should have an opinion in choosing their daughter's future husbands and only 11% of women though

that they will accept the choice of their daughters. While figure 7.18 shows women's opinion in choosing their daughter's future husbands by region, women thought they should have an opinion most in Hebron, followed by Jenin, but women in Ramallah thought most that they would accept the husband that their daughters choose for themselves.

Figure 7.17: Women's perception toward choosing their future daughters husbands

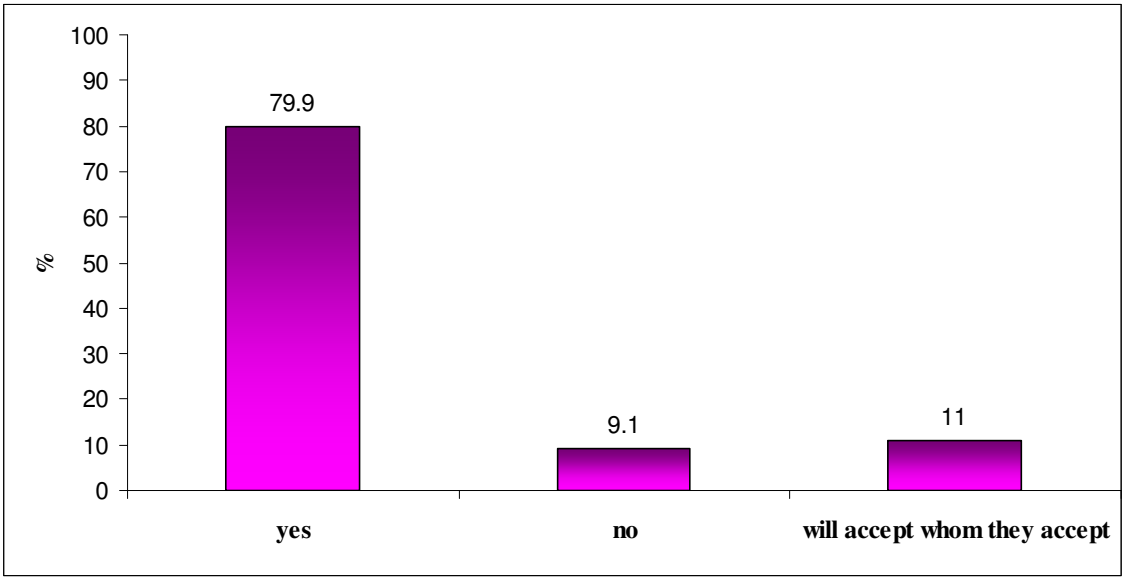


Figure 7.18: Women's attitudes toward choosing their daughter's husband by region

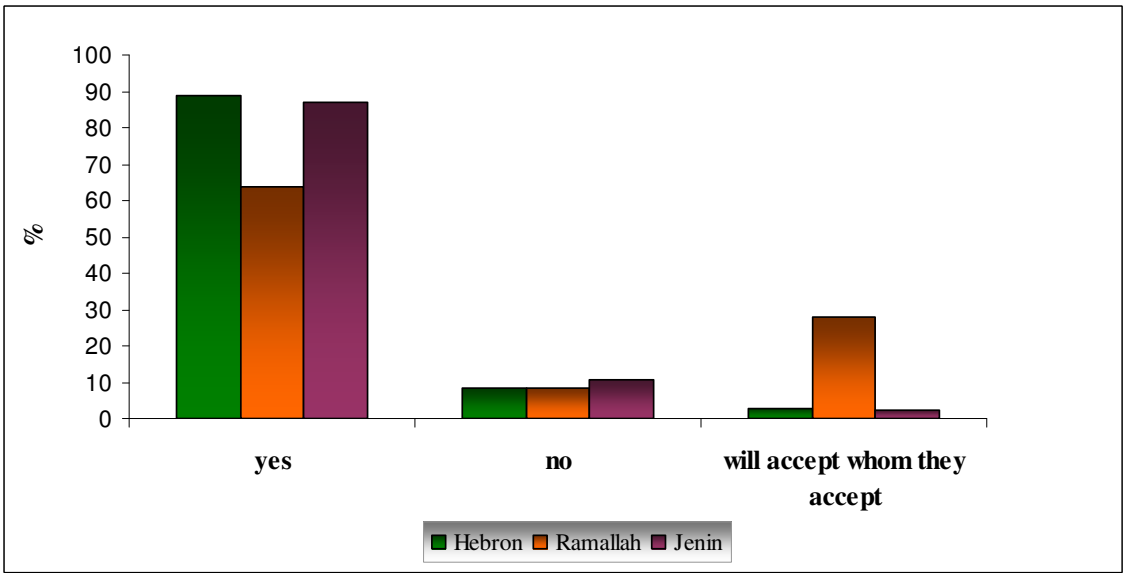


Table 7.32 presents the mean and median age of perceived women's daughters' best marriage age by region. The mean of best age for marriage in Hebron was 19 while the median is 18 years old. However, Jenin and Ramallah had similar median of best marriage age of 22.

Overall, the three regions mean of best daughter's marriage age was about 21 years old and the median age is 20 years old.

Table 7.32: Mean. median and range of perceived best marriage age of women's daughters by region

Region	Mean	Median	Range (max-min)
Hebron	19.34	18	(25-16) 9
Ramallah	21.73	22	(29-17)12
Jenin	21.36	22	(30-16) 14
Total	20.83	20	(30-16) 14

Factors associated with perceived best marriage age for the daughters of the women.

Table 7.33 present the results form a univariate analysis regarding the socio-demographic characteristics of women by their attitude toward the best marriage age for their future daughters. The bivariate analysis in table 7.33 shows that women with lower education, unemployed, lower economic status, basically from Hebron, had higher total number of children, higher total number of girls children, and married at younger age were supporting younger age of marriage for their daughters which were all significantly associated factors.

In order to check for associations between women's attitudes of the best age of their future daughter's marriage (particularly the age between 16 and 20) and the women's characteristic. Table 34 presents the results of multivariable logistic regression model that was applied to check for associated factors of women's attitudes of best age of marriage for their daughters. It shows that education, region, women's age at first marriage, women's economic stratus, and women's justification for wife beating at least in one situation were all associated factors with women's attitude of younger marriage age. As women's received lower educational level believed more of younger age of marriage compared to those who received higher educational level (OR=0.30, p=<0.001). Women who were coming from a middle social economic class reported less younger age of marriage as best for their daughters compared to those reported that they were coming from a lower social economic class (OR=2.23, p= 0.028). Regional differences were also shown in table 7.34, as women form Hebron and Ramallah were more to support younger age of marriage compared to those in Jenin (OR= 0.12, p= <0.001, and OR=0.57 , p= 0.058, respectively). Women's age at first marriage was significantly associated with women's attitude of younger marriage age, in that those women who got married at younger age support more the notion of younger age to be the best for their daughters.

There was a significant association between women's attitudes toward the acceptability of wife beating in at least one situation and supporting their daughters younger marriage age, as those who accept more wife beating, supports more their daughter younger age of marriage (67.7%, p= .011).

Table 7.33: Best marriage age for women daughters: Percent of women's attitudes towards best marriage age of their daughters by their demography, number of children, region, economic status and their age at first marriage.

Characteristics	16-20 (n=228)	21+ (n=154)	Total (n=441)	*p-value
Age				0.130
≤24	58.0	42.0	125	
25-29	45.0	55.0	149	
≥30	56.3	43.7	167	
Education				<0.001
< Secondary school	72.5	27.5	182	
≥ Secondary school	36.3	63.7	259	
Working status				<0.001
Yes	25.3	74.7	87	
No	57.6	42.4	354	
Economic status				0.006
High	35.1	64.9	37	
Middle	49.7	50.3	326	
Low	65.4	34.6	78	
Region				<0.001
South (Hebron)	79.6	20.4	142	
Middle(Ramallah)	36.0	64.0	150	
Jenin (North)	39.6	60.4	149	
Total number of children				<0.001
0-1	36.2	63.8	130	
2-3	50.3	49.7	179	
4+	67.4	32.6	132	
Total number of living girls children				<0.001
0	26.1	37.2	139	
1-2	49.1	51.6	222	
3+	24.8	11.2	80	
Age at first marriage				<0.001
≤16	20.4	8.8	65	
17-20	59.7	40.9	223	
≥21	19.9	50.2	153	
Justifies wife beating (at least once)				0.11
Yes	67.7	60.0	282	
no	32.3	40.0	159	

*Calculated from Chi –square for measuring differences, significant p<0.05

Table 7.34: Factors associated with women's attitudes towards their daughters' marriage age. (16-20 years old)

Characteristics	n[a]	(BDMA, 16-20yr.) %[b]	Adjusted[c] OR (95% CI)	p- value[d]
Age				
≤24	125	58.0	2.15 (0.96-4.79)	0.06
25-29	149	45.0	1.69 (0.89-3.23)	0.10
≥30	167	56.3	Reference	
Women's level of education				
<Secondary	182	72.5	0.30 (0.18-0.51)	
≥Secondary	259	36.3	Reference	<0.001*
Women working status				
Employed	87	25.3	1.25(0.63-2.51)	
Unemployed	354	57.6	Reference	0.51
Economic status				
High	37	35.1	2.23 (0.83-6.02)	0.11
Middle	326	49.7	2.03 (1.08-3.84)	0.028*
Low	78	65.4	Reference	
Region				
Hebron	142	79.6	0.12 (0.06-0.22)	<0.001*
Ramallah	150	36.0	0.57 (0.32-1.01)	0.058
Jenin	149	39.6	Reference	
No. of living children				
4+	132	67.4	0.95 (0.50-1.80)	0.88
2-3	179	50.3	1.06 (0.41-2.74)	0.89
0-1	130	36.2	Reference	
Total number of living girls children				
0	139	26.1	1.33 (0.56-3.16)	0.50
1-2	222	49.1	1.74 (0.84-3.59)	0.13
3+	80	24.8	Reference	
Women age at first marriage				
≤16	65	20.4	0.36 (0.15-0.84)	0.018*
17-20	223	59.7	0.32 (0.17-0.58)	<0.001*
≥21	153	19.9	Reference	
Justifies wife beating (at least once)				
Yes	159	67.7	1.93 (1.16-3.20)	0.011*
No	282	32.3	Reference	

BDMA = Women's Belief toward their future daughters best marriage age; OR = odds ratio; CI = confidence interval. [a] Number of women in each stratum. [b] Percentages of women who reported that best marriage age is between 16 and 20 years old for their future daughters. [c] Final logistic regression model included only those variables listed in column. [d] significant p=<.005

7.7.1. Age at first marriage results summary

- The mean age of first marriage among the 450 women was 20 years old while the median was 19 years old with some regional differences.
- Most women in the sample have had got married at the age between 17 and 20 years old. About one third of women got married at the age of 20 or more.
- Women from Hebron were the most to get marry at the age of 16 and at the age between 17 and 20 compared to the other two regions. On the other hand, women from Ramallah were the most to be married at the age of 21 and more followed by Jenin and then least Hebron.
- About half of the women thought that the best marriage age for their daughters was between 16 and 20 years old. While, there was regional difference in this regard to be mostly thought so in Hebron compared to the other tow regions.
- Received less education, unemployment, having high number of children, and being younger than 24 years old were all the characteristics of those women who got married between the age of 16 and 20 years old.
- About 80% of women thought that they should have an opinion in choosing the future husbands for their daughters, among those the majority were from Hebron.
- The average number of the desired children for the women's daughter is 3.7 as reported by the women themselves.
- The mean age of best marriage age for their future daughters is 21 and the median is 20 years old with regional difference.
- Lower education, younger age at first marriage, lower economical status, and justification for wife beating in at least one situation were all significantly associated factors with women's belief of younger marriage age for their daughters.

7.8. Hypotheses tests

The proposed hypotheses have been tested as the following:

Hypothesis one: There is a difference between the studied regions with respect to all of the above objectives

There was highly significant differences between regions among the overall study objectives as p-value <0.05 when I applied chi-square test, Wald test adjusted other variables and Kruskal-Wallis test. And here are some selected results:

1. Women's perceived level of importance for each one of the reproductive health right differently by regions ($p<0.05$ among all the reproductive health rights, calculated from Kruskal-Wallis test).
2. Women's perceived the rate of importance regarding the main purposes of using family planning methods differently by region ($p<0.05$, calculated from Kruskal-Wallis test).
3. Perception of women's important determinants for using family planning methods were different in 10 out of 13 determinates between regions ($p<0.05$, calculated from Kruskal-Wallis test).
4. Fertility decisions were different between regions ($p<0.05$, calculated from chi-square test, univariate analysis).
5. Women's perceived the importance of antenatal care visits differently between regions ($p<0.05$, calculated from Kruskal-Wallis test).
6. Women's perceived the importance for the most important determinants in choosing the place of delivery differently between regions (($p<0.05$, calculated from Kruskal-Wallis test).
7. There was difference between regions in relation to the factors associated with lack of attendance to postnatal care ($p<0.05$, calculated from Wald test after adjusting other variables).
8. Significant regional difference in terms of justification for wife beating ($p<0.05$, calculated from Wald test after adjusting the other variables).
9. There was significant regional difference in relation to women's attitudes towards best age of marriage for their daughters ($p<0.05$, calculated from Wald test after adjusting the other variables).

Hypothesis two:

There is a significant relationship between women's fertility decisions and their pregnancy willingness.

This was tested by chi-square test and there were significant relationship between women's fertility decisions and willingness for pregnancy ($p<0.05$)

Hypothesis three

There is a significant relationship between women's status inside the family with respect to fertility regulations and using family planning methods

This was tested as the following:

1. The right to refuse sex with husbands under certain situations was significantly associated with women's current use of contraceptives.
2. Women's status (right to refuse sex with husband under certain situations, number of household decisions, and refuse wife beating) was significantly associated with women's use of family planning based on her sole decision. ($p<0.05$ calculated from chi-square test from bivariate analysis).
3. Women's status (right to refuse sex with husband under certain situations, number of household decisions, and refuse wife beating) was significantly associated with fertility decision concerning having another child ($p<0.05$ calculated from chi-square test from bivariate analysis).
4. Women's status (right to refuse sex with husband under certain situations, number of household decisions, and refuse wife beating) was significantly associated with fertility decision concerning stop using contraceptives ($p<0.05$ calculated from chi-square test from bivariate analysis).
5. Women's status (right to refuse sex with husband under certain situations, number of household decisions, and refuse wife beating) was significantly associated with fertility decision concerning using contraceptives ($p<0.05$ calculated from chi-square test from bivariate analysis).

CHAPTER EIGHT

DISCUSSION

8.1. Reproductive health human rights as an overall concept & women's understanding

Measuring women's perception towards their reproductive health rights is prerequisite information for implementing any successful intervention reproductive health project. Women's perception could also define women's health seeking behaviors and could be a mirror for women's use of their reproductive health rights (Younis et al, 1993). The women's understanding for their reproductive health rights and the main beliefs of their rights might be the basic concept for allocating women's needs to situate interventions in order to improve the health of women in their life course and their health in a broader concept**.**

This study shows that generally, women had a positive attitude towards their reproductive health rights and a positive understanding for the meaning of health as an overall concept. These findings were consistent with a study conducted in Egypt which found that women in general understand and have positive attitudes towards their reproductive health rights (Shabana et al, 2003).

When women rate the definition of health according to their perceived importance, they had ranked the mental health as the most important meaning and concern for them followed by the physical health and the social health, respectively. Several women have indicated that "when I am not feeling relaxed and had problems, I feel I am very ill". Similar attitude was also noted by around 16% of women in a qualitative study conducted in three communities around Beirut, Lebanon, as women indicated that reproductive health means that they should feel relaxed and live without problems. Some explanations for women's perception are first perception is often influenced by one's cognitive, cultural, political, and social values (Freedman, 1993). Women in Palestine are living under a triple challenges, first as Palestinians, they live under Israeli occupation which controls every aspect of their lives, second as women, they live under the Patriarchal customs and finally as a subject member for societal discrimination (Elrashidi, 2005). Women had expressed their needs for psychological

comfort and freedom from stress as a mean to define their health, and ranked them much more than the physical and the social needs. Harris and Smyth (2001) noted that: "Reproductive health cannot be separated from the condition of insecurity in which many men and women in developing countries live". Other explanation could be that the women's rank might be influenced by their feeling at the time of interview, as their attitudes can also be variable according to the women's mood, situation and many other surrounding conditions. The health priorities that women mentioned would give the policy makers as well as the health institutions a strong impression to put more effort on the psychological aspect of health when they do plan for any intervention reproductive health programs.

The present study explores women's perception of the meanings of women's reproductive health rights. As in our open-ended question asking women to mention as much reproductive health rights as they consider, 40% of women mentioned and recognized the rights to receive full health care services during maternity process (pregnancy, delivery, and postpartum). Moreover, about 23% mentioned women's right to have available and accessible necessary medication, modern health instruments and affordable health insurance during their process of health care. The right is considered as one of the major important rights recognized by the international constitutions of human rights, which includes that women have the right to receive full health care, which should be accessible, available and affordable (CESCR Committee, 2000). However, the study in Egypt (Shabana et al, 2003) showed much higher percentage (97.4%) of women who had positive attitude towards the right for full care during the perinatal period, although it was assessed differently as a close-ended questionnaire. The broadness of thinking and the details that the women in our study gave when they described their right of health care give an impression that those women understand the need for proper and full health care as one of their rights and not only recognize it as a health care need.

About one third of women (30.7%) had also mentioned the right to receive good, respectful and caring treatment from the health care providers while receiving the health care. One explanation would be that women recognize respectful treatment and welcoming attitudes from the health care providers as a very important issue measuring their health care satisfaction (Bitar & Wick, 2007; Giacaman et al, 2006). In addition, Women's Center for legal and social Counseling (2000) found that 12% of the health care providers n West Bank were lacking knowledge regarding women's right to be treated with respect while providing the health care. Women reflect this right as what they feel it is an urgent need for them, which

should be taken into consideration. This explanation is further supported by a study performed in Zimbabwe which investigated the importance of respectful treatment and attitude of the health care providers and its effect on the use of health care services, where the disrespectful attitudes of health providers were found to be responsible for not attending perinatal care (Mathole et al, 2004).

When women were asked to rank the reproductive health rights according to their perceived importance, they did rank the right to receive information as number one priority, followed by the right to marry and to found a family, then the right to receive full health care during the maternal process together with the right to be treated without discrimination in the third rank, then followed by all the other rights. The right to receive full information is among the important rights recognized by the international human rights (Political Covenant, article 19). Houle et al (2007) argued that women are looking for more than the knowledge given to them from the health care providers, they look for a respectful, and two-way communication that is based on what do women needs and not only on what the health care provider's perception. This rank shows how much women put an emphasis on education and health information and how much they are eager to know about their health status, especially during pregnancy, childbirth and using contraceptives. Similar results were found in a recent study in Iran (Shahidzadeh-Mahani et al, 2008) who studied the determinant factor of using contraceptives. The importance of information and health education was also found in several other fields in the present study; in receiving antenatal care, delivery and in the postnatal care (these topics will be discussed later in this chapter).

Marriage, in Palestine as well as in many other Arab countries, is traditionally arranged and controlled by the family, for this reason women still marry in Palestine at a median age of 19 years and early marriage is still one of the recognized challenges for the Palestinian women (Rashad, 2005). The Right to marry and to found a family was the second important right the women did recognize. Right to marry is among the main reproductive health rights as couples have the right to marry when they reach appropriate age (Article 23 of the Political Covenant and article 10 of the Economic Covenant). One explanation behind women's rank is that marriage is supported in the Islam religion in both Koran and Sunnah and it is also recommended socially. "According to Imams Abu Hanifah, Ahmad ibn Hanbal and Malik ibn Anas, marriage is recommendatory, and for certain individuals it is obligatory. Imam Shaafi'i considered it to be preferable and marriage should not be put off or delayed especially if one

has the means to do so. Islam acts as a strong advocate for marriage, Prophet Mohammad (s) said in one of his hadeeth "when a man marries, he has fulfilled half of his religion". (http://www.jannah.org/sisters/marr.html, accessed on May 30th, 2008).

The right to full access to health care (discussed earlier in this section) and the right to be free of discrimination was considered the third important rights women did perceive. Palestinian women face daily discrimination in many dimensions, political, social and cultural. Regarding to the political discrimination, Palestinian women live under the Israeli occupation which inserts constraints in movement by creating the separation wall as well as the permanent and the temporary check points which forbid women from movement and to receive proper heath care when necessary. The ministry of health reported at least 99 delivers (MOH, 2004) that were occurred at checkpoints and many cases were died due to delay in crossing checkpoints (Al-Adli, 2006; Giacaman et al, 2006; Shabana et al, 2003). Another political discrimination was marked when the discriminatory law presented by the Israel Knesset in 2003 which bans the family unification for Israeli (Arab) citizens married to Palestinians from the occupied territories. Moreover, the law bans family unification for Palestinians in the occupied territory married with any other nationality like Jordanians for example (El-Rashidi, 2005).

Women in Palestine, as any other traditional society, live under the patriarchal authority which in itself put a social and cultural discriminatory restriction for women's reproductive choices, resection in movement which itself might restricts women's opportunity to receive health care and might put the women in danger for violence that will come out of control impulse that men need to employ (El-rashidi, 2005). However, in terms of receiving care in health care centers, women have indicated that they perceived no gender discrimination by the health care providers in West Bank (Women's Center for Legal and Social Counseling study, 2000).

Although few women (10 women from Ramallah) have mentioned the right to have clear law and legislation of heath care that would protect women from medical ignorance and mistakes, I think that recognizing this right might be very important and that it should be taken into consideration by the policy makers and the Ministry of Health. In West Bank, it was reported that women die from different reasons other than those related to maternity reasons and there were clear underreported cases of maternal mortality and morbidity as shown by Al- Adli (2006).

About 13 women have noted the right to have enough, well trained and experienced health care providers in the public health care centers. I also find these factors very important and worth to be discussed here in this chapter. Wick et al (2005) indicated that there is a discrepancy between staffing and caseloads in the governmental and private sectors. In that, about one- third of the available obstetricians and midwives worked in the governmental sectors, where almost 50% of deliveries in West Bank occurred. Bitar and Wick (2007) also reported that there were shortage of staff and high caseload in the governmental hospitals, and the health care providers are always having complains from low salaries, high workload and dissatisfaction from the overall work environment. This would put unprivileged women who are either having low cost governmental health insurance, those who are looking for low cost deliveries, those who have no available choices such women live in the southern of West Bank, or women who had sudden delivery and search for the nearest place of delivery to a high risk of being mistreated and dissatisfied form the health care received at the governmental health care institutions (Giacaman et al, 2006). Another issue which might also raise a big concern is the lack of financial support that the ministry of health is going through especially after the international community had decided to withdrew its support to the Palestinian Authority after the election victory of Hamas in 2006, where many observers were predicting a complete collapse in the health care system (Devis, 2006; Bosmans et al, 2008). More than half of the Palestinian women in both West Bank and Gaza were forced to deliver their children in the governmental hospitals; therefore, women's rights of receiving better health care services will be violated and the reason would be not blamed on the Palestinian Authority alone or the Palestinian health care system only. The overall political situation in Palestine plays a significant role in this current poorly described situation (Bosmans et al, 2008).

This study adds to the Palestinian literature more important information regarding women's reproductive health rights. The first study of women's perception of violation of their rights in the health care sectors (2000), followed by the assessment of health laws in Palestine in a review study (2005), and the study of sensitization to the terminology of reproductive health rights in West Bank and Gaza (2006) those three studies conducted by the Women's Center for legal and social counseling organization. The present study brings a different perspective in measuring women's knowledge and attitudes towards their rights while receiving different types of reproductive health care (antenatal, delivery, postnatal and family planning), which will be discussed later in this chapter according a theoretical framework using the integrative

model of both social and cognitive theory, theory of planned behavior, community organization theory and gender and power theory to better understand women's health practices (behavior) at the end. This study also reveals the importance of reproductive health rights as perceived by women. Adding the results of all the four studies together would help the policy makers and health programmers to organize and to develop health related projects that could help women understand their reproductive health rights, provide better health care services that insures women's rights and create a health care environment where women's reproductive health rights are well considered.

8.2. Family planning

8.2.1. Family planning knowledge

Awareness of family planning methods is very important for women to make decisions on whether to use contraceptives or not and which method to use. The results of this study show that Pills, IUD and male condom were among the most popular methods that women could recognize spontaneously (92.2%, 92.2%, and 42.4% respectively). In addition, women recognize mostly Pills, IUDs and then female sterilization (99%, 98.2%, and 92.9% respectively) after reading the description of each method by the interviewer. The least recognized methods were diaphragm, implants, female condom and emergency contraceptives (8.2%, 8.7%, 8.7 %and 14.2% respectively) (see Table 6.5). In comparison, women in Jordan recognize mostly pills and IUD (100% for each) among the modern methods, followed by female sterilization (98% each). Knowledge of the male condom and Injectables exists among 90% and 93% of ever-married women, respectively. The least recognized methods were emergency contraceptives, diaphragm, and female condom, with 13%, 17% and 18 %, respectively (Department Of Statistics [Jordan] & Orc Macro, 2002). While in Egypt almost all currently married women acknowledge knowing pills, IUD and Injectables, and more than 90% know about implants. Two out of three women know about female sterilization, and half of women know about condom, other methods that were less widely recognized in Egypt were male sterilization (8%) and emergency contraceptives (7%) (El-Zanaty & Way, 2005).

Women seem not to know well the emergency contraceptives neither in West Bank nor in the regional countries (as Jordan and Egypt). This could be related to lack of its availability or lack of attention given to such contraceptive method from the health care providers. Such results are consistent with what was found in several other studies (Soon et al, 2007; Moodley & Morroni, 2007; Smith & Whitfield, 1995; Shoveller et al, 2007).

8.2.2. Family planning practices

- **Ever use contraceptives**

The results show that 77% of women have ever used contraceptives in West bank compared to 80% in Jordan and Egypt (Department Of Statistics [Jordan] & Orc Macro ,2002, El-Zanaty & Way, 2005). While the percentage in Oman was much less than the above mentioned regions, as only 50.3% of women had reported ever using contraceptives (Al-Riyami et al, 2000).

IUD is the most popular ever used modern method (36.7%) in our study results followed by pills (29.8%) and male condom (28.8%). The level of ever use of traditional contraceptive methods is high. Withdrawal is the most frequently adopted traditional method as it has been used by 47.8% of women, followed by lactation amenorrhea (28.7%) and periodic abstinence (28.4%). While in Jordan and Egypt, IUD and Pills were the most popular ever used methods, as 49.2% and 60.0% of women were ever used IUD and about 40.2% and 38.9% of women were ever used pills in Jordan and Egypt, respectively (Department Of Statistics [Jordan] & Orc Macro, 2002; El-Zanaty & Way, 2005). Moreover, in Oman, Pills and Injectables were the most popular modern methods that have been ever used by women (16.4% and 15.5%, respectively) (Al-Riyami et al, 2000). Common Use of IUD's was found by previous studies to be related to its availability, long term use, older women as well as women with many children, in addition to the quality of family planning service provided (such as providing women with proper counseling in this field, focusing on IUD and giving it more attention, the medical practices provided and many other measures of quality) (Hong et al, 2006; Curtis & Neitzel, 1996; Islam, 1996).

Our results show several significant factors influencing women's ever use of contraceptives, for example, older women tend to use more contraceptives than younger women. This was found in several other studies such as in Oman, Pakistan and Jordan (Al Riyami et al, 2004; Saleem & Bobak, 2005; Youssef, 2005; Tawiah, 1997). High Parity is another factor found to be highly associated with contraceptive use, which is consistent with many previous studies such as in southern Jordan and Oman national study (Al Riyami et al, 2004; Youssef, 2005; Tawiah, 1997). Another factor was long duration of marriage, which is mentioned also by many other studies (Youssef, 2005; Tawiah, 1997). One explanation for the influence of these factors might be that the longer marriage years logically means that the woman will be older and that she would have more children and have reached more fertility satisfaction for that she tends to use more contraceptives than younger women who might have fewer children.

- **Current use of contraceptives**

Despite the fact that 77% of women have had ever used contraceptives, only 38.8% of women are currently using contraceptives. While the percentages of women in the neighboring countries were 50%, 59.2% and 31.7 in Jordan, Egypt and Oman, respectively. The most currently used modern method out of the total current use percentages is IUD, followed by male condom and pills (9.3%, 3.4% and 3.3%, respectively). Among the traditional methods, withdrawal and lactational amenorrhea were the mostly used ones (5.8% and 5.1%,

respectively). On the other hand, IUDs and Pills were the most popular currently used modern methods in Jordan and in Egypt (Department Of Statistics [Jordan] & Orc Macro, 2002; El-Zanaty & Way, 2005).

8.2.3. Fertility decisions

Among the family planning study results, it is worthwhile to discuss in this section the fertility decision-making as a mean to measure women's practices of her right to be free of choice on all aspects of women's fertility (the number, spacing and timing of their children) (ICPD, 1994). The results show that the majority of women respond that the fertility decisions (contraceptives use, discontinue or having another child) are made jointly with their husbands. The results of our study are similar to those found for the Egyptian women's, where the majority of women (60.4%) thought that family planning decisions should be based on both partners opinion (Govindasamy & Malhotra, 1996). One study in Honduras found also similar results and indicated that almost half of women reported that both partners made family size decisions (57%) or family planning decisions (52%); and men reported even higher proportions (77% and 71%, respectively) (Speizer, 2005). Moreover, the majority of Muslim religious leader in Jordan have shared the attitude that contraceptive decisions should be made jointly by husband and wife (Underwood, 2000). Another study in the Republic of Iran found that most male teachers (90%) believed that decision-making regarding the use of contraceptives should be made jointly between the wife and her husband (Tavakoli & Rashidi-Jahan, 2005). In Turkey, a study has indicated that 66.7% of men said that the fertility decision should be a joint one (Mistik et al, 2003)

Education is an important factor that might influence women's autonomy in using contraceptive; discontinue using or having new children. The results show that higher educated women tend to make more joint fertility decisions with their husbands compared to those who received lower education. However, the study also shows that education alone, play a significant role in increasing the contraceptive use, which is consistent with many other studies (Al Riyami et al, 2004; Saleem & Bobak, 2005; Youssef, 2005; Tawiah, 1997). A study in United States has found that 73% of women who received college education and 84% of college graduates had jointly planned births (Williams, 1994). Researches show that education had a stronger influence on contraceptive use more than autonomy and women's empowerment (which are defined based on the household decision making and free of

movement scale). Interestingly, it was indicated that education does not arbitrate fertility autonomy (Al Saleem & Bobak, 2005; Riyami et al, 2004). In other words, education plays a significant role in fertility regulation regardless of women's autonomy or empowerment.

This study also shows a clear regional difference among the three studied regions in terms of having joint decisions in fertility. The higher percentages were in Jenin among each of the decisions of using contraceptives; discontinue using contraceptives; and having another child (76%, 72%, and 72% respectively). Demographic factors (such as education, employment, high parity etc.) were not found to be significantly associated with fertility decision and therefore could not explain the differences among the three regions. I suppose that there are other factors that might affect this attitude such as the cultural and traditional thinking of the Palestinian families about fertility, which is a matter of family issue and sometimes the extended family. Therefore, fertility could be influenced by the extended family and not only by the partners themselves. As Jenin is one of the most traditional regions in West Bank, this might explain partly why higher percentages of women who reported joint decisions on fertility issues were found in Jenin compared to the other regions. A study in Egypt supports the idea that the culture and the traditional power might affect fertility decisions, as it found that women with a philosophy of female autonomy on family planning decision-making were only as likely to practice contraception as women favoring a more democratic view, consistent with a cultural preference for interaction and negotiation rather than autonomy. While education and employment were found to be partially mediating the relationship between the non reproductive and reproductive variables (Govindasamy & Malhotra, 1996), the authors also mentioned that in Middle Eastern cultures, interdependence rather than independence in fertility matters often results in support, status and power. A study in Oman has also argued that the decision autonomy must be culturally sensitive (Al Riyami et al, 2004).

- **Women's sole fertility decisions**

Since women's sole fertility decision was one of the results in this study (16.2% in contraceptive use, 16.9% in discontinue using contraceptives and 11.8% in having another child) (see Tables 6.13-6.15). Therefore, it is important to discuss the determinant factors that support the autonomous decision among women in the three regions in West Bank.

Age was found to be significantly associated with women's decision for using contraceptives, as older women tend to be more autonomous in making decision on the use of contraceptives

(P≤0.001). Similar finding was also stated in the Oman national study (Al Riyami et al, 2004). An explanation could be that older women in Arabic cultures normally reach the level where they have more children and more satisfactory fertility life, and therefore it is consistent with their autonomy to make decisions about using contraceptives (Al Riyami et al, 2004).

High parity might also play a significant role, where women with more children tend to make more autonomous decision for using contraceptives (p=0.003) as well as having more power to stop using contraceptives (p=<0.001).This results is consistent with other studies in Oman as well as in Pakistan (Al Riyami and et al, 2004; Saleem & Bobak, 2005). Autonomy might also lead to low parity, as what was found by Nawar (1995) In Egypt.

Women status is another important factor that was found to be strongly associated with women's ability to make self-decision in terms of using contraceptives. Women who are working for money, women who tend to refuse husbands beating, women who have more household decisions and women who refuse sex with their husbands under the six questioned situations (explained more in the results section) tend to have more ability and power to make their self-decisions in terms of using contraceptives. Several studies support such results in many ways while other might show a contradicting influence as follows:

In case of women who work for money (employed), the study in Oman has found that women employment is associated with using contraceptives and in making the decision to do so (Al Riyami et al, 2004). Furthermore, refusal for husband beating as well as refusal for sex relationship with their husbands under the six questioned situations was associated with more contraceptive use in Jordan (Department Of Statistics [Jordan] & Orc Macro, 2002), although it is was not explained there whether this result was caused by the women's self autonomy decision or from the joint decision. However, increasing contraceptive use is a positive indicator of family planning and fertility control that benefits the women.

Household decision was measured in several contexts and in different ways, for example, a study conducted in Oman has measured the influence of household decisions that are solely taken by women and computed the physical autonomy in order to measure the empowerment scale. The physical autonomy was measured by asking the women "Does your husband allow you to go alone or accompanied by your children to...'' six places: shopping, hospital/health centers, and children's schools, visit relatives, visit friends, and go for a walk". However, they

did not find a clear relationship between the empowerment and the use of contraceptives. in addition to another study in Egypt which measured women's position and fertility found that women's status (free of movement, household involvement, finance influence, and education) has a strong connection with sole or equal fertility decision making (Govindasamy & Malhotra, 1996). In Pakistan, it was found that decision autonomy was significantly associated with contraceptive use, even after controlling for a battery of socio-demographic variables (Saleem & Bobak, 2005). Nawar (1995) had explained in her study in Egypt that women who tend to participate more in decisions inside the family or being involved in work environment tend to look more over their own health and insist more on their opinion or even try to convince or settle in case of disagreement with their partners.

Our results indicated that a region is an important factor of women's autonomy regarding fertility decisions. The present study show that women who decide solely to use a contraceptive, discontinue its use or have another child are most in Hebron (23.3%, 25.3%, and 15.3% respectively). And in the question concerning consultation in choosing and using contraceptives most women (84.8%) mentioned that they would not use contraceptives based only on their own opinion and would prefer to consult others (figure 6.5). And about 30% of women out of those who reported being able to use contraceptives based on their own opinion were from Hebron. This can be explained by considering the fact that almost half of women in Hebron (44.4%) make more than three household decisions. Household decision was associated with women's fertility decision autonomy in several studies (Nawar, 1995; Govindasamy & Malhotra, 1996; Department Of Statistics [Jordan] & Orc Macro, 2002; Al Riyami et al, 2004; El-Zanaty & Way, 2005; Saleem & Bobak, 2005). The other important factor was that 42.4% of women in Hebron refuse husband beating at all and under any condition which is the highest percentage compared to the other two regions (Table 6.26) (results of the present study). Refusal husband beating was found to increase the contraceptive use in Jordan (Department Of Statistics [Jordan] & Orc Macro, 2002). Although there are lack of previous studies that had focused on the cultural and social perspectives of women in Hebron. Hebron is very conservative and family oriented city, as girls are raised up to be mothers and housewives. The social characteristics of Hebron are connected and strong, where the support from the extended families is persistent and prominent. Women in Hebron are supported by all members of the extended family and not only by the direct kin even when they are very old and have many children. Therefore women in Hebron are powerful and autonomous despite the fact that they are mostly housewives and not highly educated.

Worth to discuss her also women's preferred person to counsel in matters of using contraceptives and choosing methods. As our study shows that most women mentioned that they would consult their husbands either alone or among others regarding the method that they will choose for family planning (see Figure 6.5). Moreover, about 30% of women mentioned that they would consult their husbands together with the health care provider for the best family planning method to use. Counseling by the health care provider shows also an important role for many women, and it is considered one of the important reproductive health rights as well. This is very important because support and counseling provided by the health care providers are critical because client judgment may be influenced by misinformation and faulty reasoning or be skewed by emotions. For example, clients tend to place more weight on friends anecdote than on statistical evidence (Redelmeir et al, 1993).

8.2.4. Fertility decisions and wanting the current pregnancy and unmet need of family planning

In order to measure the unmet need, it is important to study several factors that could influence the use of contraceptives and then identify whether there is an unmet need or not. Such factors are the availability and the quality of family planning health services provided. For example, one study in Pakistan has found an increased use of contraceptives that results from improvements of service delivery, such result confirms that a substantial unmet need exists and that greater improvement in access as well as in the quality of services will further increase the contraceptive use (Shellton, 1999). Another factor is the women's intention to use family planning, which was studied in a survey data for 1998 and 2003 from Burkina Faso, Ghana and Kenya that examined the fertility desires and motivations of women who said they wanted to delay or limit childbearing (Speizer, 2006). Moreover, in India, one study concluded that the use of both contraceptive and childbearing intentions predicts contraceptive demand better than the use of either indicators alone, and may thus help program planners to estimate future demands for contraceptive services (Roy et al, 2003). Other important factors were lack of knowledge, fear of side effects and social and familial disapproval which also include household decision making inside the family and fertility decisions (as mentioned by Bongaarts & Bruce, 1995).

In this study, several limitations make it difficult to measure the unmet need of family planning. Such limitations are: first, the study was conducted in reproductive health clinics where women seek family planning care and it would be an informational bias if I questioned

family planning services availability or satisfaction. Second, this study had no intention to measure women's intention to use family planning since there were no specific and direct questions in this regard. However the study met the objective in measuring the associations between women's willingness of the current pregnancy and their fertility decisions which with other factors could give a decisive decision in relation to unmet need. The study shows that in relation to women's sole decision in terms of wanting another child or stop using contraceptives it was limited when they do not want the current pregnancy at all or when they want this pregnancy at some other time (see table 7.17). As others has taken the role in putting more power in these two decisions. One explanation could be that in Palestine, the family including the extended family and the older children might have a big role in pushing the mother to have another child particularly when the woman has no boy child, the pressure would be much stronger, in order to encourage the mother to have sons. In Arabic culture like Palestine, men are mostly in favor to have sons so as to have family name and to serve as a supporter for the parents when they get older similar to other Arabic and Asiatic cultures (Cowan, 1990; Ahmed, 1981).

To conclude the results showed that Palestinian women exerts minimal power in the decision to have another child or in the decision to stop using contraceptives which could be very important factor in assessing unmet family planning need. However, future studies need to measure women's motivation and intention and their effect on contraceptives need. It is also important to measure the family planning services availability and quality which would be very helpful in identifying unmet need and setting future family planning programs.

8.2.6. Family planning importance and the determinants for its use

Our study shows that women perceive the importance of family planning use mainly for the children's health and having time to care for their children, followed by women's health, give space to take good care for her body, birth spacing, family economic situation and least for delaying the first child. In Jordan, a study measured women's beliefs towards the family planning use and its importance found that women rank the importance of family planning as; (1) more time to care for family, (2) financial considerations, (3) taking care of one's body, and (4) birth spacing (Libbus & Kridli, 1997). In this study women had positive set of priorities for the importance of the use of family planning as they mentioned that their first priority is their family and children's health then they put their own health as the second important priority. However, women mentioned that the least important use of family

planning is for delaying the first child; this could be explained by considering that in Palestine newly married couples are expected to conceive soon after their marriage, and the newly married men are also looking forward to have their first child soon so as to prove for all the surrounding family and social networks that they are fertile as mentioned in previous studies (Dayson & Moor, 1983; Barrnet, 1998). Another explanation could be that women had an opinion that using contraceptives early before having the first child might lead to infertility as what was found in Bangladesh by Schuler et al (2006).

The most important determinants for using contraceptives mentioned by the women were; (1) the freedom for choosing the methods, (2) being satisfied from the used methods, (3) the availability of the contraceptives, (4) good information given while choosing contraceptive methods (Table 6.12). Women recognized all the family planning client's rights in their set of determinants, which shows a positive understanding of women's family planning rights (Huezo & Diaz, 1993). However, they did focus more on freedom and information while choosing the appropriate methods which could be combined in to one right as the right of informed choice. Barnett (1998) and Costello (2001) had indicated that when women had enough information and enough methods to choose, and had all their questions answered appropriately and satisfactory, they would be very much satisfied from the service given and would continue the use of the contraceptives. Informed choice and good communication around contraceptive use would also represent high quality in the service provision of family planning (Barnett, 1998; Shahidzadeh-Mahani et al, 2008)

8.3. Reproductive health care

8.3.1. Antenatal Care

The study shows that women have well understanding of the importance of antenatal care (ANC). The results show that women were mostly concerned about the health of the fetus then about their own health followed by the desire to avoid complications during pregnancy, and the concern about knowing the sex of their baby, respectively (figure 6.6). Similar understanding was found among women in Beirut–Lebanon; as they mentioned in a qualitative research that the importance of antenatal care is first for the health of the baby then their own health and pregnancy complications (Khasholian, 2000). It was also found in a Swedish study where women rank the important reasons for seeking antenatal care that their baby's health ranks first followed by women's own health (Hildingsson et al, 2002). Surprisingly, knowing the sex of the baby was the least important concern for women when they conduct antenatal care although still it does have moderate importance in the rank (mean =3.14, Table 6.19), but not among the main reasons. In many cases, women were eager to know that they are carrying sons rather than daughters. Preferences for son children are in Palestine still predominate, as in many other Arabic and Asiatic cultures (Cowan, 1990; Ahmed, 1981). In the past, Palestinian economy was highly dependent on agriculture and families were in need for labor assistance, for that, the preference for sons were a need. Moreover, traditionally, the parents depend economically on their elder son for their support when they get old. The elder son used to be nick named "the wall" that will protect his parents when they need him (Crognier et al, 2006). Additionally, sons known to be the one's who keep the name of the family in the future, while daughters follow the names of their future husband's family which that in its turn would keep the family name persistent and not to end at certain point (Crognier et al, 2006). Sons also perceived to provide the family with security and support (Gadalla et al, 1985) which all justify the reason behind the preference of sons.

Our results indicated that women's rank of important reasons for seeking antenatal care was consistent with their number of visits they actually conducted, where women had conducted more than six antenatal visits during the entire pregnancy which exceed the 4 recommended visits by the WHO (WHO, 2005). Similar finding was stated by the national demographic health survey-2004 and the ministry of heath report (MOH, 2004; Palestinian Central Bureau of Statistics, 2004). The results also show that the vast majority of women starts their antenatal care early (<3 months). Regionally, in Jordan it was reported that 85% of women

make their first antenatal care visit before the four months of pregnancy, and 81% of women make six or more antenatal care visits during their entire pregnancy (Department Of Statistics [Jordan] & Orc Macro, 2002). However, the situation in Egypt was different, where 31.2% of women conducted no antenatal visits and the majority starts their antenatal care when pregnancy is less than 5 months, while the vast majority conducted four or less visits during the entire pregnancy (El-Zanaty & Way, 2005).

Although women conduct regular and several visits of antenatal care, the results show that less than half of the women (44.9%) have received proper health education in terms of pregnancy complications. Palestinian demographic health survey (Palestinian Central Bureau of Statistics, 2004) reported that relatively high percentage of women (55.1%) did recall receiving no health education during their antenatal check ups, which is slightly similar to the case in Jordan were 57% of mothers who received antenatal care reported that they were not informed about pregnancy-related complications during their visits (Department Of Statistics [Jordan] & Orc Macro ,2002), while the percentage was (48.9%) in Egypt (El-Zanaty & Way, 2005). All of the previously mentioned studies have found that education level is a strong related factor associated with receiving health education, as the least educated women were less likely to receive health education (Palestinian Central Bureau of Statistics, 2004, Department Of Statistics [Jordan] & Orc Macro, 2002; El-Zanaty & Way, 2005). This could be related to the fact that education might empower women to ask the health care providers for more clarification and information compared to the less educated women were they accept the health care without commenting or interacting with the health care providers (Editorial, 2005, Philippines & Balayan, 1998). Women's education was also found to be related to receive the recommended number of antenatal care visits (Nielsen et al, 2001; Erci, 2003) and to start their follow up care early (Miles-Doan & Brewster 1998; Matthews et al, 2001).

Residency was another key factor found in this study that influences women's receiving health education, as women who live in the cities were more likely to be exposed to such information rather than those who live outside the cites (which is similar to the case in Egypt; El-Zanaty & Way, 2005).

Health care rights during the perinatal period were measured in this study by assessing women's rank of importance regarding the most important concern that they perceive in the antenatal health care services. Women rank the quality of care (information in terms of health

counseling during antenatal care, and the health care staff caring attitudes) at their top concern. An explanation for this could be that during pregnancy women face several changes in their bodies that might need familiarity, assurance, and support. For these reasons, women seek proper information, which is normally provided either from the health care providers or from someone with previous experience. Pregnancy is also a process of where women face a mixture feeling of fear and joy that requires care and welcoming attitudes from the health care providers. Mathole et al (2004) has found that poor relationship with the health care providers and rude attitudes women received while seeking the health care were strong barriers for women to attend antenatal care in Zimbabwe.

Our results show that the least important concern for the women is the accessibility of health services in terms of distance and cost. This can be explained by suggesting that women only mention and remember what they think they need and missing what is available and factual. Distance seems to be not a problematic concern since most of the surveyed women were living in the cities and there are many available relatively close clinics around (MOH, 2004). Moreover, cost does not seem to be problematic since Ministry of health primary health care clinics provides antenatal care free of charge (MOH, 2005).

8.3.2. Delivery Care

This study shows that the overwhelming majority (98%) of women's last childbirth took place in medical institutions and under medical supervision, and only 2% of women delivered at home (figure 6.7). This supports the national DHS survey conducted in 2004 and found that 96.4% of child births over the three years preceding the survey took place in medical settings and only 3% were delivered at home (Palestinian Central Bureau of Statistics-DHS, 2004). Similar results were recorded in Jordan, where almost all women (97%) deliver at health facility; where in Egypt only 64.7% of women delivered their last birth at health facility (Department Of Statistics [Jordan] & ORC Macro, 2002; El-Zanaty & Way, 2005 respectively). It was indicated that delivery at home is more likely to occur among older women and women living in non-urban areas, high-order births, and births to women who have no education and lower income as well as those who received no antenatal care (MARAM, 2003). This might explain our results where home deliveries were mostly found among women in the north and south of West Bank where higher percentages of women are less educated, living in rural areas, and have lower income compared to the Ramallah.

The study shows that 46% of women delivered in governmental hospitals while 49% delivered their last child in Private sectors. This is slightly different from the reported percentages stated by the Palestinian Central Bureau of Statistics-DHS (2004) who found that 44.6% of women delivered at governmental hospitals while 37.5% of women delivered in Private sector among women who live in West Bank. This difference might be related to the fact that most sampled women in our study were living in the cities where the DHS (2004) reported higher deliveries at private sector compared to those live in rural areas and camps. Consistent with the DHS study (2004), our results show those women with lower education and those who live in the south or north of West Bank were more likely to choose delivering their last child in governmental hospitals. Moreover, more women from the middle of West Bank (Ramallah) choose to deliver their last child in private hospitals than the other two regions (Palestinian Central Bureau of Statistics-DHS, 2004). Although no significant relationship was found between the number of children and choosing the place of delivery, there was a trend that women mostly choose private hospital for their first child delivery comparing to the third or forth child (table 6.21) (this was also found in the DHS, 2004).

Satisfaction of delivery was the other important issue that women note in this study. Women reported much more satisfaction from private health facilities than from governmental health facilities. The same result was found by a study conducted earlier in Palestine by Giacaman et al (2006). This can be explained as women in private settings received better privacy and lenient regulation, allowing female companion during labor and birth (Bitar & Wick, 2007), and have higher staff ratio (Wick et al, 2004) compared to the governmental hospitals. Another explanation could be that women who tend to put more out of pockets for their childbirth (delivery in private settings required women to pay for the service) represent women that are coming from a higher social background and it's a matter of showing the wealth of the family as a whole (Giacaman et al, 2006). In terms of the quality of care provided at each of private and governmental hospitals, our study shows that women did receive more information about the danger signs to monitor after delivery for their own health and their babies health when they delivered in private hospitals compared to delivery at governmental hospitals. Bitar & Wick (2007) mentioned that shortness of staff, high workload and lack of satisfaction of the staff working in governmental hospitals lead to an improper care provided to women including no health education after birth etc.

Reproductive health rights are discussed in this part of the study by asking the women to rank the important key issues when choosing the place of delivery. The most mentioned issues were the efficiency of emergency care, and well and proper baby care, followed by husband presence out of 13 other important key issues to consider when choosing the place of delivery. The importance of husband presence during delivery was discussed previously in several studies. For example, one study who assessed the perception of both couple (husband and wife) in Iran in relation to husband presence during childbirth and labour has revealed highly positive attitudes from both couples (Nejad, 2005). It was also found that husband presence during delivery could help the women emotionally and support her during the processes of delivery as well as relieving the anxiety, sense of loneliness, and fear, as indicated by other studies conducted in UK, Finland, and Germany (Somers-Smith, 1999; Vehvilainen-Julkunen & Liukkonen, 1998; Noack & Atai, 1976). Husband presence during delivery can also help in establishing earlier relationship between a father and his infant and bring the husband faster to the fatherhood feelings (Vehvilainen-Julkunen & Liukkonen, 1998; Nejad, 2005). It can also increase the relationship between the husband and the wife and increase husband's feelings of parental responsibility (Nejad, 2005; Vehvilainen-Julkunen & Liukkonen, 1998). In Palestine women are not allowed to have any companion during their delivery in governmental hospitals because several women will be delivering in the same labor room and each has her different stages of delivery. As explained by the governmental hospitals health staffs, the presence of any companion including female companion might make more disturbing to the health staff and more crowdedness in the delivery room (MOH, 2005; Bitar & Wick, 2007). This might encouraged the women to put this point as the third important point to consider when they choose the place of delivery, since it's a missing need when women are forced to deliver in governmental hospitals either because of high costs of private hospitals or because of limited access (Giacaman, 2006).

Interestingly, women ranked the quality of health care as their first priority when choosing the place of delivery (because of more information, welcoming staff and proper equipment etc.), while they put access and cost at the end of the rank. An explanation could be that most interviewed women were living in the cities and not far from the delivery settings; therefore, access was not a problematic theme for them. Although cost is considered as an important factor, but women thought more of the quality, which give an indication that they have a good understanding of what might be good for them, as regardless of the availability of resources they still have an opinion of what they think is good and important for them. This result is

consistent with the previous study of reproductive health rights conducted by the Women's Center for Legal Aid and Counseling (2000).

8.3.3. Postnatal care

The study shows consistent with two other Palestinian studies (Maram project, 2004; Palestinian Central Bureau of Statistics; 2006) only about one-third of studied women had obtained postnatal care during the 40 days following delivery. This rate is similar to the rates found in Jordan (35%) and Egypt (41.5%) (Department of Statistics [Jordan] and ORC Macro, 2002; El-Zanaty & Way, 2005).

The results suggest that there is a notable difference between women's attitudes toward the importance of postnatal care and the actual utilization of postnatal care. This was consistently observed in all three cities (see figure 6.8). One explanation for this discrepancy could be social desirability bias: Women may have over reported their attitudes in the importance of obtaining postnatal care so as to be viewed favorably by the interviewer, especially since they were interviewed in a health care setting. Another explanation may be that some women who believe in the importance of postnatal care cannot obtain it due to barriers, such as a lack of available services or cultural norms, including the traditional custom of not going out during the first 40 days after delivery. However, our findings suggest that this traditional custom is not a major reason for non-use of postnatal care among women in the West Bank. Most women who had not obtained postnatal care stated that they did not need it because they were not sick. This seems to be a common, not only in Palestine but also among women in Jordan, Lebanon, Egypt, and other countries (Goodburn et al, 1995; Department of Statistics [Jordan] and ORC Macro, 2002; El-Zanaty & Way, 2005; Dhakal et al, 2007; Kabakian-Khasholian et al, 2000; Sword et al, 2006). The fact that postnatal care was perceived to be unnecessary by women who did not feel sick demonstrates these women do not recognize the importance of postnatal care for preventive health care. Some of the negative health outcomes which can occur during the puerperium may not be noticed early or initial signs might be ignored by women. Therefore, the American College of Obstetricians and Gynecologists recommends postnatal care for all women, including those who do not perceive any problems, for the purpose of general assessment of both physical and mental well-being, to rule out postpartum depression, and to provide counseling for breastfeeding and family planning (American Academy of Pediatrics, American College of Obstetricians and Gynecologists, 1997). While a recent systematic review of randomized controlled trials showed that universal postpartum

support to unselected women at low risk did not result in statistically significant improvements for any outcome examined, including maternal mortality, the studies included in this review were limited to developed countries (Shaw et al, 2006). Early recognition and treatment might be not as important in countries where high standards of emergency care are easily available, but may be crucial under less optimal conditions.

In regard to the risk factors of not attending postnatal care it was found similar to other studies (Bryant et al, 2006; El-Mouelhy et al, 1994; Goodburn et al, 1995; Lu & Prentice, 2002; Nabukera et al, 2006; Turan & Say, 2003), our bivariate analysis revealed that women, who did not use postnatal care, married at a younger age, had lower economic status, and had an unassisted vaginal delivery without problems. Our multivariable analysis shows that after controlling for demographic characteristics, deliveries in public hospitals and without any complications were associated with non-use of postnatal care. In addition, I found regional differences: Women in Ramallah were significantly more likely not to receive postnatal care than women in Jenin.

The relatively high use of postnatal care among women who had experienced problems during their delivery (60%), or had a cesarean section or instrumental vaginal delivery (75%), is reassuring because it suggests that both women and provider recognize that these factors increase the woman's risk for postnatal complications and that postnatal care is especially important for these high-risk groups (Borders, 2006). Efforts should be directed to further increase the use of postnatal care among low-risk women.

The higher utilization of postnatal care by women who had delivered in a private hospital may be due to the fact that private hospitals have more resources and therefore may be more likely to provide individualized care to their patients. Our finding that women who deliver in a private hospital are significantly more likely to receive information about danger signs for their own health and the health of their baby than women who deliver in a public hospital supports this assumption. Only ten of 37 West Bank maternity hospitals are public hospitals, but they deliver almost half of all babies. In contrast, a total of 15 private hospitals deliver only 13% of all babies, with both hospitals types using similar levels of staffing (Wick et al, 2005). This may explain the high level of dissatisfaction women report with the care they receive in public hospitals, while private facilities do not garner as much criticism (Giacaman

et al, 2006). However, many women have no choice than to deliver in a public hospital because of low income status or lack of health insurance.

Even after controlling for the important variables “delivery with or without problems” and “private versus public hospital,” I found that postnatal care was significantly more often lacking in Ramallah than in Jenin, which had the highest utilization of postnatal care of the three clinics. This is puzzling, because overall, Central West Bank; where Ramallah is located, has the highest availability of hospital services (38,668 population per hospital) while Northern West Bank ,where Jenin is located, has the lowest availability of hospital services (61,548 population per hospital) (Giacaman et al, 2006). This suggests that there might be other determinants of postnatal care usage that are regionally different.

8.4. Domestic violence and women's attitude towards wife beating

Almost two thirds of the Palestinian women in our study believed that wife beating was justified in at least some circumstances, although the proportion of women who justifies wife beating varied for different scenarios and highest among worse situations (see figure 6.11): The highest levels of acceptance were found in situations when the wife was "insulting her husband, "disobeying her husband", "neglecting her children", and "going out without telling her husband". In addition, only 11% of women thought that wife beating was acceptable when the wife "argues with her husband" and 5% when the wife "burns the food". Factors that were associated with women's justification of violence were lower level of education, not being employed, shorter duration of marriage and having more than one child. Additionally, women who were decision makers in three or more areas of daily family life were less likely to find IPV justifiable.

The results confirm those of Haj-Yahia (1998a) and the national survey (2006) which also found a high level of justification of wife beating among Palestinian women, particularly among those holding patriarchal beliefs and having low levels of education. Our study adds other socio-demographic correlates of justifying wife beating, including employment, number of children, and duration of marriage. Rothman and colleagues (2007) suggested that employment tends to increase women's financial means, increase their self-esteem, promote their physical safety, improve their social connectedness, provide their mental respite, and provide them with motivation or a "purpose in life." These factors may empower employed women to reject wife beating.

The fact that a shorter duration of marriage is associated with women's higher acceptance of wife beating (also reported in a study in Zimbabwe by Hindin, 2003) may be due to the expectation that Arab women have to maintain the unity of their nuclear family, especially in their first few years of marriage. This is important for their own reputation and for the reputation of their family of origin especially their mothers and their sisters, since they will be the first to be blamed in case of divorce or any marital problems (Haj-Yahia, 2000). The fact that women who have more children are more likely to accept wife beating than those with fewer children may also be due to the obligation of Arab women to make a considerable effort to maintain her family unity and continuity, for her own reputation and that of her children (Haj- Yahia, 2002).

The relationship between women's involvement in decision making and their justification of IPV has been studied in Zimbabwe (Hindin, 2003), but not in Arab Palestinian women. The study adds to the limited body of literature on Palestinian women's attitudes towards wife beating by suggesting significant regional difference between women from Hebron in the South and those from the other two regions. Women from Hebron appeared to be most disadvantaged with respect to their own education and that of their husbands. Most were homemakers with no outside employment. Yet, they were the least likely to justify IPV. The data suggest that these women, more than those in the other regions, are key decision makers with respect to children's health care, large household purchases and visiting of friends and relatives. Several respondents from Hebron mentioned that they tend to get very good social support from their extended family when they encounter problems with their husbands. In addition, women from Hebron tend to feel proud of their extended family, wealth, and support (R. Sandoka, personal communication, June 2006). The Palestinian national survey (2006) found that most women seek their help when they face violence from their husbands by talking to their husbands or by asking for their family's support.

The national Palestinian survey (2006) showed that the percentages of women who reported physical violence was 19.8%, 21.5%, and 31.4% for each of north, central and south of West Bank, respectively. However, our study results showed that the percentages of women who justify wife beating in at least one situation was 73.3%, 65.3% and 55.3% for each of Jenin in the north, Ramallah in the center and Hebron in the south of West Bank, respectively. This shows lack of agreement between women's s towards the justification of wife beating (the present study) and the actual reporting of incidents of wife beating (the national survey (2006).

An explanation for this disagreement could be that the situations that the women have been asked about in our study are related to the Patriarchal traditional beliefs that the Palestinian community lives through (Haj- Yahia, 1998a). Such situations were found to be sensitive, and not acceptable by Arab men and sometimes justify wife beating, particularly the cases of insulting the husband, getting out without informing him, or disobeying him (Haj- Yahia, 1991). I think that when women acknowledge that these reasons might justify beating by the Arab traditional men, this might promote women's avoidance for such behaviors and then leads to less incidence of physical violence (as the case in the north of West Bank). On the other hand, when women consider these situations not enough to justify beating, while they

are still considered sensitive by their husbands, this might increase the incidence of physical violence (as the case in the south of West Bank).

The patriarchal society as recognized by Haj- Yahia (2002) put certain expectations from the Arab woman that include understanding her husband, respecting, obeying, and change her behavior towards him and his family. These pressures ascertain that women need to understand the reasons that provoke their husbands and that might lead to physical violence. This is confirmed by the fact that some of the respondents in our study have mentioned that they will not do any actions or behaviors what might makes their husbands angry and provoke a situation that might lead to battering.

It is suggested therefore that future studies shall examine more in-depth the attitudes of both partners towards physical violence among the three regions in West Bank, this might be more helpful to predict or change the prevalence of wife beating, through planning and implementing of more suitable empowering programs. In any case, changing the attitudes of Arab women alone without involving the men in matters of justifying wife beating might not necessarily help women or change the incidents of physical violence. In fact, Haj-Yahia found (1996, 2000b) that empowering women may cause continuation of violence against them. Noteworthy, the main idea of this not in any case to blame wife's for the violent behavior rather than understating the factors surrounding the over all situation. We also recommend studying how the traditional and family oriented values in the three cities influence women's acceptance of IPV. A better understanding of these factors may aid in strengthening women's status in the Palestinian society, which may contribute to changing norms and behaviors regarding wife beating.

Many studies have investigated sexual abuse either as a cause or as a result of IPV (Martin et al, 1999; Rickert et al, 2002; Jewkes, 2002; Pallitto & O'Campo, 2004; Houry et al, 2006; Gage & Hutchinson, 2006). The relationship between women's beliefs of the right of women to refuse sex with their intimate partners, which may indicate how empowered they are in their relationship, and their acceptance of wife beating was examined. Almost 70% of women in our sample believed that women have the right to refuse sex with their husbands in each of the situations that were described, which is higher than the proportion found in other studies (Jewkes et al, 2002). However, this belief was not associated with acceptance of IPV. The fact that there was extremely strong agreement and almost no variation for most of the situations that were assessed suggests that there may be strong cultural rules and understandings for not

having sex during menstrual period, after childbirth, if the husband has a sexually transmitted disease, and if there is lack of privacy. This question, therefore, may not capture women's empowerment and status in the relationship as we had intended.

Violent behavior against women and women's acceptance of it are not only influenced by individual factors and cultural norms. From a public health perspective, socioeconomic and political circumstances may have a large impact as well. In a violent environment such as Palestine, deteriorating economic prospects and the general frustration of married men resulting from an unfulfilled role as providers and protectors of their families, the a priori probability of violent behavior may rise substantially (Elrashidi, 2005). The political pressure, frustration and violence that the Palestinian society daily lives under the Israeli occupation thought in one study that makes the Palestinian men projects their anger towards their wives and families (Holt, 2003). In certain cases there is a risk that women might understand and justify their husband's violent behavior especially because of "difficult life conditions" (Haj-Yahia, 1998a, 1998b). Similar circumstances can be observed in other countries in the Near and Middle East.

The World Health Organization has forecasted, based on the Global Burden of Disease Study, that the group III related burden of disease (injuries, accidents, violence, homicide, suicide) will increase during the next decades, particularly in low income countries (Mathers & Loncar, 2006). Therefore, distal factors and political dimensions will have to be considered when designing public health interventions to lower the disease burden in women as a result of intimate partner violence.

8.5. Age at first marriage

8.5.1. Age at first marriage among women in the three regions

The initial timing of marriage and the continuity of marriage vary between countries. Age of marriage is very important point in women's life, because it marks a transitional period to adulthood in many societies. In addition, it marks the beginning of the exposure to the risks of pregnancy and childbearing. Therefore, choosing the right age of marriage when the women is ready physically, psychologically and socially is very important for the health of both the women and the coming children. The study shows that the median age of marriage among women in the three sites is 19 years old with a difference among the three studied regions. The median age of marriage in Hebron was 18 years old compared to 20 and 19 in Ramallah and Jenin, respectively, which is consistent with the given age of Palestinian statistic Bureau DHS, 2004. The regional difference could be explained by that the women from Hebron were the most disadvantaged women with low education, being unemployed and live in traditional and family oriented society that still believe in arranged marriages and marriages within relatives (consanguineous marriages). All these factors can reinforce women's early marriage. These traditional and cultural factors behind early marriage were also found in several other studies (Upchurch & MacKarthy, 1990; Singh and Samara 1996; Ikamari, 2005)

The majority (85.9%) of women who have gotten married at younger age (less than 20 years old) belong to the young age group (≤24 years old), which gives an indication that this phenomena is not declining. In the last 10 years, the political situation and the economical situation of the Palestinian people were massively deteriorated, which led to an increase in the poverty levels. This adds to the inherited patriarchal norms, which could directly worsen women's situation, since women were lacking the power to change and there is no law enforcement during the current Palestinian situation (Elrashidi, 2005). Poverty, patriarchal norms and political situation were also found to be among the reasons that encourage early marriage in previous studies (IPPF, 2006; Schuler, 2006)

The study revealed that lower education, unemployment, being from a lower social class, having high number of children (>4 children), and mainly from the south of West Bank (Hebron) were all the characteristics of women who have gotten married at early age. This was consistent with several other studies in different settings that marked the problems for women when they got married at earlier age (UNFPA, 2003; Rashad et al, 2005; Schuler et al, 2006; Aryal, 2007). This is associated with the fact that marrying at younger age will force

the girls to leave school at earlier age that will minimize their employment opportunities and will give longer fertility life years, which will lead to have more children as explained in the above listed studies. In relation to the reproductive health hazards that is often associated with early marriage, the study shows that among the three sites there were no associated relationship neither between age of marriage and the number of antenatal check ups nor with the contraceptive use.

8.5.2. Women's attitudes towards the best age of their daughter's marriage

In relation to women's attitudes towards the best marriage age for their daughters, the study revealed that about two third of women thought that the best age of marriage for their daughters is less than 20 years old. On the other hand, around 80% of women thought that they should have a say in which their daughter's should marry. Younger age, low education, being from the middle class, being married at younger age, women coming from Hebron, and women justifies wife beating under certain circumstances were all associated factors with women's attitudes towards their daughter early marriage age.

Women from the younger age group and attitude of women from the young age group (≤24 years old) toward their daughters best age of marriage reflects the attitude of this generation towards early marriage. This might be an alarming indicator, which reflects that early marriage might not be going to decline in the future, in contrary it might increase. This might reflect their belief of best age of marriage in general and not only for their daughters. This age group represents women who are less educated, housewives, not employed and in some how living under traditional circumstances, which were all the factors associated with early marriage (UNFPA, 2003; Rashid et al, 2005; Schuler et al, 2006; Aryal, 200).

Education was a strong factor associated with women's attitudes towards the best age of daughter's marriage. The results show that lower education was associated with women's thought of marriage at young age for their daughters in the future (Table 6.33). A recent study in Bangladesh has found that female education in one generation could influence the marriage age of the female from the next generation (Bates et al, 2007). Education was found to empower women and increases their autonomy. Jejeebhoy has linked women's education to women's five aspects of autonomy as he explained that in terms of autonomy of knowledge, educated women would have boarder access to information: (1) Decision making autonomy, educated women would have more strength in their say in decisions that affect their own

lives; (2) Physical autonomy, educated women could have better and free physical movement with the outside world; (3) Emotional autonomy, educated women could shift their loyalties from extended kin to the conjugal family. In addition to the economic and social autonomy and self-reliance, in that education could increase women's self dependence economically and enhances their social roles and status (Jejeebhoy, 1995). This might explain women's attitudes toward the best age of marriage of their daughters, as women who are not educated might not be able to recognize the risks and the complications of early marriage unless she or other related females went through some of these risks. In addition, they might not be able to have right decisions for their own life neither for their future children, and they would be more attached to the traditional dependency on their partners in all aspects (economically, socially, and emotionally). Education of the mother found to be an important factor in predicting the age of marriage for the daughters as what was found in recent studies in Bangladesh and in Nepal (Choe et al, 2005; Bates et al, 2007).

Mothers who got married at earlier age are most probably would support the idea that their daughters should marry at young age as well. A recent study in Urban Turkey has shown that adolescent marriage was more common among families with a mother who got married at young age (Gökçe et al, 2007). It is probably due to the normality in the behavior, as it will be difficult for those who got married at young age to see the risks of early marriage since they went through it.

8.5.3. Marriage tradition

Palestine is still a traditional setting, where marriage is considered a family contract and not only a relationship between two adults. The family in Palestine still has the power in choosing the right husband for their daughters and the right wife for their sons as in many other Arab countries (Rashad, 2005). However, there are differences between regions, for example, in a region such as Hebron where the whole society still are living in a family connected ties and sticking to the extended family norms, most of the older generations in the extended family need to decide on the girl's marriage, as they consider this marriage as a social event, sometimes prestigious, and economic marriage rather than an issue that concern that girl only. The study shows that this believe still prominent among women who have been interviewed as most of them believed that they should have a say in whom their daughters will marry and that was more common among women who came from the most traditional and family oriented society as Hebron. Although in patriarchal society as in Palestine, men have the final

say in choosing the right husband for their daughters, women have the most influencing factor that is played informally in arranging marriages and women are considered the key important network in the whole society and they are the ones who can connect between families etc. Therefore, assessing the opinion of women in the process of their daughter's marriage considered very important indicator in predicting the future marriage process in Palestine in general. Traditional and family oriented marriages are also found in many traditional societies in Asia such as Bangladesh (Kadir et al, 2003).

Early marriage may create a very suitable environment for domestic violence, in that women who got married at early age would be most probably economically, socially and emotional dependent on their husbands, and would feel powerless to leave the violent environment. It also has been known that those women are more tolerant to violence and less likely to leave their husbands (IPPF, 2006). It is not surprising to find in the present study that women who justifies wife beating under certain circumstances would support more early age for their daughter. As those women would most probably stick to the traditional beliefs of patriarchal society which in its terms support early marriage for girls.

8.6. Study major strength and limitations

It's important here to mention the study major strengths and limitations. One of the major strength in the study was the high response rate as it was much more than I had expected and came out of women's active participation and interest. The active participation and support of two local NGO (Juzoor Foundation For Health And Social Development and Women's Center for Legal Aid and Counseling (WCLAC)) during the process of data collection and the over all study preparations shows a big strength in this study, which could ensure sustainability in the study in the terms of active interpretations of the study results and using the study in the future for developing health projects and integrating this study with the other three previous studies conducted earlier by the WCLAC organization. The involvement of each of the UNRWA, ministry of health in the process of the study gives the study great importance at the national level, which gives a prediction that the results might be of great interest to all of the important key health parties in Palestine.

The study also shows several limitations. The first limitation was the restriction in movement in West Bank and between West Bank and Gaza strip which does not allow me to expand the study to select villages and camps around the selected cities in West Bank looking to the difficulty to reach due to the Israeli checkpoints and difficult transportation. While it make it impossible to include Gaza in the study since this would need a daily entrance permit given by the Israeli military which makes it impossible to organize or to develop the same study there. Other limitations were the available limited funding for data collection and shortage of study time that make our selection for the study target limited to women only, while it was planed earlier to target each of women, men, policy makers and health care providers. In addition, the study was planned to use both quantitative and qualitative methods using questionnaire, focus group discussion, and personal interviews but looking to lack of enough financial support for the data collection and for shortage of the study time, I had to use only a questionnaire and to include few open-ended questions.

8.7. Strength and limitations with respect to the five study themes

8.7.1. Reproductive health rights

This study has a major strength as it assesses women's knowledge and attitudes towards their reproductive health rights while receiving the health care and it is the first study to take this new perspective into consideration

However, this particular theme of the study had faced several limitations including the inability to assess other target groups such as men, health care providers, policy makers and adolescents due to shortage of financial support for the data collection and due to the limited time of the study. Data collection of this study was also limited to those women who attended the health care centers which might restricts our results to those who already have good understating of health rights and follow up on their health; excluding those women who do not follow up or visit the health care centers. However, I assume that most women should attend the health care center for baby immunization (since this was provided only by the ministry of health clinics and UNRWA mother and child health clinics), provided the high vaccination coverage in Palestine of $\geq$ 95% (MOH, 2005; WHO country profile, 2005).

8.7.2. Family planning

The study measures vary important variables in family planning and took the perception of 450 women in a three different locations in West Bank .

The major study limitation in this part was the study location. In that women's satisfaction from the family planning service received was not able to be assessed since it was measured in the clinics where this service provided. Men involvement in this study was another noticeable limitation as I think that involving men, particularly in assessing decisions on family planning, might give a clearer idea on autonomy in using contraceptives among Palestinian women.

6.7.3. Reproductive health care

- **Antenatal care**

The study of this theme shows strength in that, the characteristic of the interviewed women in this study was very much similar to what was reported by the Palestinian Central Bureau of Statistics for each of the three cities (Palestinian Central Bureau of Statistics regional

population reports for Hebron, Jenin and Ramallah, 2000) which suggests that our results are representative to the women who live in the cities of Jenin, Ramallah, and Hebron.

The ministry of health clinics was chosen for this study because many women come from both city and the surrounding villages as referral cases. However, most of the interviewed women in this study were from cities and this might limit the opinion of the study to those who live in the cities and might not be representative to women lives outside the cities (villages or camps). The access to health care services is a well recognizable problem in Palestine (Bosmans et al, 2008) was not found to be a clear problem as a results of this study and this might be behind receiving low number of women from the surrounded villages or camps. Another unavoidable limitation is that selecting women who attend antenatal care in the ministry of health clinics only, might exclude all other women who use other health care sectors (private doctor clinics, NGOs MCH centers, UNRWA clinics, and others) in West Bank. The Palestinian DHS (Palestinian Central Bureau of Statistics, 2004) reported that only 23.5% of women in West Bank receive their antenatal care in the governmental Mother and Child Health care clinics, where half of women are using private doctor clinics (50%).

- **Delivery care**

The study shows a strength in which it was easy to assess women's satisfaction from the received health care during their last delivery since the interview took place in the clinics and not in the hospital which could have made a confounding factor.

However, this part of the study had faced some limitations. The first limitation might be the lack of involvement of men, as measuring men's attitude towards choosing the best place of delivery might help us in building good opinion on what is considered for both couples and might help in building future programs. In addition, taking men's attitude regarding their participation in delivery and childbirth might be an important issue.

Although I intended to interview more women from outside the cities most women were living in the cities, therefore access to health institutions could not be discussed here profoundly.

- **Postnatal care**

Strengths of this study are the systematic sampling in three different geographic regions of West Bank.

Limitations of this study part are due to self-reported outcomes and sampling restrictions. Women may have over-reported their use of postnatal care in order to please the interviewer, especially since they were interviewed in a health care setting. However, the rate of postnatal care in our study is similar to the rates reported by two other Palestinian studies (Maram project, 2004; Palestinian Central Bureau of Statistics, 2006). There may be a possible sampling restriction in this study, as all participants were recruited through Maternal and Child Care Clinics. Seemingly, women, who do not obtain a postnatal care, would be less likely to visit these clinics and be included in this study. However, given the very high vaccination coverage in Palestine of $\geq$ 95% (Maram project, 2003; WHO-Palestine Country profile, 2007) and the fact that these clinics are the only places that offer infant vaccinations (apart from the UNRWA clinics that serve only refugee camps), most women do visit these clinics, at least to vaccinate their infants. Because most women visit these clinics and due to our sampling in three different cities, I believe that our findings reflect the experience of postpartum women in the West Bank.

8.7.4. Domestic violence and women's attitude's towards wife beating

Strengths of this part of the study are similar to those mentioned for the overall study as response rate, systemic sampling and representativeness.

Although I chose study sites that served women from the city as well as the surrounding villages and camps, most participants resided in the city. Therefore, attitudes of women residing in villages and camps may not be well represented in this study. Questions about women's acceptance of wife beating were asked towards the end of the survey after rapport had been established and most surveys were conducted in a private setting without any relatives or friends present in order to maintain confidentiality. Nevertheless, wife abuse is a very sensitive issue in traditional and transitional societies such as our study population, and self-reported acceptance of wife beating may suffer from social desirability bias.

8.7.5. Age at first marriage

The study shows strength in sampling women with diverse social status, education, and regions in West Bank, which enabled me to assess high number of women's opinion in this regard.

One of the major limitations in this part of the study is lacking the husband's opinion on their daughter's best age of marriage, which might give us an indication about the future of early marriage in Palestine. Also lacking information on the husband's age at first marriage and the age difference between the husband and the wife at the time of marriage which could help us clarifies more factors that might be related to early marriage problem. Another limitation is related to the cross sectional design and the opinion assessment in this study, which make it difficult to find strong factor associations or causal relationships, accordingly, this study would only help us to have an indication of the future of early marriage in Palestine.

CHAPTER NINE

RECOMMENDATIONS AND IMPLICATIONS OF THE STUDY

9.1. Introduction

Women's perception towards reproductive health human rights is the first key issue in improving women's reproductive health. Without considering reproductive health human rights, women's health will neither be promoted nor improved, since women recognize these rights as very important concern for them. This study along with the related previous studies in Palestine could make a good step forward to improve the status of women in Palestine and could help the policy makers to get out of a new reproductive health strategy based on the general recommendations of this study which are as follows:

- To improve the health service that could match women's health rights.
- To negotiate the results of the study with policy makers so as to improve the reproductive health of the Palestinian women.
- To empower women in order to be more familiar with their rights.
- To reach all the community levels to make a social change at the community level regarding women's health rights
- To continue the assessment process through research in order to ensure continuous improvement in the health care provided which should take into consideration reproductive health human rights

9.2. Improve the health service that could match women's health rights

The health care system and the distribution of maternity hospitals in the overall West Bank might limit women's access to the health care in case of emergency situation, as access might be a real problem in case of political instability which is the current situation in Palestine. Although this was not a direct result from this study but it was remarked and found to be related to women's attendance of postnatal care and choosing the place of delivery. Therefore, it is recommended that new delivery centers should be created in the major rural areas. There was a new approach of opining maternity homes in which it acts as a delivery centers that should be connected with an ambulance service and a back up hospital which should be

available in case of any emergency cases or complications. In spite of the fact that only 3 centers in West Bank and one in Gaza were created, those centers proved their quality of services as women showed high satisfaction from the care provided and the level of security they felt from the presence of the maternity homes nearby (Palestinian Central Bureau of Statistics, Demographic and Health Survey-DHS, 2004). I recommended that such substitution services should be available for women in the major rural areas.

From the results of this study, it was clear that women were dissatisfied from the health care services provided at the government hospitals and they did complain from the service level and from the health care provider's behaviors and attitudes. Therefore it is recommended that the governmental services be able to do the following:

- Continuous assessment of women's satisfaction from the health care services provided.
- Reproductive health rights should be integrated in all aspects of reproductive health care through educating the providers and encouraging women to complain in case of any violation of these health care rights.
- Although the health care provider's working in the governmental institutions complain of dissatisfaction from the work environment and from the inappropriate salary comparing to their high work load, this should not in any case, affect women's rights while receiving the health care services. The government needs to support the health care providers and improve their situation.
- Women's counseling and health education provided to them at all levels of care (primary and secondary) should be encouraged and the health care providers should allocate special time for that.
- Continuous training for the health providers regarding women's reproductive health rights and it's applications in health care.
- Setting quality control measures.

9.3. Negotiation with policy makers

Reproductive health human rights should be integrated in the national health policy as well as in the overall national rules and regulations. Such rights should ensure that the health care services are available, accessible and affordable for each woman, which could be done covering women with a decent health insurance that ensure receiving a proper health care with a satisfying quality. Women need for information and education should be clearly marked in the health policy and in the national rules and regulations. Women's minimum age

of marriage should be discussed at both the religious level and at the government level to set appropriate rules that match and be acceptable by both levels. The issue of violence against women should be supported by setting rules and regulations that support women and punish the violent husband. Health policy makers at the governmental hospitals should revisit the policy of allowing husband's attendance during the childbirth and to include psychological counseling into reproductive health care clinics as a need for women and as a part of their perceived health meanings. Those policy makers could be reached through the following:

- Organization of a dissemination workshops directed to all the governmental health policy makers as well as the governmental policy stakeholders and religious groups.
- Organization of individual meetings with each of the key representatives from the government and the religious leaders (such as the ministry of health, Islamic court Judges. etc).
- Organization of national conferences that include all health, government, Islamic and social leaders and key NGOs. The conference main theme of work would be the reproductive health human rights and its applicability, to come up with national recommendations and key women's health programs taking into consideration the results of the present study as well as those of the previous studies.

9.4. Empowerment of women

From the results of this study, women's empowerment sounds very important key issue in protecting women from violence, receiving health care information, proper care from the health care providers and from calling for their rights. Therefore, it is important to continue working on women's empowerment through:

- Encourage education for women and support that through media programs and providing community education supporting women's education, schools sessions, and motivating adolescents to discuss the importance of education for women.
- Open equal employment opportunities for women and encourage women to work and support them through giving appropriate maternity leaves, breast feeding duration and create kindergartens within the big institutions or close by to facilitate the working conditions for women's having breast feeding children.
- Organize community meetings and public education to change women's acceptance of violence from their husbands and empower them to take an action in case of its occurrence.

- Support women's ability to take decisions in the household and in the community as well by creating an equal decision making process at the work level as well as at family level while raising up female children.
- Encourage women to participate in the political election.

9.5. Implication on public education (change at the community level)

It is worth to mention that the results showed that women have positive understanding for their reproductive health rights and they also showed distinguishing needs between their rights and actual needs. This study was supported by the biggest two NGOs who were working on women's issues and reproductive health (Juzoor and WCLAC). The later organization has conducted previously three studies about reproductive health rights and women's legal rights. Based on the results of the present study along with the other previous studies conducted in Palestine, these organizations are expecting to work further on organizing women's health programs (this was mentioned as one of the strengths for this study as well). Therefore, the tow participating local NGOs and the ministry of health (which had supported and approved the process of the present study) should work on public awareness regarding reproductive health rights by the following activities:

- Organize and conduct three workshops in the three cities of Jenin, Ramallah and Hebron, disseminate the results and open a community discussion of the best future women's programs.
- Print health education materials that are directed to the public so as to increase community awareness on reproductive health rights.
- Organize women's group meetings and open a big discussion of reproductive health rights and women's issues such as early marriage.
- Specific attention should be given to the information about family planning client's rights as it should be posted in each family planning clinic to be seen which might help to empower women by knowing their rights.
- Health education materials discussing family planning contraceptives should be available in each family planning clinic and women should receive enough, clear, and interactive information in this regard.

9.6. Implication for future studies

Studies on reproductive health human rights is very limited in Palestine, so this study came to give a clear picture of women's understanding of their rights while receiving the health care services as well as in their general understanding of the meaning of their rights. However, there is still a need for several further researches in each of the topics discussed in this study, such as reproductive health rights, family planning, reproductive health care, domestic violence and early marriage.

- In terms of reproductive health rights, due to logistic limitations this study was limited to only three cities in West Bank and targeted only the women's perception. Therefore it is recommended to conduct studies to:
  - Take women's perception in regions that was not covered by the present study such as women in Gaza, in villages and camps.
  - Take men's opinion in women's reproductive health rights meanings and perception.
  - Take into considerations the adolescent's opinions of their reproductive health rights.
  - Measure the understandings of the health care providers at all levels (technicians, professionals, and specialists) of women's reproductive health rights and their major activities and practices to protect these rights.

- In terms of family planning, based on the results of this study, it is recommended to conduct future research to:
  - Measure adolescent's knowledge and perception towards family planning contraceptives.
  - Measure women's satisfaction from the current family planning services together with their pregnancy intentions.
  - Measure the knowledge and the attitudes of health care providers towards the use of emergency contraceptives.

- Regarding reproductive health care, major future researches should take men's opinion in husband's presences during childbirth. While in terms of postnatal care, future studies should focus on the amount of information given for women regarding the importance of postnatal care follow up visits.

- The study of domestic violence revealed that the following points should be taken into consideration in the future researches:
  - Future studies should involve men's opinion in wife beating and the justifying reasons for beating (if there is any).
  - Cultural and social studies for the three regions should be conducted in the future and in more depth to understand the social dynamics in each of the three regions.
  - Special studies should be conducted to combine the prevalence of wife beating and the attitudes to investigate the effect of one over the other.

- The last topic discussed in this study was early marriage which revealed that men's opinion in their daughter's best age of marriage should be assessed in the future.

CHAPTER TEN

CONCLUSIONS

10.1. Reproductive health rights

Despite the political constrains that the Palestinian women are living through and the cultural values that they are forced to follow, and many other demographical factors that could influence women's perception, Palestinian women have positive attitudes towards the meaning of reproductive health rights. They also have good understanding of what is considered right, and what is considered a need for them. Women valued the psychological health more than physical or the social health.

Since the study measured reproductive health human rights taking women's perception while receiving the health care services, there are specific conclusions for each section of the study as follows:

10.2. Family planning

Pills, IUD and male condom are widely known and used by the Palestinian women; though, not many women were able to know the emergency contraceptives. Older women, longer marriage years, and high parity were all associated factors with women ever and current use of contraceptives. Unmet need for family planning was hard to measure based on this study results. Fertility decisions (contraceptives use, discontinue or having another child) were mostly made jointly with the husbands. Education was found to be a strong influencing factor in both fertility use and decisions. Women tend to consult their husbands and the health care providers most when they decide to use and to choose between contraceptives. Women's status inside the family as employment, number of household decisions made, refuse wife beating, and refuse sex with husbands under certain conditions were highly related to women's autonomy in fertility decisions. Although women had positive understanding towards the important use of family planning, they still not accept the use of contraceptives for nulliparous women. Information and free of choice were among the most important determinates for women to use contraceptives.

10.3. Reproductive health care

Women had positive understanding of the importance of antenatal care. Therefore, women conduct high number of antenatal care visits and start their follow up early. However, women receive not enough information regarding the expected complications during pregnancy and the important measures to take in case of its happening.

The majority of women deliver their last child in a medical institution. Women tend to be more satisfied for the received health care in private hospitals than the governmental hospitals. Crowdedness, shortage of staff and lake of health staff satisfaction might be the reasons behind women's lack of satisfaction from the received care in the governmental hospitals. Women had positive understanding for their rights during delivery as quality of health care was high in their rank. Husband presence during delivery was very important issue to consider by women.

In Palestine, attendance of postnatal care is very limited. Women perceived postnatal care attendance as important mainly when they are sick and having problems. There is a consistency between women's attitudes towards the importance of postnatal care and their attendance, however the higher use of postnatal care among high-risk women is appropriate, but some of the clinically dangerous conditions can also occur in low-risk women. Discrepancy between private and governmental hospitals was also obvious in this study section as women who attended postnatal care were mostly delivered their last child in private settings.

10.4. Women's attitudes towards wife beating

Despite recent political and social developments in the Middle East that have empowered women to some extent, the data suggest that the majority of women in Palestine still accept that wife beating is justified, at least in some situations. Regional differences in women's acceptance of IPV should be studied in more details, as findings may inform future efforts to increase women's rights and safety. Given the long-standing tradition and acceptance of wife beating in this society, strategies to change prevailing norms regarding this public health issue should include public education and advocacy directed to both men and women, continued working on raising the status of women through education and employment, and legislative actions.

10.5. Age at first marriage

Early marriage is considered a real women's reproductive health issue in Palestine as women still marry at age less than 20 (65.8%) and they still consider this age to be the best marriage age for their daughters. This might indicate that women will continue to be marrying at an early age and this phenomenon is not changing soon. Tradition and family play a strong role in the marriage process in Palestine and women's autonomy in choosing their future husbands might be difficult to be achieved soon.

CHAPTER ELEVEN
SUMMARY

Reproductive health rights ensure that people are able to have satisfying and safe sex life and that they have the capacity to reproduce with freedom to decide, when and how often to do so. The right to be informed in order to be able to make decisions and to have good access to high quality, affordable and effective family planning programs. All the methods that had been proved its evidence and effectiveness in regulating fertility should be also available for couples. Reproductive health rights also include the access of women to high quality health care services that help in protecting women during pregnancy and childbearing and providing the couples with the best chances of having healthy infant (Cook, 1993).

One of the basic human and reproductive health rights for the women is the basic right to life. The World Health Organization (WHO) had estimated that every year about 515,000 women world wide die of complications of pregnancy and childbirth (WHO, 2001). Out of which 90% of deaths occur in developing countries. However, most of the deaths and some of the severe complications could be prevented by cost-effective health interventions (WHO, 1999). Policymaking and decision negligence, devaluation, and discrimination against women often result in a preventable loss of life and tragic results (WHO, 1999).

In order to help save women's life, WHO (2005) had recommended four antenatal goal oriented visits during the course of pregnancy. The importance of antenatal visits is to support women in the care of their infant, advice them if necessary, educate them about all the health prevention and promotion aspects necessary during pregnancy, reassure them that pregnancy is a normal process and not a disease and provide them with treatment if appropriate (Petrou et al, 2001). Moreover, they also recommended that women need to be delivered under the assistance of skilled birth attendants and that the postnatal care needs to be provided at 6 hours, 6 days, 6 weeks and 6 months post delivery for each woman.

Violence is also considered one of the major public health problems. Violence against women is "one of the crucial social mechanisms by which women are forced into a subordinate position compared with men" (UN, 1993). Studies that have assessed intimate partner violence (IPV) in Arab societies found that women's rights are influenced by middle-eastern

cultural values and religious interpretations (Douki et al, 2003). Intimate partner violence is widely acceptable among women in developing countries (Department of Statistics [Jordan] & ORC Macro, 2002; Hindin, 2003; Koenig et al, 2003; El-Zanaty & Way, 2005).
Marriage is considered the major context for childbearing in all developing countries. It is still a respected and a valued social institution and it may take different forms in different cultures. However, the right age of marriage may affect women's reproductive health and may sometimes violate women's human and reproductive rights. Early marriage or child marriage is defined as "[a]ny marriage carried out below the age of 18 years, before the girl is physically, physiologically and psychologically ready to shoulder the responsibilities of marriage and childbearing" (IAC, 2003). It has been reported that the leading cause of mortality in 15–19-year-old girls are Pregnancy-related risks, as those aged less than 15 years are five times more likely to die than those aged over 20. In addition, infant deaths are also twice as high in babies of very young mothers (UNICEF, 2001).

In Palestine, reproductive health rights might be an important indicator for women's health. Women live under hard and long term political instability which creates discrimination towards Palestinians in general and women in particular. In addition to the political conditions, women live under social and cultural discriminations based on gender and power. All of these factors would put the Palestinian women at risk of death and poor health. Deaths occur mainly due to avoidable causes, such as the inability to timely reach the health care services because of the political instability and restriction of movement that the Palestinians were forced to go through (Al-Adli et al, 2006).

In Palestine, it was stated that only 50.6% of women age 15-49 are currently using contraceptives and that the majority of women had received at least four antenatal checkups during their most recent pregnancy, though these check-ups did not necessarily involve all the internationally recommended components of antenatal care (Palestinian Central Bureau of Statistics, Demographic and Health Survey-DHS, 2004). Although close to half of deliveries took place in governmental hospitals (Wick et al, 2005), women were more satisfied in delivering their last child in private hospitals than in governmental hospitals (Giacaman et al, 2006), Women's attendance of postpartum care in West Bank was 23.4% in 2003, 34.4% in 2004, and 27.4% in 2005 (Maram, 2003; Palestinian Central Bureau of Statistics -DHS, 2004, PalMOH, 2004). Recent studies have found that 45 to 50% of Palestinian women believed that wife beating is justified under some conditions (Haj-Yahia, 1998; Palestinian Central

Bureau of Statistics, 2006). The mean age of marriage for women in Palestine is 19 years and 18.6 % of women gave their first child at age under 18 years (Palestinian ministry of health annual report, 2004). Another study in Palestine has stated that 30% of women have got married at age less than 17 years old (Elrashidi, 2005).

There are few previous studies conducted in Palestine that have assessed women's reproductive health and human rights (Women's Center for Legal and Social Counseling, 2000, 2004, 2005). However, none of these studies have assessed women's understanding of their reproductive health rights while receiving reproductive health care, discussed factors associated with early marriage, or factors associated with women's beliefs towards their intimate partner violence. Therefore, the present study would be the first to discuss these public health concerns.

The main purpose of this study was to assess knowledge, perception, attitude, and practices of reproductive health rights (RHR) among the Palestinian women of reproductive age (15-49). While the specific study objectives were to:

1. Find out the amount of information that women in reproductive age know about their reproductive heath rights and reproductive health care including (antenatal, delivery, postnatal and family planning).
2. Assess women's perceived importance for each of the specific reproductive health right.
3. Assess women's perceived importance for each of reproductive health care provided and it's determinants for using service.
4. Check whether there is a relationship between unmet family planning needs and reproductive heath rights in Palestine.
5. Examine the relationship between social, demographical and political factors with the understanding of reproductive health rights in the selected research topics.
6. Assess women's level of utilization of reproductive health services during and after delivery
7. Assess women's attitudes towards wife beating and the factors associated with their attitudes.
8. Explore the factors associated with early marriage among women in the three selected study sites.

9. Assess women's attitudes towards the best age of marriage and its related effects on reproductive health.

To achieve these goals, I have conducted a cross-sectional survey at three clinics that provide Mother and Child Health Care in the West Bank. The clinics were located in the three largest cities in the West Bank: Jenin in the north, Ramallah in the center, and Hebron in the south. They were selected from a list of clinics that was provided by the Ministry of Health (MOH) based on identified selection criteria. A total of 84 clinics in the West Bank met those criteria (Primary Health Care- MOH facilities and services-2004). Seven clinics were selected: one clinic was in Jenin, two were in Ramallah, and four were in Hebron. In Ramallah and Hebron, I choose the clinics that visited by the highest number of patients.

A questionnaire was developed on the basis of a literature review and adopted questions from previous studies including the Demographic and Health Surveys (DHS) and the national survey of Sultanate of Oman, some of which had been conducted in Arabic language (Al-Riyami et al, 2000; Department of Statistics [Jordan] & ORC Macro, 2002; El-Zanaty & Way, 2005) It assessed issues related to reproductive health: postnatal care, attitudes towards domestic violence, use of family planning methods and the understanding of reproductive rights. The questionnaire was first composed in English and then translated by two independent translators into Arabic. Cases of disagreement were discussed among both translators together with the researcher. It was pilot tested to assess acceptability and comprehension (Oppenheim,1991) among 30 women in the Ramallah clinic. Data from the pilot tests are not included in the analyses conducted for here in this thesis. Based on results from the pilot test, the questionnaire was slightly revised and shortened from 35 to 25-30 minutes by deleting some questions and rephrasing others. A total of 450 women, 150 women in each clinic were interviewed. Response rate was 99%.

SPSS 12 statistical software was used to enter and analyze the data. Cross tabulation and Pearson chi-square test were used for descriptive and bivariate analyses. Multivariable regression model was also developed to check for associated factors for certain dependent variables.

The results of this study revealed that in general, women had positive understanding for their reproductive health rights. The most important right that the women have perceived was the right to receive full information concerning their health (mean rank=1.54), and the least important was the right to limit the number of children (mean rank= 2.00 out of 5.00).

Women mentioned the right to have good access to health care during and after the course of pregnancy as their first important right.

The majority of women recognize the modern contraceptives, such as pills (99.1%) and IUDs (98.2%). Emergency contraceptives were among the least recognizable contraceptives. 77% of women have ever used contraceptives in their lives and only 38.8% of married women are currently using any contraceptive method. Women ranked the use of family planning importance as: (1) The children's health and good raising up, (2) The mother's health, (3) Birth spacing, (4) Economic reasons, (5) limiting the number of the family, (6) Delaying the first child. Information about family planning contraceptives was the forth important mentioned determinants factor for using contraceptives. Most women mentioned that they made the fertility decision together with their husbands.

Women start antenatal care at a relatively early stage of their pregnancy (before 4-month pregnancy), 78.2 % of women make six or more antenatal care visits during their entire pregnancy. Almost all women delivered their last child in medical institutions and under medical supervision. Women were most likely more satisfied from the private health facilities than from the governmental facilities. Health education after delivery regarding the women's health and their baby's health was most likely not well provided neither in the private nor in the governmental facilities of delivery. However, more information was provided in the private settings. Among the important determinants in choosing the place of delivery husband presence during delivery was the third important determinants

Although the majority of women considered postnatal care necessary (66.1%), only 36.6% of women obtained postnatal care. The most frequent reason for not obtaining postnatal care was that women did not feel sick and therefore did not need postnatal care (85%), followed by not having been told by their doctor to come back for postnatal care (15.5%). Based on a multivariable analysis, use of postnatal care was higher among women who had experienced problems during their delivery, had a cesarean section, or had an instrumental vaginal delivery than among women who had a spontaneous vaginal delivery. Use of postnatal care was also higher among women who delivered in a private hospital as compared to those who delivered in a public hospital.

Overall, women perceived wife beating to be justified if a wife insults her husband (59%), if she disobeys her husband (49%), if she neglects her children (37%), if she goes out without telling her husband (25%), if she argues with her husband (11%), and if she burns the food (5%). Sixty-five percent of women agreed with at least one reason for wife beating, but there were statistically significant regional differences. Wife beating was most accepted in Jenin (73% acceptance of at least one reason) and least accepted in Hebron (55%). Lower level of education, not being employed, having more than one child, being married for less than 10 years, and making few household decisions were all associated with women's acceptance of wife beating.

The mean age of first marriage among the 450 women is 20 years old while the median is 19 years old with a difference between regions. Women from Hebron are the most to get marry at the age of 16 and at the age between 17 and 20 compared to the other two regions. On the other hand, women from Ramallah are the most to be married at the age of 21 and more followed by Jenin. About half of the women thought that the best marriage age for their daughters is between 16 and 20 years old. Less education, unemployment, having high number of children, and being younger than 24 years old were all the characteristics of women who got married between the age of 16 and 20 years old. Moreover, lower education, younger age at first marriage, lower economical status, and justification for wife beating in at least one situation were all significantly associated factors with women's belief of younger marriage age for their daughters.

This research presents a clear picture of women's perception towards their reproductive health right while receiving the health care, intimate partner violence and early marriage, which will add to the Palestinian literature regarding women's health and reproductive health care and rights. It is recommended based on the results of this study to consider these results when planning for any women's health programs and projects. There is a need to improve health care services based on women's needs and priorities, setting a new policies and regulations that protect women against violence, organize public education programs to change women's perception towards intimate partner violence and age of marriage. Empowering women through education and open employment opportunity might help women in making decisions regarding their fertility and taking an active role when they receive any reproductive health rights violation.

Finally it is recommended to expand this research to Gaza strip and to include men, adolescent, health care providers, health policy makers and key law and religious leaders.

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APPENDICES

APPENDIX I. English version of the questionnaire

APPENDIX II. Questionnaire proposed analysis plan

APPENDIX III. Study cards

APPENDIX IV. Study brochure

APPENDIX V. Refusal for participation form

APPENDIX VI. Clinic assessment form

APPENDIXES VII. Conferences participation and articles

APPENDIX I

Universität Bielefeld

School of Public Health
Department of Public Health Medicine

Questionnaire serial number	
Clinic name and place	
Date	
Starting Time:	Finishing Time:

Questionnaire
Reproductive Health Human Rights in Palestine

Women's knowledge, Attitudes and Practices Towards Their Reproductive Health Rights in Palestine

Consent Form

My name is Enas Dhaher and I am here conducting this study as part of my doctoral study, which is aimed to see what do mothers think and feel about their health, family planning and their rights to have all of those. This study will serve also all who care about health in Palestine to improve the services and to help the mothers to have better health care. For that, I will be asking you some questions regarding your reproductive health and family planning and I will be highly appreciative to hear your personal opinion regarding these issues that concern your health. I highly appreciate your cooperation and your acceptance to enter this study, looking to the fact that the given information will be dealt with high privacy and full security and no one will have the access to your personal data. The results of this study can be published and those who are interested in health care can use the results for improving the health care in Palestine.

Would you like now to participate in this study?

Can I start asking you the questions?

Signature for the interviewer…….
Signature for the participant…….. 1

The participant refused to share in the study……. . 2…….. End of the interview

A. Reproductive health and reproductive health rights

A.1	What is the main reason for you visiting this clinic today? **IF WOMEN CAME FOR THE FIRST WEEK BABY AND MOTHER CHECKUP AFTER DELIVERY WRITE POSTNATAL CARE**	1. Follow up the pregnancy (antenatal care) 2. Being High risk pregnant and this is one of the follow up check-ups 3. Taking my self immunization during pregnancy (Tetanus) 4. Checking up my self after my delivery (postnatal care) 5. Giving my baby immunization 6. Others (write) _____	☐
A.2	1 Do you have children?	1. Yes....**GO TO A.2.2** 2. No .....**GO TO A.3**	☐
A.2	2. How many children do you have?	No. of Boys |_____|_____| No. of Girls |_____|_____| Total number of children |_____|_____|	
FOR THOSE WHO ANSWERD IN A.1. AS BEING FOR ANTINATAL CARE (1), HIGH RISK (2) OR TETANOUS IMMUNIZATION (3)			
A.3	How many months are you pregnant right now	1. No. of months |_____|_____| 2. No. of weeks |_____|_____| 3. Am not sure **ASK THE WOMEN THE QUESTION AND THEN IF SHE ANSWERED IN WEEKS OR MONTHS WRITE IT DOWN**	**REPORT In Weeks** _____ _____
A.4	How many months pregnant were you when you first received antenatal care for this pregnancy?	1. No. of months |_____|_____| 2. Don't know	☐
A.5	How many times did you receive antenatal care during this pregnancy?	1. No. of times. |_____|_____| 2. Don't know	☐
A.6	1. Were you told about any signs of pregnancy complications? **PROBE** **(FOR EXAMPLE; BACK PAIN; VOMITING; NAUSEA; EDEMA..ECT)**	1. Yes.....**GO TO A.6.2** 2. No..... **GO TO A.7**	☐
A.6	2. Were you told what to do if you had had complications?	1. Yes 2. No	☐
A.7	What is the main reason for you to conduct antenatal care? **DO NOT READ THE ANSWERS** **PROBE TO GET THE RIGHT ANSWERS** **THE WOMEN MIGHT HAVE MORE THAN ONE ANSWER , WRITE IT ALL**	1. My mother and my mother in law advised me to do so 2. My husband wants me to do it 3. I think its very important for my health 4. I think its very important for the health of baby 5. Every body does it 6. Don't know	☐ ☐

A.8 Why do you think you should conduct antenatal care visits, what is most important to you?

1. Knowing the sex of the baby
2. Follow up on my health during my pregnancy
3. Follow up on the health of my baby during my P.
4. Being safe and free from complications during my P.
5. having a healthy baby
others (write & rank the importance)
6. _____
7. _____
8. _____
9._____

SHOW THE WOMEN CARD WITH THE RANK

Level of importance

	very	Important	Some what	less	not	code
1.	1	2	3	4	5	
2.	1	2	3	4	5	
3.	1	2	3	4	5	
4.	1	2	3	4	5	
5.	1	2	3	4	5	
others						
6.	1	2	3	4	5	
7.	1	2	3	4	5	
8.	1	2	3	4	5	
9	1	2	3	4	5	
10	1	2	3	4	5	
11	1	2	3	4	5	

A.9 1. At the time you became pregnant, did you want to become pregnant then, did you want to wait until later, or did you not want to have any more children at all?

1. Then.....**Go A.10**
2. Later……**ask A.9.2**
3. not at all.....**Go...A.10**

☐

A.9 2. How much longer would you like to have waited?

1. Months
2. Years

☐

A.10 Have you ever had an injection in the arm to prevent tetanus?

1. Yes----------when was that_____
2. No----------**go to A11**
3. Don't know

☐

A.11 1. When you think of choosing the place where you can give birth for your coming baby, what is most important for you to have?
(RANK LEVEL OF IMPORTANCE FOR EACH QUESTION

14. How far is the place of delivery from where you live
15. Cost of delivery
16. Being safe, and secure in that place
17. The equipment that that place has
18. having your privacy while you deliver
19. Having all the necessary information during the process of delivery
20. Being informed before administering any medical procedure to you
21. Being comfortable in receiving the care
22. Having your husband with you during your delivery
23. Having kind , welcoming staff working with you
24. Having good care of your baby after your delivery
25. Having all the necessary emergency care in case of emergency
26. Having your baby around you from the moment you deliver until you leave the place of delivery

SHOW THE WOMEN CARDS OF RESPONSES

Level of importance

Q.	very	Important	Some what	less	not	Code
1.	1	2	3	4	5	
2.	1	2	3	4	5	
3.	1	2	3	4	5	
4.	1	2	3	4	5	
5.	1	2	3	4	5	
6.	1	2	3	4	5	
7.	1	2	3	4	5	
8.	1	2	3	4	5	
9.	1	2	3	4	5	
10.	1	2	3	4	5	
11.	1	2	3	4	5	
12.	1	2	3	4	5	
13.	1	2	3	4	5	

GO TO A.26

A.11	**2. If she had children**: How satisfied were you with the services you received during your last delivery?	1. Very satisfied 2. Somewhat satisfied 3. Neutral 4. Somewhat dissatisfied 5. Very dissatatisfied	☐

FOR WOMEN WHO ANSWERD IN A.1, BABY IMMUNIZATION (5) POST PARTUM CARE (4)

A.12	During your last pregnancy how many times did you receive antenatal care?	1. No. of times |_____|_____| 2. Don't remember	
A.13	Why do you think you should conduct antenatal care visits, what was the most important to you? **1.** Knowing the sex of the baby **2.** Follow up on my health during my pregnancy **3.** Follow up on the health of my baby during my P. **4.** Being safe and free from complications during my P. **5.** having a healthy baby others (write & rank the importance) **6.**_____ **7.**_____ _____ **SHOW THE WOMEN CARDS WITH THE RANK**	**Level of importance**	

	very	Important	Some what	less	not	code
1.	1	2	3	4	5	
2.	1	2	3	4	5	
3.	1	2	3	4	5	
4.	1	2	3	4	5	
5.	1	2	3	4	5	
others						
6.	1	2	3	4	5	
7.	1	2	3	4	5	
8.	1	2	3	4	5	
9	1	2	3	4	5	
10	1	2	3	4	5	
11	1	2	3	4	5	

A.14	**Where** did you deliver your last baby?	1. Government Hospital 2. Private hospital 3. Private doctor clinic 4. At home	☐
A.15	Before you delivered your last baby where did you **intend** to make your delivery?	1. Public Governmental hospital 2. Private hospital 3. Private doctor clinic 4. at home 5. no preference 6. other (write)……	☐
A.16	1. Did you delivered in the same place? **COMPARE THE TWO ANSWERS IN A.15 AND A.16.1 IF DIFFERENT ASK A.16.2**	1. Yes….**Go to A.17** 2. No…..**Go to A.16.2**	☐
A.16	2. Why have you changed the place of delivery? **READ CHOICES**	1. Better service 2. Closer to where I live 3. Delivery was very fast and un expected 4. Husband wanted to change 5. Based on the relatives and friends advice 6. Cost/ less 7. The house is better 8. Couldn't reach that place due to closures that day 9. Others (write)……	☐
A.17	1. When you think of choosing the place for delivery, what is most important for you to have? **(RANK LEVEL OF IMPORTANCE FOR EACH QUESTION)**		

	1. How far is the place of delivery from where you live **2.** Cost of delivery **3.** Being safe, and secure in that place **4.** The equipment that that place has **5.** having your privacy while you deliver **6.** Having all the necessary information during the process of delivery **7.** Being informed before administering any medical procedure to you **8.** Being comfortable in receiving the care **9.** Having your husband with you during your delivery **10.** Having kind , welcoming staff working with you **11.** Having good care of your baby after your delivery **12.** Having all the necessary emergency care in case of emergency **13.** Having your baby around you from the moment you deliver until you leave the place of delivery **SHOW THE WOMEN CARD OF RESPONSES**	**Level of importance** **Q. very Important Some what less not Code** **1.** 1 2 3 4 5 **2.** 1 2 3 4 5 **3.** 1 2 3 4 5 **4.** 1 2 3 4 5 **5.** 1 2 3 4 5 **6.** 1 2 3 4 5 **7.** 1 2 3 4 5 **8.** 1 2 3 4 5 **9.** 1 2 3 4 5 **10.** 1 2 3 4 5 **11.** 1 2 3 4 5 **12.** 1 2 3 4 5 **13.** 1 2 3 4 5
A.17	**2. If she had children**: How satisfied were you with the services you received during your last delivery?	1. Very satisfied 2. Somewhat satisfied 3. Neutral 4. Somewhat dissatisfied 5. Very dissatisfied
A.18	Who assisted you with the delivery of your last baby? Any one else? **PROBE FOR THE TYPE OF PERSON AND RECORD ALL PERSONS ASSISTING.** **IF RESPONDENTS SAY NO ONE ASSISTED, PROBE TO DETERMINE WEATHER ANY ADULTS WERE PRESENT AT THE DELIVERY!**	1. Health professional a. Doctor b. Nurse/ midwife 2.Other persons a. Traditional birth attendance b Relative/Friend 3. No one assisted Who was present _____
A.19	How was it your process of delivery? Was it…..	1. Normal delivery 2. Cesaererian section 3. Delivery with instruments
A.20	Did you face any problems during your delivery? **READ ALL RESPONSES** **THE WOMEN MIGHT HAVE MORE THAN ONE ANSWER PLEASE WRITE IT ALL.**	1. There was no problem 2. The baby was in different position (Breach…ect) 3. Bleeding 4. Convulsions 5. Big vaginal tear 6. Delivery with instruments (Vacum or Forceps delivery) 7. Premature delivery 8. Others (write).....
A.21	Before you left the place where you delivered, did any one of the health care providers tell you or advise you about the important signs that you need to monitor in your own health after delivery (danger signs)?	1. Yes 2. No 3. Don't remember

A.22	Before you left the place where you delivered did any one of the health care providers provide you with the necessary information regarding the important signs of complications after delivery for your baby?	1. Nes 2. No 3. Don't remember	☐
A.23	1. The first 40 days after delivery, did you follow up in your health with your doctor after your delivery?	1. Yes …….**Go to A.24** 2. No ……..**Go to A.23.2**	☐
A.23	2. Why did you not go to follow up after delivery? **DO NOT READ ANSWERS** **PROBE TO GET MORE ANSWERS** **THE WOMAN MIGHT HAVE MORE THAN ONE REASON CHECK IT ALL** **SKIP TO QUESTION 26**	1. The health facility is too far 2. Too expensive 3. Waiting time is too long 4. Facility not well equipped 5. Not enough qualified staff 6. Not well received 7. No need to go not sick 8. Not aware of the availability of the service 9. Husband/family opposed 10. Not supposed to go out <40 days 11. No one to take care of the baby during my visit 12. that is not my first child and I have good experience of my self care 13. Others (write)_____	☐ ☐ ☐
A.24	During your postnatal check-up, did any one in the health facility counsel you about the family planning?	1. Yes 2. No 3. don't remember	☐
A.25	During your post natal check- up did any one in the health facility counsel you about breast feeding?	1. yes 2. No 3. Don't remember	☐

ASK FOR ALL RESPONDENTS

Health issues and reproductive health rights

Now I would take your opinion in some issues that are important to you as well as every Palestinian woman. These issues concern your health and your reproductive health rights as well.

A.26	In your opinion, do you consider postnatal care necessary for the woman's health?	1. Yes 2. No 3. don't know	☐

A.27 In your opinion what is important in a place where a woman can conduct an antenatal visits?

1. Not far from where I live
2. Cost is not high
3. to feel assured and secure in that place
4. to have every and all equipment necessary for the examination
5. to be comfortable in receiving the care
6. to have full privacy
7. to have someone who can answer all my questions and concerns

SHOW THE WOMEN CARD WITH RESPONSES

Level of importance

Q.	very	Important	Some what	less	not	Code
1.	1	2	3	4	5	
2.	1	2	3	4	5	
3.	1	2	3	4	5	
4.	1	2	3	4	5	
5.	1	2	3	4	5	
6.	1	2	3	4	5	
7.	1	2	3	4	5	

Now I would like to ask you about different aspects of ***your health.***
With health I mean not merely the absence of disease but complete physical health, metal health, being well adjusted and social health

A.28 How important are these aspects of health for you?

CLARIFY THE TERMS TO THE WOMAN.

Level of importance

Q.	very	Important	Some what	less	not l	Code
1. Your physical health: being free of diseases and infirmity	1	2	3	4	5	
2. Your mental health being well adjusted	1	2	3	4	5	
3. Your social health Social justice and personal justice, and being healthy , happy or prosperous, and welfare.	1	2	3	4	5	

A.29 Now I would like to ask you about your medical care for yourself.

Many different factors can prevent women from getting medical advice or treatment for themselves. When you are sick and want to get medical advice or treatment, is each of the following a big problem or not?

	Big problem	Neutral	Not a big problem
1. Knowing where to go	1	2	3
2. Getting permission to go	1	2	3
3. Getting Money needed for treatment	1	2	3
4. the distance to the health facility	1	2	3
5. Having to take transportation	1	2	3
6. Not wanting to go alone	1	2	3
7. Concern that there may be not a female health provider	1	2	3

SHOW THE WOMEN CARD WITH RESPONSES

A.30 Have you had a breast cancer self-exam or an exam by a health specialist to detect breast cancer in the last twelve months?

1. Yes
2. No
3. Not applicable (when the women is 3-5 months after delivered)

☐

A.31 A. In your opinion what are the three major important things that you consider part of your reproductive health rights?

HELP THE RESPONDENTS TO CHOOSE THREE MAJOR ISSUES THAT SHE CONSIDER IMPORTANT AND THEN WRITE THE PRIORITIES THAT THE WOMEN CONSIDER.

_____
_____
_____
_____
_____
_____

A.31.B Now I would like to ask you in more details about the importance of your health rights even if you have to repeat your priorities that you have just mentioned in the previous question.

SHOW THE WOMEN CARD WITH RESPONSES

Level of importance

Q.	very	Important	some what	less	not	Code
1. Your right to receive the full care during your pregnancy, during your giving birth and after your pregnancy	1	2	3	4	5	
2. Your right to choose the place for the health care given to you	1	2	3	4	5	
3. Your right to choose any family planning method	1	2	3	4	5	
4. Your right to receive full information concerning your health	1	2	3	4	5	
5. Your right to make your own decisions concerning your health for example: (operation, family planning etc)	1	2	3	4	5	
6. your right to be treated without any discrimination	1	2	3	4	5	
7. To have the right to marry and to found a family	1	2	3	4	5	
8. right to limit the number of children you have	1	2	3	4	5	

B. Family planning and contraceptives use

Now I would like to ask you about family planning, the various ways that a couple could use to delay or avoid pregnancy.

CHECK CODE 1 FOR B.1 EACH MENTIONED SPONTANEOUSLY. THEN PROCEED DOWN COLUMN B.2 READING THE NAME AND DESCRIPTION OF EACH METHOD NOT MENTIONED SPONTANEOUSLY. CIRCLE CODE 1 IF METHOD SPONTANEOUSLY RECOGNIZED; AND CODE 2 IF NOT RECOGNIZED. THEN, FOR EACH METHOD WITH CODE 1 CIRCLED IN B.2 ASK B.3

What are the methods that you know?

B.1 spontaneously mentioned √

1. Female sterilization	
2. Male sterilization	
3. IUD	
4. Injections	
5. Implants	
6. Female condom	
7. Male condom	
8. Diaphragm	
9. Foam and Jell	
10. Pill	
11. LAM	
12. RPA (Rhythm of periodic abstinence)	
13. Emergency contraception	
14. Others (write)……_____	

READ THE NAME AND DESCRIPTION OF EACH METHOD. CIRCLE CODE 1 IF METHOD SPONTANEOUSLY RECOGNIZED; AND CODE 2 IF NOT RECOGNIZED. THEN, FOR EACH METHOD WITH CODE 1 CIRCLED IN B.2 ASK B.3

B.2	Which ways or methods have you heard about? **READ FOR ALL, SO AS TO GIVE MORE INFORMATION TO THE WOMEN REGARDING EACH METHOD AND THEN COMPARE THE TWO RESULTS, ASK**: Have you ever heard of (method)?		B.3 Have you ever-used (Method)?
01	Female Sterilization: Women can have an operation to avoid having any more children.	Yes…….1 No…….2=↓	Have you ever had an operation to avoid having any more children? Yes……...1 No……2
02	Male Sterilization: Men can have an operation to avoid having any more children	Yes…….1 No…….2=↓	Have you ever had a husband who had an operation to avoid having any more children? Yes…….1 No……..2

03	Pill: Women can take a pill every day to avoid becoming pregnant	Yes……1 No……2=↓	Yes……1 No……..2
04	IUD: Women can have a loop or coil placed inside them by a doctor or a nurse.	Yes……1 No……2=↓	Yes……1 No……..2
05	Injections: Women can have an injection by a health provider that stops them from becoming pregnant for one or more years	Yes……1 No……2=↓	Yes……1 No……..2
06	Implants: Women can have several small rods placed in their upper arm by a doctor or a nurse which can prevent pregnancy for one or more years	Yes……1 No……2=↓	Yes……1 No……..2
07	Condom: Men can put a rubber sheath on their penis before sexual intercourse.	Yes……1 No……2=↓	Yes……1 No……..2
08	Female Condom: Women can place a sheath in their vagina before sexual intercourse.	Yes……1 No……2=↓	Yes……1 No……..2
09	Diaphragm: Women can place a thin flexible disk in their vagina before intercourse	Yes……1 No……2=↓	Yes……1 No……..2
10	Foam or Jelly: Women can place a suppository, jelly, or cream in their vagina before intercourse.	Yes……1 No……2=↓	Yes……1 No……..2
11	Lactation Amenorrhea (LAM): up to 6 months after childbirth, a women can use a method that requires that she breastfeeds frequently, day and night, and that her menstrual period has not returned	Yes……1 No……2=↓	Yes……1 No……..2
11.1	Have you every used breast feeding as a family planning method more than 6 months		Yes……..1…….**11.2** No……..2……**12**
11.2	For how long have you used breast feeding as a family planning method?		Months more than 6_____
12	Rhythm of periodic abstinence: every month that a women is sexually active she can avoid pregnancy by not having sexual intercourse on the days of the month she is most likely to get pregnant.	Yes……1- No……2=↓	Yes……1 ↓ 12.1 No……..2
12.1	What kind of rhythm of periodic abstinence have you heard and used?	Specify_____ _____	Specify_____ _____
13	Withdrawal: Men can be careful and pull out before climax	Yes……1 No……2=↓	Yes……1 No……..2
14	Emergency Contraception: women can take pills up to three days after sexual intercourse to avoid becoming pregnant.	Yes……1 No……2=↓	Yes……1 No……..2
15	Have you heard of any other ways or methods that women or men can use to avoid pregnancy?	Yes……1 _____ specify _____ specify No……2	Yes……1 No……..2 Yes……1 No……..2
B.4	Check B.3 Not a single "Yes" (never used) write code 2 ☐ ↓	At Least One "Yes" (Ever used) ☐ → write code 1	B.8

	For Not a single yes mentioned		
B.5	Why are you not currently using any family planning method? **PROBE TO HELP THE WOMAN ANSWER** (***There could be more than one response, write it all)***	1. Willing to have baby 2. Newly married 3. I became pregnant…….**skip to B.16** 4. Religious reasons 5. Against using 6. Husband oppose 7. Family oppose 8. Fear from side effects 9. Don't know much about the appropriate method 10. Cost/expensive 11. Don't know from where to get it 12. First six weeks after delivery 13. Others (write)……...	☐ ☐ ☐ ☐
B.6	Would you like to use family planning methods in the future? **READ THE RESPONSES**	1. Definitely yes 2. Probably yes 3. Not sure 4. Probably not 5. Definitely not	☐
B.7	Is it possible for you to ask your husband to use any method instead of you? **GO TO B. 20**	1. yes 2. I can't do that 3. don't know	☐
	FOR THOSE WHO HAVE ONE OR MORE SINGLE YES IN B.3		
B.8	1. Are you using any method right now?	1. Yes……**B.9** 2. No--------**Go to Question B.8.2**	☐
B.8	2. Why are you not using right now any family planning method? **PROBE,** ***THE WOMAN MIGHT HAVE MORE THAN ONE RESPONSE, WRITE IT ALL*** **GO TO B.20**	1. Willing to have baby **2.** I became pregnant⟶ **skip to B.16** 3. Religious reasons 4. I oppose using family planning methods 5. Husband oppose 6. Family oppose 7. Fear from side effects 8. Don't know much about the appropriate method 9. Cost/expensive 10. Don't know from where to get it 11. I had problems with the last method 12. the clinic is very far from where I live 13. Menopause 14. First 6 weeks after delivery 15. Others (write)……..	☐ ☐ ☐
B.9	What is the method that you are using right now? **WOMEN MIGHT USE MORE THAN ONE METHOD TOGETHER WRITE IT ALL**	1. Female sterilization 2. Male sterilization 3. Pill 4. IUD 5. Injections 6. Implants 7. Female condom 8. Male condom 9. Diaphragm	☐ ☐

		10. Foam and Jell 11. LAM 12. RPA 13. Emergency contraception 14. Others (write)……	☐
B.10	From where did you get this method? **READ RESPONSES**	1. Public sector Gov. Hospital Gov. Health center Gov. MCH 2. Private Sector Private Hospital Private Doctor Pharmacy 3. UNRWA health Center 4. None Governmental Organization clinic 5. Other source Friends/Relatives Others (write)_____	☐
B.11	Who advised you to use that current method? **PROBE,** **THE WOMEN MIGHT HAVE MORE THAN ONE TOGETHER, WRITE IT ALL**	1. The doctor 2. Midwife or Nurse 3. Self decision 4. My husband 5. My mother 6. Some relatives 7. Friends/ neighbors 8. Others (write)……	☐ ☐
B.12	You obtained (current method) from (source of Method), at that time, did someone give you all the necessary information regarding positive and negative effects of that method?	1. Yes 2. No 3. Don't remember	☐
B.13	1. Were **<u>you ever told</u>** by **<u>a health</u>** or family planning worker about side effects or problems you might have with the method?	1. Yes…..**Go to B.13.2** 2. No…….**Go to B.14**	☐
B.13	2. Were you told what to do if you experienced side effects or problems?	1. Yes 2. No 3. Don't remember	☐
B.14	Were you told by a **<u>health or family planning worker</u>** about other methods of family planning that you could use?	1. Yes 2. No	☐
B.15	When you first used family planning methods, how many children did you have?	1. Number of boys……. 2. Number of girls……. 3. Total number of children |_____|_____| 4. Do not have children at all **GO TO B.20**	☐

FOR WOMEN ANSWERED BECOME PREGNANT IN B.8.2			
B.16	What is the last method that you were using before becoming pregnant? **PROBE,** **SHE MIGHT USE COMBINATION WRITE IT ALL**	1. Female sterilization 2. Male sterilization 3. Pill 4. IUD 5. Injections 6. Implants 7. Female condom 8. Male condom 9. Diaphragm 10. Foam and Jell 11. LAM 12. RPA 13. Emergency contraception others (write)……	☐ ☐
B.17	For how long did you stop using that method before becoming pregnant?	Number of months…….. Don't remember…….. Less than one month……..0	☐
B.18	Why did you stop using that method before becoming pregnant? **PROBE,** **THE WOMEN MIGHT HAVE MORE THAN ONE RESPONSE, WRITE IT ALL.**	1. Willing to have baby 2. Fear from side effects 3. Become pregnant 4. Method not efficient 5. Husband/family oppose 6. Difficult to find 7. The clinic is too far to reach 8. Expensive/ cost 9. Religious reasons 10. Others (write)…….	☐ ☐
B.19	Did you become pregnant unintentionally while using the method or did you deliberately stop to become pregnant?	1. Unintentionally 2. Deliberately 3. Not sure **CONTINUE TO B.20**	☐
ASK FOR ALL RESPONDENT			
B.20	Who is responsible for making the final decision for using the family planning methods? **ASK FIRST AND WHEN NOT ANSWERING SPONTANEOUSLY PROBE**	1. Me myself 2. My husband 3. Me and my husband's together 4. My husband family 5. Others……	☐
B.21	In your family who makes the final decision in stopping the family planning method use? **ASK FIRST AND WHEN NOT ANSWERING SPONTANEOUSLY PROBE**	1. Me myself 2. My husband 3. Me and my husband together 4. My husband's family 5. Others……	☐

B.22	Who is responsible for making the final decision for having another baby? **ASK FIRST AND WHEN NOT ANSWERING SPONTANEOUS PROBE**	1. Me my self 2. My husband 3. Me and my husband together 4. Our children 5. My husband family 6. Others……	☐
B.23	Are you for or against a couple using family planning methods in order to avoid pregnancy? **SHOW WOMEN CARD OF SCALE**	1. Totally for 2. Mostly for 3. Not for or against 4. Mostly against 5. Totally against	☐
B.24	In your opinion, what is the perfect number of children that you wish to have before using family planning? **PROBE FOR THE DETAILS**	Number of Boys: |_____|_____| Number of Girls: |_____|_____| Total Number of children |_____|_____| Don't know/ not a numeric answer_____ The sex is not important in the total number: _____	
B.25	In your opinion what is the perfect number of children that you wish for your daughter to have in the future? **ASK WHETHER SHE HAS A DAUGHTER OR NOT.** **PROBE TO TAKE MORE DETAILED ANSWER REGARDING THE SEX OF THE CHILDREN**	Number of children Number of boys: |_____|_____| Number of girls: |_____|_____| Sex of children is not important Don't know/ none numeric answer_____ _____	

B.26 How important is family planning for you for…

Q.	very	Important	Some what	less	not	Code
1. delaying the first child	1	2	3	4	5	
2. spacing the birth	1	2	3	4	5	
3. Limiting the number of the family members	1	2	3	4	5	
4. Economic reasons	1	2	3	4	5	
5. the mother health	1	2	3	4	5	
6. the children health and good raising up	1	2	3	4	5	

B.27	Now I would like to ask you about your husband's opinion in using family planning methods. **SHOW THE WOMEN THE CARD OF THE SCALE**	1. Totally for using 2. For using 3. Not for or against 4. Against using 5. totally against using 6. Don't know	☐
B.28	How often have you discussed using family planning methods with your husband?	1. Very often 2. Often 3. Rarely 4. Not at all	☐

		READ THE RESPONSE	
B.29.	1. Can you use family planning based on your own opinion alone?	1. yes 2. no----------B29.2 999. don't know	☐
B.29	2. with whom you think you should consult? Do not read the answers probe only	1. Husband 2. mother 3. mother in law 4. neighbors/ friends 5. relatives 6. health care provider 7. others	☐

B.30 In your opinion how important are the following factors for you to use family planning methods?

Show the women card of the scale

13. Number of children you have
14. Accessibility to FP methods & clinics
15. Privacy in the health center
16. Confidentiality in Health care center
17. Cost of the FP methods
18. Information about FP methods
19. Husband participation
20. Free in choosing the method
21. Being safe from any harm in using FP
22. Your opinion in using the methods
23. The continuity in having FP methods
24. Being relax , comfort and satisfied in family planning methods use

Level of importance

Q.	very	Important	Some what	less	not	Code
1.	1	2	3	4	5	
2.	1	2	3	4	5	
3.	1	2	3	4	5	
4.	1	2	3	4	5	
5.	1	2	3	4	5	
6.	1	2	3	4	5	
7.	1	2	3	4	5	
8	1	2	3	4	5	
9	1	2	3	4	5	
10	1	2	3	4	5	
11	1	2	3	4	5	
12	1	2	3	4	5	

B.31 Couples sometimes do not agree in everything, please tell me if you think that the wife has the right to refuse having sex with her husband?

Choices	Yes 1	No 2	Don't know 3	Code
1. If your husband has any sexual transmitted diseases	1	2	3	
2 You have newly delivered a baby (first 40 days after delivery)	1	2	3	
3. Tired and not in the mood	1	2	3	
4. during the menstrual period	1	2	3	
5. if you have lack of privacy (such as having children around	1	2	3	
6. if your husband assaults you physically or psychologically	1	2	3	

Others_____
_____

C. Marriage

C.1	1. Have you married only once or more than once?	1. once 2.more than once	☐
	2. Married Once only ☐ → In what month and year did you get married	Married more than once ☐ → now we will talk about your first husband: In what month and year did you get married?	Month_____ Don't know month……..99 Year_____ Don't know the year….9999 I know how for how many years only (write)

		_____	
C.2	How old where you are when you got married?	Age: |_____|_____|	
C.3	If you have a daughter and she wants to get married, in your opinion what is the best age for her to get married? **PROBE TO GET THE ANSWER**	1. Age: |_____|_____| 2. When she finishes her education (Tawjehi) 3. when she finishes her education (University) 4. When she has a good marriage chance (good man) 5. When her destiny (Naseeb) comes	☐
C.4	If you have daughters, do you expect to have an opinion in choosing their future husbands? **DO NOT READ THE CHOICES, PROBE ONLY**	1. Yes 2. No 3. Whom they will accept I will accept too 4. her father has the full authority 5. Don't know	☐
C.5	Does your husband have another wife (other wives) besides you?	1. yes 2. No	☐
C.6	Who in your family usually has the final say on the following decisions: **SHOW THE WOMAN THE CARD OF CHOICES**	***Respondent=1*** ***Husband=2*** ***Respondent and husband Jointly= 3*** ***Someone else=4*** ***Respondent and someone else jointly= 5*** ***Decisions not made/ not applicable=6***	
C.7	1. Sometimes, a husband is annoyed or angered by things that his wife does. In your opinion, is a husband justified in hitting or beating his wife in the following situations?		
	2. Besides the situations we just have mentioned, in your opinion, are there any other situations in which a husband is justified in hitting or beating his wife? If **YES** in what situations?	1.Yes_____ (specify) 2.No 3. Don't know	☐

q.	choices	code
1.	1 2 3 4 5 6	
2.	1 2 3 4 5 6	
3.	1 2 3 4 5 6	
4.	1 2 3 4 5 6	
5.	1 2 3 4 5 6	
6.	1 2 3 4 5 6	

7. Your own health care?
8. Your children health care?
9. Making large household purchases?
10. Making household purchases for daily needs?
11. Visits to family or relatives?
12. What food should be cooked each day?

Q.	Yes	No	Don't know	code
1.	1	2	3	
2.	1	2	3	
3.	1	2	3	
4.	1	2	3	
5.	1	2	3	
6.	1	2	3	

7. If she goes out without telling him?
8. If she neglects the children?
9. If she argues with him?
10. If she burns the food?
11. If she disobeys him?
12. If she insults him?

D. Demographical data and background information

D.1	What is your marital status?	1. Married 2. Divorced 3. widow 4. Single	☐

	Q.	1. Wife	2. Husband	Code
D.2	How old are you? **COMPARE THE TWO ANSWERS AND THEN WRITE THE CORRECT AGE**.	Date of Birth: Day/month/year |___|___| / |___|___ /19|___|___| Age in years:_____	Date of Birth Day/month/year **|___|___| / |___|___ /19|___|___|** Age in Years_____	1.☐ 2.☐
D.3	Do you live together with your husband? **READ THE CHOICES**	1.Yes 2. No 3. Not all the week days (specify)_____ 5. Not all the year time (specify)_____ 6.		☐
D.4	1. Where do you live right now?	Write in details the place of living. _____ 1. City 2. Village 3. Camp 4. out side the country (where)_____	Write in details the place of living. _____ 1. City 2. Village 3. Camp 4. Out side the country (where)_____	1.☐ 2.☐
	2. For how long have you lived in this place?	1. Years_____ 2. all my life	1. years_____ 2. all my life	1.☐ 2.☐
	3. Where did you live before?	Write in details the place. _____ 1. City 2. Village 3. Camp 4. out side the country (where)_____	Write in details the place. _____ 1. City 2. Village 3. Camp 4. out side the country (where)_____	1.☐ 2.☐
D.5	What is your level of education?	1. Never went to school 2. Primary school 3. Secondary school and Tawjehi 4. Diploma or professional training 5. University	1. Never went to school 2. Primary school 3. Secondary school and (Tawjehi) 4. Diploma or professional training 5. University	1. 2.

D.6	1. Are you working?	1. Yes 2. No	1. Yes 2. No	1. ☐ 2. ☐
	2. What do you work?	Write in details what is her profession? _____ 1. Professional 2. Own business 3. Manual worker 4. Office employee	Write in details what is her profession? _____ 1. Professional 2. Own business 3. Manual worker 4. Office employee	1. ☐ 2. ☐

D.7	1. Do you help financially with the household expenses?	1. Yes 2. No	☐
D.7	2. On average, how much of your household's expenditures do your earnings pay for? **SHOW THE WOMEN CARD OF CHOICES**	1. Almost none 2. Less than Half 3. about half 4. More than half 5. All 6. None, her income is all saved	☐
D.8	In your opinion, how do you estimate the economic status of your family compared to other Palestinian families?	1. High 2. Middle 3. Low	☐
D.9	What is your religion?	1. Muslim 2. Christen 3. others_____	☐

Observations

1. Please, observe the mother's dress and right down the following:
   1. Religious representatives:_____
   2. Culture dress from that area:_____
   3. Level of social status (jewelry, expensive dress etc…) _____

2. Write down if the mother answered all questions at ease or if she was hesitant in answering some questions and which ones she was shy or hesitant to answer.

_____
_____
_____

3. Observe if there was someone accompanying the mother at the clinic (write whom exactly)
_____
_____
_____

4. Did you have privacy during the interview?

Yes ☐ No ☐ 3. Partial ☐

APPENDIX II

PROPOSED ANALYSIS FOR EACH QUESTION IN THE QUESTIONNAIRE

Reproductive Health Human Rights in Palestine

Women's knowledge Attitudes Practices Towards Their Reproductive Health Rights in Palestine

Key:
K= Knowledge
A= Attitude
P= Practice
D= Demography & Background

QUESTION	KAP	LEVEL OF DATA	ANALYSIS	CORRELATIONS AND COMMENTS
A.1	P	Nominal	%	
A.2.1	D	Nominal	Nominal	
A.2.2	D	Ratio	Average	
A.3	P	Ratio	Average	
A.4	P	Ratio	Average	
A.5	P	Nominal	Frequency & %	
A.6.1	K	Nominal	%	
A.6.2	K	Nominal	%	
A.7	A	Nominal	%	
A.8	A	Interval	Mean, variance, Standard deviation	
A.9.1	P	Nominal	%	Combine with B.12 & B.22
A.9.2	P	Ratio	Average	
A.10	P	Nominal	%	
A.11	P	Ratio	Freq. & %	
A.12	A	Interval	Mean, variance, Standard deviation	
A.13	P	Nominal	Freq, %, Mode	
A.14	P	Nominal	Freq, %, Mode	
A.15.1	P	Nominal	Freq, %, Mode	
A.15.2	p	Nominal	Freq, %, Mode	
A.16	A	Interval	Mean., SD	
A.17	P	Nominal	Freq, %, Mode	
A.18	P	Nominal	Freq, %, Mode	
A.19	D	Nominal	Freq, %, Mode	
A.20	K	Nominal	Freq, %, Mode	
A.21	K	Nominal	Freq, %, Mode	
A.22.1	P	Nominal	Freq, %, Mode	
A.22.2	A	Nominal	Freq, %, Mode	
A.23	K	Nominal	Freq, %, Mode	
A.24	K	Nominal	Freq, %, Mode	
A.25	A	Nominal	Freq, %, Mode	
A.26	A	Interval	Mean, SD	
A.27	A	Nominal	Freq, %, Mode	
A.28	A	Interval	Mean, SD	
A.29	A+P	Nominal	Freq, %, Mode	

A.30	P	Open ended Q.	Subject analysis	
A.31.A	K	Nominal	Freq, %, Mode	
QUESTION	**KAP**	**LEVEL OF DATA**	**ANALYSIS**	**CORRELATIONS AND COMMENTS**
A.31.B	A	Nominal	Freq, %, Mode	
B.1	K	Nominal	Freq, %, Mode	
B.2	P	Nominal	Freq, %, Mode	
B.3	P	Nominal	Freq, %, Mode	Combining point 9 with B1+B2+
B.4	P	Nominal	Freq, %, Mode	
B.5	A	Nominal	Freq, %, Mode	
B.6	A	Nominal	Freq, %, Mode	
B.7	P	Nominal	Freq, %, Mode	
B.8	P+A	Nominal	Freq, %, Mode	
B.9	P	Nominal	Freq, %, Mode	
B.10	P	Nominal	Freq, %, Mode	
B.11	P	Nominal	Freq, %, Mode	
B.12	K	Nominal	Freq, %, Mode	Combining B14+B15, with B1 & B2
B.13	K	Nominal	Freq, %, Mode	
B.14	K	Nominal	Freq, %, Mode	
B.15	K	Nominal	Freq, %, Mode	
B.16	D	Ratio	Mean	
B.17	P	Nominal	Freq, %, Mode	
B.18	P	Ratio	Mean	
B.19	A	Nominal	Freq, %, Mode	
B.20	P	Nominal	Freq, %, Mode	
B.21	A	Nominal	Freq, %, Mode	Combining with B1+B2+B3
B.22	A	Nominal	Freq, %, Mode	Combine with B3+B19+B21
B.23	A	Nominal	Freq, %, Mode	Combining with B3
B.24	A	Ordinal	Median, Range	
B.25	A	Ratio	Mean	
B26	A	Ratio	Mean	
B.27	A	Ratio	Freq, %, Mode	
B.28	K	Nominal	Mean	
B.29	A	Ordinal	Freq, %, Mode	
B.30	p	Nominal	Median, Range	
B.31	A	Nominal	Freq, %, Mode	
B.32	A+k	Interval	Mean, SD	Combining with B1+B2+B3
C.1	D	Nominal	Freq, %, Mode	
C.2	D	Interval	Mean	
C.3	A	Nominal	Freq, %, Mode	
C.4	A	Nominal	Freq, %, Mode	
C.5	D	Nominal	Freq, %, Mode	
C.6	A+P	Nominal	Freq, %, Mode	Combining with B1+B2+B3
C.7	A+P	Nominal	Freq, %, Mode	Combining C6+c7 and B1+b2
D.1	D	Nominal	Freq, %, Mode	

D.2	D	Ordinal	Median, Range	
QUESTION	**KAP**	**LEVEL OF DATA**	**ANALYSIS**	**CORRELATIONS AND COMMENTS**
D.3	D	Nominal	Freq, %, Mode	
D.4	D	Nominal	Freq, %, Mode	Representation purpose
D.5	D	Nominal	Freq, %, Mode	Empowerment purposes
D.6	D	Nominal	Freq, %, Mode	
D.7.1	D	Nominal	Freq, %, Mode	Empowerment purposes
D.7.2	D	Ordinal	Median, Range	Combining with B23, B24, B25
D.8	D	Nominal	Freq, %, Mode	
D.9	D	Nominal	Freq, %, Mode Freq, %, Mode	

There will be three main factors that the analysis will be based one:

1- level of education
2- Residency and place of stay
3- Empowerment which is represented through profession and finical participations

These three factors will be correlated with many other factors represented in the questionnaire and in the proposal objectives, for-example family planning use, or using the reproductive health facilities and taking their rights for health care.

APPENDIX III STUDY CARDS

Card for Respondent

Level of importance

Q.	Very important	Important	Less important	Not Important	not at all	
1.	1	2	3	4	5	
2.	1	2	3	4	5	
3.	1	2	3	4	5	
4.	1	2	3	4	5	
5.	1	2	3	4	5	

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Card for level of importance
Q. A.8, A.11, A.13, A.17, A.27, B.29
Questionnaire (Reproductive Health Human Rights in Palestine)

Card for Respondent

Q. B.24, your position toward family planning

1. **Totally For**
2. **Mostly For**
3. **Not For or against**
4. **Mostly Against**
5. **Totally Against**

Q. B.29. your husband position toward family planning

1. **Totally for using**
2. **For using**
3. **Not For or against**
4. **Against using**
5. **Totally against using**
6. **6. Don't know**

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Questionnaire (Reproductive Health Human Rights in *Palestine)*

Card for Respondent

	Big problem	Neutral	Not a problem
1. Knowing where to go	1	2	3
2. Getting permission to go	1	2	3
3. Getting money needed for treat-ment	1	2	3
4. The distance to the health facility	1	2	3
5. Having to take transportation	1	2	3
6. Not wanting to go alone	1	2	3
7. Concern that there may be not a female health provider	1	2	3

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Card to use din Q. A. 30 (problem or not problem card)
Questionnaire (Reproductive Health Human Rights in Palestine)

APPENDIX IV STUDY BROCHURE

Reproductive Health Human Rights

We will summarize our findings in a brochure like this one. You can get it at the health center after the study is finished

Thank you

For being interested in this study and for your cooperation

Universität Bielefeld

JUZOOR

Doctoral Study Research

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Doctoral Study Research

Women's Reproductive Health Human Rights in Palestine

Women's views

Women's' views toward their reproductive health rights in Palestine

My Name is Enas Dhaher and I am conducting this research study with Juzoor organization as part of my doctoral study at the University of Bielefeld –Germany.

This study is aimed to learn about the Palestinian women's views, and practices toward their reproductive health rights. It will target three clinics in west Bank, that conduct women's health services in the three districts covering the south, middle and north of West Bank, these districts are as follows: Jenin that will represent the north of West Bank, Ramallah which represents the middle of West Bank, and Hebron that represents south of West Bank.

The study will include women between age 15-49 years old who are visiting the clinics in the above mentioned areas. We will interview women from 30-40 minutes about their health rights.

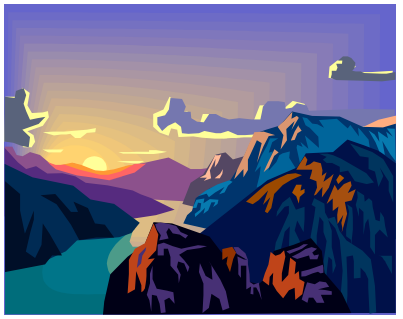
Main Reproductive Health Rights

This study will discuss three reproductive health rights that are approved by the world commissions and recognized by many European countries:

1. Freedom from all forms of discrimination.
2. Liberty and security, marriage and the foundation of families, private and family life and information and education.
3. Access to health and the benefits of scientific progress

Study Objectives

1. Find out what do women **know** about their reproductive health rights.
2. Understand why women still do not use **family planning** methods.
3. Find out the major factors affecting women's use of **health care services** during and after pregnancy.
4. Find which **main reproductive health** rights ar most im-



Doctoral Study Research

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APPENDIX V

Universität Bielefeld

School of Public Health
Department of Public Health Medicine

None- Response Questionnaire

Questionnaire serial number	
Clinic name and place	
Date	

Questionnaire
Reproductive Health Human Rights in Palestine

Women's knowledge, Attitudes and Practices Towards Their Reproductive Health Rights in Palestine

Consent Form

My name is Enas Dhaher and I am here conducting this study as part of my doctoral study, which is aimed to see what do mothers think and feel about their health, family planning and their rights to have all of those. This study will serve also all who care about health in Palestine to improve the services and to help the mothers to have better health care. For that, I will be asking you some questions regarding your reproductive health and family planning and I will be highly appreciative to hear your personal opinion regarding these issues that concern your health. I highly appreciate your cooperation and your acceptance to enter this study, looking to the fact that the given information will be dealt with high privacy and full security and no one will have the access to your personal data. The results of this study can be published and those who are interested in health care can use the results for improving the health care in Palestine.

Would you like now to participate in this study

Can I start asking you the questions?

Signature for the interviewer…….

Signature for the participant…….. 1

The participant refused to share in the study……. . 2…….. End of the interview
w

Reasons for refusal

1. **No time**
2. **No interest**
3. **Others**_____

A. Reproductive health and reproductive health rights

A.1	What is the main reason for you visiting this clinic today?	7. Follow up the pregnancy (antenatal care) 8. Being High risk pregnant and this is one of the follow up check-ups 9. Taking my self immunization during pregnancy (Tetanus) 10. Checking up my self after my delivery (postnatal care) 11. Giving my baby immunization 12. Others (write) _____	☐

D. Demographical data and background information

	Q.	**1. Wife**	
D.1	How old are you? **COMPARE THE TWO ANSWERS AND THEN WRITE THE CORRECT AGE**.	Date of Birth: Day/month/year |___|___| / |___|___ /19|___|___| Age in years:_____	
D.2	What is your level and your husband level of education?	**Woman** 1. Never went to school 2. Primary school 3. Secondary school and Tawjehi 4. Diploma or professional training 5. University	**Husband** 1. Never went to school 2. Primary school 3. Secondary school and Tawjehi 4. Diploma or professional training 5. University
D.3	1. Are you working	**Woman** 1. Yes 2. No	**Husband** 3. Yes 4. No

Observations

1. Please, observe the mother's dress and right down the following:
   1. Religious representatives:_____
   2. Culture dress from that area:_____
   3. Level of social status (jewelry, expensive dress etc…) _____

3. Observe if there was someone accompanying the mother at the clinic (write whom exactly)

APPENDIX VI

Clinic Assessment Tool

Clinic name: __ _____
Address: _____
Telephone if available: _____
Telephone number for any contact person: _____
Name of the person who conduct the assessment _____
Date: _____

1. How many rooms available with description for the service for each in the clinic

2. Please fill all the activities for the clinic each day in the week?

service	Saturday	Sunday	Monday	Tuesday	Wednesday	Thursday
Antenatal service						
Postnatal services						
Tetanus immunization						
Babies immunization						
High risk pregnancy						

3: Please fill the average number of women per day for each service:

service	No. of women Sat.	No. of women Sun	No. of women Mon	No. of women Tues.	No. of women Wed	No. of women Thu
Antenatal service						
Postnatal services						
Tetanus immunization						
Babies immunization						
High risk pregnancy						

4. What is the maximum waiting time that in average women needs to wait before having the service?

_____

5. Is there any room or place where woman can have privacy in order to conduct the interview with her?
Yes No

APPENDIX VII

CONFERENCES PARTICIPATION & PUBLISHED ARTICLES

Some of the results of this study were presented at the following conferences

Presentation titled: Beliefs and attitudes towards intimate partner violence among Palestinian women of reproductive age" at the conference of Medizin und Gesellschaft"Prävention und Versorgung innovativ – qualitätsgesichert – sozial, 17. - 21. September 2007 in Augsburg-Germany.

Poster „Intimate partner violence: are the attitudes of the Palestinian women towards violence improving? at the European Conference: "Equity in Access to Health Promotion, Treatment and Care for all European Women" from 5 – 7 October 2007 in Berlin- Germany.

Poster "lack of postnatal care among Palestinian women: attitudes, reasons and related results" at the Deutschen Gesellschaft für Epidemiologie (DGEpi) „Epidemiologie in Wissenschaft und Öffentlichkeit"

Published and accepted articles

1. Dhaher E**,** Mikolajczyk RT**,** Maxwell AE**,** Krämer A. (2008). Factors associated with lack of postnatal care among Palestinian women: a cross-sectional study of three clinics in the West Bank. *BMC Pregnancy Childbirth*,18 (8),26. (Free text available at http://www.pubmedcentral.nih.gov/articlerender.fcgi?tool=pubmed&pubmedid=18638395).
2. Dhaher E**,** Mikolajczyk RT**,** Maxwell AE**,** Krämer A**.** Attitudes towards Wife Beating among Palestinian Women of Reproductive Age from Three Cities in West Bank. Accepted from the Journal of Interpersonal Violence on 14.9.08. (Note: citation information will be updated on publishing)