

**Primary Health Care Initiatives
(PHCI)**

**Unmet Need and Missed
Opportunities For Family
Planning Among Married
Women 15-49 Years Users
of MoH Health Centers**

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Prepared by

Family Health Group

PHCI Research Team

For

Ministry of Health of Jordan



Abt Associates Inc. ■ 4800 Montgomery Lane, Suite 600, Bethesda, MD 20814 ■
Tel: 301/913-0500 ■ Fax: 301/652-3916

In collaboration with:

University of Colorado ■ Initiatives, Inc. ■ TransCentury Associates



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Salah Mawajdeh
Principal Investigator

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▶ Executive Summary

1. Background : In spite of the reduction in fertility rates and the rise in the prevalence of contraceptive use in Jordan, the gap between women's knowledge of family planning methods and the actual use of these methods is apparent. The 2002 Jordan Population and Family Health Survey (JPFHS) indicated that 11.1% of the currently married women (age 15-49) had an unmet need of family planning (FP) with 5.6% for spacing and 5.5% for limiting births.

2. Purpose : This study aimed at assisting the Jordanian Ministry of Health to better understand the existing gap between women's need for family planning services and the actual use of these services, better known as "unmet need". The study also aimed at measuring the prevalence of unmet need with an attempt to estimate the proportion of women intending to use family planning methods in the future. Reasons for not using family planning methods, as well as some of the main distinguishing features between women with unmet need and users of family planning methods, were identified. Study findings aim at assisting decision makers in developing family planning programs that focus on reducing barriers to providing family planning services.

3. Methodology: A nationally representative sample of 2,406 women using ministry of Health facilities was obtained applying a two-stage cluster sampling technique. Six strata were identified based on three geographical regions and two types of health centers. Complemented by four focus group discussions, data for the study was collected using three forms of structured questionnaires. Eleven teams, each composed of three trained research assistants, collected the data through face-to-face interviews. Both standard and expanded definitions of unmet need were used when performing data analysis.

4. Results: The study results showed that the overall prevalence of standard unmet need to be at 16.3%, composed of 6.8% of women who wanted to limit births and the remaining 9.5% who wanted to space births. According to the expanded definition of unmet need, women who were either using a traditional method or a method that is inconvenient, unsafe, or incorrectly used were considered as having an unmet need. When adopting the expanded definition of unmet need the prevalence figure increased to 33.6%.

A negative significant correlation was found between standard unmet need and educational level of women. There was a higher level of standard unmet need in the south compared to other regions. Women's age categories showed high standard unmet need in the young and old categories compared

to the middle age category of 25-35 years of age. A similar pattern was also seen when the number of living children was examined. There was an inherent variation between women who had standard unmet need and those who were currently using a family planning method, both in terms of demographic and reproductive characteristics.

The study results showed that only 22.6% of women or their husbands objected to discussing family planning issues with a male provider. More women and their husbands move to the opposition group as male provider of care involvement increases in provision of family planning services. For example, more opposition was seen when women were asked if they objected to receive family planning services from a male provider (29.7%). Explicit preference for a female provider (91.9%) was seen when women were asked about their preferences if IUD insertion was needed.

The study results showed that even though women were frequent users of Ministry of Health services, yet results indicated that women were generally not counseled for family planning during their visits. For example, 84% of visits to the general practitioner were missed opportunities for counseling on family planning.

5. Conclusion and Recommendations:

Given the wide network of primary health care facilities and the relatively high literacy rate among women, the study results showed a level of standard unmet need for family planning among women using Ministry of Health clinics. Based on study results, lowering the prevalence of unmet need in Jordan is possible. First, women's reported reasons for non-use are not insurmountable as some blamed their husband, while others blamed their own bodies or voiced fears of unlikely or erroneous side effects. Second, health care providers did not take the opportunity to offer family planning counseling to women visiting health centers. Third, health care providers failed to find the exact fit between women's needs, preferences for certain contraceptive methods, and what suits them on medical grounds. Generally, women are least likely to use a method in the long term if it was not of their own choosing. Regular follow-ups, management of side effects, and making different methods available help women find a satisfactory method that meets both their needs and desires.

I. Introduction

This study was conducted by the Family Health Group through a subcontract by the Primary Health Care Initiatives (PHCI) project in Jordan in cooperation with the Ministry of Health. The main goal of the PHCI project is to improve access to and quality of reproductive and primary health care and to assist the Jordanian Ministry of Health (MOH) achieve its Primary Health Care strategy. The study at hand was designed and implemented to examine the unmet need (both the standard formulation and the expanded definition) and missed opportunities for family planning among users of MOH services. Documenting the unmet need for family planning among users of MOH services and factors influencing it can assist in developing programs that target high priority subgroups. Understanding the intentions of non-users can assist in creating markets for available family planning methods. Furthermore, exploring missed opportunities at the health center level can assist in eliminating barriers that affect family planning need, especially among the non-served clients.

I.1 Demographic background

Jordan is a small Middle Eastern country with an area of 90,000 square kilometers. Population size for Jordan was recently estimated at 5.04 million individuals, compared to a figure of one million in 1960 and 4.09 million in 1994¹. The country is highly urbanized with almost 80% of the population living in urban settlements. More than 95% of adult males are literate as compared to 85% of females¹. Annual population growth rate in 1950 was 2.5 compared to 3.1 in 1960, 3.4 for the period 1986-1990^{2,3,4,5}, and 2.8 in 2002. Among the factors contributing to this high growth rate are the high fertility rates combined with the improvements of both child survival rates and life expectancy. Total fertility per woman aged 15-49 years decreased from 6.6 children in 1983 to 5.6 in 1990 and 4.4 in 1997^{2,3,4}. The 1997 Jordan Population and Family Health Survey (JPFHS) showed that if all unwanted births had been avoided, the total fertility rate for the three-year period before the survey would have been 2.9, which is 34% lower than the actual observed rate for that year. The most recent JPFHS survey of 2002 reported the total fertility at 3.7.

The infant mortality rate in Jordan has fallen gradually from 151 per 1,000 live births in 1960 to 24 in 2002^{2,3,4,5}. The National Population Council adopted the Birth Spacing National Program in 1991, which was approved by the government in 1993 as part of the official population policy.

I.2 The concept of unmet need

The concept of unmet need was first explored in the 1960s, when data from the KAP surveys indicated the existence of a gap between some women's desire to stop or delay childbearing and their

contraceptive behavior⁷. The standard definitions of unmet need includes all fecund women who are married and not using any method of contraception and who either; do not want to have any more children; or want to postpone their next birth for at least two more years. Those who want to have no more children are considered to have unmet need for *limiting* births, while those who want more children but not before two years are considered to have an unmet need for *spacing* births. The standard unmet need group also includes all pregnant married women whose current pregnancies are unwanted or mistimed and who became pregnant because they were not using contraception. Similarly, women who recently have given birth, but are not yet at risk of becoming pregnant because they are amenorrheic postpartum, are considered to have an standard unmet need if their pregnancies were unintended^{8,9,10}.

In the standard formulation, the unmet need group does not include pregnant or amenorrheic women whose current pregnancy or recent birth was intended, even if they do not want to become pregnant again right away. In addition, women who became pregnant unintentionally because of contraceptive method failure are *not* considered to have unmet need for family planning in general, although they may need more reliable contraception¹⁰.

The *standard formulation* of unmet need does not identify the full extent of the need for family planning^{11,12}. The standard formulation may be taken to suggest that all women using any contraception, whether effective or ineffective, appropriate or inappropriate, have their contraceptive needs met. The *expanded formulation* suggests that contraceptive users could be considered to have an unmet need if they are using an ineffective method, using a method incorrectly, or using a method that is unsafe or inconvenient for them.

Karen Foreit and colleagues have called this broader formulation the unmet need for "appropriate contraception"¹³. For example, contraceptive users may need a more appropriate method because they are using a method best suited to spacing births when in fact they want no more children¹¹.

In countries where many women use traditional methods of contraception, it may be more appropriate to define unmet need as including women using traditional methods, such as periodic abstinence and withdrawal^{14,15,16}. This is because contraceptive failure rates are high for traditional methods.

I.3 Unmet need in developing countries

Over 100 million women in developing countries are reported as being at risk of having an unmet need¹⁷. Repeated Demographic and Health Surveys (DHS) in 44 countries verify the existence of a gap between the desired fertility and the actual reproductive behavior of fecund married women. The literature refers to this gap as the "KAP GAP". An increased attention over the unmet need

"phenomena" can be detected in recent literature. In all developing countries, except China, about 20% of married women of reproductive age have an unmet need for family planning. Among countries surveyed by the DHS in Sub-Saharan Africa, unmet need ranges from 15% in Zimbabwe to 37% in Rwanda. Among Asian countries surveyed, unmet need varies from 11% in Thailand to 32% in Pakistan. In North Africa and the Near East, unmet need is close to 20%, except in Turkey, where it is 11%. In six of the 11 countries in Latin America and the Caribbean unmet need is below 20%. In Bolivia, Ecuador, El Salvador, Guatemala, and Mexico, the level is between 24% and 29%¹⁸.

Estimates of the expanded unmet need for family planning are widely dependent on the criteria used. The International Planned Parenthood Federation (IPPF) estimates that 111 million of the 200 million current users could have unmet need under the expanded definition¹⁹. Variation between countries is mainly due to variation in types of contraceptive methods used. In Romania 43% of married women use withdrawal or periodic abstinence. Only 10% of women had unmet need as they were not using contraceptive methods, but 39% had unmet need as they were not using modern methods²⁰. A DHS study in Sri Lanka showed that unmet need increased from 15% (using the standard definition) to 31% (using the expanded definition)¹⁵.

Reviewing changes in levels of unmet need in some countries, which have conducted two DHS surveys since 1985, show that there was a slight decline in Columbia, Dominican Republic, Egypt, Morocco, Ghana, Indonesia, and Kenya while the decrease was substantial in Bolivia, Peru, and Zimbabwe²⁰.

I.4 The status of family planning in Jordan

In Jordan, results from the 2002 JPFHS indicated that 56% of married women were using a contraceptive method. Forty-one percent of current users relied on modern methods. The IUD was the most widely adopted modern method (24%) followed by the pill (8%). Fifteen percent of currently married women were using traditional methods, mainly withdrawal or periodic abstinence⁶.

The 2002, JPFHS in Jordan indicated that 11.1% of currently married women are in need of family planning, a 50% decline from the 1990 JPFHS's figure of 22.4%. The unmet need for spacing births and limiting births was 5.6% and 5.5% respectively. According to the 1997 JPFHS, of the 53% of women using contraception, 18% reported using it to delay their next birth, while 34% wanted to stop childbearing.

The standard definition of unmet need was used for the calculation of the unmet need in both surveys. Total demand for family planning in the two surveys was defined as pertaining to women who were not using a contraceptive method, women who were using a method and women who used a method that

failed. The results of the family planning KAP study,²¹ which was conducted in Jordan in 1997 using the same definition of unmet need, was comparable to the JPFHS findings. The KAP study indicated that unmet need for spacing was 7.6% as compared to 11.2% for limiting. Total demand for family planning in the KAP study was 69.5%, and the percentage of satisfied demand was 72%.

The 2002 JPFHS shows that 60% of non-users intend to use a contraceptive method in the future as compared to 21% in the KAP study⁶. The 1997 JPFHS showed that 72% of non-users were intending to use a contraceptive method in the future. The 1990 JPFHS indicated that the proportion of women who did not plan to do anything to avoid a pregnancy in the future was 43%.

I.5 Objectives of the study

Following are the main objectives of the study:

- ◀◀ To measure the prevalence of unmet need for family planning among married women aged 15-49 years, who use MOH facilities, and to identify different categories of unmet need.
- ◀◀ To identify characteristics of women in different categories of unmet need compared to users of family planning methods and compared to each other.
- ◀◀ To determine the proportion of non-users who intend to use family planning methods over the coming year and the method they prefer.
- ◀◀ To explore missed opportunities for family planning counseling and provision with emphasis on the health center level.
- ◀◀ To examine options and make recommendations on how to meet the family planning needs of the selected subgroups.

II. Methodology

The study follows a cross sectional design employing both quantitative and qualitative methods. The quantitative section used interview questionnaires (Appendix A) and the qualitative section used a series of focus groups.

II.1 Quantitative section

Three forms of questionnaires were used to collect quantitative data on unmet need and missed opportunities. This data was compiled by synthesizing responses on questions using selective criteria.

II.1.1 Definition of variables

Unmet need was explored within its *standard* (classic) and *expanded* context. The main variable definitions used for the purpose of this study are found below.

Standard Unmet Need was defined as an estimate based on the computation of data from the following response descriptions:

- a. Non-pregnant and non amenorrheic women who reported not using any method of contraception and who indicated a desire to postpone their next birth for at least two years (*spacing*) or a desire to stop childbearing (*limiting*).
- b. Pregnant women who reported not using any method of contraception before getting pregnant and who indicated that their pregnancies were unwanted (*limiting*) or mistimed (*spacing*).
- c. Amenorrheic women (less than 40 days after delivery) who indicated that their recent pregnancies were unwanted (*limiting*) or mistimed (*spacing*) and who had not used any method of contraception before becoming pregnant with their recent birth.
- d. Pregnant and amenorrheic women who responded that their current pregnancies or births were unintended and that they did not want to have any more children, but who also responded to another question indicating that they wanted another child, were classified as having unmet need for *spacing*.

Expanded unmet need was defined as all women with an unmet need according to the standard definition in addition to:

- a) Contraceptive users who were assessed as using either one of the following:
- ◄◄ An ineffective method
 - ◄◄ A method incorrectly
 - ◄◄ An unsafe method
 - ◄◄ An inconvenient method
 - ◄◄ Traditional methods

Table 1: Expanded Unmet Need Classification Criteria		
Method	Loose Criteria	Stringent Criteria
Pill	<ul style="list-style-type: none"> a. Taking combined pills and breast feeding b. Forgetting to take the pill more than two times per month c. Not mentioning that she would take the two forgotten pills and use another barrier method in the event of forgetting to take two pills 	<ul style="list-style-type: none"> a. Current smoker and above the age of 35 years b. Forgetting to take the pill twice or more every month and not taking the missed pills the same day or next day c. Forgetting two pills and not taking both missed pills and not using an additional method
IUD	<ul style="list-style-type: none"> a. Complaining of abnormal vaginal bleeding 	<ul style="list-style-type: none"> a. Having either abnormal vaginal bleeding b. Complaining of frequent reproductive tract infections
Condom	<ul style="list-style-type: none"> a. Reported husband's allergy to condom as ALWAYS b. Husband ALWAYS expresses dislike of the method c. Condom reportedly ever was torn and nothing was done about it to prevent possible future 	<ul style="list-style-type: none"> a. Reported husband's allergy to condom as OFTEN TIMES b. Woman reported that husband SOMETIMES expresses dislike for the use of the condom
LAM	<ul style="list-style-type: none"> a. Child above the age of 6 months b. Child using supplementary food or drink c. Woman having her period return 	

For the purposes of this study, two criteria were used to classify "inappropriate contraceptive users" into the unmet group when using the expanded definition (**Table 1**). These criteria were grouped into either loose or stringent categories based on the extent to which the use of the method by the woman and/or her husband deviates from technically recommended standards of use. The loose criteria give some leeway of deviation while the stringent method is less tolerant. Therefore, minor deviations would label a woman as falling into the expanded unmet need group. The presence of any situation under the loose criteria formed a base for the expanded definition of a women's unmet need.

For the purposes of this study expanded unmet need calculations were based on the loose criteria.

Missed opportunity was defined as an opportunity for family planning counseling that was missed at the health center, assessed by asking the woman to report:

- a. Whether she visited a health center during the last year (counseling eligibility)
- b. The type of health service sought at the health center
- c. The occurrences of any family planning advice/communication given by health workers during each reported visit
- d. The person who gave the counseling.

The prevalence of missed opportunities for family planning counseling was calculated as the number of women who had missed opportunity for counseling divided by total number of visits to the respective clinic.

II.1.2 Sampling

A pilot survey was conducted to test the study methodology, logistics and study instruments. The pilot study results helped in specifying the sample allocation and the size of secondary sampling units in each stratum.

II.1.2.1 Sampling design

A two-stage stratified cluster sampling design was applied. The country was divided into six strata based on the administrative distribution of three regions (north, central, and south), and on the two types of health facilities, comprehensive health centers (CHC) and primary health centers (PHC). Thus, each stratum included a single type of health center in a specific region.

The Primary Sampling Unit (PSU) for this study was the health center. The exact number of PSU's covered in the sample was calculated based on the results of the pilot survey and other previously conducted studies. Table 2 illustrates the six strata used, the relative number of PSU's and the sample distribution.

Strata		Number of PSU's		N Selected SSU's	N of Completed Questionnaires
No.	Description	In Frame	Selected		
1	Central CHC	21	13	390	379
2	Northern CHC	14	6	180	155
3	Southern CHC	10	6	180	167
4	Central PHC	97	26	780	713
5	Northern PHC	120	28	840	738
6	Southern PHC	57	11	330	254
Total		319	90	2700	2406

II.1.2.2 Sampling frame

The Ministry of Health provided an updated frame that included all health centers and provided essential information for each center such as the availability of MCH services and the average number of weekly visits for year 2001. This information was used to specify the target population and to calculate relative importance (weight for each PSU).

II.1.2.3 Sample size and allocation

Due to the limited number of PSU's in most of the strata in the frame, the sample fraction for the first stage was found large enough to represent all the health centers in the frame (the sample fraction was about 50% of the frame). The PSU were allocated between strata proportionally with some adjustments to make the sample more efficient.

An equal sample size from each PSU was used to draw the sample in the second stage. The number of SSUs in each cluster was 30, divided into three targeted types of women (pregnant/post partum), user, and non-user). The sample size was estimated before conducting the survey. The suggested number of PSUs was a number falling between 80 and 100. The final total number of PSU's to be used was 90 health centers, and a suggested number of 30 eligible women to be covered in each center.

II.1.2.4 Sample selection

The PSUs in each stratum were drawn by probability proportional to the number of women between the ages 15-49 visiting the health centers. In the second stage, eligible women were selected systematically using an equal time distance between each SSU (half an hour) during a minimum of two days of data collection spent at each center. In cases where the total number of women visiting the center was expected to be less than 10, a complete coverage of all women at the center was applied. In many cases, the number of completed questionnaires was less than the targeted 30.

II.1.2.5 Weighting the results

This sample follows a self-weighting design at the stratum level. However, the adjustments of weight in each stratum were made in order to take into consideration non-response rate and other field problems. The final weights and relative weights were calculated, after taking into consideration non-response rate and failed interviews.

II.1.3 Study instruments

Three data collection questionnaires (Appendix A) were constructed based on a text format. National survey questionnaires, which focused on assessing unmet need and family planning in many countries worldwide, were reviewed and utilized in structuring the interview questions. The study questionnaires were tailored to collect information from the three study groups (pregnant/postpartum women, users of family planning methods, and non-users of family planning methods). Data on the following topics was commonly collected from all three study groups:

- a. Utilization patterns of health services with special focus on family planning services
- b. Exposure to family planning information/communication
- c. Knowledge of family planning methods
- d. Attitudes (with religiosity focus) towards family planning methods
- e. Intention for future pregnancy
- f. Demographic and reproductive data

Each study group was further asked specific questions relevant to the reproductive status identified at the start of the interview. The following items were outlined in each of the three questionnaires according to the relevant study group:

- a. Reasons for non-use of family planning and intentions for future use
- b. Use of family planning prior to pregnancy and intention for future use by pregnant and amenorrheic women
- c. Information on specific family planning method used by current users

II.1.4 Data collection process

Any married woman of reproductive age visiting the health center for any reason, whether seeking medical services, reproductive services, or child health care services, was given the chance to be selected. As women registered at the health facility, a few filtering questions were administered in order to verify whether she qualified for an interview or not. All women who registered during that day were recorded on a pre-prepared sheet and the total number of these registered women was used as a denominator for weighing purposes during data analysis.

Questionnaires designed for this study were used by trained data collectors who employed interviewing techniques with special consideration for privacy and confidentiality. Interviews were carried out at the health center facility in an uninterrupted and quiet environment.

II.1.4.1 Data collection teams

Thirty-three field workers were selected from the MOH. These included physicians, nurses, midwives and one pharmacist. Selection of data collectors was based on preset qualifications. The qualifications for the supervisors included prior experience in conducting health survey interviews, managing survey interviewers, and personal ability to lead others. Moreover, interviewers were selected based on previous experience in health survey research with preference for those who had maternal and child health experience. The selected data collectors were divided into 11 teams composed of three field workers each. One member of each team acted as the supervisor for that team.

II.1.4.2 Training for data collection

Research assistants and supervisors (data collectors) were trained over a three-day period. By the end

of the training period, participants were knowledgeable of the study rationale, purpose and logistics. Training focused on the following areas:

- a. Sampling of women using the stratified sampling approach
- b. Interviewing skills
- c. Use of the study instruments

The training methodology involved standard in-class presentations, question-by-question review of instruments, and role-play. A field manual was prepared and given to each research assistant to be used during data collection. Supervisors were given guidelines for checking the quality of data collection as well as instructions for managing fieldwork.

II.1.4.3 Pilot study

Each team was asked to complete three questionnaires from each of the three forms, from any health center in their areas, provided that the center was not included in the study sample. To ensure accuracy of data collection, each field worker was asked to concentrate on one type of the three questionnaire forms throughout the study duration.

The pilot study was carried out under the supervision of the study investigators, and the project supervisor. The results of the pilot study were useful in identifying problems in data collection before starting the actual fieldwork. Necessary changes were made to questionnaires in accordance with the findings of the pilot test.

II.1.4.4 Field work

Eleven data collection teams were fielded for data collection. Field workers visited the health facility as many days as needed in order to obtain the target number of women. Data collection began with the opening of each health center and adjourned at the end of the working day. Each team supervisor was present on daily basis.

Each supervisor met daily with the research team at the end of the day and reviewed all data forms to ensure completeness, quality, accuracy and consistency. Completed questionnaire forms were sent by express mail to the central office where they were checked again before being sent to data entry. In addition, all difficulties and problems encountered by the research teams were discussed with the project supervisor and study investigators on a periodic basis.

Fieldwork was carried out over a period of five weeks. By the end of which 90 health centers were visited, 25 of which were Comprehensive Health Centers (CHC) and 65 Primary Health Centers (PHC). A total of 2,411 questionnaires were filled out, 5 of which were excluded because the interviews were incomplete.

Most health centers were visited on two consecutive days to collect the needed number of women (30 subjects). Because some health centers had specific days for prenatal and postnatal care, field supervisors planned their visits on non-consecutive days for such centers. Four health centers were visited three times instead of two in order to achieve the required sample size. These health centers were those of low daily client volume.

There were sporadic supervisory visits from the study investigators and the project assistant during fieldwork in order to ensure adequate data collection. In three supervisory visits, three different teams were found leaving earlier than expected (closing of business day). Data collected from these health centers during those visits was excluded and the three teams were asked to repeat their visits to those facilities.

II.1.5 Data entry and analysis

Codes for data entry were developed prior to the start of fieldwork. Data entry commenced as soon as data forms were filled with a maximum lapse of two days. Data entry was done using Microsoft Access. The data entry screens were designed with the capability of range and logical checking. A dry run of frequency was made when two days of data entry were completed to check both fieldwork and data entry. Appropriate corrections were made. The SPSS software package was used to produce results parallel with the study objectives. Examining frequencies and means of variables for different population categories within the sample served as the primary approach for generating results. Appropriate data were mostly presented in the form of frequency table distributions. Prediction of unmet need was done by modeling relevant covariates.

II.2 Qualitative section

A total of four focus group sessions were conducted. Two of these were conducted in urban areas and another two in rural areas. The need to carry out these focus groups in urban and rural areas was decided because of the inherent variations between urban and rural areas in terms of fertility patterns, perception of need and differentials in programmatic interventions. The first session was conducted with women who were pregnant and whose pregnancies were mistimed or unwanted. The second session was conducted with women who were not pregnant, did not want children at the time of the study and were not using any family planning methods.

Two focus group guides were prepared. A trained moderator and a note-taker were hired to conduct the focus groups. All sessions were tape-recorded and then transcribed. Focus group content was analyzed and a report produced for each session. Initial results from the quantitative data analysis assisted in formulating important issues related to unmet need and missed opportunities. Such issues formed the foundation for focus group discussions. Information that was not well captured in the quantitative component of the study was introduced into the qualitative part.

III. Results

The study results are based on face-to-face interviews with 2,406 women. Due to weighting, the study results hereafter are based on a total sample of 2,407 women broken down into the categories of pregnant/post partum (20.4%), users of family planning methods (55.6%), and non-users of family planning methods (24.1%). Table 3 shows the number of missing values for selected demographic characteristics.

Demographic Characteristics	Valid	Missing
Age or respondent	2397	9
Number of years of marriage	2391	15
Number of pregnancies	2398	8
Number of deliveries	2355	51
Number of living children	2406	0
Monthly family income (JD's)	2313	93
Educational level	2396	10
Husband's educational level	2395	11
Region	2406	0
Presence of health insurance	2396	10

III.1 Characteristics of study population

Women in the study have been married for about 10 years with an average age of 30.7 years. On average, women in the study reported having been pregnant 4.7 times, with an average of 4.0 deliveries. The average monthly family income of the interviewed women was JD 214.4 (Table 4).

Table 4 : Mean Values of Selected Demographic Characteristics of the Three Study Groups

Demographic Characteristics	Type of respondent			Total N=2407
	Pregnant post partum n=491	User n=1337	Non user n=579	
Age of respondent	27.7	31.2	31.9	30.7
Number of years of marriage	7.0	11.3	11.5	10.4
Birth spacing interval in months	32.1	35.0	34.6	34.4
Number of pregnancies	3.8	5.1	4.6	4.7
Number of deliveries	2.6	4.5	4.2	4.0
Number of living children	2.5	4.3	3.9	3.8
Number of living boys	1.7	2.3	2.1	2.2
Number of living girls	1.6	2.0	2.0	1.9
Monthly family income (JD's)	198.6	221.4	211.4	214.4

Only 5.1% of women reported having no formal school education as opposed to 21.8% having college or university schooling.

The frequency percent distribution of husbands' educational level was rather similar to that of the women. About two thirds of women (68.7%) had some form of health insurance (Table 5). Over a third (37.9%) of the insured had public insurance, and 57.4% had military insurance. Further analysis showed that only 2.9% of women had insurance coverage from more than one source (multiple). With 68.2% of women living near to a health center, more than half (56.5%) reported walking and 34.3% reported using public transportation to get to the health center.

Table 5: Distribution of Women According to Specific Demographic Characteristics by Type of Respondent

Selected demographic characteristics	Type of respondent			Total N=2407
	Pregnant/post partum n=491	User n=1337	Non-user N=579	
Age categories				
<25 years	34.3	14.8	19.3	19.9
25-35 years	50.8	55.0	44.5	51.6
>35 years	14.8	30.2	36.2	28.5
Number of living children				
<3 Children	57.1	22.3	34.3	32.3
3-4 Children	25.0	39.8	31.8	34.8
=>5 Children	17.9	37.9	33.9	32.8
Educational Level				
Illiterate	3.9	4.5	7.5	5.1
School	74.1	73.6	71.2	73.1
college or university	22.0	21.9	21.3	21.8
Husbands Educational				
Illiterate	3.0	3.5	4.0	3.5
School	78.2	72.4	74.3	74.0
college or university	18.8	24.1	21.7	22.5
Income categories				
<=130	22.2	17.9	19.6	19.2
131-159	20.1	21.5	18.9	20.6
160-200	30.7	24.8	32.3	7.8
201-260	10.0	13.7	10.1	12.1
>260	17.0	22.2	19.1	10.4
Health insurance				
Yes	67.2	66.7	74.7	68.7
No	32.8	33.3	25.3	31.3
Region				
Central	34.6	56.0	39.1	47.6
North	57.2	34.4	44.6	41.5
South	8.2	9.6	16.3	10.9
Employment				
Yes	12.0	11.3	11.7	11.5
No	88.1	88.7	88.3	88.5
Husbands employment				
Yes	96.6	94.1	93.3	94.4
No	3.4	5.9	6.7	5.6

Analysis of the distribution of the three groups of women according to selected demographic characteristics showed age differences between respondent categories. Pregnant/post partum women tended to be younger than women who were either users or non-users of family planning. Table 5 also shows that 34.3% of pregnant/post partum women were below the age of 25 years compared to 14.8% and 19.3% for the user and non-user categories respectively.

Moreover, the highest percentage for women over 35 years of age was that of the non-user group. No major differences were noted in the educational level of women or their husbands' level of education, or employment of respondents. However, higher proportions of the user group were in the highest two income brackets when compared to the pregnant/post partum women and non-user categories. Differences were also noted between the study groups by husband's employment status with the highest proportion of husband unemployment in the non-user category (6.7%), compared to 3.4% for the pregnant/post partum women category (Table 5).

III.2 Prevalence of unmet need

The study results showed that the overall prevalence of unmet need, using the standard formulation, was 16.3% broken down into 9.5% unmet need for spacing and 6.8% for limiting. Moreover, using the expanded definition (using the loose criteria), an additional 17.3% of women had unmet need thus bringing the total unmet need to 33.6% (Table 6). Appendix B presents a series of tables that show the frequency distribution of relevant variables that were used to construct loose and stringent criteria that formed the basis for expanded unmet need calculations.

Type of Unmet Need	Spacing		Limiting		Total	
	N	%	N	%	N	%
Standard Unmet Need	228	9.5	165	6.8	393	16.3
Expanded Component	254	10.5	163	6.8	417	17.3
Total Unmet Need*	284	20.0	328	13.6	810	33.6
Met Need					1597	66.4
Total**					2407	100.0

* Total unmet need is the sum of the standard unmet need and the expanded component

** Total is for the expanded unmet need and met need

Analysis of the prevalence of standard unmet need by type of respondent categories showed that standard unmet need for pregnant/post partum women was 15.9%. The corresponding standard unmet need for non-users was 54.4% (Table 7).

Table 7: Distribution of Standard unmet need by type of respondent

Unmet need status	Type of respondent						Total	
	Pregnant/post partum		Users		Non user			
Need for family planning	N	%	N	%	N	%	N	%
Unmet	78	15.9	0	0.0	513	54.4	393	16.3
Met	413	84.1	1337	100.0	264	45.6	2014	83.7
Total	491	100.0	1337	100.0	579	100.0	2407	100.0

III.3 Characteristics of women with standard unmet need

When standard unmet prevalence was broken down by selected demographic characteristics, the study results showed that older women (>35 years) had the highest standard unmet need prevalence (21.2%), compared to 17.7% for the below 25 years of age group, and 13.1% for the group of women between 25 and 35 years of age. When standard unmet need was examined against the number of living children study results showed that the highest prevalence of standard unmet need (20.0%) was observed in women who had five children or more (Table 8). No apparent trend was noted when the income categories were compared. Table 8 also shows that illiterate women had the highest standard unmet need prevalence (30.2%), when compared to women who had some form of schooling (16.1%) or women with higher education (13.8%). Women with health insurance had higher standard unmet need than women with no health insurance. In addition women living in the southern region had highest standard unmet need (26.7%) than women living in the northern (18.7%) or the central region (11.9%). Analysis of types of standard unmet need, whether for spacing or limiting births, and selected demographic characteristics showed that with increasing age, the prevalence of standard unmet need for spacing goes down. The prevalence of standard unmet need for spacing among women below the age of 25 years was 16.9%, while it was 9.7% for women 25-35 years of age and 3.8% for women above the age of 35 years. The pattern of standard unmet need prevalence for women who intended to limit births showed a rising prevalence with increasing age (Table 8). Similar patterns were seen when the number of living children was analyzed. Table 8 shows that the prevalence of standard unmet need for spacing births for women with five or more children was 4.9% compared to 15.1% for women with standard unmet need for limiting births. No particular pattern was seen when income categories were

examined. Moreover, when the educational level of women was analyzed, with increase in the level of education, the prevalence of standard unmet need showed an increasing trend for women who intend to space births and a downward trend for women who intended to limit births. There were also minor variations noted when health insurance, and employment were studied (Table 8.) Both types of standard unmet need (limiting and spacing) showed higher prevalence figures in the southern region (13.3% and 13.4% for spacing and limiting respectively) and northern region (12.1% and 6.6% respectively) when compared to the central region (6.3% and 5.6% respectively).

Explanatory Variables	N	Standard unmet need		Spacing	Limiting
		N	%	%	%
Total	2407	393*	16.3	9.5	6.8
Age					
<25 years	477	84	17.7	16.9	0.8
25-35 years	1238	162	13.1	9.7	3.4
>35 years	648	145	21.2	3.8	17.4
Number of living					
< 3 children	778	123	15.9	15.1	0.8
3-4children	839	111	13.3	8.6	4.7
5 children	791	158	20	4.9	15.1
Income Quantiles					
<=130	444	81	18.3	10.9	7.4
131-159	476	83	17.4	8.5	8.9
160-200	643	116	18.1	12.0	6.1
201-260	279	30	10.9	7.4	3.5
>260	471	74	15.7	7.5	8.2
Education					
Illiterate	123	37	30.2	8.3	21.9
School	1753	282	16.1	9.4	6.7
Higher Education	523	72	13.8	10.1	3.7
Health Insurance					
Yes	1648	297	18	10.2	7.8
No	749	95	12.7	7.9	4.8
Region					
Central	1145	136	11.9	6.3	5.6
North	999	187	18.7	12.1	6.6
South	263	70	26.7	13.3	13.4
Employment					
Yes	277	46	16.8	9.2	7.6
No	2122	345	16.3	9.5	6.8

* Due to missing values not all categories of explanatory variables add to 393

III.4 Expanded unmet need

III.4.1 Characteristics of women with expanded unmet need

Analysis of expanded unmet need prevalence by selected demographic characteristics showed that women in the youngest age category (<25 years), had the lowest expanded unmet need (14.5%), compared to 16.9% for the 25-35 years of age category, and 20.0% for women above the age of 35 years if age. Moreover, women with 3-4 children had the highest expanded unmet need (20.0%). No particular pattern emerged from examining the income quantiles where expanded unmet need prevalence ranged between 13% and 22% (Table 9).

Moreover, illiterate women had the lowest expanded unmet need when compared to the other education categories. Table 9 shows that women with health insurance coverage had higher expanded unmet need (17.7%) when compared to women without health insurance (16.3%). Unlike the pattern of regional distribution with the standard unmet need, women living in the south region had the lowest expanded unmet need (14.4%) compared to women living in the northern or central regions.

Table 9: Distribution of Expanded Component of Unmet Need by Explanatory Variables

Explanatory Variable	Unmet Need		Total
	N	%	N
Total	417	17.3	2407
Age categories			
<25 years	69	14.5	477
25-35 years	209	16.9	1238
>35 years	137	20.0	684
Number of living children			
<3 Children	103	13.2	778
3-4 Children	168	20.0	839
=>5 Children	146	18.5	791
Income Quantiles			
<=130	60	13.5	444
130-160	86	18.1	476
160-200	108	16.8	643
200-260	61	21.9	279
>260	86	18.3	471
Educational Level			
Illiterate	11	8.9	123
School	309	17.6	1753
Higher Education	94	18.0	523
Health insurance			
Yes	291	17.7	1648
No	122	16.3	749
Region			
Central	216	18.9	1145
North	163	16.3	999
South	38	14.4	263
Employment			
Yes	58	20.9	277
No	357	16.8	2122

Due to missing values not all categories of explanatory variables add to 417

III.4.2 Types of expanded unmet need

Further analysis of the expanded unmet need by type of family planning method used and whether women intentions were for limiting or spacing showed that women who intended to limit births and were using the pill had the highest proportion of expanded unmet need. Expanded unmet need for pill users was 53.4%, while for the condom users it was 43.9 % using the loose criteria. Using the stringent criteria, expanded unmet for pill users and condom users was 42.6%, and 48.8% respectively, (Table 10). However, women whose intentions were to space births showed a different picture. Table 10 shows that the highest proportion of expanded unmet need for women using the loose criteria was for those relying on lactation amenorrhea (34.7%), while those using the condom still had the highest expanded unmet need using the stringent criteria (60.0%). It is worth noting that the all (100%) of natural methods were considered to have unmet need since by definition women relying on natural family planning methods are deemed using unreliable methods and thus are at risk of pregnancy.

Table 10 : Expanded Unmet Need Using Loose and Stringent Criteria

	Limiting		Spacing	
	N	% ^a	N	% ^b
Loose Criteria				
Oral Contraceptives	53	53.4	70	24.6
IUD	47	26.1	67	29.4
Condoms	18	43.9	27	28.4
Natural Methods	52	100.0	62	100.0
Lactation Amenorrhea	4	22.2	17	34.7
Total (N=417)	174	35.6	243	33.0
Stringent Criteria				
Oral Contraceptives	52	42.6	128	44.9
IUD	65	36.1	97	42.5
Condoms	20	48.8	57	60.0
Natural methods	52	100.0	62	100.0
Lactation Amenorrhea	4	22.2	17	34.7
Total (N=554)	193	39.5	361	49.0

a. The denominator consist of women who were using the method for limiting births.

b. The denominator consist of women who were using the method for spacing births.

III.5 Prediction of standard unmet need

Table 11 shows the results of the multivariate analysis using a logistic regression equation where the dependent variable was the standard unmet need and the independent variables were selected demographic characteristics. Age was found to play a significant role in the prediction of standard unmet need where an increase of one year in a woman's age contributes 4% to the likelihood that she has standard unmet need for family planning ($p < 0.01$). The number of living children and income were not significant predictors of standard unmet need, (Table 11). Compared to women with high education, illiterate women had more than two fold increase in the risk of having standard unmet need ($p < 0.01$), while women with some form of schooling had a statistically insignificant 25% higher chance of having standard unmet need compared to women with high education. Women in the central region had a two fold lower chance ($P < 0.01$) of having standard unmet need when compared to women in the southern region, (Table 11). However, women in the north region had a one and a half lower chance of having standard unmet need when compared to women in the southern region.

Table 11 : Logistic Regression Analysis on Standard Unmet Need				
Explanatory Variable	Odds Ratio	P value	95% CI	
Age of respondent	1.04	0.01	1.01	1.06
Number of living children				
< 3 children	1.29	0.18	0.89	1.89
3-4 children	0.86	0.33	0.63	1.17
=>5 children*	-----	-----	-----	-----
Income Quantiles				
<=130	1.29	0.22	0.86	1.94
131-159	1.18	0.41	0.79	1.76
160-200	1.22	0.30	0.84	1.77
201-260	0.71	0.16	0.44	1.15
>260*	-----	-----	-----	-----
Education				
Illiterate	2.06	0.01	1.22	3.48
School	1.25	0.17	0.90	1.74
Higher Education*	-----	-----	-----	-----
Health Insurance				
Yes	1.29	0.09	0.97	1.71
No*	-----	-----	-----	-----
Region				
Central	0.45	0.00	0.32	0.64
North	0.64	0.01	0.46	0.89
South*	-----	-----	-----	-----
Employment				
Yes	1.10	0.66	0.72	1.69
No*	-----	-----	-----	-----

* : Comparison group

III.6 Prediction of total unmet need

The results of the multivariate analysis using a logistic regression equation for the total unmet need are shown in Table 12. The dependent variable was the total unmet need and the independent variables were selected demographic characteristics. The study results showed that with the exception of age and region of residence, none of the studied independent variables had a significant impact on prediction of total unmet need. Age plays a significant role in the prediction of total unmet need where an increase of one year in a woman's age contributes 3% to the likelihood of having total unmet need for family planning ($P < 0.01$). Women living in the central region had 45% lower chance of having total unmet need when compared to women in the south ($P < 0.01$), while women living in the north had a 30% lower chance of having total unmet need in comparison to women living in the south ($P < 0.08$).

Table 12 : Logistic Regression Analysis on total Unmet Need				
Explanatory Variable	Odds Ratio	P value	95% CI	
Age of respondent	1.03	0.00	1.01	1.05
Number of living children				
< 3 children	1.00	0.99	0.74	1.35
3-4 children	0.99	0.93	0.78	1.25
=>5 children*	-----	-----	-----	-----
Income Quantiles				
<=130	1.12	0.49	0.81	1.55
131-159	1.27	0.13	0.93	1.72
160-200	1.23	0.16	0.92	1.65
201-260	1.11	0.55	0.79	1.56
>260*	-----	-----	-----	-----
Education				
Illiterate	1.24	0.34	0.79	1.96
School	1.17	0.21	0.92	1.49
Higher Education*	-----	-----	-----	-----
Health Insurance				
Yes	1.14	0.22	0.92	1.42
No*	-----	-----	-----	-----
Region				
Central	0.69	0.01	0.52	0.93
North	0.77	0.08	0.58	1.03
South*	-----	-----	-----	-----
Employment				
Yes	1.32	0.10	0.95	1.83
No*	-----	-----	-----	-----

* : Comparison group

III.7 Unmet need and use of family planning

III.7.1 Use of family planning methods

One-third of FP users were currently using IUDs (34.1%) and 32.4% were using oral contraceptives. It was also found that 11.4% of women were using condoms, 9.6% were using natural family planning methods, and 5.3% of women were using LAM. When compared to women who intended to space births, women who desired to limit births were more likely to use the IUD (31.0% versus 36.9%). Women who intended to space births were more likely to use oral contraceptives (38.7%) compared to 24.9% for women who intended to limit births. Moreover, women who intended to space births were more likely to use the condom. It is worth noting that lactation amenorrhea and natural methods were mentioned by 14.3% of women who intended to limit births, (Table 13).

Table 13 : Distribution of Current Users of FP Methods According to Method Used

Method	Limiting	Spacing	Total	
	(n=489)	(n=736)	(n=1337)	%
Oral Contraceptives	24.9	38.7	433	32.4
IUD	36.9	31.0	456	34.1
Injectables	5.0	3.2	48	3.6
Norplant Implants	0.3	0.0	1	0.1
Condom	8.5	13.0	153	11.4
Diaphragm	0.4	0.0	2	0.2
Spermicides	0.0	0.2	2	0.1
Female sterilization	10.4	0.0	51	3.8
Vasectomy	0.0	0.0	0	0.0
Natural Methods	10.7	8.4	129	9.6
Lactation Amenorrhea	3.6	6.7	71	5.3
Total	100.0	100.0	1346*	100.0

* : some women were using more than one method.

III.7.2 Demographic characteristics of users versus standard unmet group

Analysis of the contrast between women in the standard unmet group and women in the user group showed that women with standard unmet need were slightly older than users of family planning methods (31.9 years versus 31.2 years). Those with standard unmet need also had been married for a slightly longer period, had the same number of pregnancies, but had a slightly lower number of deliveries than the user group (Table 14). None of the demographic variables studies reached statistically significant levels except income where users of family planning had higher family income (JD221.4) than women in the standard unmet group (JD 204.1).

Table 14 : Mean Values of Selected Demographic Characteristics of the Standard Unmet Need Group and Users of Family Planning Group

Demographic Characteristics	Unmet Need	Users
Age of respondent	31.9	31.2
Number of years of marriage	11.7	11.3
Number of pregnancies	5.1	5.1
Number of deliveries	4.4	4.5
Number of living children	4.2	4.3
Number of living boys	2.2	2.4
Number of living girls	2.1	2.0
Monthly family income (JD's)*	204.1	221.4

*: Statistically significant (p<0.05)

When compared to women in the user group, women in the standard unmet need group had a higher proportion of respondents in the young age group (21.5% versus 14.8%) as well as in the illiterate category (9.5% versus 4.5%).

In addition, women in the user group had higher proportions in the two highest income brackets (JD200-260 and >JD260) (Table 15). No significant variations were noted when the regions of residence, presence of health insurance or employment were examined (Table 15).

Table 15 :Distribution of Users and Standard Unmet Need Group According to Selected Demographic Characteristics		
	Standard unmet group and users of FP	
Demographic Characteristics	Unmet Group	Users
Age categories*		
<25 years	21.5	14.8
25-35 years	41.4	55.0
>35 years	37.0	30.2
Educational Level*		
Illiterate	9.5	4.5
School	72.1	73.6
College or university	18.5	21.9
Income categories*		
<=130	21.2	17.9
131-159	21.5	21.5
160-200	30.3	24.8
201-260	7.9	13.7
>260	19.2	22.2
Presence of health insurance*		
Yes	75.8	66.7
No	24.2	33.3
Region*		
Central	34.7	56.0
North	47.5	34.4
South	17.9	9.6
Employment		
Yes	11.9	11.3
No	88.1	88.7

*: Statistically significant $p < 0.05$

III.7.3 Reasons for non-use and future intentions

Table 16 shows reasons why women were not using contraceptive methods. The most frequent responses were, desire for more children (29.0%), health concerns about using contraception (25.7%), followed by lack of knowledge about family planning. The latter group of women thought that they could only become pregnant once every 3 years, and thus did not think they needed a contraceptive method.

Objections to family planning was another important category, with husband opposition making up 6.7% of responses.

Table 16 : Percent Distribution of Reasons for Not Using FP Methods by Non-Users	
Reasons (Number of responses=1192)	%
Desire for more children	29.0
Poor Access	
Lack of knowledge	25.1
High cost	0.8
Distance	0.3
Sources limited	0.2
Concerns about Using Contraception	
Health concerns	25.7
Inconvenience	2.6
Objection to Family Planning	
Husband opposition	6.7
Personally opposed	1.4
Others disapprove	1.5
Religion	0.8
Other	5.8
Total	100.0

Table 17 shows that the main reported reason for not using contraceptive methods among women with an unmet need (using standard definition) for limiting was lack of knowledge (40.5%) compared to 37.9% for women with unmet need (using standard definition) for spacing. Health concerns were also the most frequently reported reason for not using FP among women with an unmet need (using standard definition) for limiting (16.9%) and for spacing births (20.7%).

Table 17 : Reasons for Not Using FP Methods in the Two Types of Standard Unmet Need Categories

Reasons	Types of Unmet Need for FP	
	Limiting (194)	Spacing (n=142)
Poor Access		
Lack of knowledge	40.5	37.9
High cost	1.0	0.0
Distance	1.5	0.0
Sources limited	0.5	0.0
Concerns about using contraception		
Health concerns	16.9	20.7
Inconvenience	1.0	2.1
Objections to FP		
Husband opposition	6.2	8.6
Fatalism	2.6	2.1
Personally opposed	1.5	2.1
Others disapprove	2.1	0.7
Religion	0.5	0.0
Others	25.6	25.6
Total	100.0	100.0

Thirty-two percent of non-users intended to use family planning methods during the next year. In general, the intention of women was mostly directed towards the use of the IUD (50.8%), followed by pills (24.9%), and lactation amenorrhea (8.2%) (Table 18).

Table 18 : Methods Non-Users Intend to Use within the Next Year		
Type of method	N	%
IUD	178	50.8
Oral Contraceptives	87	24.9
Lactation Amenorrhea	29	8.2
Spermicides	13	3.7
Natural Methods	6	1.8
Injectables	6	1.7
Female Sterilization	3	0.8
Other	1	0.3
Condom	1	0.2
Total	324	100.0

About one-third of women (31.5%) not intending to use contraceptives indicated that their reason was that they wanted more children. Other reasons indicated by those women included age (the fact that they thought they were too old to become pregnant and thus did not need to use family planning methods) (17.2%), fear of side effects (12.3%), and disapproval of family planning (11.9%), (Table 19).

Table 19 : Non-Users' Reasons for Not Intending to Use FP Methods During Next Year

Reasons	N	%
Wants more children	72	31.5
Age	39	17.2
Becomes pregnant every 2-3 years	37	16.1
Disapproves of family planning	27	11.9
Fear of side effects	28	12.3
Husband reasons	17	7.5
Desires to have a resting period	13	4.2
Other	8	3.5
Total	227	100.0

The vast majority (91.4%) of pregnant/postpartum women intended to use family planning methods during the next year. More than three quarters of women (80.8%) intended to use modern methods. The most common method mentioned was the IUD (45.5%), (Table 20). The rest intended to use oral contraceptives (17.8%), natural family planning methods (12.3%), condoms (5.5%), and lactation amenorrhea (6.5%).

Table 20 : FP Method to Be Used Within Next Year by Pregnant/ Postpartum Women

Method (number of responses =493)	N	%
IUDs	224	45.5
Oral Contraceptives	88	17.8
Natural methods	60	12.3
Lactation Amenorrhea	32	6.5
Condom	27	5.5
Female Sterilization	16	3.2
Injectables	12	2.3
Spermicides	3	0.6
Norplant	2	0.4
Other	29	5.9
Total		100.0

The reasons for not intending to use family planning methods by pregnant/ postpartum women were the desire to have more children (58.4%), disapproval of family planning (15.4%), belief they can only get pregnant every 2 to 3 years (16.1%), and fear of side effects (6.6%).

III.7.4 Problems in using family planning methods

The study results also showed that about one-third (33.6%) of women who were users of family planning methods reported facing problems with the current method they were using. More detailed inquiry into the types of problems that women face (analysis focused on commonly used methods) showed that the commonest problems for pill users were nervousness (25.9%), headaches (25.5%), or menstrual in nature (12.6%). Moreover, IUD users complained of infections (28.6%), Menstrual problems (27.6%), or backache (27.6), (Table 21).

Table 21 : Distribution of Types of Health Problems Women Reported While Using Selected Family Planning Methods

Type of problems	Pill		IUD	
	N	%	N	%
Period related problems	30	12.6	85	27.6
Backache	15	6.3	68	22.1
Increased vaginal discharge	0	0.0	10	3.2
Headache	61	25.5	8	2.6
Infections	5	2.1	88	28.6
Nervousness	62	25.9	3	1.0
Limb pain	12	5.0	7	2.3
Nausea	12	5.0	3	1.0
Sexual impact	0	0.0	2	0.6
Weight changes	25	10.5	2	0.6
Vaginal dryness	1	0.4	3	1.0
Stomach pain	9	3.8	26	8.4
Breathing difficulty	2	0.8	0	0.0
Tiredness	5	2.1	3	1.0
Total	239	100.0	308	100.0

III.8 Knowledge, attitudes, and practices of family planning

III.8.1 Knowledge of family planning methods

When women were asked to mention all family planning methods they knew, minor variations were seen. The standard unmet need group, as compared to the users group, was less likely to know the IUD (94.6% versus 95.5%), condom (48.8% versus 66.8%), and spermicides (11.2% versus 16.1%). They were more likely to know other methods, particularly female sterilization where the percentage for the standard unmet need group was 12.5% compared with 9.8% for the users group (Table 22)

Table 22 : Respondents' Knowledge of Family Planning Methods

Methods	Study Group		P-Value
	Standard unmet (N=393)	Users (N=1337)	
Oral Contraceptives	91.8	97.2	0.00
IUD	94.6	95.5	0.41
Injectables	51.2	57.7	0.00
Norplant Implants	12.9	18.4	0.16
Condom	48.8	66.8	0.00
Diaphragm	1.5	1.9	0.32
Spermicides	11.2	16.1	0.11
Female Sterilization	12.5	9.8	0.00
Vasectomy	4.7	1.7	0.00
Natural Methods	43.9	44.8	0.27
LAM	21.1	10.6	0.00

III.8.2 Perception of religion stance on family planning

Table 23 compares the user group with women who had unmet need for family planning regarding their religious perception of family planning. Both groups of women highly believed that family planning is religiously acceptable (86.8% and 91.9% for the unmet need group and user group respectively). Women with unmet need for family planning were more likely to consider family planning as religiously unacceptable when compared to the users group (3.9% versus 2.1%). Table 23 shows that women with unmet need were also more likely to respond that they do not know whether family planning is religiously unacceptable or acceptable (7.3% versus 4.3%).

Table 23: Religious Perceptions of Family Planning Methods by Study Group

Religious Perception	Study Group			
	Standard unmet Need		Users	
	N	%	N	%
Acceptable (Halal)	340	86.8	1229	91.9
Unacceptable (Haram)	15	3.9	28	2.1
Not Preferable (Makrouh)	8	2.0	23	1.7
Doesn't know	28	7.3	58	4.3
Total	393	100.0	1337	100.0

*: Chi-square = 9.5 and P < 0 .02

Analysis of the distribution of women with types of standard unmet need according to their religious perceptions of contraceptive methods is shown in Table 24. The vast majority of women (90.2%) with standard unmet need for spacing thought that family planning was religiously acceptable compared to 82.1% of women with standard unmet need for limiting. In addition, 7.2% of women with standard unmet need for limiting births thought that family planning was religiously unacceptable compared to just 1.6% of women with standard unmet need for spacing births (Table 24). Another 8.5% and 6.5% of women with standard unmet need for limiting or spacing births respectively did not know whether family planning was religiously acceptable or not.

Table 24 : Distribution of Women's Religious Perception of Family Planning by Type of Standard Unmet Need

Religious Perception	Type of Standard Unmet Need			
	Limiting		Spacing	
	N	%	N	%
Acceptable (Halal)	135	82.1	205	90.2
Unacceptable (Haram)	12	7.2	4	1.6
Not Preferable (Makrouh)	4	2.2	4	1.8
Doesn't know	14	8.5	14	6.5
Total	165	100.0	228	100.0

In general, both groups of women shared a common belief that the permanent methods, including female sterilization and vasectomy, were religiously unacceptable where 71.3% of the standard unmet need group and 72.4% of the user group thought that female sterilization was unacceptable. The comparable figures for vasectomy were 60.3% and 63.4% reported by the standard unmet need group and user group respectively. In contrast, only 5.2% of the standard unmet need group and 3.0% of the user group thought that the pill was religiously unacceptable (Table 25). The other temporary methods, including the IUD, condom, diaphragm, and natural methods, had low figures for being religiously unacceptable.

Minor differences between the two groups emerged when women attitudes were studied for each method. Specifically, the standard unmet need group were more likely than the user group to say that oral contraceptives and IUDs were religiously unacceptable and to respond that they did not know whether the use of oral contraceptives and IUD was religiously unacceptable or acceptable. The percentages of women with standard unmet need for family planning who did not know whether the pill or IUD were religiously acceptable (18.8%, 16.6% respectively) exceeded the percentages for users of family planning. The standard unmet need group were also more likely to say that the use of condoms is not preferred on religious grounds (6.0% versus 4.5%). Lactation amenorrhea was more acceptable on a religious basis in the standard unmet need group where the percentage was 88.5% as compared to 88.1% for users of family planning (Table 25).

Religious Characteristics	Family Planning Method	Oral Contraceptives	IUD	Injectables	Norplant	Condom	Diaphragm	Spermicides	Female Sterilization	Vasectomy	Natural Methods	LAM
Acceptable (Halal)	Standard Unmet Need Group	74.1	75.6	48.6	22.6	51.1	18.7	34.1	9.1	1.9	81.0	88.5
	Users	82.9	83.4	55.1	26.8	68.4	21.1	41.5	10.9	2.7	85.8	88.1
Unacceptable (Haram)	Standard Unmet Need Group	5.2	5.4	6.8	4.7	4.6	2.9	3.1	71.3	60.3	4.4	0.2
	Users	3.0	2.9	6.8	5.4	3.3	1.6	1.7	72.4	63.4	3.0	0.1
Not Preferable (Makrouh)	Standard Unmet Need Group	1.9	2.4	6.4	5.3	6.0	2.0	3.2	2.6	1.6	0.8	0.1
	Users	3.6	2.6	5.5	4.1	4.5	2.0	2.5	3.1	2.4	0.7	0.0
Doesn't Know	Standard Unmet Need Group	18.8	16.6	38.2	67.5	38.3	76.5	59.7	16.8	36.2	13.8	11.2
	Users	10.4	11.0	32.6	63.7	23.8	75.3	54.3	13.6	31.6	10.5	11.8

III.8.3 Attitude towards family planning methods

There were no variations between women who intended to limit or space births with regards to their expectations of the method they wanted to use. Both groups indicated that the preferred contraceptive method should be safe, easy to use, convenient, efficient, available, and should not affect sexual function. The latter attribute (impact on sexual function) had the lowest score of 8.8 out of 10 for women who intended to limit births. Scores for all other attributes had scores more than or equal to 9.5 out of 10 (Table 26).

Table 26 : Mean Scores for Attitudes Toward Family Planning by Type of Standard Unmet Need

Degree of Importance On a Scale of 1 to 10	Types of Standard Unmet Need	
	Limiting	Spacing
Safety	9.6	9.8
Ease of Use	9.6	9.7
Convenience	9.5	9.6
Efficiency	9.6	9.9
Preference	9.5	9.6
Impact on Sexual Function	8.8	9.3
Availability	9.9	9.9

Analysis of the contrast between how the standard unmet need group and users of family planning methods viewed certain family planning methods in general showed that the score for the degree of importance of selected criteria of the "preferred family planning methods" to be 10 out of 10 for both users and the standard unmet need group. Those criteria included the degree of importance of safety, ease of use, convenience, efficiency, method preference, and impact on sexual function. The only reading which was different between the two groups' rating was the impact on sexual function, which scored 9 out of 10 for the standard unmet group compared to 10 out of 10 for the user group (*data not shown*).

Analysis of the distribution of women attitudes in terms of their responses to specific characteristics of the different family planning methods showed that LAM and natural family planning were the most preferred methods by women with unmet need. Women considered these two methods, along with condoms, to be safe, easy to use, convenient, and efficient. The overwhelming majority of women approved the use of family planning method to space births regardless of being a user of a method (99.5%) or belonging to the standard unmet group (96.0%). The latter group was composed of 56.4% in the spacing of birth category and 39.6% in the limiting group.

Users were more likely to report husbands' approval of using family planning to space births (95.3%) than women with unmet need (87.0%). Moreover, women reported husbands' approval of using family planning to limit births was 21.7% and 10.5% for users and women with standard unmet need respectively. When compared to use of family planning methods to space births, approval to use family planning to limit births dropped down to 23.7% in the user group and 11.7% in the standard unmet group. Women reporting of their husband's approval echoed their own responses. It is worth noting that the majority of those who approve the use of family planning methods to prevent pregnancy fell in the category of standard unmet need for limiting births. Users were also more likely to discuss family planning with others (94.1% versus 75.3%) and to encourage others to use family planning methods (93.4% versus 79.9%) (Table 27).

Approval Statement	Study Group*		
	Standard unmet		Users
	Limiting	Spacing	
Approval of using FP to space births	96.0		99.5
	39.6	56.4	
Husband's approval of using FP to space births	87.0		95.3
	35.6	51.4	
Approval of using FP to limit births	11.7		23.7
	9.7	2.0	
Husband's approval of using FP to limit births pregnancy	10.5		21.7
	8.4	2.1	
Discussion of FP with someone else	75.3		94.1
	29.9	45.4	
Encouragement of someone else to use FP	79.9		93.4
	32.8	47.1	

* : All chi-square values had p-value < 0.01

Average scores for rating specific characteristics of family planning methods are rated on a scale that measured attitudes towards different family planning methods in terms of their safety, efficacy, convenience and impact on sexual function are shown in Table 28 . Apart from few exceptions, women in the standard unmet need group were more likely to rate the characteristics for the different family planning methods lower on a scale of 1 to 10 than women in the user group.

The highest preference score for the user of family planning methods were for LAM (8.6/10), followed by the IUD (7.3/10). With the exception of the diaphragm women in the user group, as opposed to women in the standard unmet group, tended to believe that family planning methods were safe, more convenient, and more efficient. With the exception of Norplant and Diaphragm, women in the user group thought that family planning methods were easier to use. However, when compared to the other methods, both study groups thought that the diaphragm had a higher impact on sexual function. Although women users of family planning methods gave lower preference ratings for the long-term methods, still they gave these methods a higher rating on efficiency than the standard unmet need group (Table 28).

Characteristics	Family Planning Method	Oral Contraceptives	IUD	Injectables	Norplant	Condom	Diaphragm	Spermicides	Female Sterilization	Vasectomy	Natural Methods	LAM
	Safety											
Users		6.5	7.7	5.0	4.9	7.4	7.6	6.9	7.5	7.5	8.8	9.6
Standard Unmet Group		6.3	7.6	4.8	4.8	7.1	8.8	6.6	6.7	5.6	8.3	9.4
Easiness												
Users		8.1	8.4	7.4	5.7	7.5	7.1	7.5	7.0	6.4	8.2	9.6
Standard Unmet Group		7.6	8.0	6.4	5.8	6.8	8.7	6.4	6.1	5.8	7.7	9.2
Convenience												
Users		7.1	7.8	6.2	5.5	6.7	6.9	6.2	8.1	6.1	7.9	9.5
Standard Unmet Group		6.8	7.4	5.6	4.1	5.8	7.2	5.5	5.1	4.8	7.3	9.1
Efficiency												
Users		8.7	9.0	8.4	7.8	7.3	7.1	6.3	9.5	7.5	7.3	8.4
Standard Unmet Group		8.1	8.5	7.7	6.0	6.7	8.1	6.1	7.5	5.2	6.8	7.7
Preference												
Users		5.9	7.3	3.7	3.3	5.1	4.6	3.5	6.2	1.7	6.1	8.6
Standard Unmet Group		5.7	7.2	3.2	3.0	4.9	7.6	4.1	3.2	3.0	6.6	7.6
Impact on Sexual Function												
Users		3.3	3.2	3.6	3.5	4.5	6.5	3.2	2.0	4.8	3.2	2.8
Standard Unmet Group		4.7	4.6	4.4	3.5	5.5	7.7	4.3	4.7	4.7	5.3	4.0

Analysis of women's attitudes was further examined where women responded to a set of specific statements. In general, women in the standard unmet need group tended to agree more with statements that supported cultural beliefs favoring more children. They also were less likely to link repeated childbirth with a negative impact on a woman's health status. More specifically, the study results showed that the user group was more likely to disagree that more children confers upon the family a status of higher respect in the community, called *ezwa* in Arabic, (73.9%) compared to 67.2% in the standard unmet need group (Table 29). The findings also indicated that the users group was more likely than the standard unmet group to disagree on the following items: family planning improves levels of living (4.3% versus 2.9%), a woman who has only girls should keep on childbearing until she succeeds in having a boy (67.2% versus 60.6%), and having more children is an expression of manhood (84.4% versus 78.8%) (Table 29).

Table 29: Responses of Women Towards Specific Reproduction-Related Statements

Statement	Study Group			P-Value
	Response scale	Standard unmet need (N=531)	Users (N=834)	
Having more children gives a woman greater respect (ezwa)*.	Agree	28.8	22.6	0.01
	Disagree	67.2	73.9	
	Not sure	4.0	3.5	
Having more children is an expression of husband's manhood.	Agree	15.8	13.4	0.09
	Disagree	78.8	84.4	
	Not sure	5.3	2.2	
Having more children is an expression of a woman's fertility.	Agree	17.0	15.8	0.89
	Disagree	77.5	80.2	
	Not sure	5.5	4.0	
Having more children improves one's level of living.	Agree	95.5	95.2	0.64
	Disagree	2.9	4.3	
	Not sure	1.6	0.6	
A woman should keep having children until she has at least one boy.	Agree	32.6	25.6	0.89
	Disagree	60.6	67.2	
	Not sure	6.8	7.2	
Childbearing has a negative impact on maternal health.	Agree	95.7	96.6	0.09
	Disagree	3.6	3.1	
	Not sure	0.7	0.3	
Family planning allows a mother to give more time to care for her family.	Agree	98.8	99.7	0.01
	Disagree	0.9	0.1	
	Not sure	0.2	0.2	

*EZWA: A family status gained in the community by having more children

** : Agree category includes the strongly agree and the disagree group also includes the strongly disagree group

III.9 Gender of health care provider

When women were asked about whether they or their husbands had any objection to discussing family planning with a male physician, less than one quarter (22.6%) said that they would object. When asked specifically who would object, 25.8% reported that the husband would object, another 30.1% said that they themselves would object, and the remaining 44.0% said both they and their husbands would object (Table 30). In addition, 42.3% reported that both the husband and the woman herself would object to receive such services from a male physician. Preference for a female physician was clearly indicated when women were asked about their provider gender preferences when IUD insertion is needed. A little more than 9 out of 10 women (91.9%) said that they would prefer a female physician, and only 6.1% said that it didn't matter (Table 30). When women were asked about their preferences for a provider if a female physician were not available, only 25.1% said that they would not mind seeing a male physician, and 57.6% would prefer having a midwife insert the IUD. Another 9.8% gave other varied responses such as that they would switch to another method, that they would go to another health facility, or they would wait until a female provider was available.

Table 30: Distribution of Women's and Their Spouses' Preferences for Provider Gender in FP Settings

Preference variables	%
Objection of woman or husband to discuss FP with male physician (n=2407)	
Yes	22.6
No	57.0
No opinion	20.4
Who objects to a discussion with a male physician? (N=546)	
Husband	25.8
Women	30.1
Both	44.0
Objection of woman or husband to receive FP services from a male physician (n=2404)	
Yes	29.7
No	51.8
No opinion	18.5
Who objects to receiving FP services from a male physician? (N=715)	
Husband	24.7
Women	33.1
Both	42.3
Preference for provider gender in case IUD insertion is needed (n=2407)	
Male physician	1.0
Female physician	91.9
Doesn't matter	6.1
Other	1.0
Preference for a provider in case IUD insertion is needed when female physician is unavailable (n=2399)	
Male physician	25.1
Midwife	57.6
Doesn't matter	7.5
Other	9.8

III.10. Role of the husband

The vast majority (98.6%) of women users of family planning methods reported that they have discussed family planning methods with their husband prior to use. In most cases (93.9%), husbands were supportive and encouraged women to use a method. Those who did not encourage their wives to use a method wanted their wives to switch to a different method (32.5%), discontinue the use of family planning methods (14.7%), or postpone using family planning methods for sometime (50.9%) (Table 31).

Table 31: Distribution of Selected Social Support Indicators for Users of Family Planning Methods

Selected Variables	%
Discussed FP methods with husband prior to use (n=1324)	
Yes	98.6
No	1.4
Husband encouraged use of method (n=1335)	
Yes	93.9
No	5.1
Other	1.0
Intentions of husband who discouraged their wives (n=44)	
Switch method	32.5
Discontinue using FP	14.7
Postpone using FP	50.9
Other	2.0

III.11. Missed opportunities

The vast majority (82%) of women reported that they have visited the health center during the last year. Table 32 shows that, in at least one of the visits made to the clinics during the past year, about three-quarters of women (73.9%) reported that they had visited a general practice clinic, 29.5% took their children to a vaccination clinic, and about one-quarter (24.7%) went to a clinic for prenatal care.

When asked about the availability of a physician in the clinic at the time of visit, women's responses varied by type of service. As shown in Table 33, the highest percentage of physician availability in the clinic was during general practice visits (96.8%) and the lowest percentage was during postnatal visits (88.0%).

Type of visit	N	% of responses	% of cases
General practice clinic	1504	41.8	73.9
Vaccination	599	16.7	29.5
Prenatal care	502	14.0	24.7
Postnatal care	36	1.0	1.8
Family planning	586	16.3	28.8
Specialty	73	2.0	3.6
Dental	290	8.1	14.3
Others	4	0.1	0.2
Total	3595	100	176.7

Table 33: Distribution of physician availability in the clinic by type of visit

Type of visit	%
General practice clinic	96.8
Vaccination	90.9
Prenatal care	92.6
Postnatal care	88.0
Family planning	90.7
Specialty	96.8
Dental	94.4
Others	100.0

As for the discussion of family planning issues, there were variations among the service areas studied, with the highest being during family planning visits (71.2%), followed by prenatal visits (47.4%). Discussion of family planning during visits to the general practice and vaccination services was found to have occurred in 16.0%, and 32.5% of the visits respectively (Table 34).

Table 34: Distribution of Service Areas Where FP Discussions Took Place

Type of Clinic	Number of Visits*	FP Discussion	%
General Practice	1504	241	16.0
Vaccination	599	195	32.5
Prenatal Care	502	238	47.4
Postnatal Care	36	23	62.8
Family Planning	586	417	71.2
Specialty	73	10	14.4
Dental	290	14	4.7
Other	4	0	0.0

*: Number of visits is based on multiple response

Midwives were the caregivers most likely to engage in family planning discussions regardless of clinic type. Analysis by location of service showed that, in almost all service locations, the midwife remains the focal provider who discusses family planning with women (Table 35). In general practice clinic, midwives' engagement in family planning discussion were reported by 38.9% of women. Higher figures were reported in the vaccination clinics (57.1%), prenatal care (58.0%), post natal care (52.0%), and family planning clinics (56.0%).

Type of Clinic	Physician	Nurse	Midwife	Health Educator	Social Worker	More than One
General Practice (n=236)	27.9	17.7	38.9	1.5	0.2	13.9
Vaccination (n=192)	6.4	17.3	57.1	1.1	0.0	18.2
Prenatal Care (n=239)	8.0	13.2	58.0	0.4	0.5	19.8
Post Natal Care (n=23)	5.0	0.8	52.0	0.0	0.0	42.2
Family Planning (n=416)	15.1	8.4	56.0	0.1	0.6	19.8

Analysis of whether discussions on family planning issues with women who visited health centers during the past year had any impact on women indicated that about one quarter of women reported no impact whatsoever, while about 13% actually re-visited the health facility in response to the counseling that they received. Moreover, the remaining bulk of about 60% either thought about making the visit or discussed it with their husbands). Table 36 shows that there were variations between service sites in terms of impact on women. About one quarter (21.1%) of women who visited general practice clinics reported that the discussion of family planning issues had no impact on them, compared to 5.4% in postnatal care clinics, and 5.8% in family planning clinics.

Type of Clinic	No impact
General Practice (n=235)	21.1
Vaccination (n=194)	15.6
Prenatal Care (n=239)	20.1
Post Natal Care (n=23)	5.4
Family Planning (n=416)	5.8
Specialty (n=10)	16.6
Dental (n=14)	31.2

* Impact refers to whether women thought of using a method, discussed use with her husband, or actually used a method.

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Type of Clinic	N	%
General Practice (n=236)	118	50.0
Vaccination (n=192)	113	58.9
Prenatal Care (n=239)	129	54.0
Post Natal Care (n=23)	13	56.5
Family Planning (n=416)	215	51.7
Specialty (n=10)	2	20.0
Dental (n=14)	1	7.1

Analysis of women experience with family planning services was based on the reporting of 25 women in the study sample. The vast majority of these women (91.6%) did not face any problems. A minority of 8.4% reported some complaints. Table 38 provides information on problems faced by women who sought family planning. Most of the reported complaints were due to physician unavailability (31.9%), frequent postponement of service provision (29.3%), unavailability of family planning methods (27.9%), or long waiting times (24.5%).

Table 38: Distribution* of Problems Faced by Women Seeking FP Services		
Type of Problem	N	%
Physician unavailability	16	31.9
Frequent service postponement	15	29.3
Method unavailability	14	27.9
Long waiting time	12	24.5
Unkindly treated	9	18.5
Unqualified employees	8	16.8
Others	8	15.2
No privacy	1	1.9

*Percentage distribution is based on multiple responses analysis

III.12. Qualitative assessment

The qualitative part of this study intended to shed light onto the following issues

- ◄◄ Perceptions of women of child-bearing age of the FP methods they have used,
- ◄◄ Reasons for becoming pregnant despite having experienced FP method use,
- ◄◄ Women's satisfaction with their current pregnancies
- ◄◄ Primary sources of information about FP methods,
- ◄◄ Potential for using FP methods,
- ◄◄ Sources of information and services.

The methodology involved a total of four focus group (FG) discussions held in both rural and urban areas of Jordan including Amman (one FG), Swaileh (one FG), and Irbid (two FGs, one in the Irbid city and another one in Kitim village). Participants in the FG were both non-users and pregnant women. Each focus group involved 7 to 10 women with ages ranging between 20 and 47 years, and with parity ranging between 1 and 10 children. The main results of the discussions are examined below.

III.12.1 Experience with modern family planning method use

When history of past contraception was gathered from women participating in the focus groups, it was apparent that modern contraceptive method use was not high. The majority of non-users and pregnant women depended largely on natural family planning methods. A few of them had used no method at all for controlling their pregnancies. The most commonly used method in the past was the IUD, oral contraceptives, and injectables. The information source that led these women to use modern methods was often linked to close relatives and friends. Their husbands did not seem to play a major role in their decision to use such methods. However, their husbands were generally supportive when involved. Women were unhappy with their experiences with modern FP methods because of unanticipated side effects.

*"Use of the rhythm method is the safest since any other method is bound to affect my body in a negative way or cause infections."
~24 year old woman, university graduate, has one child,
past user of natural methods.*

Women mostly switched between methods and discontinued use due to health related side effects or misconceptions about side effects.

"I used almost all methods. At first I used the IUD so that I can rest for a while, and then my family kept telling me it is not good for my health and that I might not get pregnant again, so I had it removed and I got pregnant again after that. Then I switched to pills, which made me nervous, and it decreased my libido. Eventually I had to switch to another method which is the rhythm method." ~30 year old woman, finished high school, has 4 children.

Non-users and pregnant women also lacked proper knowledge about the risks of becoming pregnant, especially in older age, and about the effectiveness of the natural methods.

The health center remains the primary source for providing family planning services. The information provided about modern FP methods by the providers at the health centers was mostly reported to be related to the availability of methods. Women had sought other sources for FP services besides MoH health centers, including the Jordan Association for Family Planning and Protection and the United Nations for Relief and Works Agency (UNRWA) clinics. Generally, information about side effects of FP methods was communicated at the health centers, only when a woman developed complications as a result of using a method. Most women showed an interest in learning more about the methods with an emphasis on their side effects. Focus group discussions indicated that women had several misconceptions about FP methods, and also wanted proper counseling.

III.12.2 Intention to become pregnant

Almost all pregnant participants did not plan their current pregnancies. In the urban areas, some of them became pregnant when they stopped using the FP method believing that they were not at risk of pregnancy for a variety of different reasons.

"I tried to use the IUD and the pill. My husband refused since he preferred natural methods, especially after what I went through because of bleeding following IUD use. Eventually, I became pregnant and I was mad but my relatives calmed me down and told me it is not religiously acceptable to have an abortion."

~25 year old woman, finished high school, has 4 children, past user of the IUD.

The reasons given for stopping method use included misconceptions and experiences of side effects, vaginal infections, and pelvic wall prolapse. In the rural areas, most women who became pregnant were using natural methods at the time of pregnancy due to their dissatisfaction with the side effects of modern methods. Almost all urban and rural women intended to control their fertility after delivery by using modern birth control methods. Some of the older women with five or more children expressed their intention to use permanent methods.

"God willing, I will try to have a tubal ligation, It is the best thing, especially since none of the other methods was good for me."

~39 year old lady, finished her diploma, has 5 children, past user of natural methods.

The majority of women expressed the need and interest to learn more about the different methods and their side effects. They have asked for the best source for such information.

III.12.3 Missed opportunities

Almost all women indicated that the best opportunities to educate and counsel women about FP methods were during prenatal and postpartum care clinic visits.

"It is a must that the center staff talks about family planning during the ninth month of pregnancy. It is better for women since this will ensure that they will have future benefit."

~34 year old woman, finished high school, has 4 children, past user of oral contraceptives.

A few women indicated that education about FP methods during pregnancy and child visits was indeed taking place at some health centers. Except for one, all women said that other non-MCH clinics could be used for FP education and counseling. Physicians, in addition to nurses and counselors, were considered possible sources for such counseling.

"The quality of service is poor to the extent that if you have sore throat, they do not ask you to open your mouth for examination. They just give you a prescription. They do not give you any information."

~38 year old woman, finished her diploma, has 4 children, non-user.

Almost all indicated that the family planning services are available at the health centers at all times. However, proper counseling seemed to be the issue that was most requested by women. Few women indicated the preference for female health providers.

IV. Discussion and recommendations

The concept of unmet need refers to the presence of a discrepancy between the fertility goals expressed by women and their actual use of contraceptive methods. Women non users of family planning methods and want to have no more children are considered to have unmet need for limiting births, while those want more children, but not before two years, are considered to have unmet need for spacing. Reducing unmet need for family planning helps couples achieve their desired number of children and reduces unintended pregnancies that may lead to the birth of an unwanted child that might be a burden on the family or may lead to an unsafe abortion. Moreover, reducing or eliminating unmet need for family planning may lead to a substantial decline in fertility rates.

Contraceptive use increased dramatically in recent years in many developing countries, including Jordan. The prevalence rate of contraceptive use in Jordan increased from 26% in 1983, to 40% in 1990, 53% in 1997 and to 56% in 2002. There was also a noticeable increase in the use of the IUD, which rose from 15% in 1990 to 24% in 2002⁶.

The literature shows that the unmet need (using standard definition) for family planning in Jordan in 1998 to be 14.2% (7.4% for spacing and 6.8% for limiting)³. The most recent data from the Jordan Population and Family Health Survey of 2002 showed that the overall percentage of women who do not want any more children was 43.9%. The survey also showed a positive correlation between the number of living children and a woman's desire for limiting births, starting from a low figure of 2.8 for women with just one child and rising up to 81.9% for those with more than 6 children. The same survey showed that the overall standard unmet need for family planning was 11%, broken down into 5.6% and 5.5% for spacing and limiting births respectively. The JPFHS 2002 also showed that the proportion of women who were spacing births decreased with age while the proportion of women who were limiting births increased with age. The highest standard unmet need figure, the JPFHS survey reports, was for women with no education (16.1%).

In this study, the overall standard unmet need prevalence was 16.3%, being higher than the prevalence reported by the last JPFHS of 2002. It is worthwhile mentioning that this study is facility-based and limited to Ministry of Health centers as opposed to the JPFHS which community based study. Women who receive care from Ministry of Health may have different socioeconomic characteristics and different reproductive health profile.

Adoption of the expanded definition of unmet need which defines current users as having expanded

unmet need by examining the effectiveness, safety and convenience of family planning method used, added another 17.3% thus bringing the total prevalence of unmet need to 33.6%. These figures emphasize the burden that the health care system has to face in order to lower the unmet need to acceptable levels. More time needs to be spent with clients in order to screen for the best suited methods, counseling them to know what their expectations and fertility desires are. Family planning methods which require active participation of users, such as the condom, pills, spermicides, or diaphragm, unlike passive methods such as the IUD or Norplant, dictate that women need to be educated on proper ways of dealing with these methods.

Overall, this study has shown that a high percentage of women who intended to space births had higher levels of education (secondary school, diploma, and university), while women who intended to limit births had little or no education. This finding may be attributed to the fact that women with higher education were relatively younger than women with limited or no education, and thus had not yet reached their desired number of children.

The impact, real or perceived, of the use contraceptive methods on women's health, was a significant barrier to the use of contraceptive methods. About twelve percent of non-users indicated that health problems associated with the use of contraceptive methods were the main reasons for non-use. Lack of effective counseling and regular follow-ups coupled with women's lack of knowledge of family planning could partially explain the role of health problems as a barrier to the use of contraception.

Women with standard unmet need had inadequate basic knowledge about some contraceptive methods. Only 48.8% of respondents knew of the condom, 43.9% knew of natural family planning methods, and only one-fifth of women knew LAM (21.1%). It was indicated by many women who were not using contraceptive methods that they believed they would not become pregnant because they were getting old or because they rarely had sexual intercourse. Other non-users in the study believed that some methods would have a negative impact on their sexual functions. Lack of adequate information encourages such erroneous rumors.

Although Islam, in principle, accepts the use of contraceptive methods as a way of planning births, the perceived religious beliefs of some couples might have prevented them from using contraception. In general, the standard unmet need group was more likely to perceive that Islam forbids the use of contraceptive methods. Women's answers were also discriminatory when types of methods were analyzed. This study has shown that perceived religious acceptability of family planning methods decreases dramatically for long-term or permanent methods such as female sterilization and vasectomy.

Moreover, the power of religion as an influencing factor was shown to vary between users and non-users of contraception. Women who had an unmet need (using the standard definition) were far more likely to believe that FP is not religiously acceptable in comparison to women who were actual users of these methods.

Data on women's intentions to use contraceptives in the future is very important as it can enable family planning program managers to make appropriate decisions and assess future demand for contraceptives. The 2002 JPFHS showed that 60% of non-users intended to use a contraceptive method in the future, as compared to 21% in the KAP study of 1997. This study has shown that the vast majority of pregnant/postpartum women (91%) intended to use contraceptives during the next year, while the percentage for non-users was about 31%. The strikingly high figure for intention by pregnant women and the comparatively low intention figures for non-users should be considered seriously by policy makers and program managers. Focusing the attention of family planning programs to the postpartum period would certainly satisfy some of the need of pregnant women for FP services. The group of women who are non-users and who have no intention of using family planning services in the future poses a real challenge to program designers. Women who had the intention to use family planning services were more likely to opt for the IUD and oral contraceptives, followed to a lesser extent by natural family planning methods. Those who said that they had no intention of using contraceptives during the next year reported that they or their husbands either desired more children, disapprove of family planning, or fear possible side effects of contraceptives.

Provision of family planning counseling was shown to be low when type of service delivery was examined in relation to whether family planning discussion took place even in areas where family planning activities are at the core of clinics' usual activities. Discussion of family planning was reported to have taken place in post-natal clinics by only 62.8% of women even though this is a critical period for helping women avoid future unintended pregnancies. This finding is critical as this study also shows that 91% of pregnant/postpartum women stated their intention to use family planning in the future. In family planning clinics discussions occurred during only 71.2% of reported visits. Provision of health education material was also low. The impact of these visits and discussions seemed to have played an important role with 94.2% and 79.9% of women visiting family planning and antenatal clinics respectively either discussing family planning issues with their husband or actually returning to the health centers for further FP services.

The relatively high rates of unmet need both in its standard formulation and expanded definition call on the Ministry of Health staff to increase efforts and pay special attention to these groups of women who

are known to come to health facilities either when they are sick or for their children's growth monitoring and vaccinations.

In summary, the prevalence of standard unmet need remains high in spite of a wide network of PHCs and CHCs, in addition to numerous projects targeting Jordanian women as the recipients of IEC materials. On the surface, women's knowledge of family planning methods seems to be high. However, specific knowledge of each method seems to be deficient. Lack of solid information has given room for confusion as to the stance of religion on family planning and the religious acceptability of particular methods. As this study showed, health care delivery systems have failed to seize daily opportunities for delivering FP information. Women, who came for their children's vaccinations or visited the general practice clinics, were looked at by health care providers as nothing more. According to women reporting, there were opportunities for family planning counseling and or service delivery. Since women express that they want no more children and were not using family planning methods, set the stage for potential health care delivery in the form of counseling to say the least. Therefore, the potential demand for family planning service delivery is clearly present.

The following set of recommendation is presented for development of future family planning projects. These recommendations address the following broad categories: IEC interventions, training, management of family planning programs, and health promotion.

1. Since the majority of women knew about family planning methods, but lack detailed information about the specifics of each method, future IEC interventions should provide method-specific contraceptive information in order to equip women with the needed knowledge base. Health providers should work on activities directed at empowering women with sufficient information on various family planning methods in order to enable them to make their own informative decisions on the choice of a method.
2. While strengthening the efforts to reach the 16 percent of women with unmet need, special concern should be made for age, region and education as the main predictors for unmet need. Therefore, family planning programs should address women who are illiterate in order to inform them of birth control measures. Efforts to strengthen family planning programs in the southern region are recommended. Particular attention should be made to tailor family planning messages to women who are over 35 years of age and are nonusers of family planning.
3. Adopting an unmet need strategy within the process of planning and delivering family planning programs is recommended. To address the need to help women meet their fertility needs, such programs should allow for regular follow up and management of contraceptive side effects

along with a choice of alternative family planning methods. Such a strategy is expected to allow women to switch between methods until they finally determine a satisfactory method that meets their needs. Special focus should be given to program activities that allow women to obtain advice on switching between methods comparable to their fertility needs.

4. Efforts to increase access and use of contraceptive methods should be pursued. Health care providers should be trained in developing and maintaining systems that can allow monitoring the use and supply of contraceptives. Training in communication is also recommended in order to promote discussions and counseling on family planning method use and desire. IEC material should be made more readily available at the health centers and providers should be trained on using these materials during family planning counseling and instruction.
5. Family planning programs should continue to encourage women to breast feed and to use the LAM. The opportunity to instruct on LAM should be viewed as an excellent opportunity for assessing fertility goals in order to promote the use of modern family planning methods.

Finally, it is worthwhile noting that unmet need is a phenomenon of a non-static nature involving the interaction of two variables: fertility desire and contraceptive use. Therefore, high prevalence of unmet need is not explicit of failure in family planning programs nor is a low prevalence indicative of success. Accordingly, when developing an unmet need strategy, program planners and decision makers should consider the unmet need concept within its various composites and correlates. Meeting the unmet need in any population can limit the number of unintended pregnancy thus contributing to the promotion of health for women and their families.

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Appendix A

Form A: Pregnant/post partum women

Unmet Need and Missed Opportunities For Family Planning Among Married Women 15-49 Years Users of MoH Health Centers

To be filled by field supervisor: -

Pregnant

Postpartum

Utilization of health services:-

1- Did you visit the health center for any reason during last year ?

a. yes

b. no

c. don't know

2- Clinic	3 - Number of Visits	4- During your visit, do you usually find physician available	5- Did any one in the health center discuss FP with you ?	6- Who discussed FP with you ?	7- Did the discussion make an impact on your decision about FP?	8- During your visits did the health provider give you FP health education material ?
1- General practice		1-yes 2-no 3-don't know	1-yes 2-no (go to Q10) 3-don't know	1-physician 2-nurse 3-midwife 4-health educator 5-social worker	1-nothing 2-I thought of visiting MCH 3-discussed FP with my husband 4-I visited health center or physician for FP 5-others / specify -----	1-yes 2-no 3-don't know
2- Vaccination						
3- MCH a- ANC b- PNC c- FP						
4- Specialty						
5- Dental						
6- Others / specify -----						

15- During the last year, did you hear, read, or watch anything about FP methods from any of following sources?

(Interviewer :- read choices)							
	Radio	TV	Newspapers & Magazines	Posters	Brochures	Lectures	Friends/ relatives
1-yes							
2-no							
3-doesn't remember							
4-not applicable							

16- What was the impact of watching or reading about FP methods ?

- 1- nothing
- 2- I discussed FP with my husband
- 3- I visited a FP clinic
- 4- I have used a FP method
- 5- others , specify-----

17- What does FP mean to you ?

- 1- limiting births
- 2- spacing births
- 3- planning family life
- 4- others , specify -----

Perceptions & Attitudes

We want to evaluate contraceptive methods you know. We would like to ask you to give a rating from 0 to 10, where very important method get the highest rating, less important between 0 and 10, and the lowest in importance gets the lowest rating.

(Interviewer :- ask questions only for methods the lady knows)

	1- which FP methods you know	2- to which degree you consider this method safe (harmless) to your body	3- to which degree is this method easy to use	4- to which degree you consider this method comfortable (convenient)	5- to which degree you consider this method effective	6- to which degree you prefer to use this method	7- in your opinion to which degree this method impacts sexual function
1- Oral Contraceptives							
2-IUDs							
3-Injectables							
4-Norplant Implants							
5-Condom							
6-Diaphragm							
7- Spermicides							
8-Female sterilization							
9-Vasectomy							
10-NFP							
11-LAM							
12-other, specify-----							

We want to evaluate the importance of contraceptive methods to you. We would like to ask you to give a rating from 0 to 10 , where very important gets the highest, less important between 0 and 10, and the lowest in importance gets the lowest rating.

(to interviewer :- read answers)

What is the importance of the following?	Degree of Importance
8- method is safe (harmless)	
9- method is easily used	
10- method is convenient (comfortable)	
11- method is effective	
12- method preference	
13-method has no impact on sexual function	
14-method is easily available	

15- Do you consider this method

- 1- religiously accepted
- 2- religiously unacceptable
- 3- religiously hated
- 4- other, specify-----

(Interviewer: ask the lady all methods mentioned.)

16- Do you consider this method 1-religiously accepted 2-religiously unacceptable 3-religiously hated 4-other, specify ----- (Interviewer: ask the lady all methods mentioned.)	17- If it is religiously unacceptable, why?							18- If it is religiously acceptable why?				
	1- unnatural	2-permanent	3-causes bleeding	4-has side effects	5-affects body in the future	6-has negative impact on sexual function	7-other, specify -----	1- natural	2- has no side effects	3-safe (harmless)	4-supports good family life	5-other, specify -----
1- Oral Contraceptives												
2- IUDs												
3-Injectables												
4-Norplant implants												
5-Condom												
6-Diaphragm												
7-Spermicides												
8-Fmale sterilization												
9-Vasectomy												
10- NFP												
11-LAM												
12-Others, specify												

To which degree you agree with the following:	Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree	Other, specify
19- Having more children is "EZWA" "EZWA" means to have high social status						
20- Having more children is an expression of manhood						
21- Having more children is an expression of a woman's fertility						
22- FP improves the standard level of living						
23- If it happens that all children were girls, one should keep on having more children to get a boy						
24- Having more children (childbearing) has a negative impact on maternal health						
25- FP allows the mother to give more time to care for her family						

26- Do you approve of using FP methods to postpone pregnancy?

1- yes 2- no 3- other, specify -----

27- Do you think that your husband approves using FP methods to postpone pregnancy ?

1- yes 2- no 3- doesn't know

28- Do you approve of using FP methods to prevent pregnancy ?

1- yes 2- no 3- other, specify -----

29- Do you think your husband approves to prevent pregnancy ?

1- yes 2- no 3- doesn't know

30- Did you discuss FP with someone else ?

1- yes 2- no 3- doesn't know

	Husband	Mother	Mother in law	Father	Father In law	Relative	Friend & neighbors	Clergy men	Physician	Nurse	Other, specify -----
31- With whom did you discuss it?											
32- Importance of his/her opinion: 1-very important 2-somewhat important 3- not important at all 4- other, specify-----											
33- Do you think this person will agree on using FP? 1-yes 2-no 3- other , specify----- -----											

34- Did you ever encourage someone else to use FP methods ?
 1- yes, I did 2- no, I didn't 3- didn't discuss it with any one

Pregnancy Desire

1- Prior to this pregnancy, did you have a desire to have more children ?

1- yes

1-1- how many ?-----child

2- no

1-2- You wanted to postpone pregnancy or you didn't want any more children at all?

1-I wanted to postpone

1-2-1- how many more children you intend to have ? mention the number /----- child

2- I don't want any more children

3- not sure

2- Prior to this pregnancy, did your husband have a desire for more children ?

1- yes

2-1- how many ?-----child

2- no

2-2- he wanted to postpone pregnancy or he didn't want any more children at all?

1- he wanted to postpone

2-2-1- how many more children he intend to have? mention the number /----- child

2- he doesn't want any more children 3- not sure

3- Prior to this pregnancy, for how long you wanted to wait before getting pregnant :-

-----month /-----year

(Fill 888 if the lady is not sure about time, fill 000 if the lady doesn't like to wait, and fill 999 if the lady or her husband do not want any more children)

7- What is the impact of this information on your use of FP methods?
1- nothing 2- I thought of visiting MCH 3- it corrected my information

4- discussed FP with my husband

5- visited the physician/HC to get the method

6- others, specify-----

8- Do you think that the information you have about FP is enough?
1- yes 2- no 3- don't know/not sure

9- Do you like to know more information about FP methods ?
1- yes 2- no 3- don't know/not sure

10- What information do you like to know ?-----

11- In your opinion, what is the best way we should use to provide you with such information -

■ *knowledge & Utilization of FP methods* ■

1- What are the FP methods you know a man or woman can use to stop or postpone pregnancy ?

1- Pills

2- IUDs

3- Injectables

4- Norplant implants

5- condom

6- Diaphragm

7- Spermicides

8- Female sterilization

9- Vasectomy

10- NFP

11- LAM

2- Did you or your husband use any FP method before you got pregnant ?

1- *yes*

2- *no* 2-1- Why -----

2-2- Did you ever use any FP method in the past :-

1- *yes*

2- *no* (go to q 14)

2-2-1- What was the last method used -----

3- What FP methods you used in the past :-	4-Where did you get it from ? (only modern methods) (look answer number in the table down) *	5-Who prescribe this method for you :- 1-physician 2-nurse 3-midwife 4-pharmacist 5-health educator 6-social worker 7-nobody	6-Who explained to you its usage:- 1-physician 2-nurse 3-midwife 4-pharmacist 5-health educator 6-social worker 7-nobody	7-When they prescribe it for you, was it :- 1-available 2-or they ask you to get it from somewhere else 3-or they ask you to come later to get it (Interviewer:- <i>read choices</i>)	8-The method you use was the same one you wanted to have: 1-yes 2-no	9- If not , what was your preferred method:- (use method code)	10- What was the reason you didn't get the method you wanted to have :-
1-pills							
2-IUDs							
3-Injectables							
4-Norplant implant							
5-Condom							
6-Diaphragm							
7-Spermicides							
8-Female sterilization							
9-Vasectomy							
10 NFP							
11-LAM							
12- other, specify----- -----							

* 1- Health center 2- UNRWA 3- FP Association 4-Military health center / FP 5- NGO
6- Private hospital 7- Governmental hospital 8- Military hospital 9- Private physician
10- Pharmacy 11- doesn't know 12- Others ,specify-----

11- When you became pregnant, were you or your husband using any FP method or not ?

1- we were not using

2- I got pregnant while using the method

11-1- What was the method -----

11-2- For how long you used that method before getting pregnant -----

3- Others, specify -----

12- When you were using the FP method, did you think of discontinuing its use ?

12-1- Why -----

1- yes

2- no

3- don't know

13- While using the FP method did you think of switching to another method ?

13-1- Why -----

13-2- Which method you wanted to switch to -----

1- yes

2- no

14- Is it your decision to use FP methods or your husband or both of you ?

1- husband

2- wife

3- both

4- others, specify -----

15- Did you plan (intend) to get pregnant this time ?

15-1- Why do you think it was unintended

1- yes, planned

2- no, I didn't want it, it was unintended

3- yes, but not now

4- not sure

16- When you knew you became pregnant, were you happy or not ?

1- happy

2- unhappy,

16-1- Why unhappy -----

3- didn't care

4- others -----

17- When you knew you became pregnant , did you want it or not ?

17-1-Why-----

1-I wanted it

2- I didn't want it

3-not sure

18- Do you like to get pregnant again in the future?

1-yes, without postponing

2- yes, but I like to postpone it

3-not sure

4- no, I don't want any more children

5- others, specify-----

19- For how long you want to wait then get pregnant :-

-----month/-----year/ (if not sure fill 888)

20- Tell me more, why you picked this period-----

21- a) If pregnant , do you or your husband intend to use FP methods within one year after you deliver ?

B) If postpartum , do you or your husband intend to use FP methods within one year from now?

1-yes

21-1- Which FP methods?

(To interviewer :- respondent may choose more than one method)

1- Pills	2- IUDs	3- Injectables	4- Norplant implants	5- Condom	6- Diaphr
7- Spermicides	8- Female sterilization	9- Vasectomy	10- NFP	11- LAM	12- Others, specify ----- -----

2- no

21-2- What is the main reason-----

3- Don't know

Demographic information

Now, I want to ask you some questions. These questions will help us in analyzing your answers in comparison with other responses and we hope that the study findings help in providing better health services:-

Address :- (mention name of city or village)-----

1- Age :-----yrs

2- For how long have you been married :-----yrs

3- Please indicate the highest educational level achieved :-

1- illiterate 2- read & write 3- elementary 4- preparatory
5- secondary 6- diploma 7- university

4- Please indicate the highest educational level your husband achieved :-

1- illiterate 2- read & write 3- elementary 4- preparatory
5- secondary 6- diploma 7- university

5- Do you work for a living :-

1- yes 5-1- What is your job -----
2- no

6- Does your husband work for a living :-

1- yes 6-1- What is his job -----
2- no

7- When did you give birth to the last child ?----- month ----- year

8- How many times you were pregnant?

9- How many times you deliver

9-1- Dead

9-2- Alive

9-2-1- Girl

9-2-2- Boy

Form B: Users of family planning

**Unmet Need and Missed Opportunities
for Family Planning Among Women 15-49 Years
Users of Ministry of Health Centers**

Utilization of health services:-

- 1- Did you visit the health center for any reason during last year ?
a. yes b. no c. don't know

2- Clinic	3 - Number of Visits	4- During your visit, do you usually find physician available	5- Did any one in the health center discuss FP with you ?	6- Who discussed FP with you ?	7- Did the discussion make an impact on your decision about FP?	8- During your visits did the health provider give you FP health education material ?
1- General practice		1-yes 2-no 3-don't know	1-yes 2-no (go to Q10) 3-don't know	1-physician 2-nurse 3-midwife 4-health educator 5-social worker	1-nothing 2-I thought of visiting MCH 3-discussed FP with my husband 4-I visited health center or physician for FP 5-others / specify -----	1-yes 2-no 3-don't know
2- Vaccination						
3- MCH a- ANC b- PNC c- FP						
4- Specialty						
5- Dental						
6- Others / specify -----						

15- During the last year, did you hear, read, or watch anything about FP methods from any of following sources?

(Interviewer :- read choices)							
	Radio	TV	Newspapers & Magazines	Posters	Brochures	Lectures	Friends/ relatives
1-yes							
2-no							
3-doesn't remember							
4-not applicable							

16- What was the impact of watching or reading about FP methods?

- 1- nothing
- 2- I discussed FP with my husband
- 3- I visited a FP clinic
- 4- I have used a FP method
- 5- others , specify-----

17- What does FP mean to you ?

- 1- limiting births
- 2- spacing births
- 3- planning family life
- 4- others , specify -----

1- what are the FP methods you know a man or woman can use to postpone or prevent pregnancy:-	2- Which FP method you are using now	3-Where did you get it from ? (only modern methods)	5-Who prescribe this method for you :- 1-physician 2-nurse 3-midwife 4-pharmacist 5-health educator 6-social worker 7-nobody	6-Who explained to you its usage:- 1-physician 2-nurse 3-midwife 4-pharmacist 5-health educator 6-social worker 7-nobody	7-When they prescribe it for you, was it :- 1-available 2-or they ask you to get it from somewhere else 3-or they ask you to come later to get it (Interviewer:- read choices)	8-The method you use was the same one you wanted to have: 1-yes 2-no	9- If not, what was your preferred method:- (use method code)	10- What was the reason you didn't get the method you wanted to have :-
1-pills								
2-IUDs								
3-Injectables								
4-Norplant implant								
5-Condom								
6-Diaphragm								
7-Spermicides								
8-Female sterilization								
9-Vasectomy								
10 NFP								
11-LAM								
12- other, specify----- -----								

* 1- Health center 2- UNRWA 3- FP Association 4-Military health center / FP 5- NGO
6- Private hospital 7- Governmental hospital 8- Military hospital 9- Private physician
10- Pharmacy 11- doesn't know 12- Others ,specify-----

Perceptions & Attitudes

We want to evaluate contraceptive methods you know. We would like to ask you to give a rating from 0 to 10, where very important method get the highest rating, less important between 0 and 10, and the lowest in importance gets the lowest rating.

(Interviewer :- ask questions only for methods the lady knows)

	1- which FP methods you know	2- to which degree you consider this method safe (harmless) to your body	3- to which degree is this method easy to use	4- to which degree you consider this method comfortable (convenient)	5- to which degree you consider this method effective	6- to which degree you prefer to use this method	7- in your opinion to which degree this method impacts sexual function
1- Oral Contraceptives							
2-IUDs							
3-Injectables							
4-Norplant Implants							
5-Condom							
6-Diaphragm							
7- Spermicides							
8-Female sterilization							
9-Vasectomy							
10-NFP							
11-LAM							
12-other, specify-----							

We want to evaluate the importance of contraceptive methods to you. We would like to ask you to give a rating from 0 to 10 , where very important gets the highest, less important between 0 and 10, and the lowest in importance gets the lowest rating.

(to interviewer :- read answers)

What is the importance of the following?	Degree of Importance
8- method is safe (harmless)	
9- method is easily used	
10- method is convenient (comfortable)	
11- method is effective	
12- method preference	
13-method has no impact on sexual function	
14-method is easily available	

16- Do you consider this method

- 1- religiously accepted
- 2- religiously unacceptable
- 3- religiously hated
- 4- other, specify-----

(Interviewer: ask the lady all methods mentioned.)

To which degree you agree with the following:	Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree	Other, specify
19- Having more children is "EZWA" "EZWA" means to have high social status						
20- Having more children is an expression of manhood						
21- Having more children is an expression of a woman's fertility						
22- FP improves the standard level of living						
23- If it happens that all children were girls, one should keep on having more children to get a boy						
24- Having more children (childbearing) has a negative impact on maternal health						
25- FP allows the mother to give more time to care for her family						

26- Do you approve of using FP methods to postpone pregnancy?

1- yes 2- no 3- other, specify -----

27- Do you think that your husband approves using FP methods to postpone pregnancy ?

1- yes 2- no 3- doesn't know

28- Do you approve of using FP methods to prevent pregnancy ?

1- yes 2- no 3- other, specify -----

29- Do you think your husband approves to prevent pregnancy ?

1- yes 2- no 3- doesn't know

30- Did you discuss FP with someone else ?

1- yes 2- no 3- doesn't know

	Husband	Mother	Mother in law	Father	Father In law	Relative	Friend & neighbors	Clergy men	Physician	Nurse	Other, specify
29- With whom did you discuss it?											
30- Importance of his/her opinion: 1-very important 2-somewhat important 3- not important at all 4- other, specify-----											
31- Do you think this person will agree on using FP? 1-yes 2-no 3- other , specify----- -----											

32- Did you ever encourage someone else to use FP methods ?

1- yes, I did

2- no, I didn't

3- didn't discuss it with any one

32- Did you ever encourage someone else to use FP methods ?
1- yes ,I did 2-no, I didn't 3-didn't discuss it with any one

33- Did you discuss with your husband about the FP method you are using now before using it ?
1-yes 2-no 3- other, specify

34- Did your husband encourage you to use this method ?
1- yes 2- no
3- not important 4- other, specify -----

34-1- What does he want you to do ?
1-switch to another method
2- discontinue the use of the FP method
3-postpone the use of the method, to have more children
4- other, specify -----

35- Do you face any health problem(s) while using FP methods ?
1-yes 2- no

35-1- What are these problems:- -----

36- Do you like to get pregnant again in the future ?
1-yes, without postponing
2-yes, but I like to postpone it for a while
3-not sure
4- no, at all I don't want any more children
5- other, specify -----

37- For how long you want to wait then get pregnant-----month-----year/
(fill 888) if not sure

38- Tell me more , why you picked this period-----

7- What is the impact of this information on your use of FP methods?

- 1- nothing
- 2- I thought of visiting MCH
- 3- it corrected my information
- 4- discussed FP with my husband
- 5- visited the physician/HC to get the method
- 6- others, specify-----

8- Do you think that the information you have about FP is enough?

- 1- yes
- 2- no
- 3- don't know/not sure

9- Do you like to know more information about FP methods ?

- 1 - yes
- 2- no
- 3- don't know/not sure

10- What information do you like to know ?-----

11- In your opinion, what is the best way we should use to provide you with such information -

Instructions to interviewer :- read the FP method that the lady is currently using from page (3) then fill the questions in pages 10 - 17 accordingly .

Pills users

- 1- Which type of pills you are using ?
 - 1- combined pills
 - 2- Progestin pills
 - 3- Don't know
- 2- Are you currently breast feeding ?
 - 1- yes
 - 2- no
 - 2-1- For how long
 - 1- less than 6 weeks
 - 2- from 6 weeks - 6 months
 - 3- more than 6 months
 - 4- others, specify-----
- 3- Are you currently smoking ?
 - 1- yes
 - 2- no
 - 3-1- Regularly?
 - 3-2- Did you smoke during the last months :-
 - 1- yes
 - 2- no
 - 1- yes
 - 2- no
- 4- Did you ever forget to take your pill ?
 - 1- yes
 - 2- no (go to q7)
 - 4-1- How often does this happen :-
 - 1- once a month
 - 2- twice a month
 - 3- more than that
- 5- When you forget the pill , what do you do ?
 - 1- I take it in the same day
 - 2- I take it the next day
 - 3- I don't take it
 - 4- others
- 6- If you forget to take two consecutive pills , what do you do ?
 - 1- I take one of them
 - 2- I take both of them
 - 3- I use additional methods
 - 4- others, specify-----

(Instruction to interviewer :- read the list below)

DISEASE	1- yes	2- no	3- don't know
1- Hypertension 2- liver problems 3- Gall bladder problems 4- Heart diseases 5- Breast cancer 6- Thrombosis 7- Frequent vomiting & diarrhea 8- Nausea 9- Headache(migraine) 10- vaginal bleeding 11- Epilepsy (convulsions)			

Are you on treatment ?

1- yes

2- no

Injectables users

1- When was the last time you had a normal menstrual period ?

-----month

2- In general, are you taking the injections every 3 months?

1- yes , 2-1- Do you do that on a regular basis? 1- yes 2- no

2- no

3- Do you complain from any of the following diseases :-

(Instruction to interviewer :- read the list below)

DISEASE	1- yes	2- no	3- don't know
1- Hypertension 2- liver problems 3- Gall bladder problems 4- Heart diseases 5- Breast cancer 6- Thrombosis 7- Frequent vomiting & diarrhea 8- Nausea 9- Headache(migraine) 10- vaginal bleeding 11- Epilepsy (convulsions)			

Are you on treatment ?

1- yes

2- no

(Instruction to interviewer :- read the list below)

DISEASE	1- yes	2- no	3- don't know
1- Hypertension 2- liver problems 3- Gall bladder problems 4- Heart diseases 5- Breast cancer 6- Thrombosis 7- Frequent vomiting & diarrhea 8- Nausea 9- Headache(migraine) 10- vaginal bleeding 11- Epilepsy (convulsions)			

Are you on treatment ?

1- yes

2- no

Spermicides users

- 1- Are you or your husband have allergy to spermicides ?
 - 1- myself
 - 2- my husband
 - 3- both of us 4- others, specify -----

- 2- Do you complain frequently from reproductive tract infections ?
 - 1- yes
 - 2- no

- 3- Do you use spermicides before every sexual intercourse ?
 - 1- yes
 - 2- no

- 4- Do you make vaginal douches during the first 6 hours after each sexual intercourse ?
 - 1- yes
 - 2- no

- 5- Do you wash the applicator with soap & water after each sexual intercourse ?
 - 1- yes
 - 2- no

- 6- Is your husband satisfied with this method ?
 - 1- yes
 - 2- not all the time
 3. No at all
 4. others , specify -----

Condom

- 1- Is your husband allergic to condom?
1- yes 2- no 3- don't know
- 2- Does your husband like to continue using this method ?
1-yes 2-no 3-don't know
- 3- Can your husband keep an erection while using condom ?
1-yes 2- no 3- don't know
- 4- Does your husband prefer late ejaculation ?
1- yes 2- no 3- don't know
- 5- Does your husband use new condom in each intercourse ?
1- yes 2- no 3- don't know
- 6- Are condoms always available at home ?
1- yes 2- no 3- don't know
- 7- Did the condom ever got torn during inter course?
1-yes 7-1-What have you done to prevent pregnancy
2- no

1- **nothing**

2- **I've done the following**-----

-

Lactation Amenorrhea Method (LAM) users

- 1- What is the age of your youngest child ?-----month

- 2- Do you exclusively breast feed your child both day & night ?
 - 1- yes , completely
 - 2- almost completely
 - 3- give fluids or food

- 3- How many times you breast feed during day time-----

- 4- How many times you breast feed during night-----

- 5- Do you have your menstrual period regularly?
 - 1- yes
 - 2- no

Demographic information

Now, I want to ask you some questions. These questions will help us in analyzing your answers in comparison with other responses and we hope that the study findings help in providing better health services:-

Address :- (mention name of city or village)-----

1- Age :-----yrs

2- For how long have you been married :-----yrs

3- Please indicate the highest educational level achieved :-

1- illiterate 2- read & write 3- elementary 4- preparatory
5- secondary 6- diploma 7- university

4- Please indicate the highest educational level your husband achieved :-

1- illiterate 2- read & write 3- elementary 4- preparatory
5- secondary 6- diploma 7- university

5- Do you work for a living :-

1- yes 5-1- What is your job-----
2- no

6- Does your husband work for a living :-

1- yes 6-1- What is his job-----
2- no

7- When did you give birth to the last child ?----- month----- year

8- How many times you were pregnant?

9- How many times you deliver

9-1- Dead

9-2- Alive

9-2-1- Girl

9-2-2- Boy

Form C: Non Users of family planning

**Unmet Need and Missed Opportunities
for Family Planning Among Women 15-49 Years
Users of Ministry of Health Centers**

Utilization of health services:-

- 1- Did you visit the health center for any reason during last year ?
a. yes b. no c. don't know

2- Clinic	3 - Number of Visits	4- During your visit, do you usually find physician available	5- Did any one in the health center discuss FP with you ?	6- Who discussed FP with you ?	7- Did the discussion make an impact on your decision about FP?	8- During your visits did the health provider give you FP health education material ?
1- General practice		1-yes 2-no 3-don't know	1-yes 2-no (go to Q10) 3-don't know	1-physician 2-nurse 3-midwife 4-health educator 5-social worker	1-nothing 2-I thought of visiting MCH 3-discussed FP with my husband 4-I visited health center or physician for FP 5-others / specify -----	1-yes 2-no 3-don't know
2- Vaccination						
3- MCH						
a- ANC						
b- PNC						
c- FP						
4- Specialty						
5- Dental						
6- Others / specify -----						

15- During the last year, did you hear, read, or watch anything about FP methods from any of following sources?

(Interviewer :- read choices)							
	Radio	TV	Newspapers & Magazines	Posters	Brochures	Lectures	Friends/ relatives
1-yes							
2-no							
3-doesn't remember							
4-not applicable							

16- What was the impact of watching or reading about FP methods ?

- 1- nothing
- 2- I discussed FP with my husband
- 3- I visited a FP clinic
- 4- I have used a FP method
- 5- others , specify-----

17- What does FP mean to you ?

- 1- limiting births
- 2- spacing births
- 3- planning family life
- 4- others , specify -----

Perceptions & Attitudes

We want to evaluate contraceptive methods you know. We would like to ask you to give a rating from 0 to 10, where very important method get the highest rating, less important between 0 and 10, and the lowest in importance gets the lowest rating.

(Interviewer :- ask questions only for methods the lady knows)

	1- which FP methods you know	2- to which degree you consider this method safe (harmless) to your body	3- to which degree is this method easy to use	4- to which degree you consider this method comfortable (convenient)	5- to which degree you consider this method effective	6- to which degree you prefer to use this method	7- in your opinion to which degree this method impacts sexual function
1- Oral Contraceptives							
2-IUDs							
3-Injectables							
4-Norplant Implants							
5-Condom							
6-Diaphragm							
7- Spermicides							
8-Female sterilization							
9-Vasectomy							
10-NFP							
11-LAM							
12-other, specify-----							

We want to evaluate the importance of contraceptive methods to you. We would like to ask you to give a rating from 0 to 10 , where very important gets the highest, less important between 0 and 10, and the lowest in importance gets the lowest rating.

(to interviewer :- read answers)

What is the importance of the following?	Degree of Importance
8- method is safe (harmless)	
9- method is easily used	
10- method is convenient (comfortable)	
11- method is effective	
12- method preference	
13-method has no impact on sexual function	
14-method is easily available	

16- Do you consider this method 1-religiously accepted 2-religiously unacceptable 3-religiously hated 4-other, specify ----- (Interviewer: ask the lady all methods mentioned.)	17- If it is religiously unacceptable, why?							18- If it is religiously acceptable why?				
	1- unnatural	2-permanent	3-causes bleeding	4-has side effects	5-affects body in the future	6-has negative impact on sexual function	7-other, specify -----	1- natural	2- has no side effects	3-safe (harmless)	4-supports good family life	5-other, specify -----
1- Oral Contraceptives												
2- IUDs												
3-Injectables												
4-Norplant implants												
5-Condom												
6-Diaphragm												
7-Spermicides												
8-Fmale sterilization												
9-Vasectomy												
10- NFP												
11-LAM												
12-Others, specify												

To which degree you agree with the following:	Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree	Other, specify
19- Having more children is "EZWA" "EZWA" means to have high social status						
20- Having more children is an expression of manhood						
21- Having more children is an expression of a woman's fertility						
22- FP improves the standard level of living						
23- If it happens that all children were girls, one should keep on having more children to get a boy						
24- Having more children (childbearing) has a negative impact on maternal health						
25- FP allows the mother to give more time to care for her family						

26- Do you approve of using FP methods to postpone pregnancy?
1- yes 2- no 3- other, specify -----

27- Do you think that your husband approves using FP methods to postpone pregnancy ?
1- yes 2- no 3- doesn't know

28- Do you approve of using FP methods to prevent pregnancy ?
1- yes 2- no 3- other, specify -----

29- Do you think your husband approves to prevent pregnancy ?
1- yes 2- no 3- doesn't know

30- Did you discuss FP with someone else ?
1- yes 2- no 3- doesn't know

	Husband	Mother	Mother in law	Father	Father In law	Relative	Friend & neighbors	Clergy men	Physician	Nurse	Other, specify -----
29- With whom did you discuss it?											
30- Importance of his/her opinion: 1-very important 2-somewhat important 3- not important at all 4- other, specify-----											
31- Do you think this person will agree on using FP? 1-yes 2-no 3- other , specify----- -----											

32- Did you ever encourage someone else to use FP methods ?

1- yes, I did

2- no, I didn't

3- didn't discuss it with any one

knowledge & Utilization of FP methods

3- What FP methods you used in the past :-	4-Where did you get it from ? (only modern methods) (look answer number in the table down) *	5-Who prescribe this method for you :- 1-physician 2-nurse 3-midwife 4-pharmacist 5-health educator 6-social worker 7-nobody	6-Who explained to you its usage:- 1-physician 2-nurse 3-midwife 4-pharmacist 5-health educator 6-social worker 7-nobody	7-When they prescribe it for you, was it :- 1-available 2-or they ask you to get it from somewhere else 3-or they ask you to come later to get it <i>(Interviewer:- read choices)</i>	8-The method you use was the same one you wanted to have: 1-yes 2-no	9- If not , what was your preferred method:- (use method code)	10- What was the reason you didn't get the method you wanted to have :-
1-pills							
2- IUDs							
3-Injectables							
4-Norplant implant							
5-Condom							
6-Diaphragm							
7-Spermicides							
8-Female sterilization							
9-Vasectomy							
10 NFP							
11-LAM							
12- other, specify-----							

* 1- Health center 2- UNRWA 3- FP Association 4-Military health center / FP 5- NGO
6- Private hospital 7- Governmental hospital 8- Military hospital 9- Private physician
10- Pharmacy 11- doesn't know 12- Others, specify-----

9- Did you ever use FP methods ?

1- *Yes*

9-1- What was the last method you used -----

9-2- For how long did you use it -----month -----year

9-3- Why did you discontinue using it -----

10- Do you intend to use FP methods in the future?

1- *Yes*

10-1- Which method -----

10-2- When you intend to use it :-

1- during one year or less

2- more than a year but less than two years

3- two years or more

2- *No*

10-3- Why, what is the reason -----

11- Why you are not using family planning methods :-

1- Wants more boys	8- Wants more girls	15- Husband wants more children	22- FP methods are religiously unacceptable	28-FP methods are harmful	
2-Can't obtain FP methods	9- Busy with family responsibilities	16-Menopause / hysterectomy	23- No or little sexual intercourse	29- Amenorrhea/ breast feeding	
3- Pregnant	10-Disapprove	17- Husband objection	24- Health problems	30-Not suitable	
4- Conflicts with physical body function	11-Newly married, have no children	18- Naturally, I get pregnant only every 3 years	25- Don't know	31- Getting rest	
5- Widow	12-Objection of other family members	19- In treatment for infertility	26- Psychological fear	32- Doesn't like to use FP methods , depends on herself in pregnancy planning (NFP)	
6-Depend on LAM	13- Tubal ligation	20-Didn't get pregnant since 10 years	27- Doesn't know about FP methods	33- FP methods prevent pregnancy in the future	
7- Far away from the health center	14- High cost	21- Doesn't know the source of method	34- Other, specify----- -----		

11- From the list , what are 3 most important reasons for not using FP methods :-

1- -----

2- -----

3- -----

12- Do you intend like to get pregnant again in the future?

1-yes, without postponing

2- yes, but I like to postpone

3- not sure

4- no , at all I don't want any more children

5- others , specify-----

13- For how long you want to wait then get pregnant :-

month-----/year-----/not sure (fill 888)

14- Tell me more , why you picked this period-----

7- What is the impact of this information on your use of FP methods?
1- nothing 2- I thought of visiting MCH 3- it corrected my information

4- discussed FP with my husband

5- visited the physician/HC to get the method

6- others, specify-----

8- Do you think that the information you have about FP is enough?
1- yes 2- no 3- don't know/not sure

9- Do you like to know more information about FP methods ?
1- yes 2- no 3- don't know/not sure

10- What information do you like to know ?-----

11- In your opinion, what is the best way we should use to provide you with such information -

Demographic information

Now, I want to ask you some questions. These questions will help us in analyzing your answers in comparison with other responses and we hope that the study findings help in providing better health services:-

Address :- (mention name of city or village)-----

1- Age :-----yrs

2- For how long have you been married :-----yrs

3- Please indicate the highest educational level achieved :-

1- illiterate 2- read & write 3- elementary 4- preparatory
5- secondary 6- diploma 7- university

4- Please indicate the highest educational level your husband achieved :-

1- illiterate 2- read & write 3- elementary 4- preparatory
5- secondary 6- diploma 7- university

5- Do you work for a living :-

1- yes 5-1- What is your job -----
2- no

6- Does your husband work for a living :-

1- yes 6-1- What is his job -----
2- no

7- When did you give birth to the last child ?----- month ----- year

8- How many times you were pregnant?

9- How many times you deliver

9-1- Dead

9-2- Alive

9-2-1- Girl

9-2-2- Boy

Appendix B

Table 39: Distribution of expanded unmet need selected variables: Pill users

		N	%
Type of pills	combined	154	59.3
	progestin	106	40.7
Total		259	100
Currently breast feeding	Yes	113	43.5
	No	147	56.5
Total		260	100
Currently smoking	Yes	19	7.1
	No	242	92.9
Total		260	100
Ever forget to take pill	Yes	151	57.9
	No	110	42.1
Total		260	100
How often she forget to take pill	once a month	93	63.2
	twice a month	35	23.9
	more than that	128	12.9
Total		256	100
What she do if she forget one pill	take it same day	47	31.7
	take it next day	92	61.4
	doesn't take it	6	4.2
	Others	4	2.8
Total		150	100
What she do if she forget two pills	take one	27	17.7
	take both	47	31.3
	use additional method	11	7.5
	Others	65	43.5
Total		150	100

Table 40: Distribution of expanded unmet need selected variables: IUD users

	N	%
Complain from excessive vaginal bleeding not usual pattern		
Yes	78	26.7
No	215	73.3
Total	293	100
Complain frequently from RTI		
yes frequently	58	19.9
yes sometimes	87	29.8
No	148	50.3
Total	293	100

**Table 41: Distribution of expanded unmet need selected variables:
Condom users**

Husband allergic to condom	Yes always	2	1.8
	Yes sometimes	13	14.8
	No	76	83.4
	Total	91	100.0
Husband likes to continue using condom	Yes always	48	52.6
	Yes sometimes	22	23.9
	No	18	20.0
	Doesn't know	3	3.6
	Total	91	100.0
Condom ever got torn during intercourse	Yes	12	13.2
	No	79	86.8
	Total	91	100.0
Did she do anything to prevent pregnancy	Yes	1	4.4
	No	11	95.6
	Total	12	100.0

**Table 42: Distribution of expanded unmet need selected variables:
Lactation Amenorrhea users**

		N	%
Age of youngest child	<6 month	37	82.2
	6 months	4	8.9
	>6 months	4	8.9
Total		45	100.0
Exclusively breast feed	yes completely	31	70.4
	almost completely	7	15.7
	give fluids or food	6	13.9
Total		44	100
Have menstrual period	Yes	5	12.5
	No	38	87.5
Total		44	100