Strategies to widen access to family planning in the Arab world: A case study of Zarqa, Jordan.

The London School of Hygiene and Tropical Medicine
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Dedication

I dedicate this thesis to my late aunt Nimra,

I also dedicate it to my father and mother, who never let me down, and made this dream come true,

To Dr. Gillian Hundt who believed in my potential...

To my mentors, Usama and Samia El Khalidi, Dr Ibrahim El Khalidi, Dr Rafi Alwash

To the honoured members of my committee, and all other professors, staff members and students of the London School of Hygiene and Tropical Medicine

To the dedicated policy makers and health providers who helped me
To the unforgettable men and women I have come to know in Jordan and Zarqa

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Strategies to widen access to family planning in the Arab world: A case study of Zarqa, Jordan.

Abstract:

This thesis identifies the constraints to FP utilisation at the policy, service, community and household levels based on the perspectives of policy makers, providers of services, and men and women in different communities of Jordan. It contributes strategies to widen access to FP that are transferable to other countries of the Middle East and the developing world.

The policy environment is analysed to assess whether it encourages or deters FP utilisation. The National Population Strategy is highlighted. Improving co-ordination between the different policy players is a major challenge faced in its implementation.

FP utilisation is portrayed in four clinics using different models of provision. Service statistics, clinic observations, in-depth interviews, focus and natural group discussions are used to compare the degree of access to FP. Strengthening co-ordination mechanisms between the service providers is an important strategy to increase FP utilisation.

The findings suggest that FP decisions are mostly influenced by men who remain concerned, to a varying degree, with the permissibility of FP utilisation in Islam. A culturally competent strategy proposed to increase utilisation is to communicate to men that FP is permissible in Islam. Religious men are proposed vehicles for implementing this communication strategy, basing their discourse on socio-cultural tradition, namely Islamic jurisprudence.

The thesis has three sections introduction, findings and conclusions. Chapter One explores the literature. Chapter Two reviews the Jordanian setting. Chapter Three sets out the methods used in this research. Chapter Four examines the policy environment and policy makers' perspectives. Chapters Five to Eight explore the models of service provision concluding with an evaluation of the strengths and weaknesses of the different models. Chapter Nine elaborates on the community's perspectives. Chapter Ten is the concluding chapter that sets out strategies to widen access to FP, by utilising the socio-cultural context of the region.

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List of Abbreviations

CBD	Community-Based Distribution
CDC	Centre for Communicable Diseases
CPP	Comprehensive Post Partum
CPR	Contraceptive Prevalence Rate
CSM	Contraceptive Social Marketing
DHS	Demographic Health Survey
DOS	Department of Statistics
EU	European Union
FAPPD	Forum of Africa and Arab Parliamentarians of Population and Development
FG	Focus Group
FHS	Family Health Survey
FP	Family Planning
FRH	Family and Reproductive Health
GDP	Gross Domestic Product
GP	General Practitioner
GS	General Secretariat
HM	His Majesty
HRH	Her Royal Highness
ICPD	International Conference on Population and Development
IEC	Information, Education, Communication
IGO	International Governmental Organisations
IPM	International Population Movement
IPPF	International Planned Parenthood Federation
IUD	Intrauterine Device

JAFPP	Jordanian Association of Family Planning and Protection
JICA	Japanese International Co-operation Agency
JLCS	Jordan Living Conditions Survey
JPFHS	Jordan Population and Family Health Survey
JUST	Jordan University of Science and Technology
KAP	Knowledge, Attitudes and Perspectives
LAM	Lactation Amenorrhea Method
MAQ	Maximising Access to Quality
MIS	Medical Information System
MOE	Ministry of Education
MOH	Ministry of Health
MOI	Ministry of Information
MOP	Ministry of Planning
NGO	Non Governmental Organisations
NPC	National Population Commission
NPS	National Population Strategy
OC	Oral Contraceptive
RH	Reproductive Health
SAP	Structural Adjustment Program
SFWC	Soldiers' Families Welfare Clinic
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
UNDP	United Nations Development Program
UNFPA	United Nations Family Planning Agency
UNICEF	United Nations International Children's Education Fund

UNRWA	United Nations Relief and Works Agency
USAID	United States Agency for International Development
WFS	World Fertility Survey
WHO	World Health Organisation
WID	Women in Development

List of Arabic Terms

Al-Asheera or *Al Hamula*	Tribe
Al-I'ddah	A time interval of three months
Al-Azl	Coitus Interruptus (contraceptive method, withdrawal method)
Aqeeda	Ideology
Bedu	Desert Dwellers or Bedouin
Daya	Traditional Birth Attendant
Dishdasheh	Large traditional Arab popular dress
Ezweh	Tribal concept built on valuation of male progeny
Fatwa	Ruling
Fiqh	Jurisdiction
Gheela	Killing of a soul
Hadeeth	The tradition of Prophet Mohammed
Ibada	Religious practice
Ijmaa'	Consensus
Iltihabat	Infections
Imams	Islamic preacher
Ird	Honour
Istilhabat	Word invented by local people meaning severe infections
Makrouh	Forbidden
Masmouh	Permitted
Muharram or Haram	Absolutely Forbidden
Mustahabb	Recommended
Muta'a	Pleasure
Nafaqa	Financial Support
Qabila	Tribe
Qawm	Clan

Qiyass	Analogy
Quran	The word of God
Rizk	Personal fortune
Shari'ah	Islamic Jurisprudence and legacy
Shia	Islamic sect
Sunni	Islamic sect
Sura	Verse from the Quran
Tahdeed el Nasl	Birth control
Tahtheeb al nafs	Discipline of the inner self
Tanzeem el Usra	Family planning by birth spacing
Tarbiah	Education
Umma	Nation
Usra	Family
Wa'd	Genocide
Wajib	Obligatory
Wasat	Center, moderate
Wasita	Brokerage for kin
Waqf	Religious endowments

Strategies to widen access to family planning in the Arab world: A case study of Zarqa, Jordan.

Chapter one

Introduction

I. Aim of the study:

The main research question addressed in this study is how can family planning, as a component of reproductive health, become more accessible to the community, with socially and culturally appropriate advocacy, policies and provision. Using the case of Jordan, which might represent many other countries in the Middle East, Asia, North Africa, and certain parts of Eastern Europe, this thesis argues that FP utilisation can be widened by taking into account and building on aspects of cultural traditions and the social structural context. This thesis analyses the influence of the policy environment, the structure of the services and the shortage of resources on utilisation. It also analyses the influence of social traditions, class, gender, education, geographic location and the interpretation of religion on the beliefs and attitudes of the service providers, and on the beliefs of users and non-users of family planning services and methods.

II. Objectives:

To explore contextual strategies to widen access to FP at the policy, service, community and household levels.

At the policy level

1. To analyse the population policy environment in Jordan, the National Population Strategy, and the challenges faced in strategy implementation.
2. To recommend strategies at the policy level to widen access to FP.

At the service level

3. To review and compare FP provision in the different sectors (Public sector \ NGO\ international organisations \ private sector) and analyse FP utilisation.
4. To explore service barriers to FP utilisation and identify strategies at the service level that increase FP utilisation.

At the community and household levels

5. To identify community and household barriers to FP utilisation.
6. To recommend culturally sensitive community-based strategies that increase FP utilisation.

III. Theoretical framework, statement of the problem and rationale

The theoretical framework includes an exploration of the multiple levels and meanings of access. There are a range of constraints and barriers to access. By analysing the policy makers', providers' and users' perspectives, this thesis highlights both the match and mismatch of lay and professional expectations, perceptions, and needs.

If family planning programs addressed the local socio-political and cultural context would this increase access to FP? This thesis unfolds the different interpretations of the position of Islam concerning family planning (policy makers, religious men, providers in the different sectors and men and women in the different communities) in an attempt to answer this question.

The following review explores literature relevant to the theoretical framework and perspective of this thesis that contributes to the literature on international population policy.

IV. Literature review

1. Access and the barriers at the different levels

Currently, there is a global problem of access to FP services, and it is estimated that about one hundred and twenty million couples have unmet needs for family planning (Population Reports 1996, WHO 1996c). Shortages in resources and problems in approach, policies, and access to services have caused this (Guillebaud 1996, Jain 1992, Thaddeus and Maine 1994). In an organised effort aiming at widening access to FP services, Jain and Bruce (1989) have developed 'indicators of programme effort', while Cochrane and Sai (1993) have maintained that the FP programmes themselves need to create demand, as well as provide services.

Bertrand et al. (1995) suggest using access, accessibility, and availability as synonyms. Many definitions of access have been forwarded; the ones most pertinent to this thesis are

> *'Access is the degree to which family planning services and supplies may be obtained at a level of effort and cost that is both acceptable to and within the means of a large majority of the population' (Bertrand et al. 1995:65).*

Access has also been defined as the degree of fit between the clients and the health system, or the relationship that results from ensuring equal use for equal need (Puentes-Markides 1992). Access is identified as the passage of a patient through the health care system, including the outcome of this passage, and the patterns of utilisation of services.

While previous research focused mainly on the geographic or physical access, Bertrand et al. (1995) perceive access as a multidimensional construct consisting of five key elements. 'Geographic or physical accessibility' is the extent to which the family planning service delivery points are located so that a large proportion of the target

population can reach them with an acceptable level of effort (Bertrand et al. 1995). 'Economic accessibility' is the extent to which the costs of reaching service delivery, or supply points, and obtaining contraceptive services and supplies, are 'affordable' to a large majority of the target population. 'Administrative accessibility' represents the extent to which unnecessary rules and regulations that inhibit contraceptive choice and use are eliminated (restricted clinic hours for family planning services, or limitation of contraceptive distribution to clinic hours). 'Cognitive accessibility' is the extent to which potential users are aware of the locations of services, or supply points, and of the services available at these locations. 'Psychosocial accessibility' represents the extent to which potential users are not pressurised by psychological, attitudinal, or social factors, in seeking out family planning services (Bertrand et al. 1995). However, Thaddeus and Maine (1994) point out that even if the clients make a timely decision to seek care, 'the accessibility' of health services remains an acute problem in the developing world.

'Barriers' or 'constraints' to accessing services are factors that affect the decision to seek care: they are closely interwoven and almost never acting independently on health seeking behaviour (Thaddeus and Maine 1994). This 'web of causation' is further complicated by gender according to Inhorn (1994, 1996), Joseph (1996) and Ghannam (1996). While Eschen and Whittaker (1993) have related barriers to socio-economic, and political factors:

> *'For most developing countries, these variables interact with others related particularly to the structure of the health services and the behaviour of the providers, and influenced by economic policies, so as to result in a complicated web of restricted access to health care, and limited solution to health problems' (Puentes-Markides 1992:619).*

- *Geographic barriers to access*

Distance is the most commonly cited barrier to access, particularly important in rural areas (Thaddeus & Maine 1994, Shyamini & Helen 1995). Research results have reached contradicting statements regarding the association between the proximity of the service and utilisation. While some of them have deduced higher utilisation with proximity basing on service statistics, others found that physical proximity did not necessarily increase utilisation (Thaddeus & Maine 1994).

- *Medical barriers to access*

Bertrand et al. (1995), Cottingham and Mehta (1993) and Inhorn (1994, 1996) elaborate on 'medical barriers' such as outdated contraindications and 'process hurdles' where physical examinations and laboratory tests are required as a pre-requisite for clients to obtain contraceptives. This deters the use of family planning services. In addition, medical rationales building on the 'biomedical model' that are not always scientifically justified are sometimes used to deny contraceptive use (Bertrand et al. 1995). 'Provider bias' is another medical barrier that favours some methods, and discourages others, in the absence of a medical rationale (Diaz and Diaz, 1993). A wide literature has described how bleeding which sometimes accompanies contraceptive method utilisation, may be of great personal and cultural importance to women, and yet is dismissed as normal by the providers (WFS 1985, Eschen & Whittaker 1993, Bertrand et. al. 1995, WHO 1994d, Ward et. al. 1992, WHO 1991).

- *Barriers at the policy level*

Structural and organisational problems such as bureaucracy, centralisation, top down administration, and insensitivity to clients' needs at the periphery, are other barriers to

access (WHO 1986, Klitsch & Walsh 1988, World Bank 1993, Thaddeus & Maine 1994, WHO, 1994c, Diaz & Diaz, 1993).

WHO (1991) and Eshen and Whittaker (1993) mentioned how government policies are at times very restrictive. Some countries prohibit the advertisement for, and distribution of contraceptive methods, prevent trained field workers from distributing contraceptives and basic medicines, and restrict the purchase of contraceptives to women who have their husbands' agreement (Bertrand et al. 1995, and Cottingham & Mehta, 1993). Others have very high import duty on contraception, and lengthy and tedious clearing procedures at Customs. Adding to these 'regulatory barriers' some countries have not approved certain contraceptives, despite evidence of their safety (Cottingham and Mehta 1993, Eschen and Whittaker 1993).

Further barriers to access are the use of incentives, which become at times coercive, even in clinical trials, and the bias towards provider-dependent methods, which compromise women's right to choose, and could be used as a means of coercion by family planning programs (WHO 1994c).

- *Barriers at the service level*

When family planning programs are integrated with maternal and child health services, they often ignore important groups in the community that need those services, such as men, adolescents, unmarried women, and non-pregnant women.

Furthermore, Diaz and Diaz (1993) elaborate on how the providers frequently do not feel empowered to help their clients, because of a lack of information, and poor working conditions. Nearly one in four staff members working in family planning and communication have no training neither in family planning provision nor in

communication (World Bank 1993 and Diaz and Diaz 1993). While in Egypt, the reasons given by women for not using governmental family planning services were as follows:

> *'The lack of contraceptive methods, the location being too far, bad treatment by clinic staff, inconvenient working hours, and other personal reasons relating to perception of poor service quality (The Egyptian Fertility Care Society 1995:37).*

- *Cultural barriers and barriers at the community level*

Cultural barriers to family planning are the fear of infertility, or undressing in front of a stranger to have a medical procedure (WHO 1994d, Inhorn 1994, 1996). In addition, behavioural issues related to motivation, health seeking behaviour or perception of illness are contributing barriers to access for women in low socio-economic strata. Since friends, neighbours and relatives are a major source of knowledge about contraceptives, misconceptions are common (Shyamini and Helen 1995, WHO 1994c).

Socio-cultural factors such as values, education, religion and demographic variables related to age are other community barriers to access (Puentes-Markides 1992, Inhorn 1994, 1996, Joseph 1996, and Eschen and Whittaker 1993).

The continuing demand for children to be fostered, is one of the major barriers to fertility decline. African programmes did not have a good yield in fertility decline due to a lack of individual demand, and a lack of support for fertility decline from the leadership, for cultural reasons (Caldwell and Caldwell 1987, Pearce 1995, Renne 1997, Hollos and Larsen 1997).

The motivation of couples (their acceptability of, and compliance with a contraceptive method) is a barrier at the household level, and the failure rates of contraceptives are important indicators for their effectiveness (WFS 1985). Some simplistic views, however, have laid the blame for the under utilisation of FP services on

the 'victim' i.e., on the lack of demand due to ignorance, poverty or illiteracy, laziness or superstition (Thaddeus & Maine 1994).

- *Other determinants of access and FP utilisation*

The reproductive stage in a couple's life is a determinant of FP utilisation. Ravindran (1993) identified three stages in the reproductive life of a couple: the 'yet to begin', the 'ongoing', and the 'completed desired family size'. During the 'yet to begin' stage, contraceptive prevalence is nil, because of cultural beliefs associated with the value of having children, particularly when young. The 'ongoing' and ' completed desired family size' stages are not clearly distinguishable. Women that claimed that they had completed their family, sometimes found themselves reverting back to the 'ongoing' stage, if they lost a child, or if they decided they needed another child after all.

Another determinant of FP utilisation was the husband's approval (Eschen and Whittaker 1993, Caldwell and Caldwell 1987, Magnani et. al. 1995). When the husband disapproved of contraception then it was extremely difficult for the woman to defy his authority, because she faced the risk of being deserted by him (WHO 1994c, Dharmalingam 1995). Men's opposition was usually due to a mixture of fear over their partner's health, and of losing control over them (Ward et al. 1992), because family planning was sometimes associated with infidelity (Fort 1989, Thaddeus & Maine 1994).

Economic status, employment status, and therefore ability to pay for services, were other major determinants of access to health care. Thaddeus & Maine (1994) argue that the financial cost of receiving care is sometimes not a major determinant of the decision to seek care, but the opportunity cost of time needed to seek health services was (Beckerleg et al. 1999, WHO 1994c).

2. The political dimension of international population policy and programs

Historically, international population policy focused on the problem of numbers that was considered a global issue the solutions of which were seen to be national. Population control programs that have started in Asia were and still are criticised for their focus on demographic objectives built more around rates and numbers rather than individual's needs (World Bank 1993).

Ravindran (1993), Kamran (1996) and Morsy & El Bayyoumi (1998) have described how donors and multilateral agencies used direct coercive methods (mass sterilisation's without informed consent), and indirect coercive methods (economic incentives and disincentives) in implementing FP programs, transforming their clients into resistant and 'uncooperative targets'. Foucault (1979) critiqued this unilateral process as one illustration of the power/resistance dichotomy between the North and the South, and named this process 'biopower'. He perceived it as being bipolar at a number of different levels: male and female, provider and client interactions. Foucault's (1979) analysis of 'anatomo-politics' i.e. the manipulation of individual bodies and manipulation and control of populations is relevant to the methodology of implementation of FP programs. In this critique, population programs are perceived as a tool of oppression:

> *'In relation to Egypt's current "openness", the targeting of Egyptian women's bodies within the framework of the North's international population control campaign is but one element of this multi-prolonged assault which affects male and female adults, and not least, Egypt's children' (Morsy and El Bayyoumi 1998: p78).*

Many family planning programs have led to strong local resistance an example of which has led to the fall of the Indian government in the late seventies (Ravindran, 1993).

Morsy and El Bayyoumi (1998), condemns the experimental trials of contraceptives in Egypt that had not yet been approved by the Food and Drug Administration of USA:

> *'The same type of experimental research on contraception, well documented for Puerto Rico and other parts of the Global South, took place in Egypt and was touted as a form of modern health promotion. As part of international trials, Egyptian women have been injected with Depo-Provera and implanted with the five year Norplant. These trials occurred at a time when neither contraceptive had been approved by the FDA in the US' (Morsy and El Bayyoumi 1998:89).*

This critique is now widespread in India and Egypt. Kamran (1996) feels that development programs (population and FP included) are partly responsible for leading certain factions of people towards fundamentalism, in a misdirected attempt to fill the gap that the failure of development projects had left behind.

> *'The crisis of modernity, linked to the failure of the development project in the Third World gives rise to new social movements of the dispossessed and the marginalized' (referring to fundamentalist movements) (Kamran1996: 15).*

3. The economic dimension of international population policy and programs

Following a different interpretation, Green (1992) and Sen (1994) have associated global destabilisation with inequity in the distribution of world resources, rather than population growth. In their analysis, the industrialised countries were ignoring their rate of consumption, and the inequities in the global distribution of wealth, because they controlled world resources.

> *'The pursuit of growth and financial adjustment without a reasonable concern for equity is ultimately socially destabilising' (McNamara, 1980 cited in Green, 1992:9).*

A few years earlier, Green (1992) came out with an interesting formula illustrating the global politics of population growth. His perspective was that:

'Rapid population growth burns nature's candle at both ends- generating more consumers, while reducing natural productivity (Green 1992:11)'.

The formula is **I** (impact)= **P** (population) x **A** (affluence) x **T** (technology)

Environmental impact (I) is the product of P (population size) by A (personal affluence measured by consumption of goods and services), and by T (technology). The developed nations' part is to slow down A (affluence) and T (technology). So far they have failed in this respect, especially the USA: Less than one-fourth of the world's population (North America) consume roughly three-fourths of its raw materials and energy, and produce three- fourth of its solid waste (Green 1992). The developing world, in its turn, must do all in its power to decrease the P factor of the equation, the growing monster, population. They have failed in that respect too, especially in India, and at the beginning of October 1999, the world population had reached six billion.

To date, it seems that some developed countries have favoured their economic and political interests at the expense of global stability (the decisions to reduce industrial toxic emissions for the preservation of the ozone layer, and the decisions to stop nuclear testing, were both rejected by the American congress). Moreover, since developing countries do not take serious measures to control population growth, the prospects of global stabilisation based on Green's formula seem very remote, and its application remains utopian.

There is now a lack of consensus between the different political streams in the North - donors, multi-laterals, NGO's, feminists, human rights and environmental activists - and the policy makers in the South - MOH, NGOs - regarding policy agendas for population growth control. International donors maintain that the Ministries of Health are directly

responsible for decreasing fertility, increasing contraceptive use, and ensuring local community compliance with the standards set by them, while the national policy makers are consumed with their political and national agendas (Ravindran 1993, Kamran 1996).

4. The cultural dimension of international population policy and programs

Greenhalgh (1995) criticises the separation of culture from the political and economic context and advocates a 'political economy' approach to population policy

> *'Instead of separating culture from context, contraception from socio-economics, the real challenge is to construct whole demographies that illuminate the mutually constitutive relations between culture and political economy, and the implications of these relations for reproductive actors' (Greenhalgh 1995:9)*

Traditionally, population programmes focused on strategies that mainly mobilised political support, rather than dealing with the cultural barriers to reducing fertility. Examples of those cultural barriers are Confucian traditions in Korea that stress the centrality of the family, the opposition of the Roman Catholic Church in the Philippines and the Islamic movement in Indonesia (World Bank 1993).

> *'Family planning succeeded in East Asian countries by taking advantage of opportunities to mobilise political support, exploiting the existing demand for contraception, and developing innovative ways to deliver contraceptive services' (World Bank1993: 19).*

Like Greenhalgh (1995), there are a number of theorists in the field of development that argue for a contextual approach; Warwick (1988) and Airhihenbuwa (1995) maintain that programmes need to take into account the socio-cultural context in order to be sustainable

> *'Programmes must address the issues of identity and difference within the contexts of power, agency, and history, and must take into account the political dimensions of culture in the process of transformation (Airhihenbuwa, 1995).*

The perspective of this thesis is that development programs in general, and population and FP programs in particular, must be based on the socio-cultural context of the population it is supposed to serve, in order to reaffirm the community's identity. A socio-cultural approach 'allows people to count', instead of 'counting people' (Cohen and Richards 1994)

There are many definitions of culture. The most appropriate one for the purpose of this discussion is, that culture is defined as a system of interrelated values active enough to influence and condition perception, judgement, communication, and behaviour in a given society (Airhihenbuwa 1995). It is rooted in families, schools, and communication industries within the social structure (Warwick 1988).

5. Gender in international population policy and programs

In many parts of the world, women's health is affected by an accumulation of multifaceted disadvantages that are linked to injustices in the socio-economic and political systems in a systematic way (Cook 1994, Koblinsky 1993, Stern 1996, Dixon-Mueller 1993). Contributing factors to women's dispossession are the forces of commercialisation, economic diversification, labour migration, land fragmentation, and political and legal inequities and religious and social practices and institutions (Dixon-Mueller 1993). In Jordan and other countries of the region, the matrix of factors affecting women status is further intensified by deteriorating national economies due to the requirements of structural adjustment policies (Miles-Doan 1996).

National population policies have so far overlooked women's needs in their justification, formulation, or implementation (Berer 1993), and until recently, they have almost totally ignored women's partners (DHS 1996).

During the ICPD (1994) and Beijing (1995) conferences, family planning promotion was strongly advocated by the new international population movement mostly represented by feminists, environmental and human rights activists within the context of a more comprehensive reproductive health care. However, they also supported acceptance of other practices that were prohibited by world religions, namely abortion and homosexuality. The increasing incidence of HIV and AIDS in developing countries has resulted in focusing on human sexuality issues in family planning programs. This magnification of human sexuality issues, and the non- contextual advocacy of prohibited practices, was met by fierce resistance from the Vatican, and Muslim legislators. They attacked the ICPD's plan of action as a 'piece of cultural imperialism' as reported by Cohen and Richards (1994); Saudi Arabia, Sudan, Iraq and Lebanon, all Arab countries, boycotted the ICPD conference (Cohen and Richards 1994). Women from the South were also against this feminist advocacy in both conferences (Morsy & El Bayyoumi 1998). They were skeptical of the Western feminist dreams of creating an international consciousness of oppression in general, and perceived the Euro-American tradition in academic and feminist writing as another form of imperialism (Lock & Kaufert 1998, Morsy & El Bayyoumi 1998).

There are many questions raised by those who are against the formulation of an internationally monolithic approach to population control policy. Does the reproductive health approach alone fulfil the communities' unmet needs universally (Basu 1997)? Is the empowerment of women a sufficient way to reduce the demand for children? Is it the only effective way to reduce fertility? How universal is the demand for female employment? These questions require regional consideration. In the Middle East paid

employment is not necessarily an attractive thing that all women want to share (National Population Commission 1997).

These questions are very pertinent to the context of the Middle East and Jordan, where Islamic legislation has permitted the practice of family planning for individual welfare, as a personal decision to be made by the couple within the realm of their household. However, Islamic legislation has opposed the formulation of a national policy for fertility control, based on the interpretations of Islamic doctrine (Tamimi 1998).

Moreover, how pertinent is the feminist advocacy of reproductive rights and the individual model in a social context built on the value of the collective, where most social interactions occur in extended families, and where kinship ties are of the utmost value (Population Council 1994)? This situation is not unique to the Middle East. Lock (1998) describes this lack of fit between the Western mentality and the Japanese socio-cultural values,

> *'The response of women in this study, reveal the tension inherent in the rhetoric of individualism and freedom on the one hand (intrusions from Euro-America which pervades almost every aspect of Japanese society today), and an unavoidable immersion in and obligation toward the family on the other hand, which brings considerable satisfaction for most women' (Lock 1998:231).*

- *Gender, family size, and the dominance of male preference in fertility decisions*

The findings of twenty surveys of men (interviews with 21, 000 married men in fifteen developing countries), completed by mid 1995 have shown evidence of gender differentials in family size preference. A great majority were conducted in Sub-Saharan Africa (14 surveys), two in North Africa (Egypt and Morocco), and two in Asia (Bangladesh and Pakistan)(Ezeh et al. 1996). The mean ideal family size reported by men substantially exceeded women's ideal family size by two to four children in West Africa

(Ezeh et al. 1996). Gender differentials in family size preferences were most pronounced in Sub-Saharan Africa, the Middle East, and Pakistan, and explained by male preference dominance (DHS 1996). Another survey carried out in urban Khartoum in 1985 showed that Sudanese men (Moslem males age 18 years or above) played a major role in family planning decision-making, and the decision not to practice contraception was found to be male-dominated (Khalifa 1988). The approach taken in this research is that there is a need to consider household dynamics and the influence of men when designing FP programmes.

This call is very pertinent to the context of the Middle East and Jordan, where Islamic legislation has permitted the practice of FP, for individual welfare, provided the decision is made by the couple within the realm of their household. However, Islamic legislation has opposed the formulation of a national policy for fertility control, based on Islamic doctrine.

6. The position of Islam

- *'Shari'ah' (Islamic legacy) and the doctrine of Islam*

Islam is a major determinant of the socio-cultural profile in Jordan, (94% of the population are Muslims), the Arab world, and other countries of the Middle East. From an Islamic perspective, God is the creator of both the universe and man, and the laws and commandments that God has given through the Prophet Mohammed are expressions of man's true nature (Harpe 1983). They are meant for the purpose of taming human nature, *'Tahtheeb al nafs'* to serve the personal and common good. Islam is then a comprehensive system that regulates the spiritual, as well as civic aspects of individual and communal life in accordance with man's nature (Tamimi 1998, Awaysheh 1997,

Seestani 1997). *'Shari'ah'* (Islamic jurisprudence) is a complete detailed code of conduct, based on rules and regulations that were revealed to Prophet Mohammed in the *'Quran'* (the word of God), and *'Hadeeth'* (the Prophet's tradition and words basing on the revelation of God) (Omran 1992, Sachedina 1990, Tamimi 1998).

By referring to *'Quran'*, *'Hadeeth'*, and using *'Qiyass'* (analogy), Islamic jurists have classified all human actions into one of five categories on a spectrum: obligatory (*Wajib*), recommended (*Mustahabb*), permitted (*Masmouh*), disapproved but not forbidden (*Makrouh*), or absolutely forbidden (*Muharram or Haram*) (Sachedina 1990). Hence, Islam is more than a set of beliefs and ritual practices it constitutes a complete system of thought and behaviour (Nicolaisen 1983).

- *Family planning in Islam*

Muslim jurists used all the sources of *'Sharia'h'* (Islamic jurisprudence), i.e., the *'Quran'* (the word of God), *'Hadeeth'* (the Prophet's tradition) and *'Qiyass'* (analogy) to come to a *'Fatwa'* (ruling) concerning family planning. The second source of law, the *'Hadeeth'* (quotes from the Prophet's Tradition) was used by both Shia' and Sunni jurists. While the third source of law, *'Ijmaa'* (consensus of earlier jurists) was used by the Sunni sect only, and *'Qiyass'* (analogy) was used by jurists of both sects who were able to reach a new *'Ijmaa'* (consensus) that FP practice was not forbidden.

However, there was a variation in the *'Fatwas'* (rulings) of the different schools of both sects: They ranged from permitted (Egypt and Iran) to disapproved (Saudi Arabia), but all jurists (Shia' and 'Sunni') agreed that FP was not forbidden (Sachedina 1990, Tamimi 1998, Omran 1992, Seestani 1997).

- *Population policy legislation in Islam*

As seen earlier, despite the permissibility of practising FP at the individual level, *'Shari'ah'* (Islamic jurisprudence) forbade the enactment of policies for birth control (Omran 1992, Tamimi 1998). This might explain the reluctance of Islamic nations, and certain Arab countries, to adopt national legislation for the use of family planning to date.

- *Population growth in the Muslim world*

Despite Islamic jurists' *'Fatwas'* (rulings) concerning family planning, and historical evidence that early Islamic societies (including the Prophet's companions) practised *'Al – Azl'* (coitus interruptus) to avoid economic hardship (Tamimi 1998, Awaysheh 1997), Muslims have increased by over 235 percent in the last fifty years up to nearly 1.6 billion. (www.geocities.com/WestHollywood/Park/6443/Islam/results.htm). There are success stories however such as the Iranian experience, where population growth rate dropped from an all-time high of 3.2 percent in 1986 to just 1.2 percent in 2001, one of the fastest drops ever recorded. In reducing its population growth to 1.2 percent, a rate only slightly higher than that of the United States, Iran has emerged as a model for other countries that want to accelerate the shift to smaller families (Larsen, 2001).

- *The controversy about FP among Muslims*

There is a wide variation in the position of the Muslim authorities (Mecca in Saudi Arabia, Al Azhar in Egypt, and Qum in Iran) regarding family planning and other issues today. Despite the *'Fatwas'* (rulings), some authorities still sanction contraception without reservation, prohibit sterilisation, and abortion, while others firmly oppose national family planning campaigns (Omran 1992). Other authorities however support contraception, and give legal justifications for it (Omran 1992, Larsen 2001).

Leading Muslim jurists of *Sunni* and *Shia'* sects highlight the changing need for family planning, basing on *'Qiyass'* (analogy) reasoning (Omran 1992, Tamimi 1998, and Seestani 1997).

However, opponents of family planning among Muslims emphasise that children have been depicted in the *'Qur'an'* (the word of God) as great assets, and claim that the larger the number of Muslims, the greater their power. These opponents are particularly antagonised by family planning called for in a community (national population policies), and claim that this is a clear conspiracy from the West where it has originated, to reduce the number of Muslims, and reduce their power (Omran 1992). They quote *al-An'am (Sura 6: 151), al-Isra' (Sura17: 31), al Takwir (Sura 81: 8,9), and al-Mumtahana (Sura 60:12)* to argue that *'al-Azl'* (coitus interruptus) is infanticide, prohibited in the text because there is no text explicitly mentioning contraception, and consider its use as an opposition to predestination.

The proponents of FP advocate that rather than starting in the West, family planning originated fourteen centuries ago among Muslims. They cite Imam Ali (the Fourth Caliph) who in the presence of Caliph Omar denied that *'al-Azl'* (coitus interruptus) is *'Wa'd'*(genocide). They believe that contraception is only a means, the results of which are in the hands of God (Omran 1992). Furthermore, they base their position on the fact that Islam advocates the perpetuation of the *'Umma'* (nation), based on quality rather than quantity (Omran 1992).

- *Men and women, sexuality, , marriage and children in the legacy of Islam*

Historically, Islam arose in a tribal society in Arabia, organised along patrilineal principles of descent, inheritance, and succession (Nicolaisen 1983). A common

misconception surrounding Islam is that it has established patriarchal, patrilineal, patrilocal, kinship social networks; Islam did not; Islam was contextually embedded in them (Inhorn 1996).

Many stereotypes surrounding gender and Islam persist today in the West most probably because Western knowledge of Middle-Eastern societies was so often theoretical based on books written by Western orientalists (Nicolaisen 1983).

> *'So much of our knowledge of these societies until recently has been drawn only from literary sources. This may have furthered a far too simplistic but widespread opinion in the Western world, namely that Muslim women occupy a position of absolute subjugation; that they are under the domination of men, controlled within the family, by their fathers, brothers or male cousins, and later in marriage by their husbands' (Nicolaisen (1983): 2).*

The coming of Islam in the seventh century improved the status of women in Arabia by according them substantial legal rights: women could inherit and manage property, female infanticide was forbidden, and a woman could marry the man of her own choice, despite her guardian's approval.

However, although most life decisions were to be built on mutual consent (Tamimi 1998, Seestani 1997), women were in no way 'the equal of men', they were different by nature. The concepts of biological order, of the individual and his/her instincts, of maleness and femaleness are inherent to Islamic doctrine (Nicolaisen 1983). Harpe (1983) argues that if the laws of Islam distinguished between men and women, it is because they express a natural innate difference between the sexes. Islamic laws were therefore meant to liberate individuals and society from the 'unnatural' (Harpe 1983), and were not meant to be used for the subjugation of women and children.

Because the Islamic system is based on the 'natural', the position of women in Islam was largely defined in relation to men - daughter, sister, wife, mother (Sadik 1985). Women's potential was realised by being good daughters, sisters, wives and mothers; while men realised their roles, in addition to being good husbands, fathers, and sons, by being good providers and protectors.

Sadik (1985) analyses, how over the years, men took control of women, through being made responsible for them. Men gradually transformed gender relations to their advantage because they were the decision-makers in these patriarchal societies. A wide gap developed between Islam's laws and man's application of them within patriarchal social contexts and tribal kinship networks. With time, the legal rights accorded to women by Islamic law, and their practical access to those legal rights became two separate entities. Women gradually became marginalised from public life, in contrast to the first Muslim women, and women of the Prophet's household during his life and few generations after his death (His wife Khadigeh, daughter Fatima and granddaughter Zeinab).

Sexuality is highly valued by Muslims, and seen as a human activity with vital functions, beyond solely reproduction (Nicolaisen 1983). Within the confines of marriage, it is treated as one of the good things in life that a Muslim of both genders is meant to enjoy (Sachedina 1990). One illustration of the value accorded to sexuality in Islam is its accommodation for a marriage of pleasure, the *'Muta'a'* (pleasure) marriage in addition to permanent marriages. This temporary contract is still in practice among the *'Shia'* sect, and was banned in the *'Sunni'* sect by the second Caliph Omar (Seestani 1997). In both marriages, women have equal rights to sexual pleasure than men. There are gender

differentials however, for the number of partners to have at one point in time, according to Islamic legislation. Women are allowed one male partner at a time (temporary or permanent husband) while men are allowed many partners (within the confines of temporary or permanent marriages).

Horizontally read, this legislation seems biased in favour of men, while in actual reality it can be interpreted as offering protection for women (Seestani 1997). One of the rationales underlying this legislation is to monitor females' sexual partners, for the sake of identification and retrieval of patrilineal descent, should pregnancy result. Since men are legally and financially accountable to support their wife and child, this identification becomes necessary to give one's name, and pay *'Nafaqa'* (financial support) to the wife and child should pregnancy result from temporary marriages (Seestani, 1997).

Based on this rationale, women are not allowed to remarry before the period of *'Al I'ddah'* (a time interval of three months) expires, after the husband dies, divorce, or end of the contract of temporary marriage (Seestani, 1997, Harpe, 1983). Three menstrual cycles, between marriages, ensure that a woman is not pregnant from her previous husband (Tamimi 1998, Seestani 1997).

Children are highly valued, and are gifts from God (al-Nahl, Sura 16:72, Omran, 1992). Children from temporary marriages have equal financial and legal rights to children from permanent marriages according to *'Shari'a'* (Islamic jurisprudence) (Seestani 1997).

Fundamentalist streams have misled many Muslims to believe that it is their religious duty to multiply and populate the earth. They base their position on one *'Hadeeth'* (quotes from the Prophetic tradition), ignoring other *'Hadeeth'* sources about the harms resulting

from having a large progeny when resources are scarce (Omran 1992). This thesis maintains that despite the value accorded to children, Islam has focused on quality rather than on quantity, and on parental responsibility in quality '*Tarbiah*' (education) and raising up of children.

> *'The ability to raise children correctly is an inherent requirement of marriage in Islam' Omran (1992:31).*

7. Arab patriarchy, the concept of 'Ezweh' and child demand.

Arab patriarchy is a system emanating from the traditional Arab family structure which is patrilineal, patrilocally extended (three generations), patriarchal, pyramidally hierarchical, and preferably endogamous (Inhorn 1996, Joseph 1996, Scott 1996). Social gender roles among males and females are acquired at an early age within the family (Joseph 1996, Inhorn 1996).

There are many definitions of patriarchy, ranging from the simple 'male dominance/ female subordination' or 'gender oppression' (Inhorn 1996), to the more complex,

> *'A system which is universal and rooted in economic, legal, and political structures, as well as social and cultural institutions, that oppresses women, through the assertion of male power, dominance, hierarchy, and competition' (Inhorn 1996:2).*

Sociological and anthropological definitions concentrate on patriarchy expressed in familial relations,

> *'A patriarchal relationship is one in which the male head of the household dominates members of the house whether these are male, female, adult or juvenile. This patriarchal structure is legitimised by legal, political, and religious norms, which give the adult male a virtual monopoly over, the subordinate groups within the household (Inhorn 1996:3).*

Inhorn (1994, 1996), Farid (1996), El Khorazaty (1996) and Scott (1996) have described how Muslim Arab societies remain strongly pro-natalist because of the strong

kinship structures where much of the social interactions occur within family circles. The demand for children remains very high in this context (Zurayk 1987, Inhorn 1994, 1996, Scott 1996, Sabella 1996). Although the latest DHS in Jordan (1997) has shown that the proportion of single women is increasing, this was more probably due to economic constraints than to a change in values because marriage remains a universal value in the Arab region (Farid 1996, Ayad et al. 1996). Joseph (1996) analyses 'persistent patriarchies' in the Arab world and parts of Asia and Africa. She describes them as persistent because they are rooted in the social, economic, and political systems through kinship networks. And social institutions reproduce patriarchy.

> *'In cultural practice, it is in the patriline that the values of honour and shame are enacted, giving extended elder male patrilineal kin authority over the behaviour of women and juniors of their lineage' (Joseph 1996:204).*

Economic patriarchy is apparent in privileging males and elders in the ownership and control of wealth and resources and '*wasita*' (brokerage for kin) is another sign of economic patriarchy, which occurs in this context.

> *'Patriarchal kinship also directly supports economic patriarchy through the deployment of kin networks as 'wasta' (brokerage) and temporary or long term support' (Joseph1996: 208)*

As for political patriarchy,

> *'Kinship is central to the political system of most Arab states in multiple ways. Heads of state often refer to themselves as fathers of the nation...children's citizenship can be bequeathed only by the father' (Joseph1996: 209-211).*

Joseph (1996) argues that when people grow up in a patriarchal society, it becomes internalised shaping all their social behaviour,

> *'Patriarchy works because it becomes part of the psyche, the self, the minds and souls of people, and persons see themselves as embedded in*

critical relationships in their families...Connectivity is encouraged in both men and women' (Joseph 1996:214).

Persistent patriarchies hence deter fertility decline, and act as barriers to access of FP at the economic, political, cultural, and religious levels. Scott (1996) describes how women contributed to kin status by preserving the male honour through their chaste behaviour, and by bearing children.

However, power not only rests with the father figure of the family, but with the older women – mother, grandmother, mother-in-law (Stone & Lewando-Hundt 1987, Hundt-Lewando 1999), who use negotiating strategies with their fathers, brothers, husbands and sons to achieve specific aims (Ghannam 1996). The control of women's access to public space, and their behaviour in public, becomes often a shared responsibility among community members, so that older men and women control younger women through the social pressure (Ghannam 1996).

'Ezweh', is an aspect of Arab patriarchy that was common in the non-urban settings. The word is an adjective sometimes used as a noun *'Al Ezweh'* (when used as a noun it is preceded by the prefix *Al* for identification) describes the role of male descendants as a source of social, financial, and political support of their extended families.

Referred to as *'Azwa'* among the Negev Bedouin community, or *'Ezweh'* among the Jordanian Bedouin and Palestinian community, or *'Izweh'* among Galileo Palestinian community or *'Rajweh'* among the Azraq Druze community, it comes from the word roots *'Aza'a'* meaning consolation or *Rajaa'* meaning hope (for *'Rajweh'*). With time *'Aza'a'* is also being used to refer to condolence rites. So the concept of *'Ezweh'* becomes synonymous with consolation or a source of hope by having a numerous male

progeny to defend the clan, the fuel of the tribal system that ruled in the Arabian Peninsula before modern times, and the establishment of civil society and law.

Hence *'Al Ezweh'* becomes more powerful with the increase in number of males in a kin group, or clan in order to protect the land, the principal source of economic wealth (Scott 1996, Kanaaneh 1996). It maintained political power and prestige of kin groups *'Al Asheera'* or *'Al Hamula'* in tribal (Bedouin) societies, or villages (rural societies), from pre-Islamic times, to date. Scott (1996) fits the concept of *'Al Ezweh'* though not referring to it as such

> *'The survival of male family members was crucial because in the spread and perpetuation of the family name, in the holding of property and in defending the interests of the clan, it is the sons who count as an asset' (Scott 1996: 174)*

Kanaaneh (1996) on the other hand, describes the transformation of the concept of *'izweh* (meaning *Ezweh)* among Palestinians from the realm of the clan (before the establishment of the state of Israel), to the realm of national struggle or *'izweh of the nation'*.

> *' Nationalism conjures a gendered world in which women are principally mothers of the nation, reproducers of boys and makers of 'izweh, with limited participation in other realms' (Kanaaneh 1996:235).*

8. Population policies and programs in the Arab world

Social measures to indirectly influence the change in reproductive attitudes were introduced by many Arab governments: they raised the legal age of marriage, increased educational opportunities for women, attacked illiteracy, organised population education campaigns, and reduced infant and child mortality (UNESCO-UNEDPAS 1992, Goujon 1996, El Zanaty 1996).

Arab countries now fall into three categories with respect to population policy. Countries with an explicit national population programme are Egypt, Tunisia, Morocco and Algeria (Faour 1988, UNESCO-UNEDPAS 1992, and Ayad et al. 1996). Countries with no explicit national population program until recently (i.e., 1997 onwards) are Jordan, Syria, Lebanon, Sudan and Yemen. Pro-natalist countries are Libya, Iraq, and the Gulf countries (UNESCO –UNEDPAS 1992).

A study done by Faour (1988) on Arab Governments' perceptions of fertility found that all Arab states approved of the use of contraception. In ten countries, representing 76% of the total Arab population, the Governments had authorised and supported direct access to, and distribution of modern contraceptive methods.

The variation in the individual countries' policies however, was largely determined by the interrelationship of the social, economic, and political factors of these Arab societies (Faour 1988). In Tunisia, local communities, social groups, and associations were increasingly responsible for the implementation of the national programme by publicising the idea of smaller families, distributing contraceptives, and establishing birth control clinics in local dispensaries (Faour 1988). Access to modern contraceptives was limited in Saudi Arabia and Libya, while Iraq and Saudi Arabia used economic incentives and disincentives to encourage people to procreate (El- Khorazaty 1996, Faour 1988).

9. Strategies to widen access to FP

A strategy mostly advocated by the World Bank (1993), the role of the private sector is viewed as an important complement to the public sector in FP provision and is often overlooked. More than half of the users in many countries of Latin America and Africa, and twenty percent of all FP users world-wide rely on private outlets for family planning

services (World Bank 1993, Beckerleg et al. 1999). In Egypt many users rely on private outlets and 53.1 % of abortions are performed in private doctors' clinics, or in private hospitals (El Zanaty 1996, The Egyptian Fertility Care Society 1995:Table 9:39).

Governments can encourage private sector contribution by removing restrictions on selling contraceptives, promoting private provision of contraception through the mass media, and by permitting government employees to provide services to private patients after working hours (World Bank 1993). Collaborative ventures between the public and private sectors widen access because private agencies (NGO's, universities, pharmacies etc...) maintain consistent programmes, and are a 'continuing community presence' (World Bank 1993, Al Masarweh 1997).

Women and human rights activists and lobbyists pushed forward the linkages between family planning programs, and other developmental programs, and between population policies and overall amendment of economic and social policies to enhance the status of women and their health (Kamran 1996, Cook & Fathalla 1996). The International Conference on Population and Development (ICPD) held in Cairo in 1994 was the culmination of such efforts at the macro level (Guillebaud 1996, Cook 1994, Cook & Fathalla 1996, WHO 1996, Green 1992, Cohen and Richards 1994, Omran 1992). Population control and development were seen as 'inextricably linked', and were both dependent on the degree of empowerment of women (Cook & Fathalla 1996, Koblinsky & Timyan 1993, WHO 1994e, 1995b, 1996b, Green 1992, Cohen 1993, Omran 1992, Dixon- Mueller 1993, Stern 1996, ICPD 1994, Cohen and Richards 1994).

In the hope that integration of services would improve access and the quality of care, the Family and Reproductive Health program of the WHO (FRH) was established

following the ICPD. This links with the current approach of the WHO in its ninth general programme of work, till the year 2001 (WHO 1996a).

However the translation of this 'victory' for women's advocacy in international policy was not accompanied by practical policy changes at the national level (Basu 1997). In particular the commitment of local governments to women empowerment has not been evident (Cook & Fathalla 1996).

Around a decade earlier, the World Fertility Survey (1985) had recommended the integration of FP services because it reduced unit costs, and made the programme more acceptable in communities where FP remained a controversial issue. Empirically, integrated services were difficult to implement, when health ministries were 'understaffed and 'under funded', as in the case of most developing countries. Heavy demands for health care shifted attention from family planning, while medical staff gave priority to curative, rather than preventive services. Furthermore, when workers were overloaded with responsibilities, specifically with multipurpose workers, they did not perform any of their tasks well. If an integrated family planning service employed single -purpose workers, frictions sometimes happened with the health service staff over differences in training, seniority, salaries, and promotion.

Another strategy used in an innovative program initiated in Tunisia was integrating postpartum care and contraception with primary health care (Eschen and Whittaker 1993, Population Council 1994). It was built on the postpartum model of FP provision, mentioned by many scholars, as an effective strategy to widen access to FP (Winikoff and Mensch 1991). This model is based on the assumption that women are most receptive to contraceptive programs at the time of childbirth. Maximal motivation is assumed,

along with the assumption that women will not generally return for services, and must be 'captured' before hospital discharge (Winikoff and Mensch 1991).

The major drawback of this model however, is its contrast to a 'quality of care' orientation, where emphasis on continuity, and encouragement of clients to return for treatment of side effects, or when the need arises for additional supplies or method change (Jain & Bruce 1989). Other drawbacks of this model are the focus on contraception alone, perhaps neglecting important issues for newly delivered mothers such as breastfeeding problems, and appropriate weaning time (Winikoff and Mensch 1991). Bearing in mind these drawbacks, the forty days postpartum clinic visit was introduced, where services were provided to the mother and child (counselling, FP, and immunisation).

In Tunisia, as in many parts of the Arab world, the interval of forty days postpartum has a great cultural significance for new mothers and infants. This was capitalised on to establish the 'fortieth -day consultation'. The success of this initiative drove policy makers to consider using it at the national level in Tunisia (Eschen and Whittaker 1993).

Community-based distribution (CBD) and contraceptive social marketing (CSM) are two alternative models to clinic-based FP provision frequently used in developing countries to widen access to FP, however, they proved to be expensive because they relied on salaried employees (Vernon et al. 1988, World Bank 1993).

The WHO findings (1996b) indicate how women care for (70-80%) of sick members of the family in developing countries. Women require health care because their burden of ill-health is directly linked to their low social and economic status, the multiple work loads, and the imbalance of power, which limits their choices, and their ability to protect

their own health (WHO 1996b). Therefore, methods for measuring their perspectives on matters relating to access, quality of health care in general, and reproductive health care in particular, have become research priorities. Any strategy adopted must be based on understanding more about women's and men's needs, their preference for services mix, and their desires as to the timing and type of contraceptives available to them (Helzner 1996, WHO 1994 c, UNDP/UNFPA/WHO 1996).

Unfortunately, it is not always straightforward to research user's perspectives. Inhorn (1994, 1996) and Khattab et al. (1994) presented how women's expectations were low, and in the context of such low expectations, described how difficult it was for women to respond to questions about their 'preferences' for methods. It was equally difficult for researchers to interpret what women really meant (WHO, 1994d). In addition, there is a lack of data in research for certain population groups, who were under-served by technologies and services. The views of unhealthy women, those living in poverty or in poor circumstances, men (partners), adolescents, refugees, and migrants needed greater representation (Fort 1989, Angarita 1997, Berer 1993, Guldan 1996, Haddad et al. 1998, Palmer et al. 1999).

Historically, the majority of population programmes ignored men because they either assumed that they were against family planning, or at best indifferent (WHO 1994f). These programmes overlooked the fact that at least one- third of all couples who practice family planning use a method that requires male participation or co-operation (WHO 1994f; Angin 1998). Men's reproductive preferences and desires may constitute a major challenge to programme success (Population council 1994, Angin 1998, DHS 1996, Ezeh et al 1996, Helzner 1996). It is instrumental for policy makers, and program

managers, to address men World wide, and specifically in the patriarchal and Islamic countries of the Middle East (Ezeh et al. 1996, Mehra 1993, Magnani et. al 1995, WHO 1991, Inhorn 1994, 1996, Joseph 1996, WHO 1994 h and El Zanaty 1996).

Surveys in the 1980's found a demand among men for family planning, despite the fact that programs were usually integrated with MCH services and promoted mostly female methods (WHO, 1994f). However, the DHS program, found a gender differential with respect to fertility and contraception most pronounced in the West African surveys (Ezeh et al. 1996). Research is needed on both gender perspectives for needs assessments, programme design, and evaluation (Helzner 1996, Angarita 1997). In view of this male demand for family planning, the DHS program has carried out cross-national studies concerning their attitudes and behaviours regarding fertility and FP (DHS 1996, Khalifa 1988, UNFPA 1998)

While involving men, a gender analysis of FP provision and utilisation must be used as the basis for advocacy because it develops sensitivity and might encourage men to be more supportive partners to the women in their lives who use female-dependent methods. Gender bias can easily be measured by the breakdown by sex of the service providers, decision-makers, and researchers (Helzner 1996, Angarita 1997, UNFPA 1998). Analysing the data by gender, i.e. what roles women play versus men, the activities division by gender, time-use, and access to resources is a methodology called 'gender mainstreaming' and has helped to identify and highlight gender differences, in enhancing or deterring access (Mehra 1993, Angarita 1997, UNFPA 1998).

Furthermore, information on men's views about condoms remain contradictory or incomplete, and women's views are also sadly lacking: A gender analysis would examine

these aspects, and other aspects of couples' relationships, by taking the desires and behaviour of both partners into account (Helzner 1996). It seems important to note that discussions between partners of the method of contraception to be used, is still not widely prevalent in many countries.

Building on intangible resources, such as well-established community relations, and the respect of local leaders, and the people are equally important in widening access. Peer motivators have been effective in many countries and sometimes, peer counsellors were used to reach young people (World Bank 1993). Counsellors, that were also satisfied users of family planning methods, were especially influential in bridging the gap between people with unmet needs, and service providers (World Bank 1993, Diaz and Diaz 1993, Abdel Tawwab & Roter 1996).

National family planning programs analyse service statistics to explore how service users utilise the services (Al Masarweh 1997). However, the information provided by service statistics is limited, as they do not provide information on motives for using or discontinuing a certain contraceptive. Furthermore, information on users of traditional birth methods who do not reach the clinics, or of clients who use the private sector for contraception is needed. Another limitation of these data is when clients change clinics, it is often difficult to retrieve them. According to Donaldson and Tsui (1990), service statistics remain service-oriented rather than client-oriented, and of average quality, not reliable enough for in-depth analysis. For the purpose of this research service statistics were used along with qualitative methods (observation, group discussions and individual interviews) in an attempt to keep the balance between service orientation and client orientation. Furthermore there was an identified need for research at the household level

to provide accurate data on how the members respond to, and participate in primary health care programs (UNFPA 1998, Al Masarweh 1997). In this study, natural group discussions and in-depth interviews were done at the household level to examine men and women's perspective of family planning services and programs.

- *Service quality improvements*

Since 1986, WHO has been stressing that research should examine the motives underlying FP utilisation, focusing on the social determinants shaping those motives. Not only are the social determinants of compliance not understood, but also

> *'The operational implications of widespread non-compliance in a seemingly sound service operation are unknown' (WHO 1986:12).*

According to the international donors, there is no doubt that quality improvement of family planning programs, would reduce fertility rates, and population growth substantially (World Bank 1993, UNDP/ UNFPA/ WHO/ World Bank 1996). This might happen despite the practical barriers that limit the yield of family planning programs, such as resource constraints, human error, and reluctance of governments to take appropriate action.

At the micro level, contraceptive use (CPR) has been established as a measure of access to family planning; at the macro level, it is a significant global health-for-all indicator for women (Mehra 1993). Likewise, women health advocates urge the use of indicators of acceptability that also measure informed choice and user satisfaction (WHO 1991). If these indicators were to be used, it becomes instrumental to define 'users'. Women and men use contraceptives in the context of a sexual relationship, so that a 'user' is not only the person who swallows the pill or wears the condom, but is also the

partner of that person. Since service providers are often the gatekeepers to the use of contraceptives, they should also be considered as 'users' of products in a certain way.

Quality mass media programmes could be used not only to create awareness, but also to influence individual contraceptive behaviour (World Bank 1993).

Eshen and Whittaker (1993) described how programmes making modern contraception available, that are backed by government policies, endorsement, and education in combination with a favourable social setting are the most effective in reducing fertility. Favourable 'social setting' is understood as:

> *'Culture, religion, level of socio-economic development, gender roles, bureaucratic tradition, political commitment and other factors have had a great impact on the success or failure of programs and must be taken into account in program planning' (Klitsch and Walsh 1988:20).*

Conclusion

This chapter has reviewed the literature on current debates and issues in international population policy, and the political, economic and cultural implications of this policy at the international and national levels. Universal barriers have been reviewed along with strategies to widen access and frameworks for quality improvements in provision.

The interpretations of the position of Islam towards women, marriage, sexuality, children and FP based on Islamic jurisdiction have been presented. The characteristics of Arab patriarchy, socio-cultural traditions and kin networks in the Middle East have been reviewed because it is relevant for FP programs to build on Islamic doctrine and on local traditions in order to become more accessible to the grassroots. The next chapter will introduce the setting of this research study, Jordan.

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Chapter 2

Setting and background

Introduction

This chapter is an overview of the recent history, geography, socio-political and economic situation of Jordan. The features of its population, changing fertility trends and contraceptive prevalence are analysed within the context of the socio-cultural background and family planning provision available in Jordan.

1. Geographic profile

The Hashemite Kingdom of Jordan is a country of the Middle East located on the North -Western corner of the great plateau of Arabia with Aqaba in the South, as its only outlet to the sea (Red Sea). Syria, Iraq, Saudi Arabia, the West Bank [1] and Israel are its neighbouring countries. Home to almost 5.083 million people, its total area is about 89 000 square kilometres, 80% of which consist of steppe and desert. The majority of Jordan's population is concentrated in one-eighth of the land, mainly in the Northwest highlands (DHS 1997). Jordan has valuable deposits of potash however, water deficit is one of its serious problems, and the rates of water salinisation, depletion, and contamination increase annually (Al Masarweh 1997).

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[1] The (West Bank) of Jordan River and the Dead Sea was annexed by Jordan in 1950. This area has been under Israeli occupation since the June 1967 War. In July 1988, King Hussein renounced Jordan's claim to the West Bank. Part of the West Bank is now under the Palestinian National Authority since the Oslo Peace accord between the Palestinians and Israel in 1995.

The rapid depletion in water supply, and population natural growth (double by the year 2012), the agricultural and manufacturing sectors are expected to face a serious water deficit, not to mention the shortage in drinking water (www.kinghussein.gov.jo).

Jordan has twelve governorates grouped in three regions: the Northern region (Irbid, Jarash, Ajloun and Mafraq), the Central region (Amman, Zarqa, Balqa and Madaba) and the Southern region (Karak, Tafielah, Ma'an and Aqaba).

Figure 2.1 Map of Jordan (Scale 1: 50 000)

2. Urbanisation

No major urban centre existed in Jordan until the late 1940s. Amman, the major city of the East Bank[2], had ancient roots and was called Philadelphia (city of the seven hills) during the rule of the Roman Empire. At the end of the nineteenth century (1878), Circassians fleeing the massacres in Russia settled in Amman, and forty years later (1921), Prince Abdallah Ibn Hussein Al Hashimi (coming from Hijaz in Saudi Arabia) established his capital in Amman. It passed its first decades as a provincial trading centre and garrison on the margin of the desert and in 1943, it only had 30,000 inhabitants. Amman however grew over the next three decades (1950-1980) into a booming, overcrowded metropolitan centre.

Historically, the Amman Governorate that included Zarqa at the time had the highest growth ratio (5.6%), followed by the Irbid Governorate (4.6%), the Governorate of Balqa'a (3.7%), the Karak Governorate (3.6%) and the Ma'an Governorate (2.6%) (Fandi 1986).

- Jordan is now a highly urbanised country because of the influx of Palestinians after 1948 and 1967, its high birth rate, internal migration, and the repatriation of Jordanians after the Gulf War (1990). In the late 80s, (60% –80%) of Amman's population were Palestinians (either by origin or had a refugee status)(www.kinghussein.gov.jo). According to the 1994 Population Census findings, the urban Governorates (Amman Irbid and Zarqa) are the most populated in this order (DOS 1997: Table 3.1). Urban population continues to increase (70%-78%) in Jordan

[2] The area east of the Jordan River, the Dead Sea, and the series of valleys *(wadis)* from the Dead Sea to the Gulf of Aqaba. Roughly the former Emirate of Transjordan.

between (1997 - 2000) according to the DHS (1997), Population Reference Bureau (2000) and the World Population Data Sheet (2000) (www.prb.org/pubs/wpds)

3. Recent history

'In November 1920, Prince (later King) Abdallah led forces from the Hijaz (Saudi Arabia) to restore his brother's throne in the Kingdom of Syria. However, the French mandate over Syria obliged Prince Abdallah to delay his pan-Arab goals and focus on forming a government in Amman' (www.kinghussein.gov.jo). Jordan, a part of the Ottoman Empire until 1921, gained its independence to be declared as 'Trans Jordan' in 1923, a British mandate under King Abdallah.

During the period (1928 – 1946), Britain controlled foreign affairs, armed forces, communications and state finances in Jordan, while Prince Abdallah commanded the administrative and military machinery of the Government. A series of Anglo-Trans Jordanian treaties, culminating in the treaty of March 22, 1946 ended the British mandate and led to the full independence of Trans Jordan (www.kinghussein.gov.jo). In 1950, 'Trans Jordan' and the West Bank were united, under the Hashemite Kingdom of Jordan- its current name. King Hussein, the grandson of King Abdallah, ruled the Kingdom from 1953 till 1999. When he died, his eldest son, King Abdullah II became the ruler of Jordan.

In 1988, the West Bank was excluded from the Hashemite Kingdom of Jordan upon the request of Arab states to facilitate the establishment of the Palestinian State following a peace treaty with Israel in 1994.

4. Economy

The Jordanian economy started to take off in the 1960s. The potash, phosphate and cement industries—were developed during this time. An oil refinery was constructed in Zarqa, and the country became linked by a network of highways.

A new educational system was introduced, and in 1962, the Jordan University (first national university) was established in the outskirts of Amman. Prior to 1967 (the second war with Israel), Jordan had high rates of economic growth further boosted by remittances from Jordanian expatriates in the Arabian Gulf (www.kinghussein.gov.jo).

Following the 1967 war with Israel, 300,000 Palestinian became refugees and fled to Jordan. For many of them, this was the second uprooting in less than two decades, having been driven from their original homes in 1948. Jordan paid by far the heaviest price among the states participating in this war. Its economy was heavily affected since about 70% of Jordan's agricultural land were in the West Bank, which produced 60 to 65% of its fruits and vegetables. Half of the Kingdom's industrial establishments were located in the West Bank, and the loss of Jerusalem and other religious sites devastated the tourism industry. Altogether, areas now occupied by Israel had accounted for approximately 38% of Jordan's gross national product (www.kinghussein.gov.jo). In addition, Jordan continued to shoulder its previous administrative and financial responsibilities for the West Bank (salaries and pensions of civil servants, while administering religious endowments or (w*aqf)* and educational affairs).

Jordan's economy grew again in mid and late 70s especially in the services, construction and financial sectors. Economic and social development was helped by large

remittances that were flowing in from 400,000 Jordanian citizens that supplied skilled labour to the oil-rich Gulf states.

In 1988 however the Dinar was devaluated and Jordan signed a five-year structural readjustment package with the International Monetary Fund (IMF) in April 1989. The Government expenditures on basic social services remained 27% of the national budget (9% on education, 8% on health and 10% on housing and social development) which helped Jordan's indicators of economic and social welfare to stay well on a global scale (Samha 1995). In 1995, Jordan ranked 80th out of 174 countries in terms of the Human Development Index (UNDP & Ministry of Planning 1995). Moreover, the Jordan Living Conditions Survey (1998) findings show that

> *'The overwhelming majority of the population has access to basic infrastructure like safe water, sanitation and electricity' (Hanssen-Bauer & Kharabsheh, 1998:30)*

It remains however increasingly difficult for Jordan to maintain a balance between the economic, demographic, and social factors (DeJong 1994, Miles- Doan 1996). The demographic history of Jordan, its economic situation and lack of resources were intensified by the structural adjustment program imposed by the World Bank and the IMF. Likewise, the closure of the Iraqi and Kuwaiti markets and cessation of financial assistance from the Gulf countries in retaliation to Jordan's position from Iraq during the Gulf War were detrimental to Jordan's economy. The return of 300, 000 Jordanian expatriates after the war caused further economic imbalances (DeJong 1994). Al Masarweh (1997) discusses this recession, increasing unemployment (15%), and lowering the standard of living. According to UNICEF (1997), the percentage of

Jordanians living below the national poverty line in absolute poverty is 15-20% while 5-6% lives in abject poverty (Al Masarweh 1997). The internal riots of 1996 are but a sign of public anger at the reduction in public spending on social services, and the abolition of subsidies on food (bread).

Taking into account this burden, and wanting to avoid the consequences on Jordan of the UN economic sanctions on Iraq, the first structural adjustment program (SAP from 1992-1998) was amended. In addition, the government launched a reformation program (1991-1997) that encouraged privatisation of certain community services to decrease its load of public spending (DHS 1997).

To complement the efforts of the Economic Restructuring Program, the government developed a comprehensive and integrated Social Productivity Package aiming at alleviating poverty and unemployment in two programs. The first programme started in early 1998 involves:

- expanding the cash transfers and other benefits of the National Assistance Fund to cover more eligible beneficiaries;
- developing or upgrading the physical and social infrastructure facilities in disadvantaged areas;
- training and rehabilitation of the unemployed;
- Providing micro financing of small enterprises to generate sustained income in poor regions.

The second part of the six-year strategy aims at increasing long-term social productivity by focusing on the education, health, information and technology sectors. Funding was received for most of the Social Productivity Package, and work is in

progress to activate all the components. Several units have been established at the Ministry of Planning, Ministry of Labour and the Ministry of Social Development to co-ordinate the activities of the Social Package (www.kinghussein.gov.jo).

5. Population

The majority of Jordan's people are Arabs descended from the various tribes that have migrated to the area over the years from all directions. One of the best known groups is the Bedouin. As they are known in Arabic, the '*Bedu*', or 'desert dwellers' endure the desert and have learned to survive its unforgiving climate. It is difficult to count Bedouins, but it is generally known that the majority of Jordan's initial population is of Bedouin origin. Most of Jordan's Bedouin live in the vast wasteland that extends east from the Desert Highway (www.kinghussein.gov.jo). In addition, there are Circassians, descendants of Muslim refugees from the Tsarist Russian invasion of the Caucasus in the 19th century, and a much smaller group of Chechens. Jordan also has a small Armenian population.

The Jordanian population is experiencing a fertility decline (DHS 1997). The 1994 General Census of Population and Housing of Jordan shows that population under 15 years of age declined from 51% in 1979 to 41 % in 1994 with an increase in the 15-59 age group. These results are due to changes in fertility, mortality and migration (DOS 1997). Tables 2.1 and 2.2 show the changes in time in the age composition of the Jordanian population and its demographic characteristics according to different sources

Table 2.1 Age composition of the population of Jordan [3]

Age group	1976 (JFS)	1983 (JFFHS)	1990 (DHS)	1997 (DHS)
<15	52	51.2	44	41
15-59	43.4	44.8	51.6	54
60+	4.5	4	4.3	5
Total	100	100	100	100

Table 2.2 Demographic characteristics of the population of Jordan[4]

Characteristics	1965 (UN)	1976 (JFS)	1990 (DHS)	1994 (census)	1997 (DHS)	2000 (PRB)	% change
Demographic Population size (mil.)	2		4.6	4.14	4.6	5.08	+130
Fertility rate (children per woman)	8 (est.)	7.4	5.6	4.6	4.4 (est.)	4.4	- 37.8%
Crude birth rate (per 1000)	52.5		35	30		33.3	- 42.8%
Crude death rate (per 1000)	21.5		7	5		4.6	- 76.7%
Population growth rate (%)	3.05		3.30	3.5	4.4	2.87	- 1.6
Life expectancy	50		67	68.2		69	+36.4 %
Dependency ratio		1.30	.94		.85		- 42.3%

[3] **Sources:**
1. DHS (1990)
2. DHS (1997).

[4] **Sources:**
1. United Nations (UN), Department of Economic and Social Affairs, Population Division. 1999. World Population Prospects. Volume 1: Comprehensive Tables. New York: UN.
2. World Bank (1992) World Development Report. 1992.
3. DHS (1990)
4. Department of Statistics (DOS) (1997) 'Results of the General Census of Population and Housing of Jordan 1994'.
5. DHS (1997)
6. Hanssen-Bauer. J., Pedersen. J., Tiltnes. A. (1998) 'Jordanian Society: Living Conditions in the Hashemite Kingdom of Jordan'. FAFO report 253. 1998.
7. Population Reference Bureau (2000)

Dependency ratio: the ratio of persons in the 'dependent' ages (under 15 and 60 and over) to those in the working-age category (15-59).

According to the DHS (1997), there is no difference in the dependency ratio between refugee and non-refugee population (.83 and .82 respectively). In addition to the decrease in the dependency ratio of 42.3% between 1976 and 1997, this ratio is very similar to that for the Arab world as a whole (Randall and Kalaldeh 1998: 55).

Despite these encouraging figures, the Government's view of birth rate in Jordan in 2000 is still '*too high*' (Population Reference Bureau 2000) and population growth still alarms many. This position is justifiable in view of the fact that Jordanian population increased seven times between 1952 and 1994. Despite the decrease in population growth rate in 2000, the Jordanian population is still expected to double every 24 years (Population Reference Bureau 2000). These growth rates are partly caused by the increasing numbers of women entering the reproductive age (Hanssen-Bauer et. al. 1998, figure 2.2:53). The repatriation of 300 000 Jordanians after the Gulf War (1990) is another contributing factor to the growth of this population (Gilbar 1997, NPC 1997). According to the 1994 Census, the Jordanian population was 4.139 millions (DOS 1997). In 1997, it increased to 4.6 millions (DHS 1997), and in 2000, it increased further to become 5.089 million (Population Reference Bureau 2000).

Family size has decreased since the 1979 survey, yet the latest DHS (1997) findings show that large households were still common in Jordan (an average of six residents per household), while (19%) of households were composed of 9 persons or more. The percentage of families with nine persons or more was higher in rural areas (25%) than urban areas (18%) (DHS 1997, Table 2.7). Ninety four percent of children were under 15

years of age according to the same source, and they constituted (41%) of the Jordanian population.

Udeinat (1996) relates the low rates of working women with the young population and the high demand for children. The latest DHS (1997) findings confirm that female participation in the work force remains very low (14%), although the ratio of male to females was 103 per 100 (DHS, 1997 Table 2.13). Female participation rates are consistently low over the years in Jordan (4% in 1980 and 11% in 1996 according to Abu Hilal 1980, Abu Sundus 1986, 1989, Udeinat 1996). The urban –rural differentials in employment are small with a greater percentage of women being permanently employed in the South (16%) than other regions (DHS 1997 Table 2.13). Moreover, the average years of employment for women (3.7 years) is considerably lower than that for men (44.8 years) (Al Masarweh 1997). While (70%) of working men were married, only (35%) of working women were married. It seems that social norms drove women to restrict their employment to sectors perceived as appropriate with their caring and nurturing roles: (75.9%) worked in the services sector including (39%) of which were teachers (Shahatit, Mustapha & Khoury 1990, Al Masarweh, 1997). Education seemed to affect employment as the percentage of women not working decreased from (93%) to (62%) among educated women (DHS 1997, Table 2.11).

On the other hand the number of single women is increasing with time in Jordan (Hanssen-Bauer et.al 1998). In 1986, the proportion of single women among all women aged 25-29 was (15%); this proportion doubled (30%) ten years later for the same age group (Hanssen-Bauer et.al 1998). Another interesting finding of the DHS (1997) is that the vast majority (98%) of women (aged 15-24) were not attending school and more than

half of them (54%) claimed that they had stopped to get married (DHS 1997, Table 2.11). The most plausible explanation of this is that young women still valued marriage, however the rising costs of the wedding ceremony and social customs of marriage (house, furniture, jewellery, etc) had acted as a barrier for most young men with average income to marry.

6. Migration

Jordan's geographic location, economic situation, open migration policies, in addition to the conflicts in the surrounding countries have resulted in large waves of in and out-migration (UNFPA 1994). The growth of Jordanian cities could be largely explained by the compulsory migration following the events in Palestine. In 1948, an estimated 400 000 Palestinian refugees entered Jordan, and in 1967, following the Israeli occupation of the West Bank of Jordan, 350, 000 refugees fled to the East Bank (Samha, 1980, UNFPA 1994, DeJong, 1994).

Furthermore, a voluntary internal migration from the rural to the urban areas in Jordan mainly to Amman and Zarqa cities was partly caused by the social and economic inequities (Hammoudeh 1980, Abu Sabha and Kayed 1987). This type of migration (rural to urban) is commonly encountered in most Arab countries, and countries of the developing world. The study findings of Al Soukour (1989) confirm that (54%) of rural residents wished to migrate to the city. It is interesting to note that a great portion of internal migration to the three cities (Amman, Zarqa and Irbid) is from areas that were urban rather than rural. According to Samha (1980), the lack of satisfying work opportunities, current employment transfer, guided migration due to government employment in the capital, drove the residents of small cities and towns to migrate to

larger cities, burdening their infrastructure and environment by this unidirectional trend (Samha 1980). Kalaldeh (1986) also does not attribute urbanisation to natural causes, and blames the government agencies for directly and indirectly affecting the population structural imbalance, because the growth of employment in the public sector of Amman has played the greatest role in internal migration.

The third type of migration in Jordan was return migration when people returned to Amman, Irbid and Zarqa from abroad (Samha 1980). The first two types (compulsory and internal) however account for the bulk of migration, further accentuated in 1990, by a compulsory return migration of about 300, 000 migrants from the Gulf States, after the Gulf War (UNFPA 1994, Gilbar 1997, Al Masarweh 1997, DeJong 1994). A study done by Shakhatreh and Billeh (1991) on the socio-economic characteristics of the returnees showed that (43.7%) were below secondary education level in comparison to (65%) of the general population above 15 years of age (DOS 1997). Most of the returnees (81.7%) lived in Amman and Zarqa and they constituted (23.5%) of the economically active population aged 15 and above, and (61.5%) of the unemployed among them did not have a secondary level education. Furthermore, the monthly income of returnee families was below the poverty line (UNFPA 1994).

Finally, an external migration from Jordan mainly to the oil producing countries of the Gulf had increased between 1972 and 1977 and then decreased sharply following the Gulf War because of the political crisis between Jordan and the oil-producing countries (Hammoudeh 1980, Gilbar 1997).

Any future unpredictable migration forced on Jordan, because of regional politics with regards to the issue of the final status of the Palestinian refugees would impact on its

demographic situation, impairing its national development and infrastructure (Al Masarweh 1997).

7. Socio-cultural organisation

Many of the characteristics of the Jordanian and Arab society are inspired from the Bedouin culture. Bedouins are famous for their hospitality, and the hardship of desert life has necessitated that no guest is turned away. The tribal structure of Arab society is also visible among the Bedouins, where the clan is at the centre of social life. Each Bedouin family has its own tent, a collection of which constitutes a clan (*qawm*). A number of these clans make up a tribe, or (*qabila)* (www.kinghussein.gov.jo).

Tribes in Jordan were groups of related families (*hamula*) claiming descent from a supposed founding ancestor. Within this overall loyalty, however, descent from intermediate ancestors defined several levels of smaller groups within each tribe. Ideally, in the event of conflict, all groups would unite in an orderly fashion from the lowest level to the highest as conflict escalated. In reality, tribal segments did not always agree and unity in the event of conflict was not self-evident (Antoun 1972).

Bedouins traditionally have placed great importance on the concept of honor (*Ird*). Injury to a member of a tribal group was an injury to all the members of that group; likewise, all the members were responsible for the actions of a fellow tribal member. Before the establishment of the state, the Bedouins have long used a number of social mechanisms—including exile from the tribe, and vengeance for a crime—to maintain order in the society. Injuries were erased by appropriate revenge or through mediation to reach reconciliation based on adequate recompense (Antoun 1972).

Males in a tribe are hence perceived as *(Ezweh)* meaning a source of support, strength, power and honour because of this ancient code of honour and total loyalty to the clan and tribe for the survival of the group (Kanaaneh 1996).

The majority of Jordanians today are of Palestinian origin, forced from their homeland during the 1948 and 1967 wars with Israel. Jordan at the time was the only Arab State to grant them the right to Jordanian citizenship and many have chosen that option. In addition, one and a half million Palestinians are still registered as refugees and live in camps in Jordan, where the United Nations Relief Works Agency (UNRWA) is responsible for their welfare and provides health and education services to them. Since Palestine was more urbanised than Jordan before 1948 Palestinian Jordanians have contributed a lot to the prosperity of Jordan after they had settled in it (www.kinghussein.gov.jo).

Circassians, a *Sunni*[5] Muslim community first arrived en masse in Jordan in 1878. The Ottomans resettled the Circassians into the police and governmental structures. Until the 1940s, they continued to prefer the military and public service and to date they constitute the King's ceremonial guard because they are well known for their honesty. Circassians now live in Jerash, Sweileh, Zarqa, Azraq and other parts of northern Jordan. Estimated at 20,000 to 80,000, Circassian Jordanians are well educated and play a role in Jordan's political, economic and social life. Their culture emphasises respect of the

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[5] Sunni (from *Sunna*, orthodox) A member of the larger of the two great divisions of Islam. *Sunnis* supported the traditional method of election to the caliphate and accepted the Umayyad line. On this issue they divided from the *Shi'a* Muslims in the first great schism within Islam.

elderly and closely-knit extended families. However marriage to anyone from the family of either parent is strictly forbidden (www.kinghussein.gov.jo).

Chechens, initially about 2,000 in number, are other Caucasian people that migrated to Jordan from Grozny in waves at the end of the nineteenth century. They are *Shi'a*[6] Muslims, the only representatives of this branch of Islam in Jordan. They are now assimilated into Jordanian society, while maintaining their culture and charm: it is a marriage tradition among the Chechens, for the groom to elope with the future bride against the will of her family, as a measure of manhood, chivalry and courage. Today, this practice continues, but as a folkloric tradition.

More than (92%) of Jordanians are *Sunni* Muslims and about (6%) are Christians who live mainly in Amman, Madaba, Karak and Salt. The majority of Christians belong to the Greek Orthodox Church, but there are also Greek Catholics, a small Roman Catholic community, Syrian Orthodox, Coptic Orthodox, Armenian Orthodox and a few Protestant missions found mostly in Amman. Another religious minority is the Arabic-speaking Druze that lives near the Syrian border and in Azraq, east of the country. The north Jordan Valley hosts a small community of Turkomans and Baha'is, who moved from Iran to Jordan to escape persecution in 1910 (www.kinghussein.gov.jo).

The government has promoted cultural diversity in political and economic life. Ethnic minorities such as Circassians and Chechens, as well as the Arab Christian minority, are

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[6] A member of the smaller of the two great divisions of Islam. *Shi'as* supported the claims of Ali and his line to presumptive right to the caliphate and leadership of the Muslim community and on this issue they divided from the Sunnis in the first great schism within Islam. Later schisms have produced further divisions among the *Shi'as* over the identity and number of Imams. *Shi'as* revere Twelve Imams, the last of whom is believed to be in hiding.

equitably represented in Parliament and play a prominent role in business and government (www.kinghussein.gov.jo).

As seen earlier, kinship is the most important basis of social organisation in the urban and rural areas of Jordan where exchanges occur among extended families. Exchanges might include financial support, job information, social connections, access to strategic resources, marital partners, arrangements, protection, and support in the event of conflict, child care and domestic services, and emotional sustenance. In turn an individual's social identity and loyalty is largely oriented to the family.

Inherited from the tribal social structure, kinship is based on the ramification of patrilineal ties among men. In reality, matrilineal ties were also significant in providing access to material and social resources, though patrilineality was more reinforced in time through the practice of endogamy (i.e. marriage within the group). A wide preference for endogamy- historically prevalent in the Middle East especially for paternal cousin marriage as the number one choice, and then descending levels of relatedness as other favoured options- gave rise to a network of kin relations that are both maternal and paternal at the same time. Ultimately, the kinship system takes on many characteristics of a bilateral system. Descent and inheritance, however, are traced in a patrilineal fashion (Antoun 1972, Joseph, 1996). Analysing the characteristics and determinants of the family in Jordan, Al Hyari (1985) found that (91%) of its households were headed by males.

8. Fertility and contraceptive prevalence

The Age Specific Fertility Rates and the Total Fertility Rate (TFR) are the most common fertility measures (Randall and Kalaldeh 1998). Age Specific Fertility Rate is

'The yearly average number of children to which women in each age group give birth' (Randall and Kalaldeh, 1998:63)

(TFR) is defined as

'The number of children a woman would give birth to if she were to live the reproductive period having the current Age Specific Fertility Rates at every age' (Randall and Kalaldeh, 1998:63)

Jordan had the highest fertility rate in the Arab world in the 60s. In the last fifteen years however, a remarkable decline has occurred in (TFR), and the 1994 Population Census showed that the (TFR) dropped from 7-8 children per woman in the 70s, to 4.6 children in 1994. Now, the (TFR) is still considered high (4.4) if compared with neighbouring Arab and Islamic countries as the (TFR) is 3.2 in Tunisia, 3.6 in Egypt, and 2.7 in Turkey (Population Reference Bureau 2000, UNFPA 1994, Hanssen-Bauer et.al 1998, Fig. 2.18).

Using the Bongaarts' model of the determinants of fertility, many scholars have explained Jordan's earlier high fertility with the pattern of marriage (Obermeyer and Potter 1991, Abu Sabha and Kayed 1986, Al Ma'ani 1983, Hammoudeh 1986, Al Arabi 1987, Al Utum 1987, Bani Ata 1995). Young age at first marriage was a norm in the past. The increase in education and financial pressures resulting from the economic situation have raised the age at first marriage significantly even among non-educated women in Jordan (Hanssen-Bauer et.al 1998, DHS 1997, Hammoudeh 1986, Udeinat 1991, Nsheiwat 1991, Karadsheh 1989, Karajeh 1994). Women average age at marriage has risen from 22.6 years in (1979), to 24.7 years in (1994) (Al Masarweh 1997, Gilbar 1997). This movement towards a later age at marriage is also confirmed in 'the Living Conditions in the Hashemite Kingdom of Jordan' (Hanssen-Bauer et.al 1998, Fig. 2.6)

Low female employment rates in Jordan might have also contributed to high fertility rates. This effect however has been diluted with time as the population got more educated and women in particular, resulting in an increase in employment of the educated women (Khawaldeh 1981, Obermeyer and Potter 1991, Al Ma'ani 1983, Hammoudeh 1986).

The increase in the utilisation of contraceptives, i.e. the Contraceptive Prevalence Rate (CPR) in Jordan is a major determinant of fertility decline. Table 2.3 shows the chronologic increase in (CPR) in Jordan based on different surveys.

Table 2.3 Contraceptive Prevalence Rate (CPR) over time in Jordan

JFS (1976)		**JFHHS (1983)**		**DHS (1990)**		**JLCS (1998)**		**DHS (1997)**	
Any method (22.8%)	Modern method (17.3%)	Any method (26%)	Modern method (20.8%)	Any method (35%)	Modern method (26.9%)	Any method (42.3-59.4%)	Modern method (32.-39.4%)	Any Method (50.3%)	Modern method (37.7%)

JFS: Jordan Fertility Survey
JFHHS (1983) Jordan Family Health and Housing Survey
JLCS Living Conditions Survey, Hashemite Kingdom of Jordan 1998 (the two values are for men and women respectively)

Sources
DHS 1990, 1997
Hanssen-Bauer. J., Pedersen. J., Tiltnes. A. (1998) 'Jordanian Society: Living Conditions in the Hashemite Kingdom of Jordan'. FAFO report 253. 1998.

Like most countries of the Middle East, the most widely used methods were the IUD, OC, and female sterilisation (UNFPA 1994, Al Masarweh 1997, DHS 1997).

A Knowledge Attitudes and Perspectives (KAP) study on family planning (1996) showed that a considerable number of women had no power to control their reproduction and (20%) of them did not use contraceptives because their husbands disapproved contraceptive utilisation (UNFPA 1994, NPC 1997). Studies done on the determinants of fertility found that the duration of marriage, the number of male versus female children

and or the number of living children were the most important determinants of fertility. (Abu Sabha & Kayed 1984, Hammoudeh 1986, Al Khuzai 1990, Karajeh 1994, Joudeh 1983, Nsheiwat 1991, Bani Ata 1995)

Furthermore, the KAP study on family planning (1996) showed that most men wanted four or five children including more than two males. The 'Living Conditions in the Hashemite Kingdom of Jordan' (1998) findings show similar family size preferences (Hanssen-Bauer et.al 1998, Figure 2.23). The findings also show that marital, contraceptive and breastfeeding behaviour are quite homogeneous in the different contexts of the Jordanian society with no differentials between refugee and non-refugee populations (Randall & Kaladeh 1998, Table 2.10). The vast majority of Jordanian couples (95% or more) knew of at least one family planning method (Kalaldeh 1987). Despite these encouraging changes in fertility and reproductive behaviours in Jordan, population growth is expected to remain high in Jordan for a while because:

> *'Due to high fertility levels in the 1970s and 1980s, large cohorts of women will be entering the peak ages of their reproductive life in the coming decades, and in numbers which exceed the number of women moving out of their reproductive age. Consequently, high population growth will continue for decades to come, even if fertility continued to decline and reached replacement level' (AlMasarweh 1997:17)*

To compare the situation of Jordan with other countries of the Middle East, Table 2.4 summarises the Reproductive health indicators of Jordan and many other countries of the Middle East (Population Reference Bureau, 2000).

Table 2.4 Summary of reproductive health in Jordan and the Arab countries [7]

Country	TFR	Median Duration of Post Partum Amenor-rhea	% births attended by trained health personnel	% women using Any method	% women using traditional method	Adults (15-49) with HIV/AIDS per 10000
Algeria	4.1		77	51	43	7*
Bahrain	2.8		98	62	31	15*
Egypt	3.3	5	56	55	52	3
Iran	2.6		86	73	56	<1
Jordan	4.4	4	97	53	38	2*
Lebanon	2.5		85	61	37	9*
Libya	4.1		81	45	26	5
Morocco	3.1	3	52	58	49	3
Oman	7.1		93	24	18	11
Syria	4.2		54	40	28	1
Tunisia	2.8		79	60	49	4*
Turkey	2.6	4	76	64	38	1
UAE	4.9		99	28	24	18*
Yemen	6.7	6	43	21	10	1*

Definitions (Table 2.4)

Postpartum amenorrhea:

The period of time following birth during which a woman's menstrual cycle has not yet resumed.

Contraceptive use:

The percentage of currently married women of reproductive age who are currently using contraception. 'Any method' includes traditional and modern methods. The most commonly used traditional method is withdrawal. Modern methods include clinic and supply methods such as oral contraceptives, IUDs, condoms, and sterilisation.

9. Health services, MCH, and family planning provision

During the 1948 war, charitable societies provided maternal and child health services to the East Jordanians as well as to the Palestinian refugees. In 1948, the Royal Medical Services (military services) were founded and in 1950, the Jordanian Ministry of Health, and the United Nations Relief and Welfare Agency (UNRWA) were founded. UNRWA provided services to the Palestinian refugees in the camps.

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(Population Reference Bureau, 2000)
Estimates are from the latest available sources between 1990 and 1998. Estimates of HIV/AIDS prevalence are as of December 1997, except those estimates with an asterisk, which are for 1994 (Weekly Epidemiological Report, 1995, 70: 353-360)

The Jordanian health care system, has expanded substantially since the 50s, and in the early 90s, an additional (18%) expansion in hospital beds and number of physicians has been featured in the private sector and to a lesser degree in the public sector (Hanssen-Bauer et.al 1998). The Jordanian health system is a mixture of free government care, and fee-for -service private care, of varying quality and kind. The spectrum of medical treatment ranges from highly sophisticated practice in tertiary centres such as the King Hussein Medical Centre, the Jordan University Hospital, and leading private hospitals, to the ritual healing of traditional healers (Obermeyer and Potter 1991).

MCH and family planning services are provided in the public sector, in the Ministry of Health and military services health centres and hospitals. In order to meet the objective of providing 'health for all by the year 2000' the government developed a health strategy that aimed at developing a comprehensive health system. According to the 1995 statistics, the MOH is the largest provider of MCH services (FP included) in the country (MOH 1995). An extensive network of health care facilities has been formed and in 1996, for every 10,000 Jordanians there were 16.5 physicians, 25 nurses, 4.9 dentists and 17.9 hospital beds (Hanssen-Bauer et.al 1998). Jordan spends about (8%) of its GDP on health care, a figure comparable to most middle income and even some western industrialised countries (World Bank 1996).

The Jordan University Hospital, a teaching hospital also provides FP services. UNRWA and NGO clinics such as the Nour El Hussein Foundation, Queen Alia Fund, and the Arab Women Organisation (AWO), all provide FP services as well. The Jordanian Family Planning and Protection Association (JAFPP), an NGO affiliate of the IPPF, is a major provider of FP services in Jordan. It was established in 1963 and

received official support through the Ministry of Social Affairs. Now the JAFPP has nineteen clinics in all the regions of Jordan, and two mobile clinics, one in Zarqa, the other in Irbid, to cover rural and remote areas (Al Masaraweh 1997).

The private clinics and hospitals provide (40%) of outpatient care and (50%) of hospital admissions (Obermeyer and Potter 1991, UNFPA 1994, DeJong 1994, Al Masarweh 1997). Despite the government commitment to primary health care, (45%) of contraceptives were purchased from private outlets such as pharmacies and NGOs in 1994 (UNFPA 1994, Al Masarweh 1997).

The Ministry of Health and WHO studied the coverage of the primary health care services in Jordan in 1988. They found that primary health care services covered (95.5%) of the Jordanian population and were offered through the primary health care centers (DeJong 1994). The geographic coverage of the population was excellent however, the MOH records showed that there was a gap between antenatal home visits (1102) and postnatal home visits (430) at the national level (MOH Statistical report, 1993). WHO figures showed a low utilisation of prenatal care also (58% of Jordanian women), an average figure for a developing country (Obermeyer and Potter 1991, DeJong 1994). The average provider load (physician) was 16 patients per day however, (58%) of the physicians were not residents of the area where they practiced, which limited their interaction with the local communities, and their understanding of their problems (Al Masarweh 1997). Home visits and the home delivery services were thought to be unsatisfactory (DeJong 1994). At times, PHC centers suffered from a shortage of providers, such as public health inspectors, and laboratory technicians and shortages in sterilisation equipment and means of transportation.

Other problems in health care provision were the trend of specialisation in health care delivery, which left the system dependent on specialists and sophisticated technologies, increasing the costs of those services, which was detrimental to PHC services (Melkawi and Ma'aytah 1991, DeJong 1994). Another feature of mismanagement was the duplication among the health service sectors, and inefficient use of resources, in most of the health sectors. Jordan's high urbanisation has shifted health services and private provision to the capital and main cities. Typically, half of the obstetricians and gynecologists practice in Amman, and (30%) in Zarqa and Irbid (UNFPA 1994, DeJong 1994, Al Masarweh 1997).

Another problem in the health delivery system was the inaccuracy of data, due to underreporting, poor documentation, duplication of responsibilities, and the lack of coordination (Nsheiwat 1996). The development of the human resources of the health sector has followed the haphazard pattern of the market (Al Qsous 1985). There was an oversupply of physicians caused by the high demand for health science education, without consideration for the national needs (De Jong 1994). The doctor per capita ratio was 1 per 445 in 1993, and they were poorly distributed in the country (MOH 1993).

In contrast with the more than adequate supply of physicians, Jordan suffered from a shortage in paramedical personnel: the nurses' per capita ratio is 1 per 1640 and pharmacists 1 per 1570 (MOH 1993, UNICEF 1994). The shortage of nurses with midwifery training is especially acute (Al Masarweh 1997).

10. Policy implications of the study

Major problems facing the development of health services addressing women are the inequity in resource allocation between the curative and preventive services. Health

system reform has started in Jordan as the need increased for economic austerity to address the restructuring program in mid- nineties. Provision of low-cost primary health care services over expensive, high-tech interventions and more integrated approaches to service delivery than in the past are prominent features of this reform. Some elements of reproductive health (family planning programs and services) may receive priority attention in government budgets if needs appear urgent and affect a large proportion of the population.

This study sheds the light on the latest developments in population policy in Jordan, focusing on the national population strategy and the caveats of its implementation. The spectrum of the models of FP provision is then explored. The models are compared and contrasted in terms of their organisation, utilisation, quality of care, and community outreach activities to identify weaknesses and strengths, and to assess the levels of their accessibility to the different communities at the grassroots. Providers' perspectives are also compared with the community's perspectives to assess the degree of match and mismatch in perceptions. Strategies are identified with the policy makers, providers and men and women in the community to widen FP utilisation basing on the socio-cultural context and patriarchal household structures at the grassroots. The participatory nature of this research has aimed that the knowledge produced will be largely representative of the perspectives of men and women at the grassroots, so that policy changes in the future will be mostly based on these identified needs. Its findings have local, national and international relevance.

Conclusion

This chapter has explored the setting of this case study. The methodology used to explore barriers to FP at the policy, service, community and household levels and the strategies to widen access is drawn from epidemiological and anthropological approaches used in public health research and will be described in the next chapter.

Chapter 3

Methodology

Introduction

This chapter discusses the methodology used in this research study. Quantitative and qualitative research methods were used to identify barriers to accessing family planning services in Jordan at the policy, service, and community levels.

I. Design of the study (Appendix 3.5)

Methods used in bio-statistics and anthropology were combined to provide quantitative and qualitative information on how much the clients and the community at large accepted the available family planning programmes and services. Marshall and Polgar (1976) have highlighted the importance of anthropology in family planning, whether in the application of theories, the utilisation of methods or interpretation of data to promote understanding of reproductive and fertility patterns and behaviours in the different cultures. Mahadevan and Krishnan (1992), believed that anthropological techniques have successful methods, particularly in the use of semi- structured interviews and case studies.

The types of participatory approach used in this research were 'extractive' and 'consultative' and to some degree 'interactive' (Almedom et. al., 1998). In the 'extractive' participatory approach, the participants respond to research questions but do not influence the debate, because the results are neither communicated to them nor validated with them. In this research study, the results were validated directly with the service providers (service statistics findings) and indirectly with the men and women

(probe questions during the group and individual interviews were built on the findings of the policy makers' interviews and FG discussions with the service providers).

In the 'consultative' participatory approach, researchers define the problems and solutions for the participants that might be changed depending on their answers, and there is no joint decision-making. In this research, specific problems in service delivery and specific barriers in the community were probed with the participants. The participants were hence 'consulted' on problems and strategies (solutions) and at times they forwarded other strategies than the ones suggested by the researcher.

In the 'interactive' approach, sometimes called 'actor-oriented' (Long & Long, 1992), there is a common analysis between the researchers and participants leading to the elaboration of plans of action. This approach was used with the policy makers at the initial stages of data collection. Since this was the only way to obtain access to the field, the policy makers were consulted about the research design, research protocols, and multidisciplinary methods used to examine the multiple perspectives (Almedom et. al., 1998).

Furthermore, the policy makers helped in interpreting the data, comparing it with the findings of studies done by them or others on the utilisation and discontinuation of FP methods. This interactive approach had a positive aspect and a negative one to it. The positive being the participatory nature of the process and the latter being the limitations it introduced because of the selection bias in the sites of data collection and the selection of some interviewees. Since this was the only way to obtain access to the field (going through the gatekeepers), one had no choice but to proceed.

Men and women in the community helped in obtaining consent and organising the natural group discussions. Furthermore, they validated (triangulation) the information provided earlier by the policy makers and providers concerning the community, and explained the variations in the utilisation of services and methods from their own perspectives, contributing valuable data on the service barriers to optimal FP utilisation. They also helped in accessing couples and individuals from their relatives and friends, and formulated strategies to widen access to the services, based on their own perceived needs. Here again, there was a selection bias presented by this methodology of securing access to the community and households. It was however a necessary evil in building trust between the researcher and the community members.

The 'actor-oriented' approach is used in organisation development, organisational learning, and action research in public health. It was used in this study with the service providers with quantitative and qualitative methods (Aubel and Niang, 1996). The service providers 'collaborated' in preparing the themes of the focus group discussions, and collected part of the service statistics. Furthermore, they were able to explain irregular findings to the researcher, because they were employed in the service during the time interval included in the study, and they used their networks in providing access to the community.

II. Time and Place of the study (Appendix 3.2, Figure 3.1)

The fieldwork was done in Jordan, in the Middle East, from June 1997 to June 1998. Fifteen policy makers were interviewed in the capital, Amman. At the service level, all the sectors providing FP services in the Zarqa Governorate (i.e. the public sector, military services, international organisations, NGO and the private sector) were included

representing the spectrum of services available in Jordan. At the community level, communities from all the settings of the Zarqa Governorate, representing the Jordanian community at large were included. The low and high socio-economic urban strata and Palestinian refugees from the Zarqa camp were accessed in Zarqa City. Settled Bedouins in the town of Hashemieh, and women from the remote area of Azraq were involved, representing respectively the Bedouin and rural populations of the Governorate.

III. Research methods

Stages of data collection, methods and "instruments" used, and study settings

A. Interviews with policy makers (Appendices 3.1 and 3.4)

In the capital Amman, in-depth interviews were carried out with policy- makers (Manderson et. al., 1996), and the Higher Judge of the Islamic Court. The population policy framework in Jordan was explored using the policy makers' perspectives. The main national and international policy agendas were examined (Walt, 1994), and the invisible processes that shaped policy formulation and implementation were deduced (Baum, 1995). The main issues tackled in the interviews were, the historical determinants of the population policy in Jordan, the current strategies and important policy players, the co-ordination of agendas and priorities, the links with the regional and international population policies, and the constraints in population policy formulation and implementation. The barriers to access family planning services and strategies to widen access to those services were also delineated. (See Appendix 3.4 Policy-makers' interview guide). Prerequisites for selecting policy-makers were if they were currently influencing population policy at the national level or in international funding

organisations. A total of fifteen policy makers from national and international organisations were interviewed (See Appendix 3.1 List of policy makers interviewed).

Since 96% of the Jordanian population are Muslim, representatives of the Islamic religious authorities mobilised in population policy reform and program implementation at the national level, were also interviewed. The interviews were not taped because this might have put the policy makers on the offensive, however the interviewer took written notes during the interviews.

B. Service statistics

The different types of services providing FP in the Zarqa Governorate were included in this research study (Appendix 3.5). In the public sector these were the Ministry of Health (MOH) and the military services, while the United Nations Relief and Works Agency for Palestine refugees in the Near East (UNRWA) represented the international organisations. The Jordanian Association for Family Planning and Protection (JAFPP) represented the NGO sector. The private sector was originally included, however the private practitioners did not allow access to their service statistics.

Primary service statistics were collected from the four clinics of the different sectors, and analysed for frequency distributions to assess utilisation. It was not possible to compare the clinics with each other, because the exact catchment community of each service was not known. Although it is known that roughly about 140 000 women of reproductive age (15-45) were residing in Zarqa Governorate in 1994 (1994 Census, Table 3.6). Since many women purchased services in more than one clinic at a time, the 'contamination' of populations of service users was common. In order to study the variation in service and method utilisation, each service was compared with itself over

time, and the denominators used for each clinic were the total users of that clinic. The overall performance of the clinics over time was deduced by assessing the new FP users' recruitment versus old users, by comparing FP with other services' utilisation, and by examining the variation in providers' load for each clinic. In addition, the variation in the specific method utilisation, the method mix in each service, and the seasonal variation in FP utilisation was analysed.

Recent secondary service statistics - research studies on utilisation and discontinuation of family planning methods from 1995 to 1997 - were retrieved from the different services (Musallam, 1998, JAFPP, 1996, Madi 1996, 1997), and used by the researcher to support the analysis.

The movement of clients across the services was at times examined with qualitative methods to unfold utilisation patterns. The service record data was compared with baseline survey data of programmes (retrospective data) to analyse the impact of services and interventions. During the analysis, the findings were compared to local and national utilisation rates within the same sector.

C. Observation of the service provision (Appendix 3.6)

The researcher observed service provision in the four sites for three days in each clinic. The observations were non-participant, because most services' by-laws restricted service delivery to clinic personnel. Despite the fact that the researcher was a qualified nurse, she was denied participation in service provision during observations, by all the clinics; instead they agreed to non-participant observation.

The aim of these service observations was to determine the level of access by identifying the service barriers. The service facility, provision, provider-client interaction,

counselling sessions, human interaction, continuity and follow-up of care were observed in the four clinics in an attempt at 'process evaluation' (Dingwall, 1992). This qualitative method helped to capture the dynamic aspects of the organisation, and could only be accomplished from the inside by watching and listening (Dingwall, 1992).

The instrument used to document the service observations, 'Maximising Access to Quality' (MAQ checklist), was being introduced to the MOH and military personnel of the services participating in the Comprehensive Postpartum project (CPP), the leading USAID-funded family planning project, as a component of a program which enhances quality (See Appendix 3.6.Observation criteria). However, the documentation was done immediately after, and not during the process of observation.

Before utilising the MAQ checklist, the researcher had met with the training consultants of PATH, (a subcontractor consulting agency for USAID), who were training the service managers and providers in its use. The checklist and other components of the quality enhancement program were obtained from the CPP chief executive medical officer in Jordan, upon the recommendation of the consultants. This tool was used to organise the qualitative data retrieved, so that it would be in context with the service interventions being implemented. The different meanings and concepts of quality as perceived and expressed by the policy makers, providers, and the community were compared with what the service providers provided, and how they provided it.

D. **The clinic sites (Figure 3.1 Map of the Zarqa Governorate health services – scale 1:75 000).**

- **The public sector**

a) The Ministry of Health (MOH): Two clinic sites

1. The MCH training center in Zarqa city is a pioneer centre which has been providing MCH /FP services since 1988. This site was recommended by the Director of health of the Zarqa Governorate at the MOH. The clinic personnel were all females, and they provided Obstetrics and Gynecology, Pediatric, and Family planning services. They also did home visiting for antenatal and postnatal mothers.
2. The Prince Mohammed center is the second MOH clinic included in this study providing medical services to the Ghweirieh community of the Zarqa City. However, its FP component remains limited, because it was integrated with the other services, and the service providers were involved with many other specialities. A focus group discussion was carried out with the service providers of both sexes. Since the clinic was located near the Soldiers' Families Welfare Society (SFWC), their clients were from the same community (Ghweirieh). The only data collected in this clinic was the FG discussion with the service providers.

b) The Royal Medical Services (military services): The clinic and CBD program

The Soldiers' Families Welfare Society is a community-based society of the Royal Medical Services in Zarqa City. This society has been operating since 1990, and includes a nursery, community rehabilitation and welfare programmes only for the soldiers and their families, and a clinic (SFWC) where Obstetric and Gynaecology, and Family Planning services were provided to all the Jordanian residents of the neighbourhood who wish to use it. There was also an ongoing community-based distribution (CBD) programme of contraceptives in the community, funded by the

USAID. The clinic had been selected as one of the Comprehensive Postpartum (CPP) models centres specialising in CBD distribution of contraceptives. This site was recommended by the Chief Executive Medical Officer of the Royal Medical Services, at the King Hussein Medical Centre in Amman (directing all FP services of the military services of Jordan).

- **International organisations**

A. The UNRWA clinics: Two sites

1. The Zarqa MCH clinic established by UNRWA in December 1995 provides Obstetric and Gynaecology, Paediatric, and FP services to the Zarqa camp community of Palestinian refugees (about 35, 000). The services were clinic-based, and home visiting was also carried out by the *Daya,* the traditional birth attendant, to postpartum mothers, and to follow up women that discontinued clinic services. The Jordan field health officer in UNRWA selected this site.
2. The Musheirfeh MCH clinic provided Obstetric and Gynaecology, Paediatric, and FP services to the Shneller or Msheirfeh refugee camp of the Zarqa Governorate. The only data collected in this UNRWA clinic was the FG discussion with the service providers. The Zarqa field health officer selected this site, because this clinic provided services to a community of refugees in the same Governorate.

- **The Non-Governmental Organisations (NGO) sector**

The Jordanian Association of Family Planning and Protection (JAFPP), an affiliate of the International Planned Parenthood Federation (IPPF) provided FP services in clinics in the urban areas of the Governorate. In addition a mobile clinic provided services to the rural and remote areas of the Governorate, in agreement with the MOH. The mobile

clinic was chosen for data collection, and was used to access the remote and Bedouin communities.

The JAFPP fixed clinic of Zarqa was only used for FG discussion with the service providers.

- **The private sector**

The private practitioners denied access to their clinics, but they participated in FG discussions, and helped in accessing the women that had delivered at a private hospital (Jebel Al Zaitoun hospital). Because of the logistical difficulties of gaining access, only one FG discussion with the private physicians was carried out.

E. Focus group discussions with the service providers (Appendix 3.8)

The themes for focus group discussions with the service providers were prepared based on the data analysis of the in-depth interviews with the policymakers, service observations, and field notes. The aim of these focus group discussions was to explore how the service providers perceived and assessed the reproductive health knowledge and family planning practices of their clients. The providers' perceptions of the service, community, and household barriers, and the policy barriers to access FP services were also explored during these discussions.

The focus group discussions were carried out with providers of FP services in all the sectors of the Zarqa Governorate. Following a pilot, a total of nine focus group discussions were done.

At the MOH, two focus group discussions with the service providers of the MCH training centre, and the Prince Mohammed clinic in Ghweirieh were carried out. In UNRWA, two focus group discussions were organised with the providers of the Zarqa

MCH clinic in the Zarqa camp, and the Msheirfeh MCH clinic in the Msheirfeh camp. In the Soldiers' Families Welfare Clinic (SFWC) in Ghweirieh, one focus group discussion with the clinic providers and one focus group discussion with the community-based distributors (CBDs) were organised. Likewise, in the Jordanian Association of Family Planning and Protection (the JAFPP), one focus group discussion was organised with the providers of the fixed clinic, and the other one with the providers of the mobile clinic. Finally, one focus group discussion was organised with the private sector providers.

Consent was obtained from the managers of the services and from the participants in the discussions to tape the FG discussions, and a 'reporter' documented the sessions in writing following a methodology described by Manderson et al (1996), Jaswal (1995), and Krueger (1988). Demographic data were collected for each participant in the FG discussions, before the beginning of the sessions. The data collected were the age of the participant, the literacy level, employment, marital status, and duration of marriage. Information on the living conditions, i.e. how many members of the family were at home, the crowding conditions, whether it was a nuclear or extended family, the fertility status, and the parity of the participants was also obtained.

The moderator used a discussion guide, and the 'reporter' used it in the preliminary documentation and processing of the data (See Appendix 3.8 Focus Group discussion guide). The moderator used cues, probes, open, semi-structured questions at times documented on the discussion guide. These guides were piloted, and refined, before finalising them for the first focus group discussion.

The findings of these FG discussions were used in devising themes for natural group discussions with men and women in the different settings of the Zarqa Governorate.

F. Field notes

Field notes were written from the beginning of the data collection process to help the researcher in gathering information and data analysis. Analytic field notes were recorded by the researcher and were useful in the analysis of the findings (Gittelson and Bentley, 1996, Burgess, 1982). A chronological description of events and details of respondents and conversations were written. Methodological field notes that included the details concerning the field roles, the selection of respondents, the relationships with the gatekeepers and informants, and some self-analysis were also recorded by the researcher. They also gave an account of emotional relationships at various points throughout the research process (Burgess, 1982).

G. Natural group discussions with men and women (Figure 3.1 Map of the Zarqa Governorate; Appendices, 3.9 and 3.10)

Natural group discussions are focus group discussions with a group of people who meet together anyway and not only during the research discussion (Beckerleg et. al., 1999, Coreil, 1995). The aim of these discussions was to investigate the beliefs, perceptions and attitudes influencing decision-making concerning the utilisation of FP services, and the choice of FP methods (See Appendix 3.10. Natural group discussion themes).

Pregnant women in the last stages of their pregnancy, utilising the antenatal services, were approached to obtain their approval to be visited at home during the postpartum period. When they approved, visit dates were organised and natural group discussions were held during the postpartum visits with women and their relatives and friends visiting at the time.

This approach was 'culturally-sensitive' since the seclusion of mothers and their new-born for 40 days postpartum was a practice observed in many Arab societies, including the Jordanian one (Lewando Hundt & Forman, 1993). An exchange of information occurred in this setting among women connected by virtue of their marriages (Lewando Hundt & Forman, 1993) (See Appendix 3.11. Natural group discussions guide). The neighbourhoods where the natural group discussions and in-depth household interviews took place were:

1. One natural group discussion with women, and one with men, and two couples' household interviews were done (users and non-users of FP) in 'Al Ghweirieh' neighbourhood in Zarqa city, with about 40, 000 residents of the low, and low middle -classes of the city. Soldiers and security service members and their families originally established this area when they migrated to the city because of their employment in the public sector. They were Jordanians (East Bank) from the Bani Hassan tribe, the biggest tribe of the '*Wasat*' (the center of the Kingdom).

   Following the Gulf War, the Ghweirieh residents became more mixed, to include Jordanians of Palestinian origin however, the original residents were still a main feature of this neighbourhood. This community was matched with the SFWC, with its (CBD) program, and Prince Mohammed clinic located in northern 'Ghweirieh'.

2. One natural group discussion with women, and one with rich men, and two household interviews with women (user and non-user of FP), and one interview with a rich man were done in 'New Zarqa', a new neighborhood, established by the rich segment of the city. Following the Gulf War, many returnees resided in that neighbourhood, which boomed very quickly. Villas and elegant homes, are an important feature of

New Zarqa, and many of its residents are from Palestinian origin, because most of the merchants, traders, and contractors in Zarqa were originally Palestinian. New Zarqa community was matched with Jebel Al Zaitoun hospital, a leading private hospital.

3. One natural group discussion with men, and one with women, and two couples' household interviews (users and non-users of FP) were done in Zarqa camp, a Palestinian refugee camp that contains about 35, 000 refugees and their families. Since UNRWA provided all the health services to the camp population, this community was matched with UNRWA Zarqa MCH clinic.

4. One natural group discussion with women, one with men and two household interviews with women (user and non-user of FP) were done in Al Hashemieh town named after Al Hashemieh oil refinery, which is adjacent to it. This town is about 20 minutes to half an hour drive from Zarqa City, in the direction of the North- East. The oil coming from Iraq is refined there, and most of its inhabitants are Jordanian Bedouin settlers and their families, working in the refinery, or working as small civil servants, or army soldiers. The team of the mobile clinic selected this community to represent the Bedouins of the Zarqa Governorate. The JAFPP mobile clinic provided FP services to the Bedouin community and remote areas of the Governorate. Although there is a MOH clinic in Hashemieh, the FP services were delivered by the JAFPP mobile clinic in agreement with the MOH Directorate, because of the shortage of providers specialising in Obstetrics and Gynecology, and female doctors.

5. One natural group discussion with women, and two household interviews with women (user and non-user of FP) were done in Al Azraq, a rural town located at the East of the Zarqa Governorate, two hours drive from the Zarqa City. It used to be an

oasis, and was used by the hunters and traders as a stopover during their expeditions. Its population is mixed, half Bedouin and half Druze, a religious sect found in Syria, Lebanon, Palestine and Israel. The inhabitants of the town are estimated at 5000 residents, and the only services provided are MOH services in the comprehensive health care center, which was difficult to access. The mobile clinic was the only other provider. The Azraq community was chosen by the mobile clinic team to represent the rural remote areas of the Governorate.

H. In-depth household interviews (Appendices 3.9 and 3.12)

Following the natural group discussions, consent was obtained for further in-depth interviews, with women users and non-users of family planning services and methods of different parity and age (See Appendix 3.9. Phases of data collection in the community). Ten women using contraception and ten non-users were identified from the participants in the natural group discussions in the different settings, (one user and one non-user per natural group), and were approached for in-depth interviews. Twenty in-depth interviews were originally planned however only fourteen interviews were done because few couples agreed to be interviewed together, instead of individually. When the husbands refused to be interviewed in a couple, women were interviewed alone. All in-depth interviews were conducted by the researcher, and were not taped, to preserve trust between the interviewer and the interviewees.

The themes of the in-depth interviews were drawn from the analysis of the FG discussions with the service providers and natural group discussions with men and women in the community (See Appendix 3.12. In-depth household interview questions). The aim was to determine men and women's knowledge of fertility and reproduction and

their attitudes towards it, perceived risks associated with hyper fertility, and to identify barriers to FP utilisation. Therefore, these interviews gathered data on women and men's perceptions of service provision and providers, and on the determinants of child demand and health-seeking behaviour (Helitzer-Allen et. al., 1996). Men and women expressed their perceived needs, recommendations to improve reproductive health and FP provision, and strategies to widen access to FP. In the analysis, the information obtained from the users and non-users of family planning methods was compared and contrasted. The information obtained from the people in the different socio-cultural contexts was also compared and contrasted. The words and concepts used in relation to family planning (*Rizk, Ezweh* etc...) were examined (Gove and Pelto, 1994) to understand women and men's *'emic'* perspective of reproduction, contraception, and fertility.

IV. Access and ethical approval (Appendices 3.13, 3.14 and 3.15)

The Medical Ethics Committee of the London School of Hygiene and Tropical Medicine approved the research proposal in May 1997 (See Appendix 3.13 Letter requesting ethical approval in Jordan).

On the 23rd of July 1997, the Ministry of Health and the UNRWA approved the fieldwork, following the submission of a detailed research protocol (See Appendix 3.3. The research protocol). The Under secretary of the MOH contacted the Director of Health of the Zarqa Governorate to provide access to the MOH clinics (See Appendices 3.13, 3.14, Letters of access to the field, LSHTM, MOH,).

UNRWA approval, however, was conditional with signing an affidavit that any material for publication in this research was to have prior approval from UNRWA, otherwise legal action would be taken (See Appendix 3.15 Affidavit for UNRWA). Then,

the researcher was introduced to the Zarqa Field Health Officer who provided access to the UNRWA clinics.

The Chief Executive Medical Officer of the Royal Medical Services (the military services) approved the research, and access was provided to the Soldiers' Families Welfare Clinic (SFWC).

The President of the JAFPP approved the research orally, and introduced the researcher to the Director of services of the JAFPP. A written letter was obtained from the administrator of the JAFPP, addressed to the Director of the Zarqa fixed clinic, and access to the mobile clinic was obtained.

The private practitioners denied access to their clinics and agreed to participate in the focus group discussions.

The Director of the project co-ordinating unit, at the Directorate of Planning of the MOH, and the Director General of Health of the Zarqa Governorate wanted to participate in the design, and data collection of the study. However, the former was transferred from the MOH centre, to the Salt Governorate, and the latter was often unavailable, on field trips in the Governorate.

Before observation, data collection, or home visiting were done, the researcher obtained informed consent from the clinic directors, front line providers, women using the clinics, and women and men in the community. When approval was not obtained, the design of the data collection was altered accordingly (e.g. women being interviewed alone instead of with husbands).

1. The public sector

- *The Ministry of Health (MOH)*

The undersecretary of the MOH, was one of the professors that taught me at the Jordan University of Science and Technology (JUST), whilst I was studying for an M.Sc. in Public Health, and his assistant was one of my classmates. The fact that they knew me helped to hasten the administrative procedures. After forwarding the letter of approval to the Director of Health of the Zarqa Governorate, (a graduate from a British medical school), he provided me with a car and a social worker to introduce me to the MOH MCH training centre where I was conducting my research. After initial introductions, the physician in charge of the clinic happened to be the cousin of my neighbour, which also eased cooperation.

At Prince Mohammed clinic, one of the physicians in charge of the clinic, helped me in organising the FG discussions with the service providers, and gave me a copy of his research on discontinuers of FP methods among the MOH service users of the Zarqa Governorate. He happened to be a friend of my research assistants who were also helping him with the statistical analysis of his data. He had met me earlier at the JUST university in one of the professors' offices. As the themes of our research had much in common, we exchanged literature reviews and articles with each other, and I revised the data tables for his research, in return for his valued help.

- *The Royal Medical services (the military services)*

I met with the Chief Executive Medical Officer of the military services in the Kingdom, upon the recommendation of the Secretary of the National Population Commission (the NPC). He thought that it was essential to include the military services, if I were to carry out my fieldwork in the Zarqa Governorate, a military region. The doctor recommended the Soldier's Families Welfare Society, because it had both a

clinical component and a community-based distribution component of FP delivery. He introduced me to one of the physicians providing services at the clinic, and asked him to introduce me to the Specialist (Obstetrician and Gynecologist) in charge of the Family Planning services at the SFWC.

One strategy I used in this clinic was to help the head nurse of the clinic, a highly motivated individual and manager, in pursuing her Masters studies in public health at the Jordan University of Science and Technology (JUST). I introduced her to the process of application and admissions, and to the Head of Department of Community Medicine who helped her in securing admission. I also recommended her to one of the professors who supervised my thesis, and he became her advisor for a while.

However, it was difficult for her to work in the military services, and study at the same time, without being on leave, because this was not encouraged. Since she was divorced and supporting two children, one of which was severely handicapped, I tried to help her in keeping her job, while promoting her academic status to improve future prospects. Her university enrolment became our little secret, and this meant that she helped me as much as she could. In addition, she was truly convinced that this research would be useful to the providers and community of Ghweirieh.

2. The international organisations

- *The UNRWA clinics*

My father had been employed in UNRWA, as a health educator in the headquarters of the health division, for more than thirty years. Originally, I had not intended to use this contact in getting access to the fieldwork. I sent a letter to the Jordan Field Health Officer, who delayed my request, then transferred it with the research

protocol to the Director of Health of UNRWA, who was a friend of my father. I called him by phone, introduced myself, and explained the purpose of the research. He immediately provided access to the field, but asked me to meet with the Director of the Family Health before going to the field. She provided me with two recent studies she had done on discontinuation of FP methods, and FP users, which were useful references for the discussion (secondary service statistics). She then introduced me to the Jordan Family Health Officer, who introduced me to the Zarqa Field Health Officer, who gave me access to the clinics, and provided me with an office space at the Zarqa MCH clinic. The physician in charge of this clinic during the second rotation of the schedule happened to be one of my classmates at the JUST University.

3. The Non-Governmental Organisations (NGO) sector

The Honorary president of the JAFPP, and regional coordinator of the IPPF was a professional acquaintance of my aunt, a retired civil servant. Following initial presentations, the President of the JAFPP introduced me to the Director of Public Relations at the JAFPP, who happened to know my uncle and was named after him. A joint meeting with him, and the Director of Patient Services was organised to discuss the research protocol. Consent for the field work was obtained during this meeting. A letter was written by the Director of Public Relations to the physician in charge of the fixed clinic of Zarqa, who was also in charge of the mobile clinic, and access to the mobile clinic was obtained.

4. The private sector

To access the private sector, I had to rely totally on personal contacts. A friend and classmate of mine during my graduate studies at the university, and her husband who

was a partner of a leading private hospital in Zarqa city approached the private practitioners, and organised a FG discussion with them in the hospital. Because the doctors needed the hospital for admissions, this strategy was useful. Added to this, the management of the hospital organised a luncheon for all doctors admitting to the hospital, once a month, as a social function. Following the FG discussion, the luncheon was scheduled on the same date to make sure that attendance would be complete. The private physicians helped in obtaining consent for home visits following delivery to some of their clients.

5. Access to the community

A. Zarqa Camp and the UNRWA clinic

Originally, the researcher had planned to accompany the *'Daya'* (TBA) of the UNRWA clinic during home visits. There, a postpartum woman would be identified and approached for a home visit and a natural group discussion. But a different strategy was adopted in the field: The clinic janitor, who lived in the Zarqa camp, had agreed to have a natural group discussion with men in his home. He also agreed to approach his wife who had delivered a week earlier to obtain consent for a visit and a natural group discussion. His wife agreed, and a natural group discussion with the women was done during a postpartum visit. This way, the camp community was accessed without the help of the service providers, to minimise the 'halo effect' bias. The 'halo effect' typically is the exaggeration of the positive aspects of provision caused by intimidation from the presence of the service providers. The clients will then 'polish the apple' for fear of future retaliation if they said anything negative about the services in front of the providers.

B. New Zarqa and the private sector

A postpartum woman from a high socio-economic background was identified and approached by the obstetrician in charge of her delivery, and by the matron of the hospital (my friend). Consent for a home visit was obtained, and a natural group discussion was carried out in her home in New Zarqa. This lady's family happened to know my father's family. This fact helped a great deal in the data collection process. Two women were identified for in-depth household interviews. However, the husbands refused to participate in group discussions or in-depth interviews for 'lack of free time'.

Instead, I approached an NGO in new Zarqa, the 'Family Counselling Centre'. The President of this NGO, whom I had interviewed earlier, organised a natural group discussion with rich men of the community. They agreed to have the discussion because they knew and trusted the president from the fundraising campaigns she did for her NGO. So I used her network to get access to the rich men of the community.

C. Ghwierieh and the Soldiers' Families Welfare Society

A woman that had delivered recently agreed to receive us in her home. She was a sister of one of the Community –Based Distributors (CBD)s. The CBD had approached her earlier to obtain consent. Following the natural group discussion with the women, two ladies were identified, and agreed to have in-depth household interviews with their husbands. The lady who had delivered agreed to approach her husband and a natural group discussion with men was organised by her husband later, in their home.

This community of Jordanian civil servants was extremely co-operative in providing access, and the women agreed to have household couples' interviews even without consulting their husbands.

D. Men from the urban middle-class and the Ministry of Health, Jordanian Association for Family Planning and Protection, or the Soldiers Families' Welfare Clinic

The researcher decided to organise a natural group discussion with men from a middle socio-economic urban class. This would balance the number of natural group discussions with women (five for women, and five for men). Since the natural group discussion with the men of Azraq was omitted because most of them were not available, and because of the transportation difficulties in getting to that region at night. The NGO, 'Family Counselling Centre' network was utilised, and a natural group discussion with a group of teachers from the public service was done instead.

E. Hashemieh and the JAFPP mobile clinic

The JAFPP mobile clinic staff introduced us to the MOH Hashemieh clinic physician, a non-resident of the area. The doctor then approached the midwife, a Bedouin from the area, who used her kinship network to introduce us to a lady in her tribe that had recently delivered and agreed to a home visit. The home visit and natural group discussion were done without the clinic staff or mobile clinic providers.

The husband of the lady organised a natural group discussion with the men in his neighbourhood. However, attendance at the natural group discussion of men was low, and later on, husbands refused to have in-depth interviews with their wives at home. Other women were accessed however, through the local midwife, and agreed to have in-depth household interviews in their homes.

F. Azraq and the JAFPP mobile clinic

In Azraq, a similar approach to the previous one was adopted. A woman visiting the mobile clinic identified a cousin of hers that had recently delivered. The lady approached her cousin and obtained consent for a visit. A home visit and natural group discussions were then carried out without the JAFPP mobile clinic staff. Men were away working in Syria or Israel for months, so in-depth interviews were done with the women alone. This community was very co-operative in providing access. All women participating in the natural group discussions wanted me to visit them at home, and in order not to offend them, I had to do social visits in the homes of women with whom I did not have in-depth interviews.

The natural group discussions were all taped after obtaining consent from the participants. In New Zarqa, one of the participants was hesitant about the tape, so I turned it off. However, when she found out from her sister in-law that we had family ties, she became very relaxed, and asked me to put the tape recorder on again.

All the natural group discussions with men were done in the evenings, at their own convenience, while natural group discussions with women were done during the daytime, when their husbands were at work. The couples' interviews were usually held in the late afternoons, after the husbands had returned from their work.

V. Assessment of the efficacy of each strategy

Although some of the strategies used to gain access would be inappropriate for cultures in the West, these strategies were appropriate to the local culture of Jordan, and the Governorate of Zarqa, because they were initiated by the collaborators in the research process. I have in mind the 'Mansaf' invitation to lunch (traditional Bedouin dish), which

was welcomed by the physicians, and which meant an immediate appreciation of their cooperation in the research process. The credit for this ingenious idea goes to the owners of the private hospital, my personal friends.

My own network from the Masters studies in Health Service Administration in JUST and family relationships certainly helped in networking. They proved very useful in gaining time, and decreasing bureaucratic procedures. The gatekeepers personally committed themselves to providing access and resources, because they knew me, or knew my family.

Helping personnel in pursuing their studies, or providing academic material and articles for the researchers to use in their research, proved an extremely effective strategy in gaining their trust and approval. A unique rapport of mutual appreciation was established owing to this strategy.

At the 'Family Counseling Center', the NGO which helped me in accessing the rich and middle class men of Zarqa city, I returned my appreciation, by volunteering a series of discussions. The discussions were with married women and a teenage group of young men and women on reproductive health and sexual education. Actually, these sessions were invaluable to me, as they were highly related to my data collection, and revealed reproductive health needs and perceptions of sexuality among these two age groups. A very good rapport was established with the NGO president and staff.

VI. Data entry, processing and analysis

1. **Interviews with the policy makers**

The interviews were not taped, to avoid raising suspicion however I took notes during the interviews. Then, I translated the interviews into English, entered the data,

indexed the themes, and analysed them on the computer, using the NUDIST software program for analysis of qualitative data.

2. **Service observation**

I took notes during or immediately after the service observation. The observations were then organised and entered on the computer, by using the indicators for quality of the MAQ checklist. Critical incident reporting was part of the service observation, and was incorporated with the field notes, during the processing and analysis of the data.

3. **Field notes**

Field notes were used to generate or revise the working hypotheses whilst in the field (Burgess, 1982). I wrote them on a daily basis during the fieldwork, in the bus, before and after the data collection. The notes were then organised and entered on the computer to support analysis.

4. **Service statistics**

I collected monthly and yearly service utilisation statistics from the MOH training center, the SFWC, the JAFPP mobile clinic, and the Zarqa MCH clinic of UNRWA with the help of the clinic personnel. I then organised the data and recruited one of the research assistants (statistician), who entered it on EXCELL spreadsheets, using one spreadsheet per service. Another research assistant (doctor) then re-entered, processed, and analysed the data, under my close supervision. SPSS statistical package was used for the analysis of the service statistics. Meanwhile, I was collecting and analysing the qualitative data myself using the NUDIST software for data entry and analysis. Because of the large amount of data, I preferred to handle the qualitative data myself and contract research assistants for the quantitative data analysis. I then matched and compared the

results of the statistical analysis with the qualitative data retrieved from the services (service observations and focus group discussion findings with the service providers). In addition, I validated the findings of the statistical analysis with the service providers who provided an explanation of unusual findings.

5. Focus group discussions with the service providers (Appendix 3.8)

The FG discussions were taped and the research assistant took notes. A theme guide was used by the moderator (myself), derived from the findings of the interviews with the policymakers, and observations of service delivery. Following their consent, photos were taken of the FG discussion participants (See Appendix 3.17 Photos of the providers participating in FG discussions). Copies were given to the providers following the fieldwork. I translated the notes of the FG discussions to English, entered the data, indexed the themes, and analysed them on the computer, using the NUDIST software program for analysis of qualitative data.

6. Natural group discussions with men and women in the community (Appendices 3.10 and 3.11)

The natural group discussions were taped, and the research assistants took notes. The moderator (myself) used a theme guide. As in the FG discussions, the notes of the natural group discussions were translated into English, entered in the computer, indexed, and analysed using the NUDIST software program. The community validated the data collected during the FG discussions concerning them, by comparing their own perceptions with the providers' perceptions of their health -seeking behaviours.

7. **Household interviews, with women and couples (Appendix 3.12)**

I did all the household interviews, and they were not taped. The women set the date and time of the interviews. Two guidelines were used, one for the users of FP and one for the non-users (See Appendix 3.12). The themes of the in-depth interviews were derived from the analysis of the focus group and natural group discussions. I then translated the notes of the interviews to English, entered the data, indexed the themes, and analysed them on the computer, using NUDIST program.

This research used a mix of qualitative methods, and tools for the systematic assessment of access at the policy, service, community, and household levels. It aimed at exploring the 'behavioural pathways' at the service and household levels, which encourage or deter hyper fertility, and widen or deter access to family planning services (Almedom et. al., 1998). The qualitative anthropological data unfolded the context of decision- making concerning fertility and reproduction, and the consequent behaviour at the clinic and household levels. Possible strategies to bridge the gap between the user's needs and service provision will be identified through analysis of the data (Trostle and Sommerfield, 1996).

VII. The research team

The research team was composed of the principal investigator and a support team of four part- time research assistants. The female research assistant, was a social science graduate, experienced in qualitative data collection; She helped in the logistical preparation of FG, and natural group discussions (communications, transport, and purchasing of materials). She taped the FG and natural group discussions with women, and retrieved demographic data from the participants prior to commencing the

discussions. During the discussions, she was the reporter of 17 group discussions, and wrote up the notes, while I conducted the interviews. She transcribed the tapes, revised the notes, and submitted the data. I translated the notes into English, and entered them on the computer, and analysed the data.

One male physician with a Masters Degree in Public Health helped me to analyse the quantitative data on SPSS. However, I re-entered the processed findings on EXCELL in Canada to draw the graphs of service utilisation. The other physician, a graduate in Community Medicine, helped in the group interviewing of men (Five group discussions). He was the moderator, and a male pharmacist acted as a reporter, and taped the sessions. I trained both research assistants in the techniques of FG discussions, to master the skills of group interviewing, and a film on FG discussion techniques was shown to them and discussed with them.

I did all the interviews with the policy makers (15 interviews), and household interviews with women and couples (14 interviews) and took notes. I also moderated nine FG discussions with the service providers, and five natural group discussions with women in the community. I did the service observations, and kept field notes. I translated all the qualitative data to English, and entered it on the computer, and analysed it. I retrieved the quantitative data with the help of the service providers, and the data was analysed by the research assistants and myself.

A steering committee for the fieldwork was originally formed then dissolved due to logistical difficulties.

Conclusion

This chapter has presented the research design, time and place of the study, methods, strategies and resources used to gain access to all the settings, with a description of the research team and an overview of the process of data entry, processing and analysis. In the next section (chapters four to nine) the research findings are presented.

Section B

Results and Findings

Chapter 4

Policy makers' perspectives

Introduction

This chapter presents the current structure and function of population policy in Jordan and its key players. The global, regional and national determinants of the policy environment are explored with the policy makers in national and international organisations, along with the barriers to population policy formulation and implementation.

The definitions for population policy and policy environment used in this chapter are the same as those of 'The POLICY Project', Jordan, that was just starting at the end of 1997 as one component of 'The Policy Project' International. This project is funded by the U.S. Agency for International Development (USAID) and implemented by The Futures Group International in collaboration with Research Triangle Institute and The Centre for Development and Population Activities.

Population policy:

> *'Policies are actions, customs, laws or regulations by governments or other social/ civic groups that directly or indirectly, explicitly or implicitly affect fertility, family planning or reproductive health' (AlMasarweh & Stover 1998:2).*

Policy environment:

> *'The factors affecting program performance that are beyond the complete control of national program managers' (AlMasarweh & Stover 1998:2).*

These definitions were adopted from the Policy Project based on the rationale that it is the only international project with a population policy agenda for Jordan, with similar policy initiatives in many developing countries, all funded by (USAID). The implementation of the project however is not included in this section because it came in time after the data collection phase of this research study. The findings of the Policy Project, Jordan and International (comparisons) however are included in the discussion.

Population policy in Jordan and key players

I. Governmental organisations

1. The National Population Commission (NPC)

The Jordanian Government established the National Population Commission (NPC) in 1973 to advise on population issues related to the social and economic development of the country. The Department of Statistics (DOS) hosted NPC and its role was restricted to public ceremonies and functions. The committee met to prepare for the Arab Population Conference in Amman and for the Mexico conference on population. The committee's role was 'ad hoc'.

In 1988, HRH Princess Basma Bint Talal established the General Secretariat of the National Population Commission to have an executive function and co-ordinate population policy and research. By the end of 1994, the General Secretariat became the reference body and co-ordinator for all population activities, programs and information in Jordan. The Jordanian Hashemite Fund for Human Development now hosts the General Secretariat of NPC (Interview with General Secretary, NPC).

NPC is chaired by the Minister of Labour and a representative of the Jordanian Hashemite Fund for Human Development who acts as Vice Chairman and Secretary

General. Its members include the Secretary General of the Ministries of Planning, Health, Education, Information, Islamic Affairs, Social Development, and Civil Service Bureau. General Directors of the Department of Statistics, Passports and Civil Status, Jordan Radio and Television, and the Housing & Urban Development Corporation are also members of NPC. In addition, representatives from the main universities, the Armed Forces, National Committee for Women, Noor Al-Hussein Foundation, and the Jordanian Association for Family Planning & Protection are represented (Interview with General Secretary, NPC).

In 1993, the first national policy affecting population - the *National Birth Spacing Policy* - was approved by the Council of Ministers. For the first time openly, this policy unfolded the government's intentions to consider demographic variables in development planning. In addition, Jordan's five- year development plan (1993–1997) also included population issues to be addressed through family planning programs. This development plan started the integration of population education into school curricula (Hardee et.al, 1997).

2. The National Population Strategy (NPS)

NPC on the other hand drafted the first National Population Strategy (NPS) around the same time (early 1990s). This strategy was the first policy output i.e., the first national population policy that emanated from the efforts of NPC. It was used by the Jordanian delegation to ICPD in 1994, and was approved by the Council of Ministers in March 1996. Although the National Population Strategy did not include all ICPD recommendations, ICPD did have an effect on its development. At the end of 1997, NPC

appointed a task force to revise the strategy to reflect the recommendations of ICPD (Hardee et.al, 1997).

NPC/General Secretariat and Futures Group International (Policy Project) are working together in advocacy for the population program among members of parliament, government policy makers and other key leaders. Another aim is to enhance the capacity of the General Secretariat to plan, monitor, and evaluate and co-ordinate the national implementation plan.

The implementation of National Population Strategy includes seven 'sectors', assigned to different ministries (Ministry of Health, Ministry of Education and Ministry of Information). This multi-sectored approach in defining policy needs and in strategic planning was adopted, sometimes using quantitative objectives, to achieve consensus building in the process of population policy formulation (Interview with General Secretary, NPC). The seven sectors involved with implementation are the following:

1) Reproductive health

a) Mother and child care

i) Lowering birth induced maternal mortality rate.

ii) Lowering infant and child mortality rates.

iii) Lowering the incidence of disabilities & handicaps.

b) Family Care, Family Planning and Birth Spacing

i) Expansion of family planning services and increasing the contraceptive prevalence rate.

ii) Enhancing the civil and voluntary participation in providing family planning services.

iii) Making the best use of available opportunities for the introduction of family planning programs to society.

iv) Providing effective educational and media materials on reproductive health including family planning and birth spacing.

2) Population, information and communication

1. Creating positive attitudes towards population issues, by spreading awareness on their implications on the quality of life for the family and sustainable development for the nation as a whole.

3) Women and development

1. Lowering the illiteracy rate among women.
2. Increasing the rate of female enrolment in secondary, vocational and higher education.
3. Enhancing women's participation in labour force and in economic activities.
4. Lowering unemployment rate among women.
5. Raising the level of women's participation in public and political life.

4) Education

1. Realising the objective of basic education for all and limiting dropout rates.
2. Improving the quality of education in all stages.

3. Increasing the enrolment rate in secondary education and linking it to the requirements of both the society and development.
4. Expanding vocational training and education and improving their standards to enhance the chances of the graduates to join the labour markets in an efficient and highly productive manner.
5. Eliminating illiteracy especially among rural women.

5) Population and labour force

1. Developing human resources and regulating entry in labour market.
2. Increasing women's participation in the labour force.
3. Reducing both unemployment and public sector employment rates.
4. Expanding replacement of expatriate workers with local ones in various labour sectors.
5. Encouraging work in various vocational and technical professions where the supply of local labour is lacking.

6) Population, natural resources and environment

1. Reducing the imbalance between water supply and demand.
2. Reducing the imbalance between local production and demand for food products.

3. Increasing the level of efficiency in utilisation of local energy resources.
4. Achieving balance between population size and environmental conditions.
5. Achieving a better balance in the geographical distribution of the population between urban and rural areas.

7) Population and Housing

1. Provision of suitable housing at a suitable price for every family.
2. Limiting the expansion of luxury, high-cost housing.
3. Encouraging both private and public sectors investment in housing projects for low-income families.
4. Protecting the environment and reducing the agricultural land exploitation for the purposes of housing.
5. Provision of basic infrastructure for housing such as: transportation, communication, education, health services, waters, electricity, recreational facilities, sewage and refuse disposal.

The National Population Strategy was developed by NPC in a project funded by UNFPA. The latest numeric objectives are a reduction of the overall population growth to two percent by 2005 and 1.6 per cent by 2010 and reduction of the total fertility rate to 3.4 by 2005 and 2.9 by 2010. Policy outputs targeted for the next phase include a preparation of 'a plan of action' for all major fields and sectors, specifically the field of reproductive

health. There is a lack of consensus among the policy players in Jordan on the definition of reproductive health (Policy Project findings and the findings of this study).

> *Respondents from the MOH were aware of ICPD but did not embrace reproductive health as a new approach to the organization and delivery of services; in fact, high-level MOH respondents considered family planning a broader concept than reproductive health. Jordan's health programs cover several elements of reproductive health. Priority areas are birth spacing, safe pregnancy, well-baby care, and maternal and infant nutrition programs. Respondents noted that some reproductive health elements are not problems in Jordan, specifically AIDS (too few cases to be a priority), and female genital mutilation (nonexistent)* (Hardee et.al. 1997:16).

Other major programme components are Information Education and Communication materials on population issues, and reproductive health, together with advocacy programs to reinforce political support for the National Population Strategy.

8) The Population Information Centre

The centre administered by the NPC provides online data and information on population and development through POPLINE - the largest database on population issues in the world (250,000 records along with organised abstracts). This reference is updated once every six months.

The centre also provides help in designing strategies, projections, planning and evaluating demographic trends such as: DEMPROJ that provides future projections based on different assumptions of elements of demographic changes. FAMPLAN estimates the future needs of family planning services to reach the national goals of addressing unmet need and reaching desired fertility rates. AIM is used to estimate the dangers of AIDS. And RAPID software helps to assess the impact of demographic changes on social, economic and environmental development.

9) Publications

The NPC/General Secretariat publishes and distributes *The Population Bulletin* – issued periodically and highlights recent public discussions on population topics. *Population & Development Journal* - is an annual scientific journal that includes articles on reproductive health, demographics, policies, etc, and a *bibliography of Population Studies in Jordan* - An annual publication covering research studies conducted in Jordan during the calendar year.

10) Public information and advocacy campaigns

In 2000 NPC/General Secretariat and The Futures Group International have made over 30 RAPID presentations and disseminated approximately 2,500 'Population Impact on Development in Jordan' policy booklets to parliamentarians and governmental officials on the statistical projections of population growth and subsequent demands on national resources. They have also conducted policy-oriented research to inform and enhance planning for population and RH.

i) The Population Communication Project

- *'Together for a Happy Family'* Project (Men's participation in FP)

This project was designed according to the findings of the 'Knowledge, Attitude, Perceptions' (KAP) Survey done in 1996 by NPC and Johns Hopkins University, that showed 50% of men believed family planning decisions were to be made jointly between husband and wife. Based on this and other research findings as well, the NPC and Johns Hopkins University/Population Communication Services designed the first-ever Men's Participation in Family Planning Campaign in Jordan, 'Together for a happy family'.

Important strategies of this campaign included the involvement of religious leaders and influential persons at the neighbourhood and local community levels in motivating men to discuss family health issues with their wives. The messages of this campaign, delivered through mass media and during community meetings with men, focus on the recognition of the benefits of family planning and encourage the utilisation of services as well as highlight the accordance of FP and Islam. The two communication modes used are culturally and socially appropriate to reach Jordanian men. The campaign was launched in 1998 by NPC, with trained facilitators in the community meetings and multi-media messages. NPC has decided to extend the community meetings to three additional governorates (Zarqa, Balqa and Karak) and continue the national multimedia campaign in 1999-2000.

- *'Arab Women Speak Out'* Project

'Arab Women Speak Out' project aims at women's empowerment and participation in social development throughout the Arab world. The testimonials of women in Lebanon, Palestine, Egypt, Tunisia, and Yemen, are used in training and advocacy, because these women's significant achievements in the areas of economic and social development, education, and reproductive health, unfold the various enabling factors and resources that these women have used. Interactive meetings between the women in Arab Women Speak Out and women in the local communities of Jordan aim at providing models of achievement and self-esteem for women in comparable situations. The project activities are co-ordinated by NPC in collaboration with Johns Hopkins University Population Communication Services. In 1999-2000, local meetings were held in Princess Basma Women's Resource Centre and Noor El-Hussein Foundation.

- *'Empowering Youth as They Prepare for the Future'* a Youth Project

This project hopes to target a younger audience, and aims at linking with a wider range of Ministries and other agencies. The goal is to empower youth with reproductive health (RH) and planning information and skills so that they will understand the reproductive process, make informed decisions and take positive actions as they prepare for the future.

This youth project is included in the communication strategy implemented by NPC with technical assistance from the Johns Hopkins University/Population Communication Services.

- *RH/FP & Gender Project in Ghor District, Karak Governorate*

This is a four-year pilot project of NPC (1996-2000) to enhance awareness of RH/FP and gender in the region, strengthen RH services and upgrade health centres, and increase women's participation in economic activities. Working in close collaboration with The Jordanian Hashemite Fund for Human Development and the Ministry of Health (MOH). Over 63 MCH medical doctors, midwives, and nurses were trained in reproductive health and family planning counselling, contraceptive technology, and medical devices. 2,083 women and 751 men participated in community meetings on issues of reproductive health and family planning. Almost 94% of women participants discussed the topics with someone (husband, family member, friend, etc.). The number of women who have visited the MCH centers in Ghor District has more than doubled from 107 in 1997, to 224 in 1998. In addition, this program has initiated two income-generating activities: bee keeping and goat breeding. This project is funded by the Japanese International Co-operation Agency (JICA).

ii) Technical Training, Outreach and Dissemination Projects

In 1999, NPC sent over 83 representatives from governmental and non-governmental organisations to international, regional, and national training workshops, on-the-job-training, and program implementation in communication, strategic planning, pre-testing, production, dissemination, monitoring, and evaluation. These training activities are sponsored by Futures Group International (Policy Project), Johns Hopkins University /Population Communication Services, JICA (Japanese International Corporation Agency), USAID, and UNFPA.

On the other hand, co-ordination of efforts between NPC and the donors is ongoing and financing strategies for sustainability of FP programs are being explored with the private sector. Recently membership of NPC was broadened to include more members from the NGO sector, in harmony with international trends.

3. How policy makers' perceived NPC (in-depth interviews)

Most policy makers perceived and believed that NPC was the key player in population policy planning and development in Jordan.

- ✓ 'All international organisations must go through the NPC which is the co-ordinating umbrella of policies and programs' (Director of client services, NGO, female doctor, married, 2 children).
- ✓ 'To reform NPC to include more members 21 instead of 15 members. And to include few NGO's in NPC, and especially JAFPP. They had insisted to include the latter since 1996'(General Secretary, NPC, male, 45, married).

As seen earlier, the General Secretary of NPC summarised the chronological development of population policy in Jordan. According to him, the activation of NPC

role was truly initiated a decade ago, for political reasons. Following the Gulf war (1990) 300, 000 Jordanians of Palestinian origin returned to Jordan, following their expatriation by some governments of the Gulf States, namely Kuwait. The load of the returnees on the Jordanian infrastructure led the government to address population growth as a serious threat to the limited resources and water in Jordan (Interview with General Secretary, NPC).

4. The Ministry of Health

Most of the interviewees perceived MOH as a key player in population policy formulation and implementation, in addition to NPC and UNFPA. Two policy makers from MOH and USAID respectively, believed MOH was more important than NPC.

- ✓ 'NPC work might have changed a little bit the contents of the policies, but it is mainly MOH who determines all the policies on everything' (Technical Assistant Director, MOH, male doctor, 44, married).

MOH is now thinking of the strategy of cost sharing, as a partial remedy to financial dependence, in order to achieve sustainability of FP programs and services.

- ✓ 'There is thinking in the whole country to pay for services. All the decision -makers have this idea in mind, but there is no legislation to that effect' (senior consultant, Policy Project, adjunct to NPC, male, married, 50).

In addition, many policy makers thought that the formation of a co-ordinating body was a necessity. A project co-ordinating unit has already been established at the Directorate of Planning of MOH. However, the people directing this unit were seen as not having enough authority, as this unit was completely funded by USAID:

- ✓ 'The co-ordinating unit was established in October 1996, with a very well designed job description for the unit. However, the people in charge of this unit do not have the authority over the Comprehensive Postpartum Project (CPP) for example, because ethically speaking, the CPP project is a project administered from outside the ministry' (Technical Assistant Director, MOH, male doctor, married, 44).

I. Family Planning provision at MOH

Since 1985, free family planning services have been integrated with maternal and child health services of MOH within the primary health care system, as recommended by WHO. The RH model recommended by ICPD is not yet implemented in the MOH, because of a power struggle between the Directorate of Maternal and Child Health, and the advocates of an independent Reproductive Health Directorate that would include family planning services.

- ✓ ' In 1985, the integration of family planning services in the maternal and child health centres was recommended. WHO also recommended integrating the maternal and child health centres in the primary health care system' (Assistant Director, MOH, maternal and child health services, male doctor, 45, married).
- ✓ 'There are no specific instructions concerning the reproductive health model, and the new mechanism that they want to establish is a Directorate for family planning, but it has not been set up' (Director, health directorate, MOH, male doctor, 56, married).

5. The Ministry of Planning

This ministry was mentioned twice as a key player in the co-ordination of FP programmes and policy, albeit however a passive one.

- ✓ 'The MOP receives the project and sends it over, but there is no further follow up and monitoring of the programme from the MOP' (NPC official, male, married, 45).

6. The religious authorities

A few policy makers mentioned the religious authorities as having an impact on policy formulation and implementation. According to the Higher Judge of the Islamic Court in Jordan, the official Islamic position concerning population policy was that FP is acceptable in Islam.

- ✓ 'The religious leaders are very co-operative...On the one hand they have helped us in revising a brochure for FP based on Islamic '*Shari'a*' (law) and their directives in the newspapers are positive' (General Secretary, NPC, male, married, 45).

The Higher Judge of the Islamic Court explained how Islam left these decisions to be addressed in the realm of the couple. According to him, Islamic legislation does not encourage FP legislation at the national level, for the following reasons. If the government adopted an anti-natalist policy restricting the number of offspring per couple, the national law would then be forbidding what is allowed by Islamic law ('*Shari'a*), and that is to have as many children as one wants. If the government adopted a pro-natalist policy, it would be discouraging or forbidding the practice of FP, which is allowed in Islam, and it would be coercing people to have children that they maybe did not want. This policy would again be forbidding what is permitted according to Islamic law ('*Sharia*). He concluded that having children was not an obligation in Islam, but this was a decision to be made at the household level by the couple alone (Interview with the Higher Judge of the Islamic Court).

According to the religious authorities' perspective, the problem of poverty did not result from population growth, but from the inequitable distribution of world resources:

- ✓ 'Peoples' 'Rizk' (fortune) is all decided by God and it is up to him to provide 'Rizk' or not to people...The issue that we are dealing with here is not an issue of 'Rizk', but the human organisations and governments on the face of the earth are unfair and inequitable in their distribution of wealth and control over resources, and the presence of colonialism is the reason behind the inequitable distribution of wealth in the world!' (Higher Judge of the Islamic Court)

II. The International Governmental Organisations (IGO)- funding agencies

1. The Family Planning projects in Jordan

Table 4.1 The FP projects in the public sector of Jordan, 1997.

Project	Funding agency	Scope of project
The Family Health Services	USAID	Model centres- Quality improvement- Morbidity data
The Comprehensive Postpartum project	USAID	Hospital-based, postpartum FP provision
The MCH project	UNFPA	Supporting and expanding MCH services

There was a consensus among the interviewees that the most important funding agencies were UNFPA, USAID, EU (European Union) and JICA (Japanese International Co-operation Agency).

- ✓ 'USAID is a major player, but its mandate is different from ours, EU also contributes, IPPF, JICA, WHO are working in population issues, UNICEF are working in the health field and MCH services' (National program officer, UNFPA, female, 44, married).
- ✓ 'USAID is the biggest funder, along with UNFPA, EU, JICA' (senior consultant, Policy project, adjunct to NPC, male, married, 50).

A large number of Reproductive Health – Family Planning clinics of MOH (exceeding 200 clinics) were upgraded with medical equipment, furniture and contraceptives (long acting methods and injectables). Training programs in and outside the country and fellowship training of physicians, nurses, midwives on FP techniques including Norplant were supported by UNFPA. Four model centres were established in Jordan, for provision of services and national capacity building by upgrading the management skills of the providers (Interviews with Program officer, UNFPA and Assistant Director, MOH maternal and child health directorate). These programs will affect contraceptive and service utilisation and promote fertility transition in Jordan. The degree of impact is not measured yet, however tools to assess outcomes are being thought of by international project teams individually within their respective teams.

2. UNFPA

Many interviewees perceived this UN organisation and major funder, as a key player in policy formulation and implementation of FP programmes. Furthermore, UNFPA was acknowledged as a major supporter of NPC. The senior programme officer of UNFPA viewed their role as consultative for all international agencies working on population in Jordan. UNFPA has a set agenda (strategic plan), usually revised according to local needs before funding is provided.

The agenda of UNFPA

A major policy output advocated by UNFPA is to organise all FP services according to the RH model of service provision. Since the MOH services were still integrated with the maternal and child health services, UNFPA would advocate the RH model with MOH. In addition, UNFPA is organising advocacy campaigns for population and

development, and gender sensitisation at the national and regional levels. The mobilisation of religious authorities in the national advocacy and awareness-raising campaigns is another policy strategy practised by UNFPA.

The methodology of UNFPA is basing all activities on the findings of baseline surveys in target communities. Community outreach campaigns are then designed according to these findings. They are organised with community leaders, through the Non Governmental Organisations, to build capacity and emphasise the feeling of ownership of the programmes. The stress is on the health benefits of FP for the mother and child, more than the economic benefits (Interview with the Senior Programme Officer, UNFPA, female, married, 44).

- ✓ 'Most of the sectors included in the National Population Strategy were prepared in the UNFPA Amman office. The UNFPA gave equipment, a training component, in-service training and fellowship' (senior consultant, Country Support Team, UNFPA, male doctor, married, 49).
- ✓ 'The mobilisation of NGOs was part of this formulation and implementation of global policy in addition to the monitoring of these population programmes' (Director of client services, NGO, female doctor, married, 48).
- ✓ 'They started talking about the population policy in the TV, radio and newspapers and they involved the religious preachers in these campaigns, the preachers of the Friday prayers, starting from the Higher Judge of the Islamic court' (Senior Programme Officer, UNFPA, female, married, 44).

3. *United States Agency for International Development (USAID)*

i) The Policy Project (Futures Group International)

The international agenda of the Policy Project is to promote the Programme of Action of the 1994 International Conference on Population and Development (ICPD). The project is now operating in 32 countries.

In Jordan, The Futures Group International (Policy project) is working with the NPC to increase awareness and support for the population program among members of parliament, the government policy makers and other key leaders. They revised the National Population Strategy to include the latest information of the 1994 International Conference on Population and Development. A national plan to implement the National Population Strategy was developed. The Policy project addresses the full range of policies that support the expansion of FP and RH services

- National policies as expressed in laws and in official statements and documents;
- Operational policies that govern the provision and use of services;
- Policies affecting gender and the status of women;
- Policies in sectors affecting population such as health, education, and the environment.

The Policy project is funded by USAID in Jordan and in the 32 countries where it is operating.

ii) The Comprehensive Postpartum Project (CPP)(Pathfinder International)

This project with the largest budget among FP programmes in Jordan (11million dinars as initial budget) focuses on operational policies. It moves FP provision to ten hospitals across Jordan and one community centre where outreach community-based

distribution of contraceptives are provided for the first time in Jordan, along with FP services at the clinic. The rationale underlying the model of Comprehensive Postpartum Provision adopted by the CPP project in the hospitals is that women are more receptive to FP utilisation immediately after experiencing childbirth because of labour pains and delivery. In addition, women are usually overwhelmed by the added responsibility of caring for newborn (Interview with Chief of Party, CPP).

In addition the CPP project wants to introduce a change in the current operational policies by allowing midwives to insert IUDs after training them to remedy the shortage in female doctors. This will also address the professional and gender hierarchy (midwives all female, doctors mostly male) existent in the current system of provision at the MOH that acts as a barrier to FP utilisation since IUD is the most popular contraceptive method in Jordan (Interview with Chief of Party, CPP).

Only two interviewees, a policy maker from MOH, and the CPP project director, perceived the CPP project as important because it was going to address most of the barriers to access FP services, and would result in legal and regulatory policy outputs.

- ✓ 'Our program (CPP) is supposed to cover most of the barriers. One of the first things we realised, are the medical and service barriers. The project is still new, 1 year, and we do not yet have systematised efforts, but I think that in 3 years time from now, several components will be brought in, that will address several policy issues' (Chief of Party, CPP project, female doctor, 50).
- ✓ 'USAID wants to review FP objectives, because there is a change in contraceptive prevalence rates. They want to revise the goals according to the rates, taking into

consideration the availability and affordability of contraceptives. They want to set goals for the next 5 to 10 years' (Chief of Party, CPP project, female doctor, 50).

4. *UNRWA*

UNRWA provided services to the Palestinian refugees only. Their operational policies were centrally formulated in UNRWA headquarters. These policies were applied in all UNRWA services Agency-Wide in the Palestinian refugee camps of Jordan, Lebanon, Syria, Gaza and the West Bank. UNRWA models of provision were usually adapted from WHO.

One policy maker from UNRWA perceived it as a pioneer in adopting the reproductive model of service provision used by WHO and a provider of FP services. According to the chief medical officer, UNRWA was mostly concerned with the quality of life of the refugees, because they knew what was best for them. FP services were integrated following the reproductive health model.

✓ ' UNRWA was a pioneer of the Family Health model. In 1992, a meeting took place in Larnaca. UNRWA was a pioneer in the integration of FH services within PHC' (Chief Medical Officer, UNRWA, male doctor, 58, married).

III. The Non –Governmental Organisations (NGOs)

a) The Jordanian Association of Family Planning and Protection (JAFPP)

JAFPP was acknowledged as a major population policy player active in advocacy at the national level, and a FP provider of services of good quality, by a large portion of the interviewees. The director of services described how they were revising their operational policy to devise strategies for widening access, mainly community-based distribution of contraceptives, and the 'life-cycle' approach to service delivery.

- ✓ 'In Jordan the pioneers in FP programmes were JAFPP before the government' (Director, Family health, UNRWA, male doctor, 46).
- ✓ 'One of the activities carried out by JAFPP, two years ago, was a workshop to sensitise most policy makers, and after one year, JAFPP formed the Forum as a reminder for policy makers' (Director client services, JAFPP, female doctor, married, 48).
- ✓ ' JAFPP covers 35% of services and I am sure that JAFPP does high quality work' (Technical Assistant Director, MOH, male doctor, married, 44).

b) The family counselling centre

The Director of the centre described its reproductive health and family planning activities following the RH model, where a comprehensive approach was used, and FP education was integrated with other welfare services. The centre addresses domestic violence, child abuse, gender issues, and their programmes target the poor.

- ✓ 'Our activities in the centre include: A training program for the young men and women who are about to get married and preparation of engaged couples for marriage on how to build healthy families' (Executive Director, Family Counselling Centre, female, married, 58).

IV. Influences on population policy in Jordan as perceived by the policy makers

1. Global Influences

Only a few policy makers mentioned population growth at the global level, and efforts to control it, as impacting on population policy formulation in Jordan. It was not very clear whether they were aware of the political dimension of this link, because they restricted their discussion to a general perspective.

A few others more specifically linked the collapse of the USSR, and the emergence of the New World Order, to the formulation of a population policy in Jordan. Their analysis was based on the new political realities shaping global relations in the 90's, and they clearly related FP efforts in Jordan with these realities that impacted on the relations between the First World and the Third World.

- ✓ 'There was no actual FP policy before 1992... After the fall of the eastern block, and the establishment of the New World Order, the concept that population growth was a universal threat to the global society emerged, and a new policy to fight population growth emerged' (Director, co-ordinating unit, MOH, male doctor, married, 43).
- ✓ ' After the collapse of the USSR, and the socialist countries, it became apparent that the "market economy" has weakened the position of the developing countries in the international debate on population issues' (Senior consultant, Policy project adjunct to the NPC, male, 50, married).
- ✓ 'Yes of course there is a link. The Gulf war and the fall of the eastern block, the global village concept, the New World Order, all affected peoples' awareness and receptiveness' (Technical Assistant director, MOH, male doctor, 44, married).

Most policy makers were aware of the link between the global and national population control policies, and mentioned conferences as the linking mechanisms between the two levels. However, they differed in their perceptions of the nature of this link, and the opinions expressed represented the mosaic of positions towards FP in Jordan. Policy makers in the public sector believed in the harmony of this link with the national interests of the people, but did not perceive it as a coercive relationship, because Jordanians resisted discourses that were not in harmony with their interests.

- ✓ 'There is a link, there is a harmony between our needs for a population policy in Jordan and between the priorities of the World Order' (Director, co-ordinating unit, MOH, male doctor, married, 43).
- ✓ 'A conference takes place somewhere, and we receive the conference report following the conference, and we decide what to adopt from that report according to our own needs' (Assistant Director, MOH, maternal and child health services, male doctor, 45, married).

Typically, a USAID project manager perceived this link as beneficial to the national system, because it pushed things forward. Giving the example of the CPP project, she perceived it as definitely including a policy amendment agenda. The Director of the co-ordinating unit at the MOH that was funded by the USAID expressed the same explicit support for this link.

- ✓ 'I will give you an example from the CPP project: If by the end of this project nurses, and midwives can insert IUDs, I would have achieved a great deal, I do not want anything else! ...It means I would have pushed that system forward by allowing nurses and midwives to insert IUDs' (Chief of Party, CPP, female doctor, 50).
- ✓ 'It is actually dependent on the international funders' involvement. As long as the money is flowing there is influence, otherwise no' (Assistant Director, MOH, maternal and child health services, male doctor, 45, married).
- ✓ 'The international organisations train health providers of all levels, providing FP services, technical assistance, and expertise as needed. They also provide the needed medical equipment and instruments... All this will have an impact on national policy

although the degree of impact is not measured and difficult to assess, and is almost not directly tangible' (Senior Programme Officer, UNFPA, female, married, 44).

2. The gender sensitisation movement

The female policy makers were sensitive to the gender issue, and linked it with developments in the international platform for action. The 'Arab women speak out' project mentioned earlier is a typical example of such advocacy. Usually, this position was more represented in the NGO sector.

- ✓ 'Now most of our population messages are gender sensitive, this experience is still very modest, but we have taken some initiatives' (Director of client services, NGO, female doctor, married, 48).
- ✓ 'To formulate the RH model in the national population policy in addition to a program of action, the Women in Development WID section, will be changed to gender, and an expert on gender will be recruited internationally' (Senior Programme Officer, UNFPA, female, married, 44).

3. The regional influences on population policy

Most of the regional influences mentioned by the policy makers were political events that had occurred in the region. The Arab-Israeli conflict and the displacement of the Palestinian refugees in 1948 and 1967 were perceived as factors of instability, negatively impacting on the population policy environment.

The Gulf war was perceived as having changed peoples' attitudes. The quality of life was becoming more important than the quantity of people. The Peace Process was perceived as a factor of stability, positively influencing the policy environment. A natural

consequence of this stability in Jordan was an improvement in people's health and other social indicators in comparison with international standards:

- ✓ ' The most important determinant, is the Arab-Israeli conflict that shaped all the social and FP policies in Jordan' (Senior Programme Officer, UNFPA, female, married, 44).
- ✓ 'The population policy was the last priority to think of at that time. There were much more urgent matters like taking care of refugees, how to accommodate them, what additional resources were needed, as they constituted a burden on the government, and an additional burden on UNRWA' (Chief Medical Officer, UNRWA, male doctor, married, 58).
- ✓ 'Now because of the new political developments brought about by the Peace process, the religious and socio-cultural misunderstandings concerning FP policy are gone' (Senior Programme Officer, UNFPA, female, married, 44).

An interesting perspective of the decision-makers dealing with the Palestinian refugees linked population policy formulation with the increasing demand for a quality of life emanating from the people. This new demand was a sign of a change in peoples' awareness, partly caused by advances in technology and the changing political realities. It pushed forward the FP efforts.

At first, there was obvious group sympathy among the Palestinian refugees with the demographic struggle and nationalistic objectives, making it very difficult to advocate any population programmes or policies in the camps, as they would be interpreted as a plot for the elimination of the Palestinian people and cause. But when the political climate between Arab Governments including Jordan with Israel changed, and the Peace

Process was introduced, the Palestinian psyche was influenced by this new political reality.

- ✓ 'With the advancement in technology and satellite communications, computer technology, and the internet people saw the outside world rather than the inside, and people became very much aware of the quality of life. There became some kind of harmony between their national interests and their personal interests' (Chief Medical Officer, UNRWA, male doctor, married, 58).

As seen earlier, conferences especially ICPD, were perceived by many interviewees as regional plateaux for linking international population policy agendas to national agendas, and having an impact on these agendas. A project supported by UNFPA for the establishment of a sub- regional office for the Forum of Africa and Arab Parliamentarians of Population and Development (FAPPD) in Amman, to exchange population and development issues was one policy output of ICPD. Many policy makers perceived this project as a natural consequence of lobbying during the regional conferences.

- ✓ 'Jordan was elected as the host for the General Secretariat of the executive committee of the Forum of Africa and Arab Parliamentarians of Population and Development' (Senior Programme Officer, UNFPA, female, married, 44).
- ✓ 'When the envoys are attending conferences, and they sign the documents at the end of conferences, these policies and recommendations and guidelines are distributed to the Directorates of the MOH and other ministries. They are translated into services in their own sectors, and implemented following their return from the conferences according to the resources available' (Assistant Director, MOH, maternal and child health services, male doctor, 45, married).

The perceptions of this link were determined by the political positions of the interviewees, and depended on the organisations they worked in. A policy maker from USAID described this link as "ad hoc", neither organised nor formal, while two policy makers in the public sector, perceived that there was no link at all between the global and national bodies.

Generally, two perspectives emerged among the interviewees of the relationship between the international funding agencies. While many policy makers perceived a good link between them, and wanted to keep the status quo, a few others in the public sector believed that this link must be co-ordinated through the NPC (National Population Commission).

- ✓ 'There is no link between population policy making at the global levels and national level' (Director of health directorate, MOH, male doctor, married, 48, and Technical Assistant Director, MOH, male doctor, married, 44).
- ✓ 'Yes there is a very good link between the international players. They are USAID, the World Bank, WHO, UNFPA, JICA, EU' (Director co-ordinating unit, MOH, male doctor, 43).
- ✓ 'The link is achieved through the NPC, which is connected to some ministries, and the decisions are distributed and disseminated to the parties concerned according to their areas of specialisation…e.g. following the ICPD conference, the NPC and women's empowerment were promoted...I think that the link exists' (Director of client services, NGO, female doctor, married, 48).

4. The national influences on population policy

A few interviewees mentioned King Hussein's commitment to the issue of population growth control. His explicit political support of the issue was based on the rationale of safeguarding scarce resources.

Following his example, his sister, HRH Princess Basma, and the decision-makers at the national level became aware that the economic situation, aggravated by the Gulf War and its demographic consequences on Jordan pushed forward the need for population policy formulation at the regional and national levels. Jordanian officials became conscious of the magnitude of the problem of population growth, and with time, became increasingly committed to policy formulation and implementation.

- ✓ 'The green light was given by HM the King when he supported FP in one of his speeches in the 90s, and ever since then, policy makers started working on it' (General Secretary, NPC, male, married, 45).
- ✓ 'HRH Princess Basma became the Honorary President of the NPC and is still the president until now, this has contributed to the activation of the NPC and the reformulation of its role' (General Secretary, NPC, male, married, 45).
- ✓ 'The Under Secretary of the MOH, is very sympathetic with and supportive of the cause, as he is very much exposed to international agencies (through their delegates). He is supportive of the Maternal and Child Health / FP model' (Chief of Party, CPP, female doctor, 50).

In addition, there was a consensus among the interviewees that economic pressure drove people to approve a population control policy, because it became increasingly difficult to have and raise children. They elaborated on the burden of the economic

situation, and perceived it as a major positive determinant of population policy formulation in Jordan. A few of them mentioned vital rates (population growth, high birth rate and decrease in death rate) as influencing policy formulation.

Furthermore the policy interventions of the Jordanian Government resulted in an increase in female education and a rise in the age of marriage. Both these factors empowered women by making them more aware of their rights.

- ✓ 'The economic condition of people is a determinant of fertility. People will think every time the baby passes a stool, I have to pay 20 'qirsh' (i.e. the equivalent of 20 pence), for the price of a Pamper diaper' (Director of health, MOH, male doctor, married, 58).
- ✓ ' The most important two factors contributing to the formulation of population policy in Jordan, historically, are, the high birth rate: 4.6… The second factor is the decrease in death rate (mortality rates)' (senior consultant, Policy project, male, married, 50).
- ✓ 'Also female education is a historical determinant of population policy and fertility and the delaying of the age at marriage. Women started understanding what are their duties and what are their rights and of course all this influenced the population policy' (Director client services, NGO, female doctor, married, 48).

The link between the political environment, political events, and population policy formulation was clear to many. Some of them mentioned the Peace treaty with Israel as a factor of stability encouraging population control policies, while a few others perceived the political situation as unstable and uncertain, and expressed a fear for the future of the Middle East, especially after the Gulf War.

Many interviewees described how cultural and religious factors were perceived as sometimes deterring population policy formulation rather than enhancing it. However, other felt that the political changes and the religious authorities' acceptance of FP policies and programmes were enhancing policy formulation.

- ✓ 'We have no obstacles with the religious authorities. In 1992, there was more of a problem. Nowadays, the religious opposition groups are more positive, Even in the meeting of the women preachers, their attitude was very receptive, and way beyond my expectations. I was surprised by the rationality I encountered' (General Secretary, NPC, male married, 45).
- ✓ ' We consider ourselves in UNRWA as service providers of a population who does not have a stable future, at least in the near future' (Chief Medical Officer, UNRWA, male doctor, married, 58).
- ✓ 'And especially after the Gulf War people realised that numbers are not that important, rather it is sophisticated technology which makes people win wars' (Deputy Medical Officer, UNRWA, male doctor, married, 49).

5. Barriers to population policy formulation and implementation

Most policy makers perceived the Palestinian refugees' migration to Jordan, following the establishment of the state of Israel, as the most important barrier to national population policy formulation, owing to the Palestinians' support of a demographic struggle with Israel.

- ✓ 'The compulsory migration, and the demographic struggle, until very recently, contributed greatly to the population growth and increase of Jordan population' (Senior Programme officer, UNFPA, female, married, 44).

- ✓ 'I recall the story of a midwife who had 20 children... Every time that she was asked why she had so many children, she justified it by saying: 'I want to make up for the ones that are gone'...This was also the mentality of people at the grassroots' (Chief Medical Officer, UNRWA, male doctor, married, 58).
- ✓ 'There were great misunderstandings of the demographic struggle, and they applied it here in Jordan, a non- occupied territory' (senior consultant, Policy project, male, married, 50).

Another barrier is the patriarchal social structure. Arab patriarchy is a system emanating from the traditional Arab family structure and '*Ezweh*' is a concept that reinforces familial patriarchy, one that deeply perpetuates gender roles and power. The concept of '*Ezweh*' is based on the belief that children are a source of social security, especially in old age, a source of social prestige, especially in social functions such as marriages and funerals, and also a protection for family members in cases of trouble. The more children especially males one had, the better. Furthermore, in the absence of a social security system, increased child demand, and children were perceived as preventing an insecure old age.

Many policy makers believed that the patriarchal social structure, lack of education, and the earlier high infant and child mortality rates (MOH, technical assistant director, male doctor, married, 44) prevented the internalisation of the rationale underlying the FP concept, thus deterring population policy formulation:

- ✓ 'Our community is Bedouin, and they believe very much in the concept of "Ezweh" which has a direct impact on child demand' (Deputy Medical Officer, UNRWA, male doctor, married, 49).

- ✓ 'Ezweh...that is why the national population policy was pro-natalist, even the policy makers were pro-natalist' (Director of health, MOH, male doctor, married, 58).

Some policy makers deplored the Government and investors' support of population growth. While others described the reservations and lack of consensus in the support of FP among the policy makers. An honest and interesting perspective analysed how FP was against the political aspirations of all the segments of the Jordanian society:

- ✓ 'What made things worse was the government. The government thinks that the more people grow, the more there will be investment. I have met people in Jordan, the "whales of the country" as Dr ... called them, that are betting on future Palestinian migrations to the country from Lebanon and Syria to make business' (Chief Medical Officer, UNRWA, male doctor, married, 58).
- ✓ 'If I were in his majesty's place I would have encouraged Jordanians to have many children... Jordanians of Palestinian origin want to have children because of the demographic struggle... And Jordanians from the East Bank "the Jordanian, Jordanians" want to have more children, in order not to remain a minority in the country... So FP is not consistent with the political aspirations of both elements of the society... (And he laughed). Do not you think so? (Deputy Medical Officer, UNRWA, male doctor, married, 49)

Another important barrier was the problem of sustainability: if FP programs were totally dependent financially on international funds, how could they be sustainable? This lack of financial independence and sustainability, is a definite barrier to population policy formulation and implementation. One analysis further linked sustainability with economic restructuring that impaired economic independence:

- ✓ 'In the future, the economic restructuring will affect FP policies, and sustainability of programmes from an economic point of view, but now people do not feel that. We will face a disaster and a collapse of services if the donations are lifted (Norplant for example will cost 100JDs). If the services will not be provided, any more, by the funders, then a catastrophe will happen'(Assistant director, Maternal and Child Health Directorate, MOH, male doctor, married, 45)
- ✓ 'There is no sustainability of projects and no institutionalisation of projects, therefore the influence is only temporary' (Technical Assistant Director, MOH, male doctor, married, 44).

6. The difficulties in implementation of the national strategy

a) Lack of co-ordination

The National Population Commission enjoys full governmental support, and the programme components of the strategy are disseminated in the media however, its role was not yet fully 'activated' at the national platform, in 1997. Many decision-makers blamed the NPC for not fully assuming its role. They related the lack of implementation of the National Population Strategy to a deficiency in co-ordinating mechanisms.

Other interviewees blamed the funding agencies: practically, how could the National Population Strategy be fully implemented when the funding agencies bypassed the NPC - the co-ordinator of all population and FP activities in Jordan- and communicated directly with the NGOs to implement projects? Funding agencies justified their approach by the fact that they wanted some flexibility in disseminating their agendas without having to go through political debates with the government. In addition programmes were

implemented through the NGOs because it was easier in term of logistics and avoided the bureaucratic hassles of governmental organisations.

Another apparent difficulty was the power struggle between the NPC and the MOH, on who should take the lead. While officials from the MOH accused the NPC of wanting to take control of everything, and deplored the fact that the role of the MOH was overlooked, they themselves were having a political struggle within the ministry, on whether to have a restructuring of FP services or not. Restructuring the services for vertical provision within the MOH was a problem because the MCH Directorate did not want a separate FP directorate. Furthermore, the policy makers at the governorate level were not aware of operational policy changes at the centre, such as the establishment of the project co-ordination unit at the Directorate of Planning.

The policy makers all agreed that there was a lack of communication and co-ordination not only with the NPC, but also among all the population policy players at all the levels in Jordan. In general, there was a lack of division of roles, and power struggles. In addition, co-ordination between the donors and the implementing international agencies was weak. This resulted in both overlap and duplication of programmes and services.

There was a realisation at the national level of the need for a co-ordinating body and the project co-ordinating unit at the MOH was established for that purpose. However, the people in charge of that unit were devoid of authority.

- ✓ 'The organisational structure of the ministry is an active barrier against effective policy implementation. Any changes in the structure, for example having a Family Planning directorate or a Family Health directorate...was very strongly resisted by

the MCH Directors, and the Primary Health care directors, because they did not want to go under anybody... and because of this politically sensitive situation, no changes are occurring so far' (Director of health, MOH, male doctor, married 58).

- ✓ 'NGO's are like 'cantons', especially in their budgeting and funding. Many times, instead of passing through the NPC, the funders and NGO'S co-ordinate together their funding, without informing us, which leads to a lack of co-ordination, a duplication of programmes, and a lack of monitoring and control from the NPC...and this in my opinion is negative and does not serve the country's interests' (General Secretary, NPC, male, married, 45).
- ✓ 'MOH are left out of population policy formulation. I think that the MOH should have more of say in population policy formulation. We should be able to provide whatever we want' (Technical Assistant Director, MOH, male doctor, married, 44).
- ✓ 'IEC materials are being prepared by the CPP project, and the UNFPA, and each body does the training differently, and there is no standardisation of training, or control of what is being done, and at the end we do not know who is doing what. This is wasted effort!' (Assistant director, Maternal and Child Health Directorate, MOH, male doctor, married, 45)

b) Lack of impact and sustainability of international FP programs

The impact of internationally funded FP programs on behaviour change and socio-cultural norms is difficult to assess, despite large budget expenditures. This might be explained by the policy environment, lack of co-ordination between the projects and national authorities, lack of consensus in strategic planning and total dependency on

donor money. The lack of financial sustainability of FP programs was perceived as a major problem by many policymakers who worried about the future.

Besides, how could impact be measured when the information system is incomplete, and no baseline information available? While the budget allocated for programmes seemed insufficient, there was no real idea about the exact budget allocated to family planning services and programmes. This worried many decision-makers because the actual cost for sustainability needed to be measured. In addition, since the research findings were not disseminated, they were not being used in initiating changes. The same could be said of the training programmes.

And how were the international FP projects going to influence people's awareness and behaviour, when their agendas neither reflected, nor respected local needs? The discourse that addressed people was perceived as inappropriate hence ineffective, by the religious authorities.

- ✓ 'This is the work which is 'pasted'...and as long as you work on projects which are 'pasted' to you, they will not reflect your needs and your priorities because who knows better about your needs and priorities except yourself...' (Technical Assistant Director, MOH, male doctor, married, 44).
- ✓ 'Another barrier is the way they address the people, the discourse. You address the collective, an *'Umma'* (Nation), and not individuals. If you are to affect change you must address the religious collective of the *'Umma'* (Higher Judge of the Islamic Court)

7. Policy makers' views on FP utilisation

The attitude and behaviour of the people towards fertility and child demand were major barriers to FP programme implementation and service utilisation. Some policy makers deplored what was seen as conservative community attitudes towards FP. The tribal system and the religious authorities were perceived by one third of the interviewees as shaping peoples' behaviours, and acting against effective policy formulation and implementation. One important socio-cultural norm that affected access to FP services, was the demand and preference for sons.

In this society where women were not working because they perceived their role to be housewives, one means for them to acquire status at the household and extended family levels was through their progeny, especially males. If they were fertile they perceived themselves as securing themselves through their human assets, their children, and they felt feminine because they could still menstruate and produce.

Generally, this was a community perceived by the interviewees as having a low level of awareness. According to some of the policy makers, the community members expected the government to solve all their financial problems and were very passive in taking control of their fertility and reproduction.

Others relate the contraceptive discontinuation rates to the influence of the private practitioners who discouraged women from utilising contraceptives because it was more financially profitable for them to attend deliveries, so they encouraged women to be fertile and promoted the 'status quo'.

- ✓ 'People say 'look! This woman got more children, and nothing happened, so what are you telling us?' People still do not realise the dangers of high fertility' (Director of family health, UNRWA, male doctor, married, 45).
- ✓ 'She thinks of where she will be living in her old age, male children are foreseen as some kind of social security, and she thinks: If I have four or five males, for sure one of them will take care of me' (Technical Assistant Director, MOH, male doctor, married, 44).
- ✓ 'In their perceptions, having children and periods is a sign of femininity, of fertility, and if they do not have their period, they consider this as abnormal' (Director of Health, MOH, male doctor, married, 58).

Conclusion

This chapter has reviewed the population policy in Jordan, the National Population Strategy and the implementation of programmes. The current players and their respective agenda were described. The influences on national population policy as perceived by the policy makers were briefly analysed, by looking at the global, regional and national determinants. Among the challenges facing strategy implementation are the lack of co-ordination between organisations and programmes and the lack of sustainability because of the dependence on funding agencies.

The most important priority identified to improve the policy environment was to have a national body to co-ordinate, formulate and implement population policy. This strategy required the support of all the government sectors, despite the reservations of some of the funding agencies. Their caution was built on the dichotomy in political interests between their own and national population agendas. The Jordanian policy makers voiced their

need for active participation in policy formulation, and wanted more autonomy from international projects.

Strengthening the mechanisms of co-ordination among the policy players, by standardising the communication channels and procedures was one solution suggested by many. Another strategy identified was to build institutional capacity by incorporating the population dimension in national level development plans.

The following chapters will see how relevant the concerns of policy makers are, by looking in-depth at service provision and utilisation at the Governorate level, and by presenting the situation at the community and household levels.

Service Findings: Chapters 5 –8

Introduction

The following four chapters will review the models of FP provision and service utilisation in three clinics of the city of Zarqa, and a mobile clinic that covers the rural and remote regions of the Governorate of Zarqa.

Chapter 5 explores an MCH clinic and training centre of the MOH where FP services are integrated with MCH services. Chapter 6 examines a vertical FP provision in a community centre of the military services (Soldiers Families' Welfare Clinic), in addition to a pioneer program of community-based distribution of contraceptives that was started from this clinic. In chapter 7, FP provision following the RH model at UNRWA is reviewed. This model was adopted by the WHO after the ICPD conference and is now followed by UNRWA. Chapter 8 explores the two ends of the spectrum of provision: On the one hand, the remote areas through the mobile clinic of JAFPP and on the other hand provision for the wealthy in the private sector. Although JAFPP fixed clinics have been pioneers in providing FP services in Jordan and remain major providers, the mobile clinic was selected in this thesis instead of a fixed clinic because the mobile clinic FP provision is exclusive to JAFPP.

The findings for each clinic are presented in the same sequence in chapters 5-8 as follows:

I. Policy makers' views of FP provision (in-depth interviews).

II. Service observations (MAQ checklist criteria)

1.General Background

2. Client volume and range of services provided

3. Counselling

4. Choice of methods, continuity in provision and support system

5. Personnel

6. Organisational routines, record keeping and treatment protocols

7. Facilities, equipment and storage

8. Training equipment

9. Infection prevention practices

III. Service statistics

1. Service utilisation among new, old and total FP clients

2. New clients' utilisation of FP methods

3. Old clients' utilisation of FP methods

4. Utilisation of oral contraceptives

5. IUD utilisation

IV. National studies on contraceptive utilisation

V. Providers' views of utilisation of FP services and methods (FG discussions)

VI. Providers' views of service barriers to FP utilisation, service needs and strategies to enhance utilisation (FG discussions).

The final section of chapter 8 summarises the differences and similarities in these different models of FP provision.

Sites of data collection (clinics)

In 1994, the population of Zarqa Governorate was 639 469 representing 15.4% of the Jordanian population of 4.139 million (Population and Housing Census, 1994, Table 3.1). Women constituted 47.9% of the Governorate population (Population and Housing Census, 1994, Table 3.1). Although marriage was still an important value in the Jordanian society to date, one third of the women in Zarqa (33.4%) were single. This percentage was very close to the national figure of single women (33.9%)(Population and Housing Census 1994, Table 3.12). This was not caused by a change in people's mentality with respect to marriage, but most probably by the growing costs of getting married (ceremony, dowry etc...). These costs had discouraged young men from approaching marriage because of its expense. In addition, many families would not marry their daughters to a man who could not afford the marriage procedures, because they wanted to secure a good provider for their daughters.

The urbanisation trend in Jordan since the 50's has affected the Governorate of Zarqa where most of its population is now urban (97.3%). Consequently, most FP services are provided in Zarqa City, while being scarce in the remote town of Azraq (9193 residents) (Population and Housing Census 1994, Table 3.1). Illiteracy rates are higher among the rural women than among the urban women of this Governorate (38.4% and 17.2% respectively). This illiteracy rate is the same as the illiteracy rate of urban women in Jordan (17.2%). Illiteracy rate of rural women of this Governorate however is slightly higher than the national rate (38.4% and 33.5% respectively) (Population and Housing Census, 1994, Table3.10).

Figure 3.1 Map of the Zarqa Governorate, and location of the clinics (scale 1:75,000)

Points 1 and 1.a. (pink colour) represent the sites of the MCH training centre and Prince Mohammed clinic of the MOH. Both clinics are adjacent to the neighbourhood of Ghweirieh and are accessible by walking or by car to the residents of this neighbourhood.

Points 2 and 2.a. (yellow) represent the Hashemieh settled Bedouin, and the Azraq rural communities. The JAFPP mobile clinic provides FP services to both communities in agreement with the MOH.

Point 3 (blue) is the Soldiers' Families Welfare Clinic (SFWC) in Ghweirieh.

Points 4 and 4.a (purple) are the Zarqa MCH and Msheirfeh MCH clinics of UNRWA, located in Zarqa and Msheirfeh refugee camps.

The FP services of the MCH training centre, JAFPP fixed clinic, Prince Mohammed clinic and the Soldier's Families' Welfare Clinic are open to all Jordanian women or residents of Jordan. UNRWA services however are restricted to the refugee camp residents (Palestinian refugees). If the women in the refugee camps chose to use any of the above-mentioned services other than UNRWA, they had to use a car.

Appendix 5.1 presents the data collection methods used in each clinic.

Chapter 5

The Ministry of Health (MCH training centre)

I. Policy makers' views on provision of FP services at the MOH (interviews)

FP provision at the MOH is integrated with MCH services - an integral part of Primary Health Care since 1985 - following the recommendation of the WHO Safe Motherhood Initiative. These services are provided free of charge (Assistant Director MCH services, MOH). However, the Reproductive Health model followed by the WHO after the International Conference on Population and Development (ICPD) in 1994, is not yet implemented at the MOH, because of a political struggle between the directors of the MCH and the supporters of an independent RH Directorate that would include FP.

- 'Any changes in the structure for example having a FP directorate or a Family Health directorate and incorporate MCH services within it is strongly resisted by the MCH directors and PHC directors; because of this politically sensitive situation no changes are occurring so far' (Director MOH).

Despite this ongoing debate, a senior policy maker was concerned with quality of care and standards of practice in FP provision.

- 'We must have quality indicators for services and the first dimension of quality is access...Setting standards for service providers' practice is considered a milestone which does not require a lot of resources' (Senior planner MOH).

II. Service observations

Service observations were done for three consecutive days from November 15th to 18th, 1997, from 8am -2pm (clinic hours). Service observations are presented according to

the Maximising Access and Quality (MAQ checklist) [1] categories. This checklist was designed to help in operationalising the Maximising Access and Quality Initiative.

The MAQ initiative established in 1994 by the United States Agency for International Development (USAID), collaborating agencies such as Pathfinder International, and country partners aimed at maximising access to, and the quality of family planning and other reproductive health services in many developing countries of the world (Stinson et.al. 2000). The universal principles promoted by the MAQ initiative are client orientation, a support for quality and access from the top, building quality and access from the bottom, and building approaches to evaluate and improve services[2]. A management and supervision subcommittee for the MAQ initiative was formed at the international level to include quality specialists from most USAID reproductive health and child survival co-operating agencies to monitor and document findings of the MAQ initiative. Several meetings were held over a two-year period (1997-1999). The overall rationale is that there is a large unmet demand for voluntary contraceptive services.

The MAQ checklist is intended for USAID joint programming teams and others to assess, program or evaluate access and quality of care in family planning and related reproductive health services. The MAQ checklist categories largely inspire from Judith Bruce's (1990) framework for the assessment of quality of family planning programs. The six elements of quality identified by Bruce (1990) are choice of methods,

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[1] MAQ (Maximising Access and Quality Check list for family planning service delivery, with selected linkages to reproductive health intended for USAID programming teams, Shelton and Davis, 1996).

[2] (MAQ checklist version 1.0, July 22, 1996: p 3)

information given to clients, technical competence, interpersonal relations, mechanisms to encourage continuity and an appropriate constellation of services. Bruce's (1990) elements inspire some of the MAQ check list categories: client- provider interaction, privacy and confidentiality, technical competence, methods and commodities, support of services, policies protocols and guidelines as mechanisms to encourage continuity and constellation of services. The MAQ checklist however goes further than Bruce's (1990) framework in the assessment of infrastructure, physical facilities and equipment, infection prevention, potential barriers to quality services, Information Education and Communication provider material quality, gender roles and differences and supervision and management activities.

Pathfinder International introduced the MAQ checklist (version 1.0, of July 22, 1996) in Jordan in 1997 as one part of a training program entitled 'Managing for Quality' that addressed policy makers, program managers and service providers. The participants were mostly from MOH and Royal Medical Services including the Soldiers' Families Welfare Clinic (SFWC) who were involved with the implementation of the comprehensive postpartum project (CPP). Quality improvement experts from Pathfinder International trained participants on the rationale for, and the uses of the MAQ checklist. This USAID funded training – a component of the CPP project - aimed at identifying and implementing practical, cost-effective, focused and actionable interventions to improve the access to and quality of family planning and selected reproductive health services.

I found it timely therefore to use the MAQ check list categories for service observations because the checklist had just been introduced to the policy makers and service providers of Jordan and was going to be used in the clinics included in this study

as well. Instead of struggling to obtain political support for another tool of assessment of service provision using observation, the MAQ checklist I hoped had a threshold political support initiated by the training and overall implementation of the CPP project (policy makers and program managers). The fact that the service providers were also familiar with the MAQ checklist categories might also allow some validation of my findings based on observation with the service providers. Comparisons of findings derived from using the MAQ checklist in this study could not be made with other services not included in this study because the checklist was not yet used in all the services. Once the CPP program for quality monitoring was fully operational however, comparisons across the services at the national level might become possible. In addition, the MAQ initiative was implemented in many countries of the developing world including Egypt, Nigeria and Turkey, with similar socio-political, economic and cultural contexts to Jordan. By piloting the MAQ checklist in these countries, Pathfinder International had somewhat established its validity and reliability as part of the MAQ initiative (Huntington, D., Miller, K. and Mensh, B., 1996).

1. General background information

The MCH training centre is a major provider of FP services in Zarqa City since 1988. All the staffs of this centre are females since its establishment.

2. Client volume and range of services provided

The services provided at this centre include Obstetrics and Gynaecology, FP, and Paediatric specialities. The contraceptives available are IUDs, pills (regular dose and mini dose for lactating women) and condoms. In addition, counselling is provided for women who want to use the Lactation Amenhorrhea Method (LAM).

Based on preliminary observations, this clinic seems to be the busiest of the four clinics: fifty-one women attended the clinic (antenatal and FP) on the first day, thirty and seventeen on the second and third days respectively.

The factors probably explaining this high utilisation might be its 'open- door' policy, gender of its providers, free of charge services and accessible site, and the fact that it has been catering for the community for the last decade. In addition, the availability of an ultrasound machine seemed to encourage utilisation as this technology was often used by women to determine the gender of the child. This is an example of the cultural interpretation of medical technology that was also prevalent in other countries of the Middle East. The service observations and providers' perspectives confirmed the high utilisation of this centre.

✓ 'Frankly, there is an excellent utilisation of FP services. Last year, the number of FP clients in this clinic was 1017; this year and the year is not over yet (August) the number is 1080 to date and of course each year we start with the number one' (female nurse, 24, married, pregnant).

3. Counselling

Generally, it was observed that there was no privacy during this activity. More than one person provided counselling to the clients at the same time (social worker and midwife), and no special room was provided for counselling because of the lack of resources. At one time during service observations, there were 13 staff, students and clients in the examination room while the midwife was counselling one client!

During the Focus Group discussions, the service providers validated these observations. Clients' questions were answered, however time was a constraint and the

clinic load was very high because antenatal, postpartum, paediatric and FP services were provided in the same clinic.

- ✓ '...And let us not forget that there is no privacy ...and there is no time even to explain about the pill without embarrassment for both parties, and there is no adequate environment' (female nurse, 35, married, 4 children).
- ✓ 'What is the use of us taking FP training sessions, if we cannot find the cadre, and the time to provide counselling ...(registered nurse, 33, married, 3 children MOH). Five other nurses and a social worker agreed.
- ✓ 'The shortage of personnel, and audio-visual materials such as videos or posters...and also the time is not enough, and we are overloaded with patients. Sometimes we may see 165 patients between 9AM- 1.30PM'(female doctor, 40, married 2 children).

Table 5.1 summarises counselling at this MOH clinic using the MAQ checklist.

Table 5.1 Assessment of counselling practices at the MOH MCH training centre (MAQ checklist).

Adequate	**Inadequate**
Technical competence of staff	
FP training (2 weeks minimum)	Correct new information on methods
	Clinical staff (10 IUD insertion during training)
	Technical staff (FP refresher course in last 3 years)
Staff client interaction (Minimum 10 minutes with new clients)	Provider has IEC materials available for use (3 materials available adequate)
Clients treated with respect and courtesy	Outreach worker (1 talk per day to groups)
Communication barriers	Out reach worker (two talks/week)
Eye contact	
More than 1 hour to receive all the FP service	Provider knock on door before entering
Reassuring simple answers	All client questions welcomed
	All questions and concerns answered
Correct contraception for breast feeding clients	Probing questions
Total adequate: 8 out of 18	**10**

Table 5.1 shows that only 8 out of 18 criteria of quality counselling were met in this centre. The weaknesses were related to staff training, IEC materials and outreach activities. Staff client interaction criteria such as knocking on the door, or welcoming

client questions and concerns were other weaknesses observed. One provider employed for a long time at the centre mentioned that the attitude of the service providers towards the clients sometimes deterred service utilisation. She faced strong opposition from her colleagues, who disagreed with her and said that this might be the case in other clinics:

- ✓ 'The nurses are sometimes the cause, because their style is not good with the patients, they are either hard or dry with the patients' (nurse, 45, married, 5 children).

  (All participants react: "This is not applicable to us!")

4. Choice of methods, continuity, and support system

The contraceptives available at this clinic were injections, pills, condoms, and IUDs. Although home visiting was included in the services provided by this centre, they did not prioritise FP dropouts, and the outreach activities mostly stressed MCH services for antenatal and postpartum mothers. This might be attributed to the fact that FP services were integrated under the MCH directorate at the MOH. The providers believed that FP services were not given enough attention, with a shift towards MCH services.

- ✓ 'There is co-ordination at the level of the directors of the health centres if there are new developments but the most important points of the discussion are concerning maternity care because they prioritise MCH services... FP comes under it...but the discussion is not focused on FP' (2 female doctors, married, 40 years and 3 children, and 42 years and 4 children).

5. Personnel

Two full time female general practitioners (GPs) provided antenatal and FP services at this clinic, while a part-time female GP provided services two days of the week. All the

physicians were trained in FP procedures however only a few nurses had training in FP. This was perceived as a drawback:

- ✓ 'We would like to know, and learn, especially because after 8 years many new things have emerged, and many things have changed since that time… So there is a lack of training sessions, and experience among the providers of FP, and they do not provide training sessions although we want that' (nurse, 45, married, 5 children).
- ✓ 'Ok, when I do not know, how am I going to convince the woman, or talk to the woman about FP' (nurse, 27, married, 3 children).

The centre staff consisted of two midwives holding a diploma in midwifery (two years post- secondary certificate), a registered nurse with a Bachelors of Science in Nursing, two practical nurses and a social worker with a university degree in sociology. The providers believed that since the staffs of this centre were all females, this had encouraged utilisation because women felt more comfortable. Sometimes staff turnover was a drawback, however the staff of this clinic was relatively stable:

- ✓ 'The other centre is far, and they also say, "we are psychologically comfortable here"...Because we are female doctors, and we try to receive them well in order to encourage service utilisation, as the whole team of service providers in this clinic are females' (female doctor, 40, married, 3 children).
- ✓ 'No, we are continuously being changed… Some of us have been here long, and some of us come and go…Two of us have been here for seven years, some have been here for three months, and some are in between' (director, 42, married, 4 children).

6. Organisational routines, record keeping, and treatment protocols

FP services and contraceptive methods were provided free of charge in this facility. The midwife replenished contraceptive stocks of OCs and condoms for old FP users for a month. However, the clients wanting to use OCs for the first time were referred to the physician, and were required to do initial laboratory investigations for blood sugar, haemoglobin and protein testing. The old clients utilising OCs for more than a year were required to do these same laboratory investigations, each year.

The majority of clients waited for less than an hour to receive FP services, however a few cases were seen waiting for an hour or more. This delay was partly due to the uneven distribution of the workload among the clinic staff. The senior midwife did almost everything, without delegating tasks, a situation that resulted in a longer waiting time for clients. If there had been more than one person receiving patients and examining their vital signs, and if the clerk were performing the clerical duties she was supposed to, the waiting period would have been shortened. The same physician provided services to antenatal and FP clients, which delayed the clients further. The midwives did patient admissions, registrations, retrieving of files, history, examination, and measurement of vital signs.

There were no computers at this clinic, and all the information was documented by hand on the clinic register and patient files, which was time consuming. Based on the clinic register, a monthly statistical report of all antenatal and FP services, and providers' load was prepared by the senior midwife and submitted to the Health Directorate.

Treatment protocols for complications occurring in the facility were not established at this clinic, and the patients were referred to the Zarqa General Hospital, which was

located at the end of the street (a public sector hospital with emergency services). The assessment of the organisational routines at this centre is presented in Table 5.2

Table 5. 2 Assessment of organisational routines at the MOH-MCH training centre (MAQ check- list criteria)

Adequate routines	**Inadequate routines**
Waiting time for most clients	Waiting time for a minority of clients
Utilisation of FP service	Guidelines and protocols used in case and staff mgt.
Supervisory visits at least quarterly	Guidelines used for in-service training of staff
Full technical staff	Supervisory comments of site visit kept in register at clinic
Not more than 3 administrative steps for client to see Dr.	Supervisory tools used
	Written work plans for supervising staff
	Technical guidelines for standardisation of procedures
	MIS records and forms, definition of users
	Clients' records complete (>5%incomplete not adequate)
	Monitoring (2 mgt. Meetings per year)
	Quarterly feedback from Mgt. To field on performance
Adequate routines	**Inadequate routines**
	Monthly staff meetings
	Polyclinic director visits the clinic weekly
Total adequate:5 out of 17	Total inadequate: **12 out of 17**

This clinic met only 5 out of 17 criteria for adequate organisational routines. This low score (detailed in Table 5.2) might be one indicator of the quality of care provided, and a useful guideline for the areas to be addressed in future reform.

7. Facilities, Equipment and Storage of Commodities

The building of this MOH clinic was old, but generally kept clean. The MOH was leasing two apartments on the first floor of a building for this centre, however, since it was not purpose- built, there were no proper storage facilities. The corridor cupboards were used to store old records, and were not kept tidy or clean.

An ultrasound machine was available, along with the basic commodities needed for Obstetric, Gynaecology and Paediatric examinations. Considering the workload, the supply of IUD insertion sets seemed insufficient, and women were sometimes asked to

return on the following day, because of the shortage in these instruments. In addition, this facility did not have sterilisation equipment: instruments were only cleaned at this facility, but sterilised at the Zarqa hospital.

During the FG discussions, the providers expressed their belief that providing IUD services in all the MOH clinics, would enhance utilisation since IUDs were the preferred contraceptive method among providers and clients:

- ✓ 'Not having IUDs in each health centre is a barrier...The IUD is available in 16 centres out of the 26 centres' (male provider, 40, married, 2 children).[3]

8. Training equipment

This centre did not train physicians, but was a training centre for midwifery and nursing students. It was not provided with equipment or reference materials, and few charts or models were available for training purposes. Despite the presence of a clinical instructor, the senior midwife was mostly training the students, and demonstrating the bedside antenatal routines and procedures to them.

9. Infection prevention practices

Both staff and clients' bathrooms were clean, and the examination tables had clean sheets and were wiped after procedures (IUD insertion and other). Sets were cleaned and sterilised, and the medical staff used hand-washing techniques after examining the patients. Needles were disposed of properly. If the examination room of the midwives and nurses had a sink, this would have encouraged them to wash their hands between patients. Written infection control procedures, protocols or guidelines were not available.

[3] The male provider is in the focus group discussion of the Prince Mohammed clinic of the MOH, while the MCH training centre of the MOH is an all- female clinic.

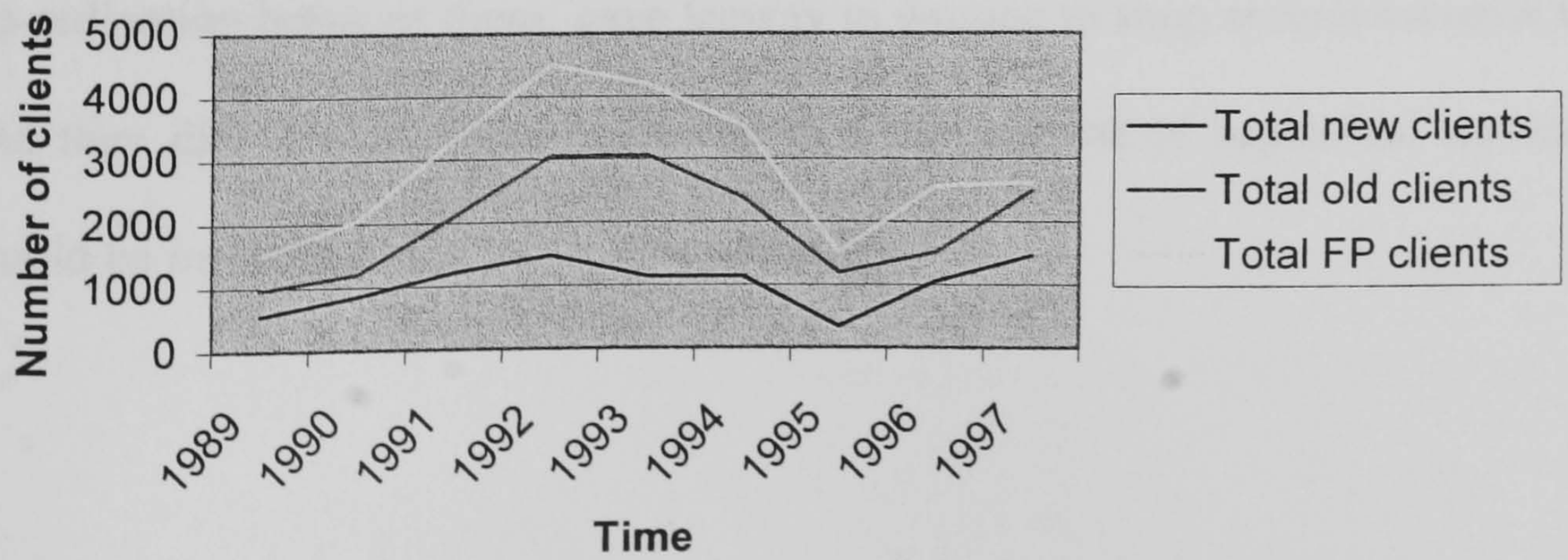
III. Service statistics

1. Service utilisation among the new, old and total FP clients- MOH, MCH training centre

'New user' is defined by the MOH as any client that utilises the FP service at this clinic for the first time in a given year, irrespective of whether this client was utilising other FP services in other clinics or whether they were using other methods in this same clinic. 'Old user' is defined by the MOH as a client who returns to receive the same method at the clinic in a given year. 'Old users' are not carried cumulatively (serial numbers) from one year to the next and are re-labeled 'new users' at the beginning of each year. If a client changes the contraceptive method she is using in a given year, then she is re-labeled 'new user' as well of the new method she is using. Serial numbers start with the number at the beginning of the year for 'new' and 'old users' of this clinic, as explained by the clinic providers.

There is an increase in total 'new users' and total 'old users' at this centre during the same time intervals (1991- mid 1992), as well as a simultaneous decrease in both total 'new users' and total 'old users' (mid 1994-mid 1995) (Figure 5.1). It is interesting to note however that there is a marked increase in the total 'old clients' in comparison to the

Figure 5.1 New, old and total FP clients, MOH, MCH training centre



increase in total 'new clients' (1991- 1994). This might mean an increase in clients using the same methods or 'old' clients during those consecutive yearly intervals (1991-1994). The possibility of the increase being explained by a cumulative effect of carrying 'old' clients from one year to the other or from one method to the other are ruled out since a change in method utilisation changes the label of the client from 'old' to 'new' user. There is a substantial drop off in FP services utilisation after 1993, most probably explained by the growing supply of new clinics in the neighbourhood and the city of Zarqa at large. In addition, the establishment of the Family Health program of UNRWA since 1993 FP services included, might be another factor explaining this drop. The unavailability of IUDs for a year at this clinic (mid 1994 to mid 1995) is another contributing factor to this drop in utilisation. As shown further in this section (Figures 5.2, 5.3, 5.4 and 5.5), IUDs are the most widely used method among the old and new clients of this clinic.

All the MOH providers participating in the study believed that FP services utilisation was excellent at this centre:

- ' It is higher than the expected level and frankly, there is a very excellent utilisation of FP services' (nurse female, 26, married pregnant). Five other nurses and one doctor agreed.

However they realised that the availability of more than one service, and the lack of co-ordination between them, gave leeway to women to shop around between the services, and they did. The providers believed that this pattern of haphazard service utilisation would be improved with better co-ordination:

- ✓ 'There is no co-ordination between the administrations...The woman goes from one service to the other in circles...It depends on the load of work that we have, if we are loaded, we do not treat her, but if we are not overloaded, then we treat her' (female doctor, 40, married, 3 children).
- ✓ 'There are two other nearby centres providing more FP services than here. We do not have IUDs, and women prefer IUDs to the pill because of forgetfulness, weight gain, or nervousness' (midwife, 31, married, 2 children, Prince Mohammed MOH clinic).

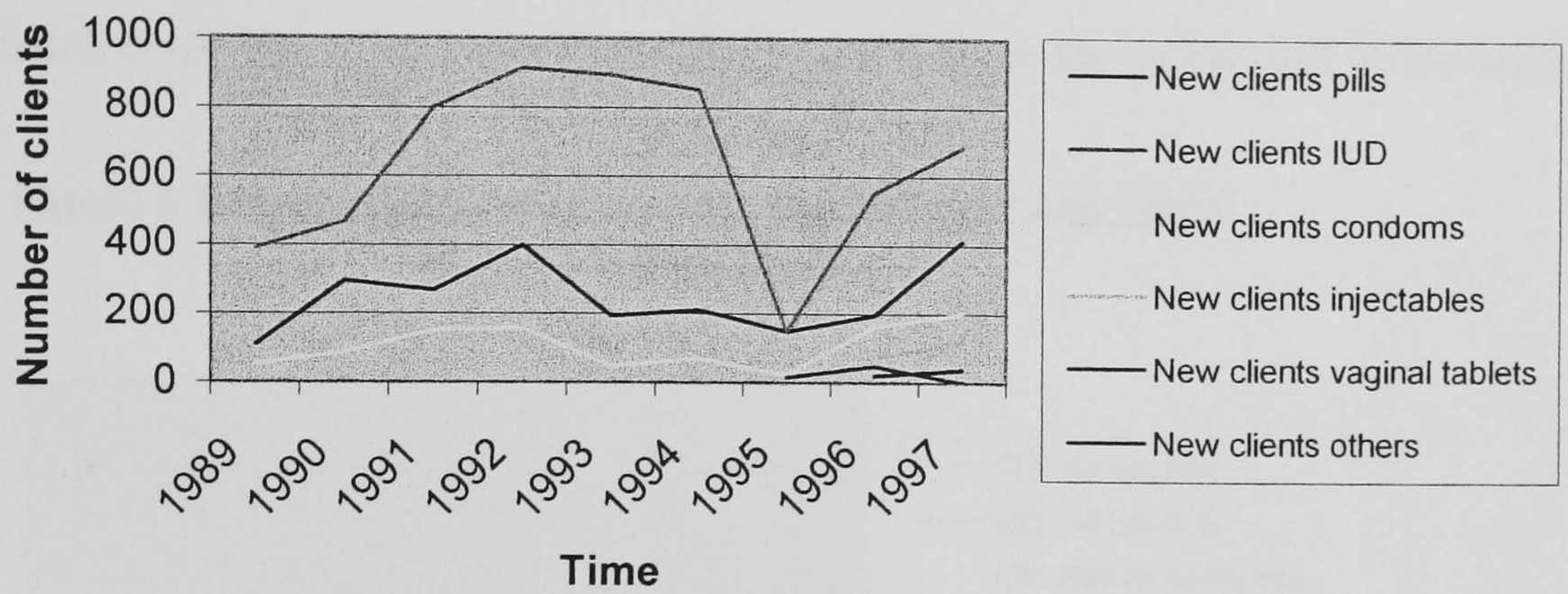
It was quite apparent during the discussions however that the providers disagreed in their valuation of the role of co-ordination and its enhancement of service utilisation. In the first clinic, the providers agreed in consensus that the lack of co-ordination among the services was deterring service utilisation. In the second clinic however, some of the providers did not even see the need for this co-ordination, and they expressed this position openly during the group discussion.

2. New clients' utilisation of FP methods at the MOH- MCH training centre

'New users' are by definition clients that use the centre for the first time in a year or a given method for the first time in a year at this centre. Figure (5.2) shows that IUD is the most widely used contraceptive method among the new clients at this centre and the pills are the second most widely used method among new clients. They are consistently the two most popular methods (1989 – 1997) among new clients. The preference to use the IUD especially when the provider was a female was confirmed by the providers and the women themselves. A sharp drop in IUD utilisation in 1994 was due to their unavailability from mid 1994 to mid 1995. The relatively large sample size means that it is unlikely that this drop occurred by chance due to statistical fluctuations. Even when

IUD utilisation was at its lowest (mid 1995), it is still the most popular method among the new FP clients of this clinic (Figure 5.2).

Figure 5.2 Method utilisation among the new FP clients of the MOH MCH Training centre



'Original' clinic data was used: the clinic register, updated by the senior midwife was retrieved from a cupboard in the clinic where old stationary was stored. It showed that IUDs were not available (mid 1994-mid 1995). In addition, the senior midwife in charge of FP provision and documentation in the register confirmed this information because she was working at this clinic at that time.

Condoms were not popular consistently over the years among the new FP clients of this clinic. Injectables and vaginal tablets were newly introduced methods, (1994 and onwards), and were also among the least popular methods. Service providers and men and women in the community confirmed these preferences in method utilisation.

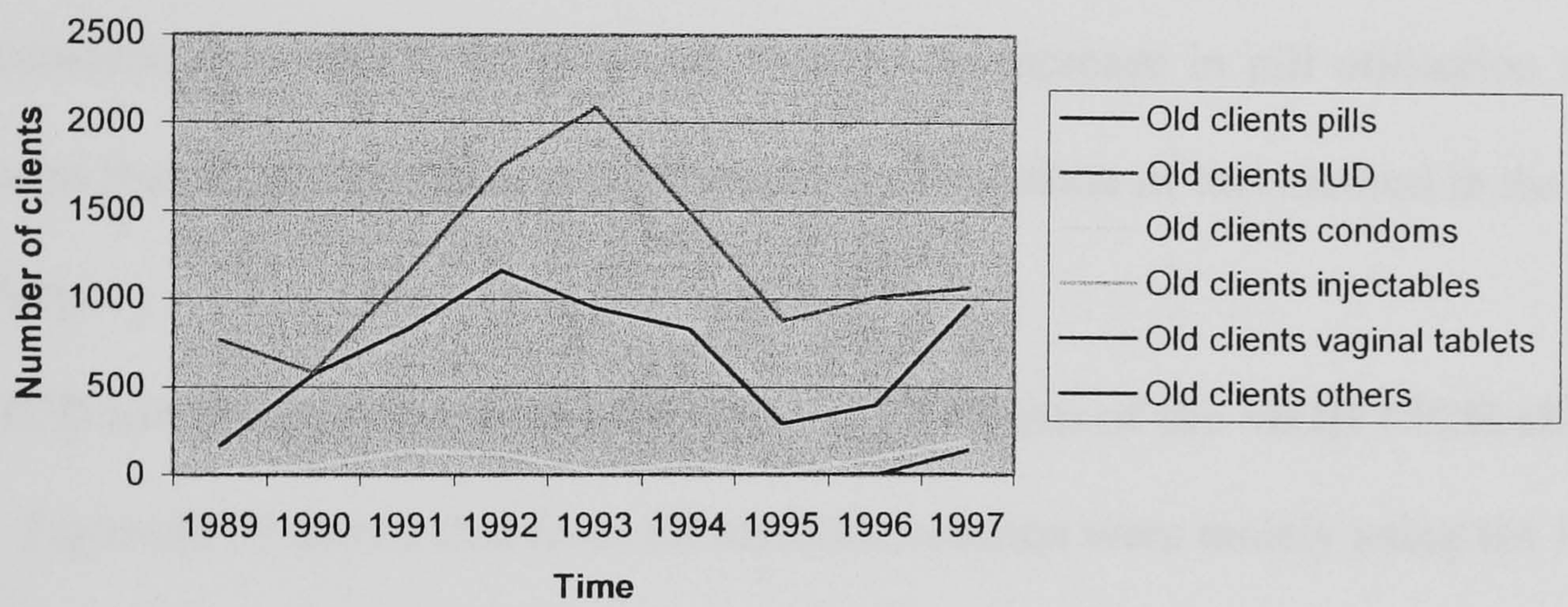
The above - mentioned findings agree with the latest Demographic and Health Survey (DHS, 1997) and the Jordan Living Conditions Survey (JLCS 1998) findings where the most widely used modern method in both surveys was the IUD (Table 4.4. and Figure 2.25 respectively). Condoms were not a popular method among the new clients of this clinic in harmony with the findings of surveys at the national level. According to the

DHS (1997) and JLCS (1998) findings, not more than (2.5%) of all the FP users in Jordan were using the condom.

3. Old FP clients' utilisation of contraceptives at the MOH-MCH clinic

The 'old users' utilisation of contraceptives at this clinic was the same as the new users' utilisation for the same time interval (Figure 5.3) in the sense that IUDs were the

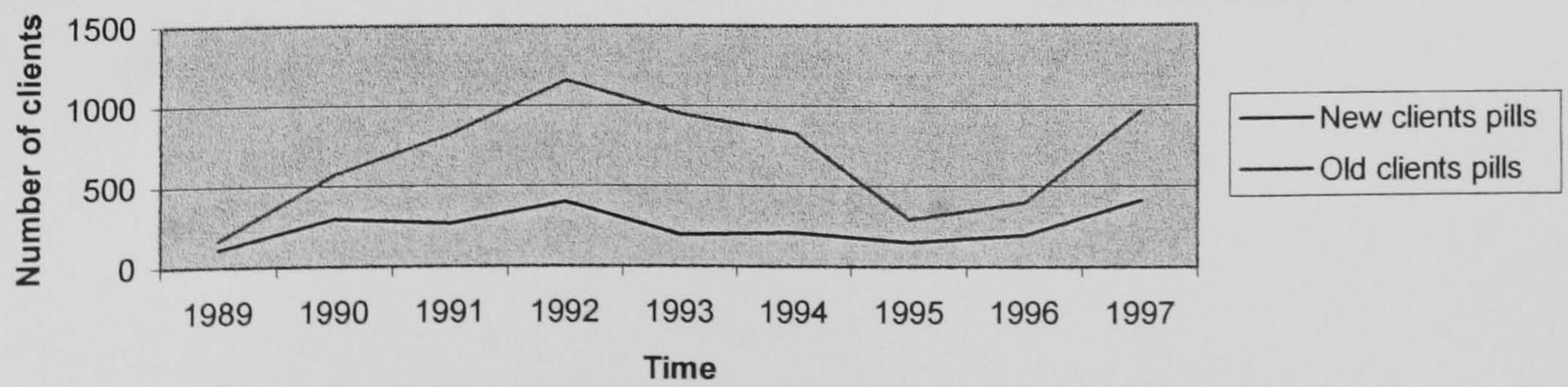
Figure 5.3 Method utilisation among the old FP clients - MCH training centre, MOH



most widely used method followed by the pills, while condoms were not popular. A major drop is seen in the absolute number of old clients utilising IUDs after mid 1993 and pills after mid 1992 (Figure 5.3). This might be explained by the burgeoning of other clinics offering similar services in the neighbourhood, the initiation of the FP program at UNRWA in 1993 under the family health division.

4. Utilisation of OCs among the new and old FP clients of the MOH, MCH clinic

Figure 5.4 Pill utilisation among new and old FP clients- MOH, MCH training centre

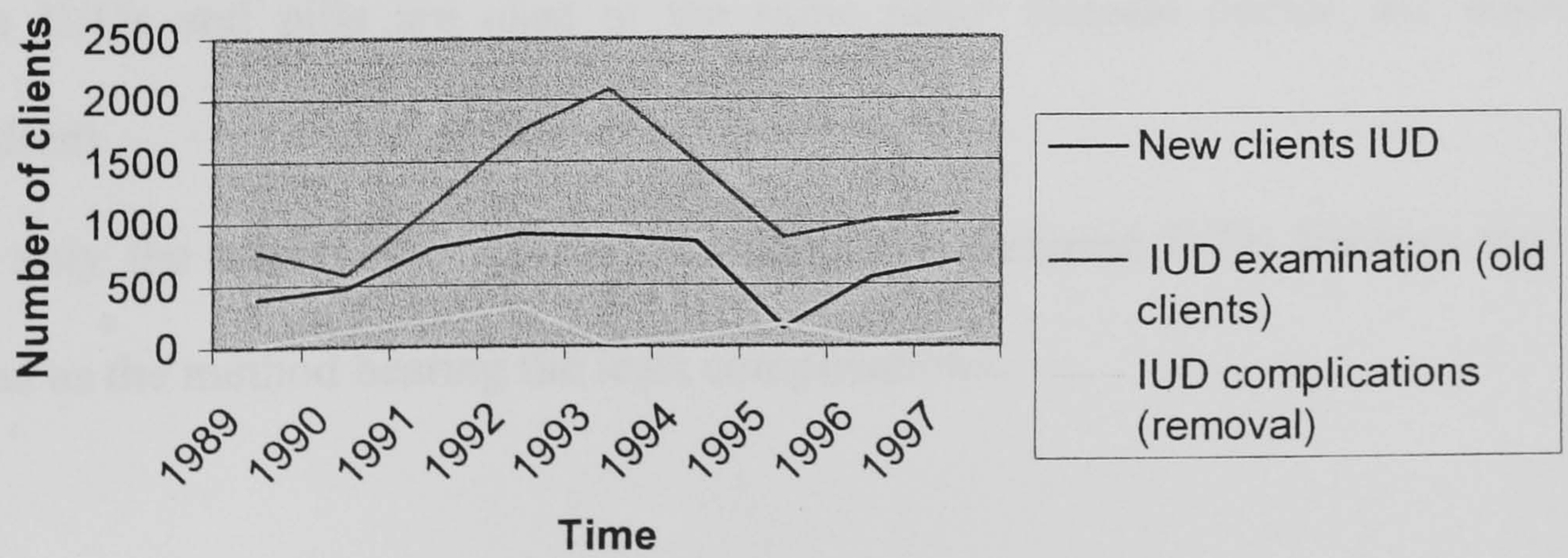


There is an increase in the number of old users using the pill (mid 1989 to mid 1992) followed by a drop in 'old users' of the pill (mid 1992- first trimester, 1995), followed by another increase in pill utilisation effective mid 1995. Throughout this period (1989-1997), 'old users' use the pill more than 'new users'. This may be related to the providers' efforts in counseling and marketing this method and the need for re-supply. Figure (5.4) shows a drop in pill users -old and new clients between mid 1992 – mid 1995 most probably because of the opening of other clinics that were supplying oral contraceptives. After 1995 however, there is an increase in pill utilisation among both groups that might represent an increase in the utilisation of this method in the community at large.

5. IUD utilisation among the new and old FP clients of the MOH MCH clinic

Figure (5.5) shows that from all methods, women were mostly using the IUDs at this clinic (1990-1997). Despite the fact that all the providers were female at this clinic, women that came for IUD examination (old clients) outnumbered those that came for IUD insertion (new clients), and women coming for IUD removal are consistently lower

Figure 5.5 IUD utilisation among the new and old FP clients of the MCH training centre, MOH



than both other groups (1989-1997). This might mean that IUD is continued longer.

The increase in IUD examination from (mid 1990 - mid 1993) and IUD insertion between (1990 - 1992) is in harmony with national trends (Isaac and Maaytah cited in Musallam 1998). While the decrease in IUD examination after mid 1993 at this clinic is most probably due to the opening of other clinics providing this service in Zarqa City effective 1993.

The MOH defines IUD discontinuation as the voluntary removal of an IUD. The increase in IUD discontinuation (mid 1989 - mid 1992) which is the peak of IUD discontinuation might be related to the fact that the clinic was still new and counseling and health education efforts were still being developed. On the whole, IUD discontinuation is lower in 1997 than (1990 - mid 1992). This might mean either a change in the clients' behaviour in continuing IUD utilisation longer (providers' efforts), or might mean that the clients' were utilising other services for IUD removal.

In agreement with the statistical findings, the service providers confirmed that the IUDs and the pills were the two most widely used methods of contraception:

' The IUD is more used...or I do not know...pills more' (female doctor, 42, married, 4 children).

✓ 'The IUDs and pills are used at the same rates' (female doctor, 40, married, 3 children).

Not only the clients, the service providers also preferred IUDs because they were perceived as the method bearing the least complications:

- ✓ 'The service providers like to insert IUDs because it does not result in as many complications as other methods, like the pill or Norplant' (female doctor, 40, married, 3 children).

Male methods (condoms) and injectables were the least popular methods (figures 5.1 and 5.2). The service providers agreed in consensus that their clients' husbands disliked condoms, and some of them explained how coitus interruptus was thought to cause dryness,

- ✓ 'The condom is not accepted by the husband, because it is psychologically and financially uncomfortable...do not forget the attitude of the man in control... He won't try it, and let us not forget that the condom could get torn. Few people use it, and some women are afraid of the condom because they fear that it might cause dryness, and vaginal infections' (female doctor, 42, married, 3 children MOH MCH training centre). Five other participants agreed.
- ✓ 'In the case of coitus interruptus the woman comes and asks about its effects on her health or her husband's health but we tell them that there is a possibility of a psychological discomfort but they think that it causes dryness' (female doctor, 42, married, 4 children).

The providers also explained how injectables were disliked because they caused irregular bleeding which interfered with local cultural practices. Women who were bleeding were exempted from praying and were not able to have sexual intercourse.

- ✓ 'As for the injections, there are severe complaints from the women after using them for a year and a half. They suffer from long periods of bleeding that could last for twenty days after receiving the injection... and then they stop having their

periods...This to most ladies, is an uncomfortable thing, and some say they feel fat and puffy' (female doctor, 42, married, 4 children).

IV. Study on discontinuation of FP methods at the MOH centres of the Zarqa Governorate

A pioneer study was done by Musallam (1998) on discontinuation of FP methods (the discontinuation of using a prescribed contraceptive method) at the MOH centres of the Zarqa Governorate (1993 - end 1996). Musallam (1998) defines discontinuation of clinic visit (dropout) as a client who received a method and missed her return appointment by one month or more.

He found out that just before the discontinuation of clinic visits, the IUD was the most widely used method among dropouts (52.5%) followed by the pills (34.5%) and condoms (10.8%) (Musallam, 1998, Appendix 4). Furthermore, the number of visits to the health centres prior to the discontinuation was inversely related to IUD discontinuation only, and this relationship was statistically significant (Musallam, 1998).

In general, the discontinuation of clinic visits and contraceptive methods seemed related to geographic location and socio-economic factors (Musallam, 1998): The highest percentage of clinic dropout by clinic location was at Dleil, a rural area (77% of total dropouts), in contrast to the lowest percentage at New Zarqa, a high socio-economic urban area (25% of total dropouts). The highest percentage of method discontinuation among clinic dropouts was in Azraq, as 100% of dropouts were method discontinuers. These findings highlight the social determinants of FP utilisation, and the geographic barriers to access FP services. Musallam (1998) found that the most common reasons given by women for discontinuing clinic visits, and /or contraceptive methods:

1) Wanting to get pregnant or being pregnant (31.1% and 46.4% respectively).

2) That women did not see any reason necessitating a visit to the health center (18.1%)

3) Health problems (14.4%).

4) Visiting another clinic (18.1%)

5) Side effects (13.6%) (Musallam, 1998:45-51).

V. Providers' views of barriers to service utilisation

The service providers were aware that geographic location, the availability of transport, and gender of the service providers were barriers to the utilisation of the FP services. Most of them however focused on the shortage in female physicians (15 physicians serviced all the health centres of the MOH in Zarqa Governorate):

- ✓ 'We go to the health centres of Bireen and Azraq because the gender of the service provider is important. Although there is a medical doctor who is able to provide the service, he is a male, and this is an obstacle. The proof of this is that we are five or six female doctors, and we take shifts in providing services in these health centres, although trained male doctors are available in those health centres' (provider, 40, married, 3 children).
- ✓ 'If the doctor is a male, she leaves, and does not insert an IUD, because the husband would have either sent someone with her, or he would be waiting for her downstairs, so that no male doctor examines her, and the decision is not hers' (1 female nurse married, pregnant). The two female doctors strongly agreed.
- ✓ 'However, sometimes it is the woman who feels shy of a male doctor, and it is her decision not to be examined by him' (female nurse, 45, married, 5 children). Five other participants (all female) agreed.

One of the two MOH clinics included in this study did not provide IUD insertion services, however required the husband's approval for this procedure. Once approval was obtained, they referred the clients to other centres for IUD insertion. The second MOH clinic however had stopped this routine based on a memo from the higher authorities to discontinue such practice as explained by a senior provider. This situation might lead to clients' confusion. In addition, another provider mentioned that a vaginal examination was now required before starting a client on OCs. Considering the local culture, this might be considered as an additional procedural barrier especially when the providers were male:

- ✓ 'In rural and remote areas, the unavailability of female doctors is always a problem, because they do not accept a male doctor inserting an IUD, or performing a vaginal exam, while they would accept him performing a general examination. But now we have instructions that vaginal exam is a prerequisite for the use of the pill. Here the woman does not accept this '(female doctor, 40, married, 3 children).

The providers mentioned contraceptive stock disruption (IUDs and OCs) because it seemed to have occurred on several occasions at this clinic: one hundred IUDs were removed and replaced in 1991. According to their explanations, IUDs had rust on them, and were expired. In 1993, ninety-two IUDs were removed and replaced. They were again not available (November 1995- January 1996). Likewise, 'Lofeminal' contraceptive pills were unavailable for almost a year (31/ 12 /94 to 30/11/95).

- ✓ 'Some time ago, we ran out of IUDs because there was a mistake in the IUDs, so they removed the stock from the clinic. It was never out of stock after that.

Sometimes we run out of contraceptive pills for breast feeding women' (female doctor, 42, married, 4 children).

Sometimes cognitive barriers led the clients to seek FP services in Zarqa City because they were unaware of the availability of the services in their locality.

'Women come from Azraq or Dleil to insert an IUD, possibly because they do not know that there are FP services, and MCH services, that provide FP services locally' (Nurse, 45, married, 5 children).

VI. Providers' beliefs concerning fertility. The needs and strategies at the service level to enhance utilisation

Although most providers expressed that the fertility in this community was more than average, most of them thought that the ideal family size was a family of four or five children! This norm of an ideal family size of four children was also found by the Jordanian Living Conditions Survey (JLCS 1998, Figure 2.22). This interesting finding shows how the providers' mentality remained closer to the community's mentality with respect to family size norms, rather than adopting a family size of two children advocated by international program planners and senior managers. This gap in mentalities between them on the one hand and the providers and community on the other hand might have constituted an additional service barrier to FP utilisation, since none of the providers included in this study were convinced that a family of two children was ideal. Few of them perceived fertility as decreasing with time:

- ✓ 'Two children are too little, they are not enough even if they are a boy and a girl' (nurse, married, 45 years, 5 children).

- ✓ 'The least is four children, even among the educated class' (female doctor, married, 42 years, 4 children).
- ✓ 'Ten years ago it was much, now it is less and it will decrease a lot in the future.'(2 female doctors 40 and 42, married, 3 and 4). A female PN agrees 45, married, 5 children

The needs and strategies at the service level to enhance utilisation

The need for female physicians was the most burning need expressed by all. However to remedy this shortage temporarily, one provider focused on allowing midwives to insert IUDs

- ✓ 'We should benefit from neighbouring countries' experiences...We went to a training session in Tunisia and there midwives insert IUDs after training... I personally encourage the training of midwives to insert IUDs more than the doctors... although people might not be convinced about midwives inserting IUDs since according to the convictions, they may think that doctors would provide a better service' (female doctor, 40, married, 3 children).

While one male physician believed that vertical provision of FP services was more effective, two female physicians of another clinic wanted FP and RH services to remain integrated with the MCH services:

- ✓ 'We think that under MCH services, the utilisation of FP services would increase because a woman can bring her son, and receive a FP method, but there must be a female doctor available daily' (female doctor, 40 years, married, 3 children).

All the providers agreed on the need for privacy during FP provision. In addition, free services, the availability of equipment and a provision of a variety of services were all

strategies mentioned to improve access. In one of the clinics, there was a consensus that provision of a female counsellor was a good strategy:

- ✓ 'We need an employee, (female), who will only be counselling women, and who knows the benefits and side effects of all FP methods. She will be doing counselling after having special training sessions in counselling, because we are overloaded with work' (Social worker, 28, female, married, 2 children). Three nurses and two doctors agree (all female, married with children, MOH, MCH training centre)
- ✓ 'This eases up a lot of processes in the work routine, maybe none of the methods available are convenient to this patient...This decreases the congestion in the corridors, saves the woman's time, and saves disturbance to both of us'. (Female doctor, 42, married, 4children) six participants agree (all female, married with children, MOH MCH training centre.

Two providers mentioned that it would be preferable to have men presenting with their wives at the clinic, although this was not directly suggested as a strategy:

- ✓ 'I prefer to have the husband present with his wife for FP services' (2 female doctors, 40 and 42 years, married, 3 and 4 children respectively).

One physician suggested having FP centres in each hospital (postpartum FP provision), however most providers objected to immediate postpartum FP provision:

- ✓ 'We heard that they are inserting IUDs immediately post delivery: (Objection from the group)... 'They can not from the beginning of the postpartum period, because the health situation might not allow it, or the position of the uterus'.

Conclusion

This chapter has presented FP provision integrated with MCH services, and service utilisation at the MOH MCH training centre of Zarqa. In harmony with national trends, IUDs and OCs were the two most popular contraceptive methods used. In general, service and method utilisation has decreased after 1993 most probably because of the availability of other services providing FP in Zarqa. However, the service providers perceived FP utilisation to be excellent at this clinic. They believed that the lack of co-ordination among the services and shortages in the supply of female providers were important barriers to FP utilisation. Other weaknesses observed that affected FP provision at this clinic, were the facility itself (old building, not purpose-oriented) the distribution of the workload among the clinic personnel, and the overall organisational routines.

Chapter 6

The military services- Soldiers' Families Welfare Society Clinic (SFWC)

Introduction

This chapter presents family planning provision at the Soldiers Families Welfare Clinic (SFWC), and looks at the model of community-based distribution of contraceptives, recently introduced by the Comprehensive Postpartum Project (CPP), starting from the clinic. Family planning provision at the clinic and in the community were exclusively selected and not the other services provided by the Soldiers Families' Welfare Society (nursery, income generating activities for women, illiteracy classes) for the purpose of this research. Family planning services are provided free to all the clients, while other services (antenatal) are only provided to the soldiers' families.

I. Policy makers' views on provision of FP services at the SFWC and the CPP project (interviews)

Only one Jordanian official from the MOH mentioned the CPP project based at this clinic and perceived it as important, whereas the CPP project administrator thought it was extremely important because it was going to address most of the barriers to access FP services, and come out with policy outputs.

- 'Our program (CPP) is supposed to cover most of the barriers. One of the first things we focused on was the medical and service barrier. The project is still new, 1 year old and we do not yet have systematised efforts, but I think that in 3 years time from now, several components will have been brought in, that will address several policy issues'(Chief of Party, CPP project, MD MPH, female)

- 'USAID want to review the FP objectives, because there is a change in contraceptive prevalence rates, so they want to revise the goals according to the rates, taking into consideration the availability and affordability of contraceptives. They want to set goals for the next 5 to 10 years' (Chief of Party, CPP project, MD MPH, female).

However, the policy makers of the NPC and MOH did not share this optimistic perspective because they perceived a lack of consensus among the key players in Jordan on how to address policy changes at the national level. They questioned the effectiveness of these international projects in influencing people's awareness and behaviour, when the projects' agendas neither reflected, nor respected local needs.

- 'This is the work which is '*glued*' (meaning imposed)...and as long as you work on projects that are '*glued*' to you, they will not reflect your needs and your priorities because who knows better about your needs and priorities except yourself...'(Policy maker, PHC services, MOH)

The officials of the MOH questioned the sustainability of these projects and perceived that the policy changes brought about by the CPP project were not effective in other policy circles than the CPP project.

- 'There is no sustainability of projects, and no institutionalisation of projects, therefore the influence is only temporary, as long as the project is ongoing, once the time period is over the national efforts are also over' (Assistant director, MCH/ FP services, MOH).
- 'The persons who formulated the policies... are living in a world of dreams... and they know nothing of the local needs' (Technical director, MOH).

In addition the MOH officials deplored that the research findings were not used in initiating change, because to start with, these results were not disseminated. The same was true for measuring the impact of training programmes.

One incident related by the Community Based Distributors (CBDs) shows a gap between the international projects and the views of the community. When the CPP project was launched, the American experts visited Ghweirieh neighbourhood, after which the community became suspicious of the project's motives, because they perceived it as an American-controlled project.

- 'When the American delegates went with us to the field in the beginning, it meant that they had made a plan to control progeny, so this visit had a negative effect on the project' (CBD, female, 32 years, married, 3 children)

In addition, the Higher Judge of the Islamic Court deplored this lack of fit between population programs and the local community. In his opinion, the current rationales used in the advocacy for family planning programs, specifically the association between gender equity inspired from western feminism and the practice of family planning were inappropriate culturally, therefore ineffective. He believed that gender equity was one of the rationales underlying the message of Islam, and Islamic rulings. He fervently believed that the advocacy for women emancipation used by the development workers must be based on an Islamic model and local tradition, rather than imported models of emancipation that were fit for other contexts. A fervent supporter of FP practice at the individual level, the Higher Islamic Judge openly voiced his disapproval of a national

legislation for FP, because it was aberrant to (*Shari'a)* - Islamic jurisdiction relying on Abu Hanifah's verdicts[1].

- 'The interference of the Government, to formulate legislation concerning FP is not permissible basing on Islamic *'Shari'a'*. Abu Hanifah's jurisprudence considers that FP, or birth control, or conception decisions, must be made by the man alone because the child takes his name, is attributed to him, and is supported financially by him' (Higher Judge of the Islamic Court).

Individually, religious men were participating in FP programs at the micro-level. The specialist doctor providing FP services at the SFWC for the last five years, perceived religious men as being very co-operative, and some of them even sought FP services for their families at the SFWC:

- 'No, there is acceptance and understanding... I even know some religious preachers who bring me their wives for IUD insertion or they take another FP method' (male doctor, married, 38 years, 3 children).
- 'People used to think that it was *'Haram'* (forbidden), but when the picture became clearer, through discussions with religious figures that it was not *'Haram'* (forbidden by *Shari'a*), it helped a lot' (male doctor, married, 38 years, 3 children).

II. Service observations

Service observations were carried out at the clinic for four days on Thursdays and Sundays (July 20th, 27th August 3rd and 24th 1997) because those days were reserved for FP services. Three days were spent in observing FP provision at the doctor's clinic and on the fourth day, counselling sessions provided by the senior midwife, and a meeting

[1]An Islamic jurist, the reference of one of the four *Sunni* schools (chapter 4 p 114).

between the head nurse and eight CBDs were attended. On December 15th 1997, the fifth day of observation, FP provision in the community was observed during the household visits of the CBDs in Ghweirieh.

1. General background information

The Soldiers' Families community centre and clinic were located on a hill, north east of Ghweirieh, easily accessible by walking to the residents of this neighbourhood.

The SFWC was selected as one of the sites for the implementation of the CPP project -a major USAID- funded FP project. The CPP is mostly a hospital-based project, with this community centre clinic being the only site of the eleven chosen for the project where community - based distribution of contraceptives was done for the first time in Jordan.

2. Client volume and range of services provided

The SFWC was the second busiest clinic of the four included in this study, where FP services and contraceptive methods were offered free of charge. High utilisation might be related to its open door policy in providing free FP services to this community since 1990. Five, seventeen, and ten clients, received FP services respectively on the dates of clinic observation.

Unlike the MOH clinic, the services of this clinic were restricted by time and type of service in the sense that there were specific days assigned for FP services at this clinic (Thursdays and Sundays). The only other services provided were Obstetrics and Gynaecology.The contraceptive methods available were IUDs, OCs, Depo-Provera (injectables) and vaginal tablets. Condoms were usually available but not during the service observation period.

3. Counselling

Unlike at the MOH MCH training centre, counselling services were a routine at this clinic, and a special time was allocated to counselling on FP days. The specialist doctor, head nurse and senior midwives all did counselling at the SFWC. Privacy and a special room were provided, and the staff was well trained to carry out this activity.

In addition, the specialist doctor seemed well aware of women's concepts and misconceptions, and explained how they had invented terms that did not exist in the Arabic language. Usually, *"Iltihabat"* was the common Arabic term used for infections. Instead of using this term, women were sometimes using an invented term, *"Istilhabat"*, originating from the word *"Iltihabat"*, to refer to very strong infections, as was observed during the client-provider interactions. Their belief based on rumours from the neighbours was that they would catch *"Istilhabat"* (very strong infections) if they used the IUD. This doctor knew his clients' terminology well, and focused on these lay views of sickness during counselling.

- 'The problem is that she puts all the blame on the method that she is using for any physical or psychological symptom or social symptom that she faces...But after explanations, there is generally an increased health awareness' (Male doctor, SFWC, 38, married, 3 children)

This clinic had the best supply of resources (models, charts and samples) in comparison to the other clinics included in the study, because of USAID funding, and the staff used them in counselling. Table 6.1 summarises the assessment of counselling at this clinic using the MAQ check- list to document the service observations.

Table 6.1 Assessment of counselling practices at the SFWC by service observation (MAQ checklist)

Adequate criteria	Inadequate criteria
Technical competence of staff	
Correct new information on methods use	
FP training 2 weeks minimum for the Doctors	FP training for the nurses
Clinical staff 10 IUD insertion during training	
Technical staff FP refresher course in last 3 years	
Provider has IEC materials available for use (3 materials adequate)	
Minimum 10 minutes with new clients	
Outreach worker 1 talk per day to groups	
Out reach worker two talks /week	
Staff client interaction	
Clients treated with respect and courtesy	
Communication barriers	
Eye contact	
Provider knock on door before entering	
	More than 1 hour to receive all the FP service
All client questions welcomed	
All questions and concerns answered	
	Probing questions
Reassuring simple answers	
Correct contraception for breast feeding clients	
Total score adequate: 15.5 out of 18	

Moreover, this clinic had the most technically competent providers of the four clinics included in this study.

4. Choice of methods, continuity, and support system

The SFWC scored the same as the MOH MCH training centre in this aspect because no attempts were made to contact clinic dropouts at home. The contraceptives available were the same as the MOH i.e., injections, pills, IUDs and condoms, and the providers were generally satisfied with the choice of methods at this clinic:

- 'Let us not forget that the methods now are almost completely and continuously available, while in the past we only had pills and IUDs, and they were not always available... But now, since a year ago, pills are available in both forms the regular pill, and the pill for women that are breast feeding and IUD and injectables also' (Male doctor, SFWC, 38, married, 3 children)

It was observed at times, that the providers of this clinic were keen on promoting Depo-Provera injections, and they suggested tubal legation, which was resisted by women. Furthermore, their description of the efforts with the clients suggested that they were putting pressure on them:

- 'When the CBDs refer a woman to this centre, we do not let her leave before providing her with a FP method, and in addition, we have a program for the postpartum ladies, so that we catch them from the very beginning and they do not object' (RN, female, 32, married, pregnant with 4 children).

5. Personnel

There is only one FP service provider at this clinic, since 1995 and he is a male Obstetrician and Gynaecologist who provides services on Thursdays and Sundays. The technical staff is composed of a head nurse, three midwives, a practical nurse, two pharmacists, and a laboratory technician. All the paramedical personnel of the clinic are females in contrast to the physicians who are males.

In addition, ten married women from the neighbourhood with a high school diploma were selected as CBDs, in addition to two field supervisors to provide outreach services. Their functions included the distribution of contraceptives in the community and clinic referrals.

In comparison to the staff of the other clinics, the SFWC staffs were the most trained in FP counselling, and the dissemination of IEC materials on FP methods. The head nurse and doctor were trained in quality improvement and team leadership. This was owing to the fact that prior to the CPP project, the SFWC was a site of implementation of more than one internationally funded project. Hence, large amounts of donor money were

invested for this purpose, in contrast to the MOH training centre where shortages of human and training resources were a chronic problem.

- 'There are workshops which are held every 2-3 months at the level of the directors of FP clinics to exchange experiences' (Male doctor, 38, married, 3 children)

6. Organisational routines, record keeping, and treatment protocols

The provision of FP services on Thursdays and Sundays only may have acted as a barrier to the utilisation of those services. In addition, waiting time at the clinic was another barrier: clients were registered at the reception, and admitted to the clinic, but were never able to see the doctor before 9:30am, because he never arrived earlier. If the patients delayed their arrival to time it with the doctors' arrival, they were deterred by the clinic personnel, and were at times sent back without seeing the physician because they had arrived 'late'.

Another observation was that although the clinic hours extended till 2:30pm, most clients were done by 1pm. The staff spent the rest of the shift relaxing, and finishing administrative documentation. One time, they were observed performing a group prayer. Some staff members took leave after 1pm.

Despite the established system of appointments, the nurses encouraged the clients to arrive early (8am -9am), and those who arrived in the late morning or at noon- time were denied access to the doctor. This seemed to be a general trend observed in all three clinics included in this study with the exception of the mobile clinic.

A good practice at this clinic, however, was that the clinic personnel used the waiting time for health education. The women were given sessions in groups, or individual counselling sessions while waiting for the doctor.

Unlike the MOH, the SFWC nurses were not allowed to provide FP services on their own. Even the replenishment of OCs, or vaginal tablets for old users was only done under the doctor's supervision. However, CBDs delivered the stocks of OCs and condoms to the old FP users (continuing users) at home. They also referred new FP users (i.e. users for the first time), or IUD clients to the clinic as needed.

Furthermore, the workload of this clinic seemed better distributed than the MOH clinic: the receptionist performed clerical duties, retrieved client files, or opened new ones, unlike at the MOH where all the clerical duties were left to the senior midwife.

The staff was trained in computer data entry. The monthly statistical report included all antenatal, FP jobs, and the providers' load for that month, and was submitted to the CPP program management.

Treatment protocols for complications were not available at this clinic, and the patients were referred to the Zarqa General Hospital, or the Zarqa military hospital, if they were families of members of the Armed Forces. Table 6.2 summarises the assessment of the organisational routines of this clinic.

Table 6.2 Assessment of organisational routines at the SFWC (MAQ checklist)

Adequate routine	Inadequate routine
	Waiting time (> than 1 hour not adequate)
Utilisation: (Inadequate if less than 50% of other sessions)	
	Guidelines & protocols used in case management and Mgt. of staff
Used for in-service training of staff	
Supervisory visits (at least quarterly)	
Register for supervisory comments during site visits	
Supervisory tools used (checklist, forms, etc.)	
	Written work plans for supervising staff
Full Technical staff	
	Technical guidelines &protocols, infection control protocols

Adequate routine	Inadequate routine
	MIS records and forms Definitions of users, new users, accuracy of definitions if 1 wrong not adequate
	Clients' records complete, (if >5% incomplete not adequate).
Monitoring: (2 management meetings per year at least)	
	Quarterly feedback from Management to field on performance
Monthly staff meetings	
The polyclinic director visits the clinic once weekly	
Less than 3 administrative steps for the client to see the Dr.	
Total score adequate: 10 out of 17	7 out of 17

The SFWC had the highest score (10 out of 17) in the assessment of its organisational routines, out of the four clinics included in this study. This score is double that of the MOH training centre, (5 out of 17), most probably because of the ongoing international - funded FP program (CPP). These results show that international programmes are usually more organised than the public sector, partly because there is more flexibility in the implementation of routines. In the public sector, centralisation and bureaucracy are major drawbacks in the organisational structure.

When the service providers were asked about co-ordination in this service, with FP services in other sectors or within the military sector, they confirmed that there were co-ordination efforts within the clinic, on a daily basis. However, there was a consensus that no meetings were held with other military clinics, or hospital staff. There were informal co-ordination efforts, with the MOH and JAFPP personnel, and with the schools of nursing and midwifery:

- 'We meet on a daily basis, and we speak about problems, or we give refresher lectures... and they provide us (the fixed clinic) with what we need'. (CBD, female, 27, married, 3 children)

- 'Not monthly... There are centres that we visit on an informal basis through our own co-ordination...our own personal efforts... We even go to the JAFPP and to the MOH' (RN, female, 32, married, pregnant with 4 children)

7. Facilities, Equipment and Storage of Commodities

The old building of the SFWC was inadequate, however, the building was renovated by the USAID CPP project, and it has now the best facility of the four clinics. Storage space and rooms are provided, and stocks are well organised. There is however no ultrasound machine, unlike the MOH training centre. Table 6.3 summarises the assessment of the physical facility of this clinic.

Table 6. 3 Assessment of the physical facility of the SFWC (MAQ checklist)

Adequate criteria	Inadequate criteria
Physical accessibility	
Water in examination and cleaning room	
Facility clean and tidy Litter or garbage (not adequate)	Old clinic not adequate, new clinic adequate
Well ventilated	
Clear and visible signs for FP services	Old clinic not adequate, new clinic adequate
Inventory of supplies for forecasting (>1 stock out in the last year not adequate)	
	Register for equipment inventory & maintenance record
Quantity of equipment adequate to work load (<than 3 IUD sets per hour , not adequate)	
	FIFO storage system of supplies
Privacy for clients receiving services including counselling	Old clinic not adequate, new clinic adequate
Client's toilet available and clean	
Total score adequate: 9 out of 11	2 out of 11

As observed and expected, the SFWC scored the highest in its physical facility (9 out of 11 adequate criteria) of the four clinics included in this study.

8. Training equipment

This clinic was a training centre for nursing and midwifery students. However, reference books and materials were not available. Training sessions and meetings were

organised by the programme managers for the team of staff and the CBDs. In addition, IEC materials and models were available for clients' use.

9. Infection prevention practices

Infection control procedures were not completely adequate at this clinic before its renovation; the rubbish cans were not emptied often enough, the rooms looked dirty, and the needles were not disposed of properly.

The situation improved dramatically however, after the building was renovated, and the bathrooms became clean, the examination tables had clean sheets. Sets were cleaned and sterilised in the clinic. The doctors and nurses washed their hands after examining the patients, because sinks were available in the examination rooms. However, written infection control procedures, protocols, or guidelines were not yet available at this clinic, even after the building renovation.

III. Service statistics

A monthly report of all the clinic activities has been filed in the record room, since the establishment of the clinic. The head nurse and clinic staff did a baseline survey of the clinic activities and contraceptive utilisation in the community of Ghweirieh from January - June 1997, at the beginning of the (CPP) project and a computerised system was introduced in December 1997. The purpose was to document all the activities of the CPP project (community-based distribution and clinic), and to upgrade the Medical Information System (MIS), now the most advanced of the four clinics included in this study. It seems important to note that the MIS system was only upgraded since the initiation of the CPP project in 1997- 1998, and that in earlier times, the system was similar to those found in other services. Since this documentation system was totally

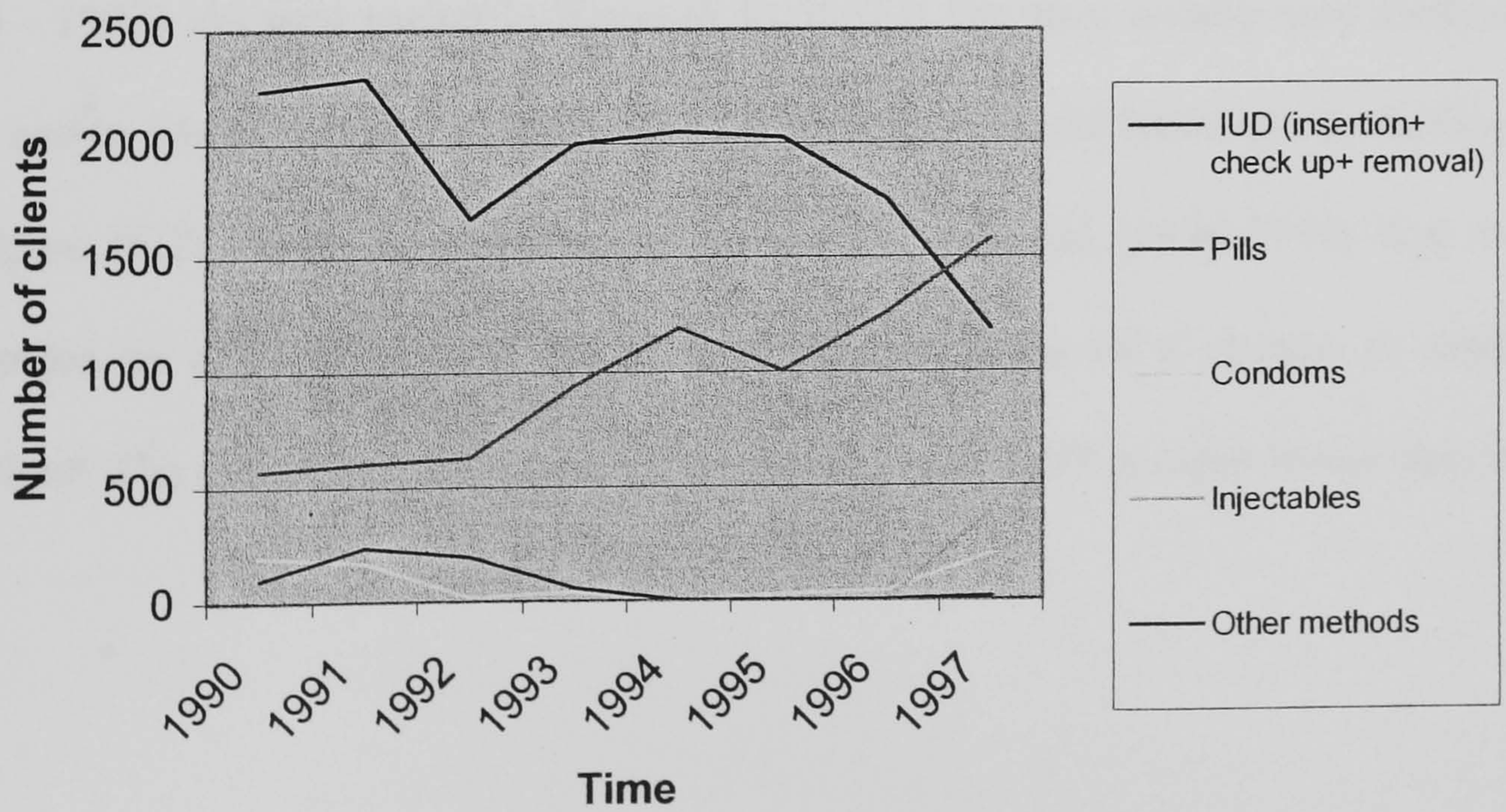
initiated, monitored, and funded by the international subcontractor of the CPP project - Pathfinder International - the question of sustainability of this MIS system after the CPP project ended is a major concern.

For the purpose of this study, the monthly statistical reports of January 1990 to August 1997 have been retrieved with the help of the head nurse and the clinic personnel.

1. Total FP clients' (old and new) utilisation of contraceptive methods at the SFWC

Unlike the MOH, the new users of FP services were impossible to retrieve separately at this clinic because the monthly statistical reports counted all new clients together, i.e. FP and antenatal. However, it was possible to retrieve total FP method utilisation (old and new users). 'New' users of a given method were the users for the first time while 'old users' were the continuing users of that given method. 'Old users' in this clinic, unlike MOH remained labelled as 'old users' across the years, if they were still using the same

Figure 6.1 Method utilisation among the total FP clients (old +new) of the SFWC



method. The sum of clients for IUD insertion, check-up and removal was calculated to

obtain IUD utilisation (Figure 6.1) at the SFWC. The utilisation of other contraceptive methods is also shown in the same Figure (6.1).

Like the MOH clinic, IUDs and OCs were the two most popular methods, with the IUD being the most widely used method (1990 – 1996 inclusive). Pill utilisation was continuously increasing between (1990-1997) to become higher than IUD utilisation in 1997. This might be due to the providers' effort in marketing oral contraceptives at this clinic and in the community (community - based distribution) and also to the gender of the provider (male since 1995).

Moreover, a sharp decrease in IUD utilisation since mid 1995 is most probably due to the gender of the provider. The clinic personnel explained that a male Obstetrician and Gynecologist started working at this clinic at the end of 1994. Female doctors provided FP services earlier, since the establishment of this clinic.

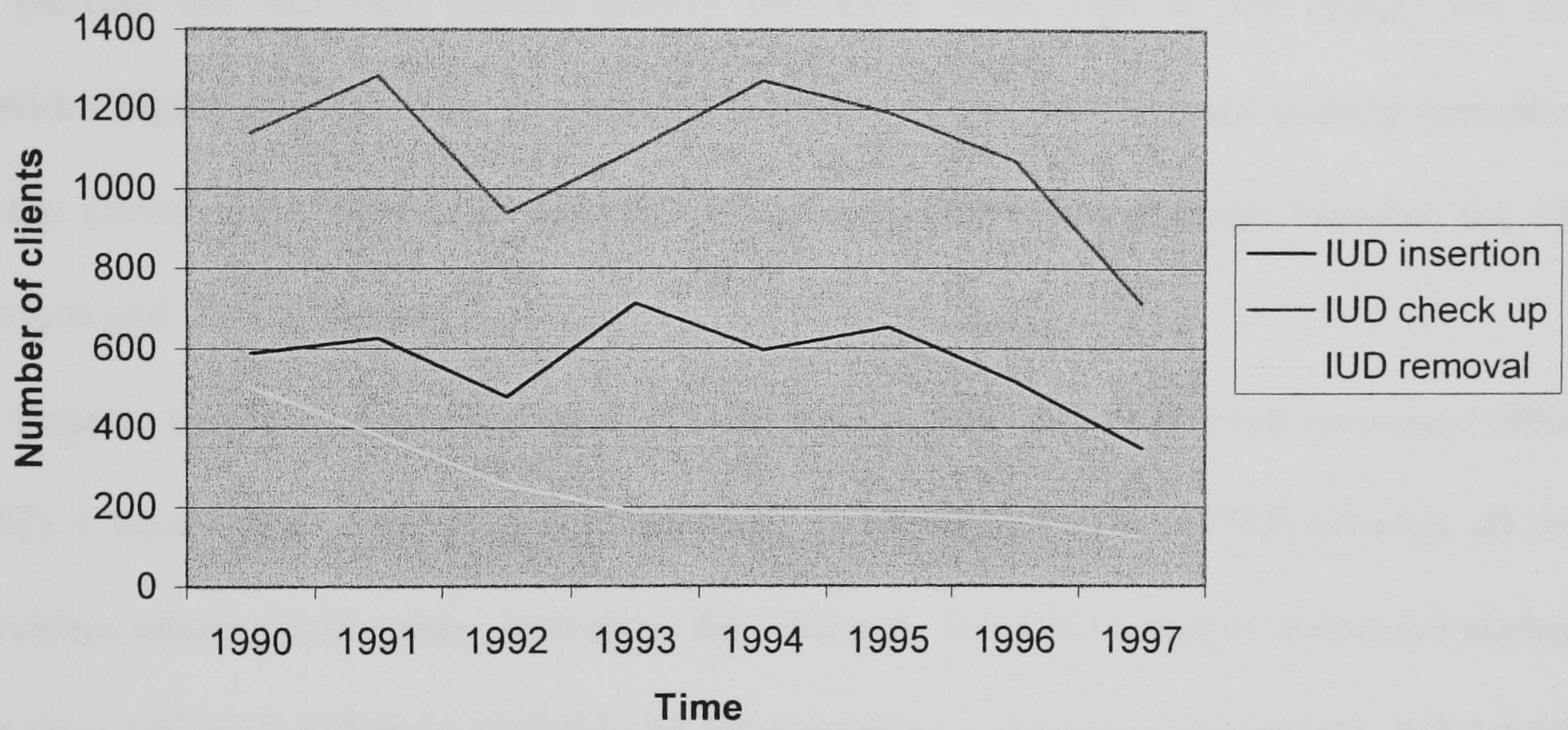
2. IUD utilisation at the SFWC

Figure 6.2 shows IUD utilisation (insertion, check up and removal) at the SFWC (1990 – 1997). As seen earlier in figure (6.1), IUD is the most widely used method at this clinic and in Ghweirieh community (63.76%) according to the basic survey findings.

Figure (6.2) shows a decreasing trend in IUD removal (1990-1997) that might be interpreted as a positive yield of FP programs in terms of a change in consumers' behaviour. The number of clients removing the IUDs in 1997 is much lower than in 1990.

Since the establishment of the SFWC, more than one international program had been implemented, the latest of which the CPP project. Counselling activities and health education efforts might have also contributed to this decrease in IUD discontinuation.

Figure 6.2 IUD utilisation among the FP clients of the SFWC



On the other hand, the number of clients for IUD insertion and examination in 1997 is much lower than in 1990. The decrease in IUD utilisation (mid 1991 – mid 1992) might be considered a low yield of the FP services of this clinic because it occurs in time prior to the establishment of other FP centres and prior to the initiation of different FP programs in 1993. Following that date, the most plausible explanation for the decrease in the number of clients for IUD insertion or examination at the SFWC is that they were using other centres to receive those services (Figure 6.2). It seems important to note that the drop in IUD examinations and possibly insertions after 1995 might not only be due to the availability of other centres, but also to the gender of the service provider. At the end of 1994, a male specialist was recruited at the SFWC and is still providing FP services till now. Clients were perhaps avoiding the embarrassment of being exposed to a male

doctor: Even when a client had an IUD inserted at this clinic, she was reluctant to have it checked again, because this would entail a vaginal examination by a male doctor. Moreover, the service providers of the SFWC did not remove IUDs without what they called a 'convincing' reason for that. Women then avoided the embarrassment by going somewhere else to remove the IUD.

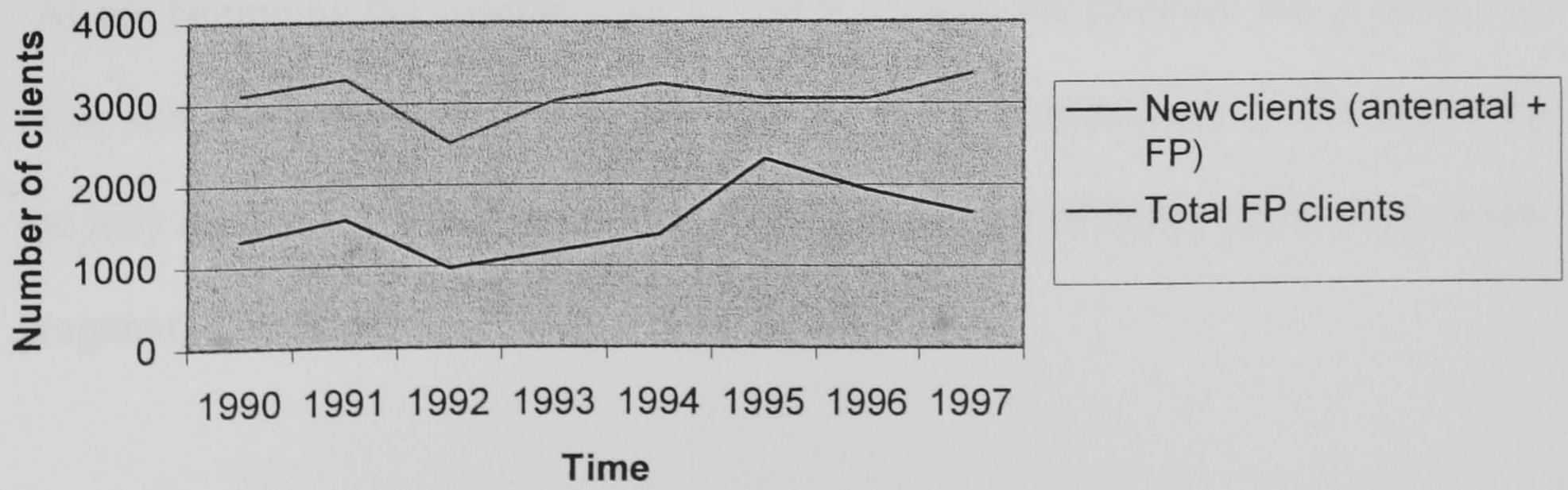
Despite the fact that service quality indicators were high at this clinic, and the provider highly qualified, his gender was a service barrier that seemed silently remedied by the community. This is an example of the gap that exists at times between the FP services and the community.

Despite this however, a decreasing trend in IUD removal is observed between (1990-1997). Clients might have used this clinic for IUD removal (1990-1993) because all the providers where female then, however, they did not, and IUD removal decreased during that time which would most probably be interpreted as a change in consumers' behaviour. With time, the number of women for IUD insertion decreased, however, once they inserted it, they tended to keep it, and did not discontinue it as frequently as before.

3. Recruitment of new clients

Since the system of recording the number of clients at this clinic counted all new

Figure 6.3 Recruitment of new clients (antenatal and FP) and total FP clients at the SFWC



clients together (i.e. FP and antenatal clients), there was no way to retrieve the number of new FP clients separately. Figure 6.3 shows the recruitment of new clients for antenatal and FP services. It also shows the total number of FP clients at the SFWC (1990-1997).

Figure 6.3 shows that the number of FP clients in 1997 is only slightly higher than in 1990, most probably because of the supply of other FP clinics.

There is a drop in the number of FP clients between mid 1991 and mid 1992 that might be associated with the fact that there were no ongoing FP programs at that time in this clinic. While FP utilisation increases between (mid 1992 - mid 1994) when there was an ongoing international FP program (1992-1994) as explained by the service providers. After the initiation of the CPP project in 1997, the utilisation of FP services is increasing (mid 1996- 1997). In Ghweirieh, community- based distribution of oral contraceptives aimed at bridging the gap between the SFWC and the community, by fulfilling their unmet need for contraceptives.

- 'There are women who want to utilise FP, but they do not know where to go, and what to do, so when we come to them, they become very happy' (CBD, female, 32, married, 7 children)

The service providers believed that counselling services, which were part of the clinic routine since its establishment, and counselling efforts in the community since the initiation of the CPP project had contributed to this change.

- 'At the beginning the woman used to worry because the provider was a male. But now, she is convinced following the lectures and gets examined. At the beginning the lady used to leave and we used to lose a big number of ladies' (RN, 32, married, pregnant, 4 children).

The number of new clients seeking antenatal and FP services has increased (between mid 1994 - mid 1995), gradually decreasing after that (mid 1995 - to mid 1997) most probably associated with the gender of the service provider.

4. Method and service utilisation at the SFWC

The increasing trend in pill utilisation between 1990 and 1997 is due to the marketing efforts of the clinic providers and the CBDs in the community. Moreover, the gender of the service provider might have encouraged women who wanted to use contraceptives to choose OCs as an alternative to IUDs.

It seems that women liked the community distribution of contraceptives. The CBDs analysed that this model of provision because it attached the clients to the SFWC, as a centre of reference:

- 'Of course the woman used to buy contraceptives from the pharmacy... and now we have saved them money ... so they receive us more and the women have started dealing with a centre' (CBD, female, 24, married, 3 children)

At the MOH clinic, new clients pill utilisation did not increase in time as markedly as in this clinic while old clients' pill utilisation raised and then dropped (Figure 5.3). This supports the view of the service providers that community-based distribution had increased OC utilisation in the Ghweirieh community.

Injectables have been recently introduced to this clinic (mid 1996), and their utilisation was increasing. It was observed however that this increase in the utilisation of injectables had more to do with the providers' initiative and bias in marketing it, rather than the clients' own choice, especially after the (CPP) project was launched.

Condoms were also not a popular method among the FP clients of this clinic. There seemed to be a cultural rejection of the condom among most communities of the Zarqa Governorate. It was deduced from the focus group discussions with men and women and household interviews with couples that men rejected this method.

One service provider from the SFWC said that men occasionally came to the clinic to take condoms. The statistics or the qualitative data did not confirm this. There is a general trend of rejection of the condoms in all the clinics included in this study, except for the mobile clinic.

IV. Baseline survey findings

The only results available for comparison at this clinic, are the Demographic and Health Survey (DHS, 1997) at the national level, and the basic survey done in Ghweirieh (February - June 1997) at the beginning of the CPP project.

In Ghweirieh, the prevalence of modern methods is (35%) and (13%) of couples use traditional methods of contraception according to the basic survey findings (1997) and (63.7%) of FP users were IUD users (basic survey findings, 1997). In this study (1997), more FP clients used pills (47%) than IUDs (35.2%) among the total FP clients of the SFWC. The higher prevalence of pills is most probably related to the providers' marketing efforts (CBD) of oral contraceptives, and the gender of the service provider.

Pills are the second most widely used modern method in Ghweirieh (22.52%) (basic survey report, 1997), and are the most widely used method (47%) at the SFWC according to this study.

According to the basic survey findings, condoms (5.6%), injectables (1.6%), vaginal tablets and jelly (1.5%), are the least used methods in Ghweirieh (basic survey, 1997).

Likewise in this study, (5.9%) of FP clients of this clinic use the condoms, while (11.3%) use injectables and (0.4%) other methods such as vaginal tablets and jelly. The higher prevalence of injectables at this clinic in comparison to the national or local prevalence rates is most probably due to the providers' bias in marketing this method at the SFWC as was deduced from service observations.

According to the basic survey (1997), the reasons given by women in Ghweirieh for modern contraceptive use are 'birth spacing' (meaning it is temporary), and 'the large number of children' (meaning that they had achieved their reproductive goals). While the reasons given for not using FP methods are mostly 'wanting to have a baby', 'health reasons' or 'other reasons'.

These reasons were similar to the findings of Musallam (1998) for the MOH clinic dropouts in Zarqa, where child demand in most communities of Zarqa seemed to be the main reason why women discontinued utilising FP methods and services.

V. Providers' views of utilisation of FP services and methods (FG discussions)

The providers' perceived an increase in FP utilisation at the SFWC and in general. The records show a total FP clients of 6149 at the SFWC in 1990. In 1997, it is 5215 FP clients till the end of August (8 months). These frequencies represent the increasing number of women of reproductive age from the natural increase of the population.

- 'There is more utilisation... and the numbers are more, especially now that we have FP services on all days of the week, except for IUD insertion and removals, which are provided only on Sundays and Thursdays, or if the woman wants to receive an injection for the first time...so the utilisation has increased' (PN, female, 37, married, 5 children).

The CBDs perceived the contraceptive prevalence to be (75%-80%) in their community, while it was only (35%) according to the basic survey (1997).

- 'There are mothers-in-law that are very receptive to FP and who encourage it and accept us a lot (meaning the CBDs), and the ones that utilise FP are more than 75-80%, and some of them say 'why did you not come a long time ago, so that we could have practised FP before now' (CBD, female, 37, married, 4 children)

The senior service provider (male doctor) seemed more realistic as he described the two types of FP users, based on his experience:

- 'I have been providing services at this clinic for five years and I can describe to you the ladies that utilise this clinic as belonging to two categories. In the first category, the woman comes to you, consults you, takes by your opinion, accepts it and follows it. In the second category, the woman comes in and says I want to insert a loop, and she persists, insisting on her choice. Sometimes this method is not suitable for her for health reasons, and we suggest another method that is more suitable for her health ...But she does not accept this even if you explain it to her in every single detail because she is convinced with her opinion.' (Male doctor, SFWC, married, 38, 3 children)

VI. Service barriers, beliefs about fertility, and needs and strategies to enhance utilisation (policy makers and providers views)

One policy maker insisted that the gender of the service providers was a major difficulty in FP program implementation, because of the shortage in the supply of female physicians in the Jordanian health market. He deplored the attitude of rejection of the

male provider in FP services, which was widely prevalent among women and their husbands, as they refused to receive FP services from a male practitioner:

- 'Some people cannot conceive a male doctor is to insert an IUD, and equate it with adultery, so we might even be shot for it' (Health director, MOH, male, 58, married)

While the providers of the SFWC did not insist on this barrier directly, unlike the CBDs and service providers of the MOH, who thought in consensus that the gender of the service provider was an important barrier in service utilisation:

- ' At the beginning the woman used to worry because the Obstetrician – Gynecologist is a male... but now following the lectures, she is convinced to be examined.... While at the beginning, the woman used to leave and we use to lose a big number of women' (PN, SFWC, female, married, 37, 5 children).
- 'The problem is the gender of the doctor, that we have male doctors... They ask whether the doctor is a female then will come, but if the doctor is a male they won't... this is based on an ideological or religious belief' (CBD, female, married, 30, two children)
- 'Having a male doctor is a barrier for religious people or sheikhs, and it is a must for the Obstetrician and Gynaecologist to be a female' (female doctor, MOH, 40, married, 3 children)

The SFWC providers focused instead on the attitude of the doctors in the public sector (MOH) and the private sector, which they perceived as a major barrier to FP utilisation. According to them, the private physicians supported rumours against certain

FP methods, especially the IUD and Depo-Provera (injections), and this had a negative impact on the utilisation of contraceptive injections:

- 'The problem is that the doctors in the civil service have a negative effect on our services because they tell them that the injections cause sterility and that nobody takes the contraceptive injections except donkeys and animals' (CBD, female married, 3 children, 27 years old).
- 'Sometimes a private physician talks negatively about a certain centre for example when he examines a woman with an IUD, he tells her that this IUD is defective because it is provided free of charge' (CBD, female, 30, married, 2 children).

Other service barriers deterring utilisation mentioned by the providers of the SFWC were the shortage of equipment and contraceptive methods. The providers believed that this was due to a lack of follow-up from the people in charge.

- 'One hormone pill is now not available, and the contraceptive pills for women that are breast feeding have been out of stock for the past three days' (male doctor, SFWC, 38, married, 3 children).
- 'The unavailability of pregnancy tests, an ultrasound machine and sonic-aid ... so we either refer her to a military or governmental hospital, or we give her the bleeding hormone tablets to rule out pregnancy although this is not a scientific method' (male doctor, SFWC, 38, married, 3 children).

Beliefs concerning fertility

The providers of the SFWC, like the MOH providers (chapter 5) perceived that child demand and fertility rates were very high in Ghweirieh and Zarqa. They believed that

poor households had more children than affluent ones, but fertility rates were dropping with time.

- 'It is noticeable that those who have low incomes have a lot of children and even sometimes they are unemployed and still have a lot of children...and those who have high incomes have only two children and do not want more' (CBD, female, 24, married, 3 children).
- 'The fertility rate here in Jordan is 5.6 per woman in comparison with the developed world where it is 1-2... A few years ago the fertility rate was 8.3 and now it is improving' (male doctor, SFWC, 38, married, 3 children).

Concerning their personal beliefs around fertility, two out of three providers of this clinic were convinced with FP and practised it. The third declared that FP methods did not benefit her.

- 'The FP methods were not of benefit to me ...(showing her stomach and laughing)...I tried a lot and it did not work with me' (RN, SFWC, female, 32, married, 4 children and pregnant).

On the other hand, many CBDs seemed convinced with FP; one of them recognised that she had not been convinced with it at the beginning of her training, while another believed in birth spacing for two years, and a third one said she was doing it without her brother's knowledge.

- ' At the beginning of my training, I was not convinced with FP, and when I faced reality, I became convinced of how necessary it was' (CBD, female, 27, married, 3 children).

- ‘ My husband and mother have approved of my work, only my brother does not know that I am doing this type of work’ (CBD, female, 24, married, 3 children)

Needs and strategies at the service level to enhance utilisation

While the clinic providers and CBDs recognised that the geographic location, free of charge FP services, supply of contraceptives, home distribution, good interpersonal relationships were good strategies that enhanced FP utilisation in the clinic and the community they stressed on the need for further counselling. The clinic providers believed that educating men about FP was an important, however they disagreed on the method of implementing this strategy in the community and the clinic:

- ‘ They might utilise a hospital team and transform it into a home counselling team, with a young man or two… during the visits the girls would address women and the young man would address men, consequently we would have a successful and complete counselling’ (nurse female, 34, married, 5 children, SFWC)
- ‘ Each method of work should be suitable for our society, so for women to knock on doors and do home visiting is suitable, but for a young man to enter the house while the husband is at work is not suitable. This might be misunderstood and leads to negative repercussions on the work’ (senior male provider interrupting her, 38, married, 3 children, SFWC)

Likewise, as one clinic nurse suggested to organise lectures for men at the clinic, the other nurse said that this suggestion was not culturally sensitive:

- ‘ There are women that ask why are there no lectures provided to men in your clinic where you explain to them that family budget is much improved when you spend on

3-4 children than the budget when you spend on 12 children (PN, SFWC, 37, female, married, 5 children)

- ' We are still Orientals and we cannot join men and women and explain to them about these subjects (RN, SFWC, female, 32 married, 4 children, pregnant).

In addition to health education efforts in the clinic and community, one clinic provider suggested that the *sheikh* of the mosque meet with men and women to educate them that FP was permissible in Islam.

- ' The *sheikh* of the mosque must meet with men and women and explain to them building on a religious rationale the permissibility of these FP methods according to Islamic *Shari'a*, and the permissibility of test tube babies' (RN, SFWC, female, 32 married, 4 children, pregnant).

The CBDs did not mention strategies addressing men but mentioned health education and safeguarding the privacy of the clients through confidentiality.

Conclusion

This chapter has presented vertical provision of FP services at the SFWC with a community-based distribution component in Al Ghweirieh. Since family planning provision in the community was initiated and is largely dependent on the CPP project, the sustainability of this model after the project is finished is a major concern, especially financial sustainability.

OCs and IUDs are the two most popular contraceptive methods at the SFWC. Pill utilisation increases with time and becomes more utilised than the IUD in 1997, most probably because of the marketing efforts and the gender of the service provider. Clinic users need for contraception drove them to use the pill instead of the IUD. The

continuous decrease in IUD removal at this clinic is most probably explained by counselling activities, a clinic routine since its establishment.

The barriers to FP utilisation as perceived by the providers were the private doctors that spread rumours against IUD and injection utilisation, because of a conflict of interest. The gender of the service providers was another barrier mentioned by both policy makers and providers, and the shortage of equipment and resources. Being aware of the need for more counselling and health education activities, the clinic providers agreed on the need to involve men in all these activities, however they did not yet agree on how to do so.

Chapter 7

The United Nations Relief and Welfare Agency (UNRWA)

Introduction

This chapter will present FP provision at UNRWA following the RH model advocated during the ICPD and implemented by the WHO after 1994, as the family health model.

I. Policy makers' and providers' views of FP services within UNRWA

Policy makers perceived UNRWA as a major pioneer in following WHO model of integrating FP services within reproductive health services. UNRWA provided FP services as part of its Family Health Division, and was viewed as being concerned with the quality of life of the refugees, 'knowing what is best for them' (Chief, Jordan health programme, UNRWA).

- ✓ ' UNRWA was a pioneer of the Family Health model. In 1992, a meeting took place in Larnaca. UNRWA was a pioneer in the integration of Family Health services in the PHC system' (Chief, Jordan health program, UNRWA).
- ✓ 'As an agency, we think of the refugees' benefits and needs, and even if the agency does not meet their demands, or even contradicts their demands, providing a quality service to them is jeopardised, when they have too many children' (Chief, Jordan health program, UNRWA).

II. Service observations

The service observations were carried out on three consecutive days, November 18th 19th and November 20th, 1997 from 8am -2pm at the Zarqa MCH clinic. The first and second days of observation took place in the FP room, where the head nurse provided

services. On the third day, the services provided by the specialist doctor were observed. He provided Obstetric- Gynaecology and FP services every Wednesday.

1. General background information

This clinic, established in December 1995, is very conveniently located near the inter-city transport terminal of Zarqa. However, access to its services was restricted to the Palestinian refugee community of the Zarqa camp, unlike the three other clinics included in this study, where an open-door policy was maintained. The clients received FP services upon presentation of their clinic card, which indicated thereafter, that they were 'active users' of FP services and methods.

Initially, the clinic card is issued upon presentation of the ration card (food card) which is only issued to Palestinian refugees. By this, it ensues that only the refugee community benefits from the health services offered at the clinic. This measure established by the UNRWA management 'for the benefit of the people', was not yet understood by the community, as explained by a service provider.

- ✓ 'The purpose of having a ration card for the pregnant woman or the child is to maintain the health and nutrition of the pregnant woman and the child but this idea is not understood'.

It was usual for women in the camps to utilise more than one UNRWA clinic at a time, and /or UNRWA and other services at a time. Consequently, it was difficult to know the exact denominator (population) of users of this clinic. Instead, the clinic performance was compared to itself over time (two years since its establishment).

However, trends and variations in service utilisation were difficult to establish because of the short history of the clinic and the fact that clients were transferred from the

other clinic and included in the statistics of 1996. The qualitative data collected from the service providers and community completed the picture of service utilisation.

2. Client volume and range of services provided

The FP services provided were typical of an international organisation following agency-wide guidelines that are derived from WHO models and standards.

The Zarqa MCH clinic is not a very busy one in terms of FP clients (Eleven clients receiving FP services on the first day and seven clients on the second day). However, on the day of the specialist doctor, the client volume rose to 20 (antenatal and FP clients). The specialist who has been providing services at this clinic for two years confirmed that he saw 20 women on average per clinic day. He has also provided services at the other UNRWA clinic of the Zarqa camp for the past four years.

This primary health care centre provided comprehensive services (Obstetric and Gynaecology, FP, and Paediatric services) like the MOH MCH training centre. The contraceptive methods available were IUDs, OCs, condoms, vaginal pessaries, while injections were not available.

3. Counselling practices

The physical set up of this clinic was helpful for counselling activities because the volume of clients was less, and there was a possibility to have privacy during counselling. As observed, the head nurse, doctor and specialist all did counselling at this clinic however, the specialist doctor did the best quality counselling. The patients were given enough time to express their concerns, and his answers to their questions were simple. He asked them to repeat the information given to them.

Many times, the head nurse gave health instructions and counselling sessions to the patients however, they were brief and not very well focused. Generally speaking, she was polite and professional. Table 7.1 summarises the assessment of counselling practices at this clinic.

Table 7.1 Counselling practices at the Zarqa MCH clinic of UNRWA.

Adequate criteria	**Inadequate criteria**
Technical competence of staff	
Correct new information on methods use	
FP training 2 weeks minimum Doctors	Nurses
Clinical staff 10 IUD insertion during training	
	Technical staff FP refresher course in last 3 years
Minimum 10 minutes with new clients	Provider has IEC materials available for use (3 materials available adequate)
Staff client interaction	
Clients treated with respect and courtesy	Outreach worker 1 talk per day to groups
Communication barriers	Out reach worker two talks /week
Eye contact	
Provider knock on door before entering	> than one hour to receive FP service with the doctor
Not more than 1 hour to receive all the FP service (with midwife)	
All client questions welcomed	All questions and concerns answered
Probing questions	
Reassuring simple answers	
Correct contraception for breast feeding clients	
Total adequate criteria: 12 out of 18	

While the SFWC scored highest in technical competence of service providers, and provider/client interaction, UNRWA was the second best clinic in that respect. The UNRWA philosophy focused on counselling aspects of provision because they perceived it as an essential preliminary in changing the behaviour of their clients. By changing their health habits, it was hoped that their quality of life would be improved.

However, it was a common observation that providers on the whole did not try to minimise social distance with their clients, because intrinsically, they believed that such a

distance existed. Most of them adopted a paternalistic approach, which is a cultural trend inherent to health service delivery in the Middle East.

- ✓ 'I will give you the pills, but if you get pregnant before two years I will be very angry with you' (charge nurse FP, female, 45, married, 1 daughter).

4. Choice of methods, continuity, and support system

UNRWA scored highest among the four clinics for its choice of methods, continuity and support system, because one of their main strategies was to focus on FP services at the regional level, across all the clinics in the region. FP services had been a major part of the Family Health program since 1993, and they are the only services that had established mechanisms for follow-up of dropouts. A documentation of the reasons for dropout of FP utilisation was maintained, and their system was the most comprehensive of the four systems included in this research. Furthermore, inter-agency research studies on contraceptive use and discontinuation were carried out.

Despite all these good indicators of quality of service provision, the service statistics and observation of the Zarqa MCH clinic did not show a heavy utilisation of the FP services by the women of the camp.

Table 7.2 illustrates the choice of methods, continuity, and support system of this clinic.

Table 7.2 Choice of methods, continuity and support system at Zarqa MCH clinic (MAQ checklist)

Adequate criteria	Inadequate criteria
Contact of drop-out cases at home	
Written appointment card system for follow-up cases	
Reason for clinic drop-out documented	
High technical staff turnover (>than 2 persons /last year not adequate)	
Choice of methods	
Number of methods (4 methods adequate)	
	Clinical provider guidebooks
Provider bias	
Administrative barriers to receiving method of choice	
Total score adequate : 7 out of 8	

This clinic almost had a complete score (7 out of 8 criteria were adequate) in their choice of methods, and support system. They were the best of the four clinics included in this research study, because they had established mechanisms of continuity, and followed international models that were tried elsewhere by WHO and UNFPA. Even the service providers, seemed to appreciate this system:

- ✓ 'And we have a very nice follow up of FP services by my colleagues - nurses and midwives' (male doctor, 36, married, 2 children).

5. Personnel

Two GPs and a specialist doctor, all males, provide services at this clinic, and the specialist doctor has been affiliated with it since its establishment in 1995. A head nurse (nursing diploma) provides FP services besides her managerial duties; she follows up the clients' files, and the FP defectors. A registered nurse, two practical nurses, and a midwife were also employed at this clinic, and a Traditional Birth Attendant (TBA) follows FP clients on outreach visits in the Zarqa camp. A laboratory technician carries out basic laboratory investigations.

The service providers of this clinic said almost everybody had received training in FP procedures, and they seemed satisfied with the quality of their training:

- ✓ '95% of the staff has received basic training in FP and most doctors have received advanced training in IUD insertion, and the complications and benefits of contraceptive methods, and training in counselling ...Some of it in Jordan, and some of it at the MOH, and some training was received in NGOs... and we always receive refresher sessions on FP on a continuous basis' (male doctor, 36, married, 2 children).

6. Organisational routines, record keeping, and treatment protocols

A system was established by the UNRWA management to organise patient flow, and waiting time of women during the hours of operation of the clinic. This is a system unique to this clinic, which did not exist in the other three services included in this study. Colour codes were followed to avoid long queues, and to organise the time of client - provider interaction. The clinic day was divided in 4 periods, each period, lasting for 90 minutes and having a different colour code.

However, the clinic staff did not implement this system fully, and encouraged all patients to arrive at the clinic before 10am on the date of the appointment, and patients who arrived in the late morning or noon time, were denied access to the provider. This was noticed in all the three clinics except for the mobile clinic.

This behaviour of the clinic staff was based on the common ground ' to get on with the work as quickly as possible and then rest'. Probably once they went home, most of the female providers were consumed with domestic chores, and tried to get some rest during their paid work because they were unable to do so when they went home!

Overlooking the fact that this unique system was established to help in monitoring clients' flow, the clinic staff imposed their own routine of work on the clinic clients, because they did not perceive any benefits for themselves in implementing this system.

Despite this non- compliance with the organisational system, most of the clients waited for less than an hour to receive FP services, and a few of them waited for more.

However, unlike the three other clinics, it was observed that clients were not allowed to see the service provider on a walk- in basis without a prior appointment. This could be another procedural barrier that explained the decrease in recruitment of new clients

between 1996 and 1997. Moreover, the same provider provided antenatal and FP services, which could delay women in receiving services, especially on the specialist clinic day. Similar to the MOH routine, the head nurse replenished contraceptive stocks of OCs and condoms for old FP users every 2 months, and clients using OCs for the first time were referred to the physician. The workload was evenly distributed, and each member of the team had a specific assignment and knew what to do. The clerk in the record room performed his clerical duties efficiently. There were no computers available, and all the information was documented by hand, on the patient register and client files. The monthly statistical report was prepared by the head nurse, and included all the ante - natal, paediatric, FP tasks, and the providers' load for that month.

Treatment protocols for complications were not available in the facility, and the patients were referred to the Zarqa General Hospital (MOH hospital). Table 7.3 includes a summary of the assessment of organisational routines at this clinic.

Table 7.3 Assessment of organisational routines at the Zarqa MCH-UNRWA Clinic (MAQ checklist)

Adequate routine	Inadequate routine
Majority of clients adequate (> 1 hour, not adequate)	Guidelines & protocols used in case management and Mgt. Of staff
Utilisation (Inadequate if less than 50%of other sessions)	Guidelines used for in-service training of staff
Supervisory visits (at least quarterly)	Supervisory tools used (checklist, forms, etc.)
Register for supervisory comments during site visits	Written work plans for supervising staff
Full Technical staff	Technical guidelines &protocols, infection control protocols
	MIS records and forms Definitions of users, new users, accuracy of definitions if 1 wrong not adequate
Monitoring: 2 management meetings per year at least	Clients' records complete, (if >5% incomplete not adequate).
	Quarterly feedback from Management to field on performance
Not > than 3 administrative steps for client to see Dr.	Monthly staff meetings
	Polyclinic director visits the clinic once weekly
Total adequate criteria 7 out of 17	

The SFWC scored highest among the four clinics for organisational routines (10 adequate criteria out of 17), because it was one of the sites of the CPP. In addition, the SFWC staffs were familiar with the assessment criteria because their managing organisation (Pathfinder International) had devised the assessment tools used in this research.

The second highest score was obtained by this UNRWA clinic, most probably because it is an international organisation of the United Nations. The management of UNRWA directs this clinic and other services independently from the Jordanian Government and their organisational standards be derived from WHO and UNFPA models of provision.

7. Facilities, Equipment and Storage of Commodities

The building of this clinic was new, clean, and purpose -oriented. It was owned by UNRWA, was very sunny and well - ventilated, in comparison to the MOH facility. However, it was not as rich in set up and resources as the SFWC and would also rate second of the four services included in this study.

Since this was a purpose- oriented building, storerooms were available, and the stock of materials and stationery were well organised and tidy. The basic commodities needed for client examinations and treatments were available, except for an ultrasound machine. The clinic was also equipped with a steam steriliser, and the equipment and instruments used were sterilised on a daily basis.

However, there was a shortage in IUD insertion sets, but this was not felt as a problem because clients did not always utilise this clinic for IUD insertion or examination (service statistics & observation). They were reluctant to insert IUDs at this

facility because the doctor was a male, and utilised the MOH or JAFPP clinics instead, because the doctors were females in those clinics.

8. Training equipment

This clinic did not accommodate any students for training, therefore training equipment reference materials and books were not available. The GP doctors were trained in FP procedures at the JAFPP, or MOH.

9. Infection prevention practices

Infection control procedures were generally adequate at this clinic. The bathrooms were clean and the examination tables had clean sheets, and were wiped after procedures. Sets were cleaned and sterilised in the same facility, and the medical and nursing staff used hand washing techniques after examining the patients, because they had sinks and soap available in the FP and examination rooms. Needles were disposed of properly however, written infection control procedures, protocols, and guidelines were not available at this clinic.

III. Service statistics (Zarqa MCH clinic – UNRWA)

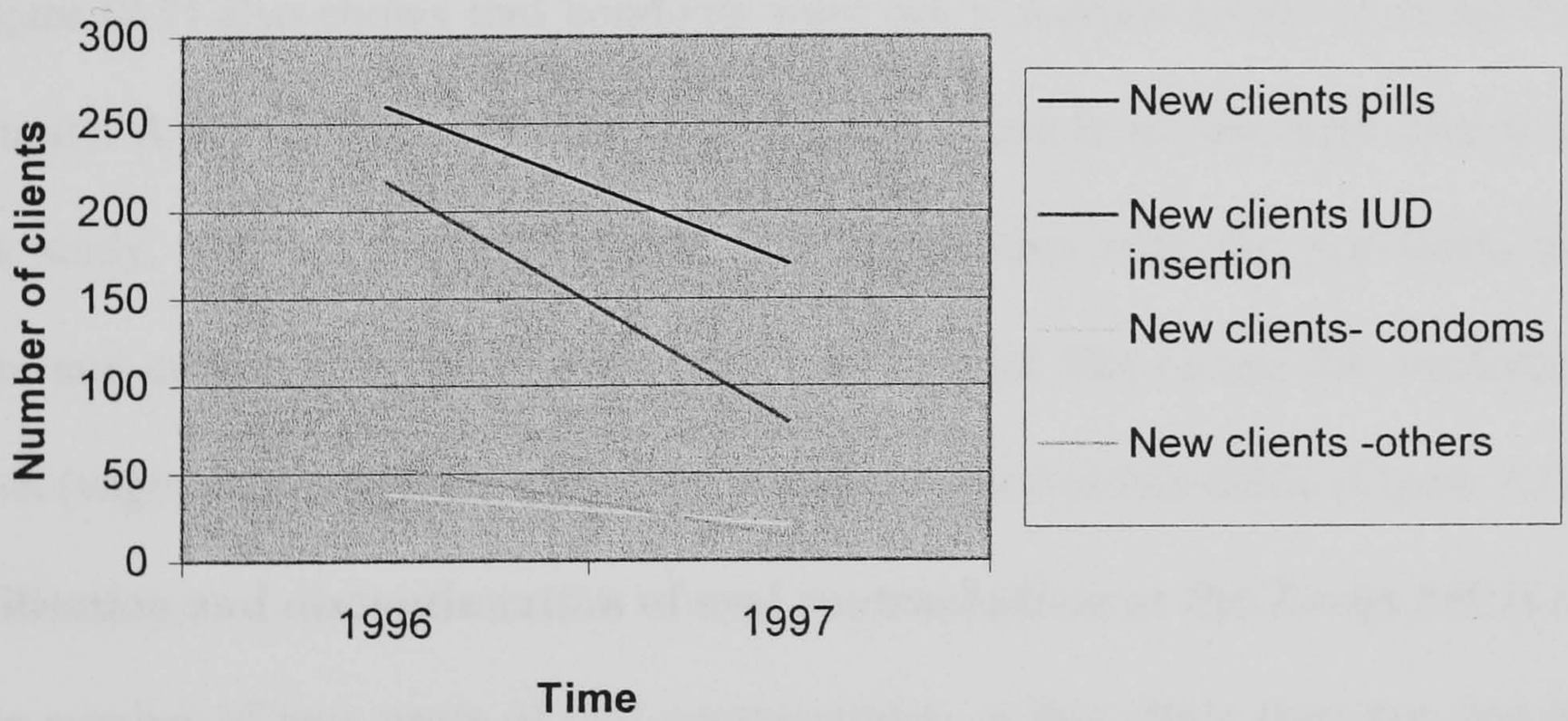
A monthly statistical report is submitted to the UNRWA headquarters, the Jordan field, and a copy is kept in the record room of the clinic. This clinic was established in December 1995. The statistical reports (January 1996 - August 1997) were retrieved and analysed in this study. The short history of this clinic (1 year and eight months) however, is a limitation in analysing FP services utilisation. In addition, the new users of FP methods at this clinic in 1996 are not actual new users but transfer clients from the other UNRWA general clinic in the Zarqa camp. They were transferred to the Zarqa MCH at the beginning of 1996 just following its establishment a month earlier for the purpose of

receiving FP services organised according to the Family Health Model. That is why the UNRWA senior managers wanted the research done in this clinic in particular because they believed it represented well their FP programs and services.

1. New clients' utilisation of FP methods at the Zarqa MCH clinic

The clients of this clinic, exclusively women from the Zarqa refugee camp utilised FP methods in a pretty similar way to women in the other neighbourhoods of Zarqa City. OCs and IUDs were the two most widely used methods by the new clients of Zarqa MCH clinic (Figure 7.1). Women in the other neighbourhoods mostly utilised these two methods as well.

Figure 7.1 Method utilisation among the new FP clients of the Zarqa MCH, UNRWA



Although IUDs were more used than the pills among the total users of all the UNRWA clinics (Madi 1997), pills were more used than the IUDs at this clinic. This might be due to the gender of the service providers, and the fact that IUD services were only provided once a week.

As seen in the previous chapter (6), pills were also more utilised than IUDs at the SFWC where a male specialist provided FP services on Thursdays and Sundays.

Women might have found it easier to use the pill at this UNRWA clinic because it was available on a daily basis, and could be provided by the head nurse; while IUD utilisation (insertion, examination and discontinuation) was not possible except by appointment with the specialist on Wednesdays. At the MCH training centre of the MOH, IUDs were more utilised than OCs most probably because this service was provided on a daily basis by the general practitioners that were all females. This might have encouraged IUD utilisation at the MOH MCH training centre.

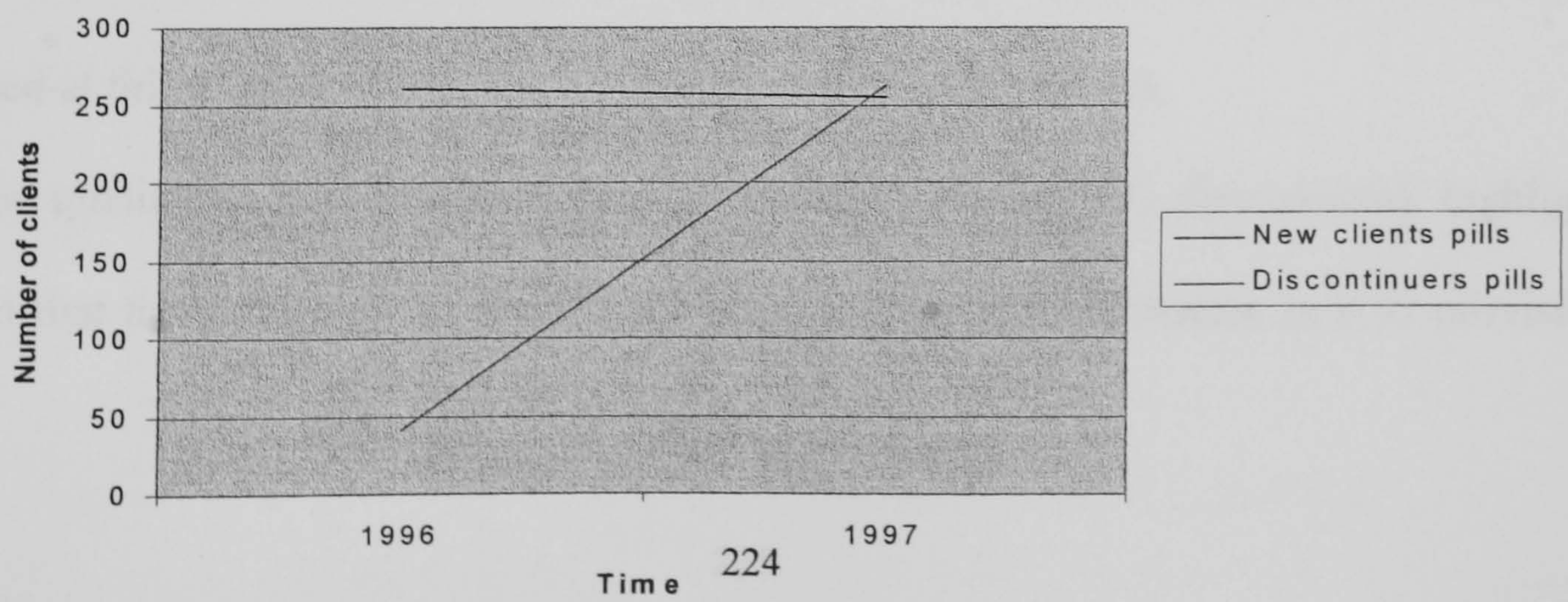
Furthermore it was noticed by observation that women were always asking about the gender of the doctor when they came in to make appointments for FP services. This was obviously an issue for the refugee women as well as for the women of the other communities of the Zarqa City and Governorate.

Figure (7.1) also shows that condoms were not a popular method among this camp community. A low utilisation of the condoms was found in all the three clinics included in this study, and the qualitative data (FG discussions with the providers, men and women, and couple interviews) show that men did not like to use the condoms. Other methods (vaginal tablets) were also not a popular method at this clinic (Figure 7.1).

2. Utilisation and discontinuation of oral contraceptives at the Zarqa MCH clinic

The number of new users of oral contraceptives at this clinic does not change much

Figure 7.2 New users and discontinuers of oral contraceptives at the Zarqa MCH, UNRWA

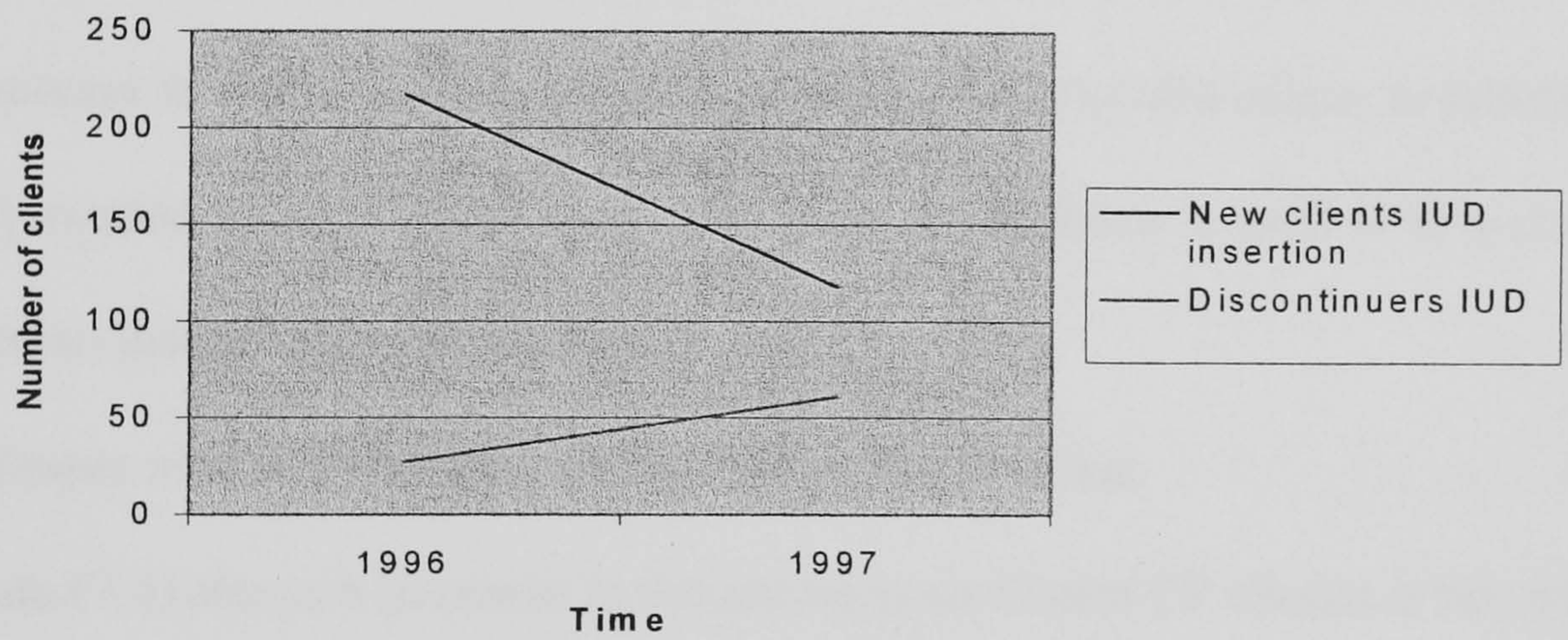


(1996- 1997) (Figure 7.2). Since the number of new clients that used the pill in 1996 not an actual number (i.e. the sum of the clients that used this method in the other UNRWA clinic (transferees) plus the actual number of new users of the pill in1996 at this clinic). One might hence deduce that the number of new clients using the pill at this clinic increased in 1997. Figure (7.2) shows an increase in pill discontinuation at this clinic as well (1996-1997).

3. IUD insertion and discontinuation at the Zarqa MCH clinic

Figure 7.3 shows a decrease in IUD insertion at this clinic (1996-1997). Since the

Figure 7.3 IUD insertion and discontinuation at the Zarqa MCH clinic, UNRWA



initial number of clients (217) considered at the beginning of 1996 is a sum of all the clients using this method at the other UNRWA clinic since 1993. And since they were transferred to this clinic when it opened at the end of 1995, one might deduce that there is no real decrease in IUD insertion at this clinic in 1997. The number of clients that had IUDs inserted at this clinic in 1997 (118) represented the actual number of IUD clients recruited at this clinic in 1997, and not transfers from other clinics.

The qualitative data however, (service observations and FG discussions), highlight the fact that the gender of the service provider, and the time limitation in IUD provision

(one day per week) at this clinic might be acting against IUD utilisation. Furthermore, as pointed by the service providers, rumours spread in the community among neighbours about the complications resulting from IUD utilisation (bleeding and infections), might be discouraging new FP clients from utilising this method (FG discussion with UNRWA providers). The number of clients that discontinued the IUD increased from 27 clients in 1996 to 63 clients in 1997.

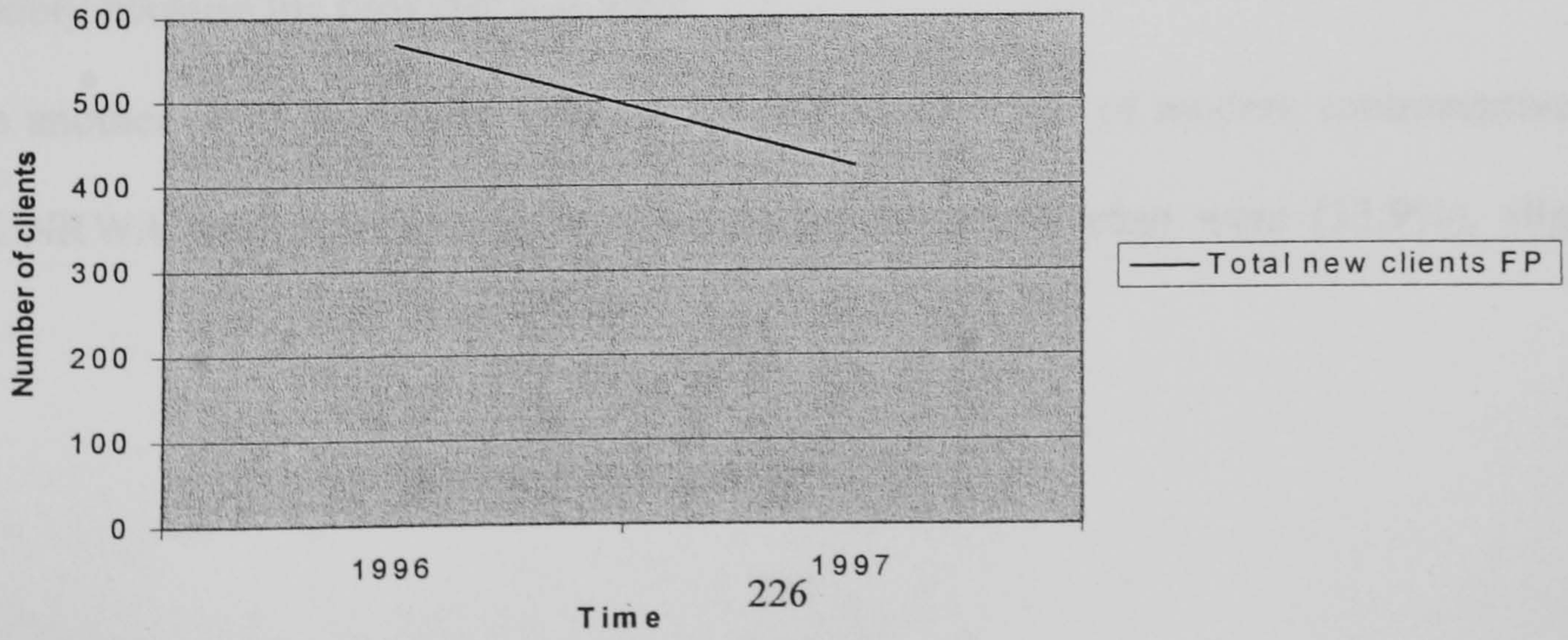
It is important to know that women from the camp (natural group discussion) said that the service providers of this clinic refused to remove IUDs that were not inserted at this clinic. They also said that the providers sometimes made exceptions for their relatives and acquaintances. There is no definite way to know whether these numbers represented an actual increase in IUD discontinuation among the clients of this clinic, or whether they were simply caused by IUD users from other clinics that knew a staff of this clinic and were allowed to discontinue the IUD here.

4. Recruitment of new FP clients at the Zarqa MCH clinic

Figure (7.4) shows a decrease in the recruitment of new FP clients at this clinic.

The head nurse of the Zarqa MCH clinic explained that this was not an actual decrease in the recruitment of new clients at this clinic (1996-1997). The total new clients (569) in (1996) was nothing but the accumulation of the total new FP clients that had

Figure 7.4 Recruitment of new FP clients, Zarqa MCH



been recruited at the other UNRWA clinic between (1993-1995). They were transferred to this clinic at the end of December 1995, and counted with the 1996 clients as ordered by the Field Health Director. They were new clients of this clinic, however had been FP clients of the other UNRWA clinic from 1993 onwards.

In 1997, the actual number of new clients recruited at this clinic is (423) Figure (7.4). This clinic has a quality environment for service provision (the building) in comparison to the MOH facility, and it scores well for counselling activities and support systems that were all devised and instituted by the UNRWA management. However, this clinic is relatively new (2 years), in comparison to the other services (10 years).

IV. UNRWA (agency-wide) studies on contraceptive utilisation and discontinuation

Madi (1997) did a cross-sectional study to assess contraceptive utilisation of mothers who attended UNRWA MCH clinics, Agency-Wide (the five sites where UNRWA operates namely Jordan, Syria, Lebanon, West Bank and Gaza). She found that the most popular method among total FP users was IUDs (57.9%), followed by the OCs (23.5%). Condoms and spermicides were much less popular methods, with percentages of utilisation of (13%) and (3.9%) respectively.

These findings matched the findings of this study in the sense that the two most popular methods among new clients of FP at this UNRWA clinic were the IUDs and the OCs. However, contraceptive pills were more popular than the IUDs at this clinic probably because the provider was male.

In another study by Madi (1996) on discontinuation rate of modern contraceptives in all UNRWA clinics, contraceptive prevalence rates in Jordan were (33.9%), slightly

higher than the overall prevalence of modern contraceptives Agency-wide (32.12%) (Madi 1997). However, the mean birth interval for Jordan was only 30 months.

Furthermore, clients in all four fields (Syria, Lebanon, Gaza and the West Bank) utilised mainly UNRWA clinics for their supply of FP methods. In Jordan, only 37.8% utilised UNRWA services, while 8.2% utilised government services, and 54% other sources, because the JAFPP, private sector, and other NGOs also supplied FP services and methods (Madi 1997).

The qualitative data of this study confirmed that women were utilising the above-mentioned providers in Zarqa, except for the private sector, which was found to be expensive, and was rarely used by them to seek FP services. This lack of utilisation of the private sector for FP services was confirmed by women in the camps, and by the private sector practitioners.

V. Providers' views about utilisation of FP services and methods (FG discussions)

Unlike the service providers of the MOH or SFWC, the service providers of UNRWA were not satisfied with FP service utilisation in their respective clinics (Zarqa MCH and Msheirfeh MCH clinics). Only one third of the total clients came for FP services, and although the situation was perceived to be changing with time, the change was slower than expected. According to many providers, the fact that FP services were relatively new at UNRWA clinics (1993) acted against optimal or maximal utilisation:

- ✓ 'If I come one day at random and observe how many pregnant women come and how many women come for FP... we would find that only one third come for FP and the rest come for pregnancy and other services' (male specialist doctor, 45, married, 3 children)

- ✓ 'Only 30% of women utilise FP services and the rest of the clinic clients are using the antenatal services or paediatric clinic' (RN, female, 48, married, 4children).
- ✓ 'Our ambition is to have more users in the future although the number is acceptable but we want more than that' (male doctor, 36, married, 2 children).

Some providers perceived utilisation as being chaotic and haphazard for the time being. Another one felt that only women with no other options utilised UNRWA clinics.

- ✓ 'Why does she come once yes and once no to the clinic appointments and then she leaves after two months... maybe because she thinks that they are going to deprive her of her referral card or ration card or of the service or of other things?' (male specialist doctor, 45, married, 3 children).
- ✓ 'We cannot know if she returns to us or to other places because we do not have a central computer' (charge nurse FP, female , 45, married, 1 child)
- ✓ 'Most people that seek our service are from the lowest social class and they are poor and not aware...'(male doctor, 44, married with 2 wives, 9 children).

The providers disagreed on the utilisation of the private sector for FP services. One of them believed that the higher social strata of the camp utilised the private sector, while another disagreed. According to him, the private sector was used for all other services except FP services:

- ✓ 'As for other classes that are more aware, they use the private sector and included in these clients are those that utilise FP' (male doctor, 44, married with 2 wives, 9 children).
- ✓ 'The private sector are busy with pregnancies, deliveries and infertility and not FP!' (male specialist doctor, 45, married, 3 children).

The service providers believed that the utilisation of contraceptives was directly related to age and the achievement of reproductive intentions,

- ✓ 'The fear is that one wants to have children when one is young and bring them one after the other ... and after forty years of age they start using FP' (charge nurse FP, 45, married, 1 daughter).

VI. Providers' views of service barriers to FP utilisation (FG discussions).

The service providers of UNRWA were all aware that their gender (male) was an important determinant of service utilisation. Since the physicians in both clinics were males, this acted as a barrier to service and specifically to IUD utilisation.

- ✓ 'If a female specialist came in my place, service utilisation would be better' (male specialist, 45, married, 3 children).
- ✓ 'We have IUD examination, but because we do not have an ultrasound, we are forced to perform an internal examination (vaginal) and the women do not like it and this does not help us. On the contrary, appointments are cancelled or they are postponed...If we had a female doctor, the situation would be different, no embarrassment for them, and less postponing of appointments' (charge nurse FP, female, 45, married, 1 daughter).

Waiting time and the fact that the specialist was not available on a daily basis, were also perceived as service barriers by the providers:

- ✓ 'The waiting time and the great numbers of the clinic users are a negative factor. And the problem is that the service provider is not always available (the Obstetrician and Gynaecologist) to insert the IUD' (male specialist, 45, married, 3 children).

Some providers expressed serious concern around the approach to clients. They did not believe in a compulsory approach, and advocated a culturally -sensitive approach:

- ✓ 'We want the woman to be willing and to like to use FP ...and the method that she chooses to be based on conviction and for her to continue using it...while if coercion is used, the woman will discontinue its use and feels that the contraceptive method causes her problems and infections' (female PN, 31, married 2 children and a male doctor, 36, married, 2 children).
- ✓ 'It is not right to give crude and straightforward information to ladies without any preliminary introduction or taking into consideration her culture or educational level...'(male doctor, 36,married, 2 children)

A gender bias was observed in the opinions expressed mostly by male service providers with the agreement of a few female service providers.

- ✓ 'The issue of having a female doctor in the clinic is not always an excellent thing as sometimes the male doctor can convince the woman in a better way than the female doctor' (male doctor, 36, married, 2 children).
- ✓ 'Let us not forget that the use of FP is based on the culture, local customs, religion, and the 'showing-off' and jealousy behaviours among women (male doctor, 36, married, 2 children).

Some of the female service providers rejected the idea of men (husbands) visiting the clinic. Female FP providers did not even discuss FP with their own husbands, showing a traditional mentality:

- ✓ 'Q: Do the men always accompany their wives to the clinic?

- Not always, even we do not like it because then there will be a mixture between men and women and we do not like it...'(charge nurse FP, 45, female, married, 1 daughter)

✓ 'We are the service providers of FP... and our husbands do not know anything about it, we do not discuss it with them' (RN, female, 48 years, 4 children).

The service providers in both clinics believed that fertility was high among the refugee community because child demand was very high. One or two providers believed that at times, jealousy among women increased child demand:

✓ '...Especially the girl who marries at 14-15 years of age she will not stop delivering till she terminates her reproductive phase...'(charge nurse FP, 45, married, 1 daughter).

✓ The woman compares herself with the wives of her brothers-in-law and neighbours, for example one woman delivers a certain number of children so the other women says: 'Why don't I deliver the same number'? Even the women who are highly educated behave in this way ...it becomes a race that explains our increasing demand for children' (male doctor, 36, married, 2 children and a female PN, 32, married, no children).

Child demand was especially high among the '*Sibawis*' (Bedouins in *Beer el Sabe*' before becoming refugees), because of the concept of '*Ezweh*'. The concept of '*Ezweh*' will be explored in details later; it is based on the belief that male progeny was a means of social prestige and status, and a means of protection, during tribal times. The providers believed that child demand was not affected by women's educational level:

- ✓ 'You have the '*Sibawis*' each one of them has 7-8-or 10 children and it is a race for '*Ezweh*'... and the one who does not deliver is divorced by her husband... and he marries another and another...These men may marry four women to increase their progeny.... And each woman wants to follow the other wife in the number of children they have (Traditional Birth Attendant, (TBA), female, 47, married, 5 children).

Birth intervals were very short in the Zarqa camps community as perceived by the providers in both clinics:

- ✓ 'A few have an interval of only one year or months' (male doctor, 42, married, 3 children).
- ✓ 'You will find some women who get pregnant every year or two and some of them get pregnant immediately after the postpartum period' (RN, female, 48, married, 4 children).

Providers' beliefs concerning fertility and FP

One provider explained how FP was based on a quality of life rationale, because it improved the economic and health status of users and their families. Most arguments in favour of FP given by the providers during the discussions were based on economic and health rationales:

- ✓ 'FP is necessary so that a child has the right to a decent life...and let us not forget the economic situation and the health of the mother. These are basic considerations. Add to this the problems and risks of late pregnancies, and that is why we must have FP to preserve the mother's health, the family's health and the community's health'(male doctor, 36, married, 2 children)

The providers believed that there was compliance with FP utilisation because of financial pressure and not because of a deep conviction with it:

- ✓ 'The improvement that occurred was not because of FP itself, but because of need, and because of the poor financial situation. It was not because they are satisfied with three children in the family... And the proof of this is that she uses the method for a month, and then you find that after a while she comes back pregnant' (RN female, 48, married, 4 children).

The service providers' opinions concerning FP and fertility were very much the result of their socio- cultural context. Their opinions and attitudes did not differ greatly from the ones expressed by the camp community, although they perceived themselves as different and more advanced. The spectrum ranged from seeing FP as a necessity of life, to believing that the ideal number of children to have is five or six children, to believing that *'Rizk'* (personal fortune) was predetermined, therefore FP did not matter much.

- ✓ 'One must have enough number of children depending on his health and familial conditions, one must have 5 children at least if his health and financial situation allow that' (nurse in charge FP, female, 44, married, 1 daughter).
- ✓ '6 children is very good' (midwife, single, 23).
- ✓ 'Birth spacing to have a child every three to four years (TBA, 47, married, 5 children)'.
- ✓ 'I was reading a religious book and it said that the souls are created thousands of years ago and also that *'Rizk'* is divided since that time...It means that with or without FP everything is predestined and written' (nurse in charge FP, female, 44, married, 1 daughter).

Needs and strategies at the service level to enhance FP utilisation:

The UNRWA providers in both clinics focused more on the community needs than the service needs during the discussions. One doctor believed vertical provision of FP would be more effective in increasing FP utilisation because of the high load of clients (FP and other) in the current integrated model, but the other doctors disagreed with him. They believed that the Family Health Model allowed them to initiate FP utilisation in a wider audience of women by counselling them when they came to the clinic to seek paediatric or antenatal services. Another doctor mentioned the shortage in female doctors, but he considered this a minor issue:

- ✓ ' The only thing is the unavailability of a female doctor in the centre and this is a minor factor which could be of little effect on service utilisation or spread of FP in the community' (male doctor, 36, married, 2 children).

One practical nurse suggested counselling couples, rather than women alone as a strategy at the clinic level to enhance FP utilisation. She perceived this to be more effective, because women were not then left alone to convince their husbands. Instead, the clinic shared this responsibility with them.

- ✓ 'They have to be together so that the decision will be better...On the contrary, when she is alone and goes back home and has to convince him about the FP method, she might fail in convincing him' (female PN, 32, married, no children, raising her husbands children).

Other providers stressed on counselling and health education, based on the health and economic rationales for FP utilisation. One doctor believed that this would be much better done when the providers were only dedicated to FP (vertical provision).

- ✓ ‘ We try to reach the woman during counselling by telling her that the husband wants a strong woman, and he wants everything for the children, and a house ready that has everything available: cleanliness and food ready and the children well brought up… and even that she looks very smart and be nicely dressed up and made up for him when he comes home’ (RN female, 48, married, 4 children).

Conclusion

FP provision in UNRWA is fairly recent, and largely determined by international models, standards, and influences of the WHO, UNFPA and the latest trends in the International Population Movement. At the regional level, the political developments around the question of Palestine, and the policies concerning the Palestinian refugees influence FP provision in UNRWA.

The facilities, organisational routines, counselling practices, choice of methods, and continuity and support system rated fairly high in comparison to the other three clinics included in this study. However, it was difficult to assess utilisation because of the short history of this clinic. Furthermore, the gender of the doctors, attitude of the clinic personnel, and their conviction with FP, in addition to the time constraints in IUD service delivery were all affecting FP utilisation. Other centres providing FP services (MOH, JAFPP) were available and utilised by women from the camp, influencing the utilisation of FP services at this clinic.

The following chapter shows utilisation in the mobile clinic of the JAFPP and the private sector and summarises the strengths and weaknesses of the different models of provision.

Chapter Eight

Additional models

The mobile clinic of the Jordanian Association for Family Planning and Protection (JAFPP) and the private sector

Introduction

This chapter reviews additional models of provision, namely the mobile clinic of the JAFPP - covering the remote areas of the Zarqa Governorate where they were the only providers of FP services in certain areas - and the private sector, almost exclusively utilised by the wealthy for family planning services. The mobile clinic of the JAFPP was selected rather than its regular fixed services to cover one end of the spectrum of FP provision available in Jordan i.e., provision for the most underprivileged. Despite the limited access to the private sector provision, it was also included in this chapter because it covers the other end of the spectrum of provision for the most privileged.

I. Policy makers' views of FP provision at the JAFPP (in-depth interviews).

JAFPP was acknowledged by a large portion of policy makers interviewed as a major population policy player and FP provider, which worked in advocacy at the national level. Furthermore, the FP services they provided were perceived as quality services by some of the policy makers. The director of services at the JAFPP described how they were revising their operational policy to devise strategies for widening access. Among future strategies to be used for this purpose were community- based distribution of contraceptives and services, and the 'life-cycle' approach to service delivery.

✓ 'In Jordan the pioneers in FP programs were the JAFPP before the government'

(Demographer and senior consultant to the NPC - Policy project, USAID, Jordanian, male, married with children)

- ✓ ' JAFPP covers 35% of services, and I am sure that JAFPP has high quality work' (senior policy maker, UNRWA, Jordanian, male, married with children).

In Zarqa, the JAFPP model of provision included a mobile clinic offering outreach to rural communities (observation, service statistics and FG discussion) and a conventional clinic (FG discussion only).

II. Service observations

Service provision observed at the mobile clinic was not typical of all of their provision. Service observations were done in Azraq on the 26th of July, and 25th of August 1997, from 10am to 2pm. On the 27th of August, service observations were carried out in the bus, and on the 28th of September 1997, at the MOH centre of Al Hashemieh housing complex. Two focus group discussions were organised with the service providers of the mobile clinic and JAFPP fixed clinic of Zarqa City on the 30th of November and 3rd of December 1997. The participants from both clinics were all female and married.

1. General background information

This NGO, an affiliate of the IPPF, was a pioneer in providing FP services since 1967. Since its establishment, JAFPP has been a major FP provider to the Jordanian population. In 1992, the mobile clinic was started to provide FP services to the remote rural and Bedouin areas of the Zarqa Governorate, and is the only FP service provider in some of its remote areas.

The mobile clinic visits Azraq once a month, where the services are provided at Azraq Women's Association, in co-ordination with the friends of the JAFPP. Unlike the three other clinics included in this study, there was a definite geographic barrier to accessing FP services for local residents of Azraq and other remote areas of the Governorate.

The mobile clinic also visited Hashemieh, a settled Bedouin community, twice a month. Once a month, services were provided at the MOH centre of Hashemieh housing complex. The second visit was at Hashemieh itself, where services were provided in the clinic bus. In agreement with the MOH officials, the bus stopped near the MOH centre of Hashemieh. There was a geographic barrier caused by the rarity of the service, for the women of Al Hashemieh to access the mobile clinic bus. In addition, there was a service barrier caused by the lack of privacy. Women were very reluctant to use the bus, because if they did, all the residents of the village would know why they were going to it. This socio-cultural barrier in accessing the mobile clinic was expressed by women themselves, who expressed their discontent during the natural group discussions.

The mobile clinic providers were aware of the barrier that infrequent visits of the mobile clinic represented to local residents of remote areas of the Zarqa Governorate:

- ✓ 'Yes, some of them would like us to go to them every day in Azraq or other regions in order to provide a service to them. Let us not forget the remoteness affects them' (female provider, mobile clinic, 33, divorced, 2 boys).
- ✓ 'Let us not forget that we have mobile clinics that reach certain places, but there are other places that we do not reach like Dleil' (female RN, fixed clinic, 43, married, 3 children).

2. Client volume and range of services provided

More women came to the mobile clinic in Azraq (more remote) than Hashemieh area on the days of service observation. The populations at risk were different but unknown for both areas. Seventeen and fourteen women received FP and antenatal services in Azraq (2 days of observation), while only eleven women came to the mobile clinic in Hashemieh for two days. These figures are not sufficient to conclude that the mobile clinic was more popular in Azraq than in Hashemieh, but women of Azraq had fewer options for service utilisation than in Hashemieh. The distance of Azraq - two hours drive away from Zarqa City - forced women in Azraq to use the mobile clinic. It seemed easier for women of Hashemieh to use the services in Zarqa City because of its proximity (15 minutes drive by car) and the availability of public transportation on a more frequent basis than in Azraq on the one hand, in addition to preserving their privacy. The women of Hashemieh expressed their preference to use the Zarqa City clinics where their privacy was preserved, rather than the mobile clinic bus.

The mobile clinic provided antenatal, gynaecologic and FP services. The contraceptive methods available were IUDs, OC, condoms, vaginal suppositories and injectables. Counselling was also provided to women as needed.

Despite the fact that the service providers were all female, IUD take up was low relatively to other methods at this clinic because of the rarity of the service. The service statistics showed a high utilisation of condoms. The limited service observations (2 days per area only) did not reflect this preference. However when the providers were asked, they said condoms were mostly used in the Jordan Valley rather than in Hashemieh or Azraq.

3. Counselling practices

The mobile clinic staff provided counselling services during consultations, and the information given was thorough, and complete. However, the provider spoke in a hurry, and too much information was given at a time. In one or two instances, the providers were observed to be in a bad mood, and lacked empathy by using sarcasm with clients. In one particular instance, they were extremely mean to a client who did not have the complete fee for the consultation. However at other times, they were cheerful and had a good rapport with them. Table 8.1 illustrates the assessment of counselling practices at this clinic.

Table 8.1 Assessment of counselling practices at the Zarqa JAFPP mobile clinic (MAQ checklist)

Adequate criteria	**Inadequate criteria**
Technical competence of staff	
Correct new information on methods use	
FP training 2 weeks minimum for doctors adequate	For nurses inadequate training in FP
	Clinical staff 10 IUD insertion during training
	Provider has IEC materials available for use 3 materials available adequate
Technical staff FP refresher course in last 3 years	
Minimum 10 minutes with new clients	
	Outreach worker 1 talk per day to groups
	Out reach worker two talks /week
Staff client interaction	Not Adequate at times
Clients treated with respect and courtesy	Style of dressing and mannerisms
Communication barriers	**Inadequate staff client interaction**
Eye contact	First clients
Provider knock on door before entering	All client questions welcomed (no)
More than 1 hour to receive all the FP service	All questions and concerns answered (no)
Reassuring simple answers	Probing questions (no)
Correct contraception for breast feeding clients	
Total adequate: 8 out of 18	**10 out of 18**

This clinic had the same score in counselling as the MOH training centre. These scores were lower than those of the SFWC and UNRWA.

4. Choice of methods, continuity, and support system

The mobile clinic providers were advocating screening for cervical cancer. Women were however not ready for such a diagnostic test, and the word cancer was still taboo to them. Many women were afraid of the procedure and did not have the extra money to pay for it. Three Jordanian Dinars was quite a considerable amount for this rural community.

5. Personnel

The mobile clinic team is composed of a female GP trained in FP, a midwife, and a driver who performs clerical and security functions. The doctor is regularly trained in FP procedures and counselling at the JAFPP headquarters, while the midwife is not.

6. Organisational routines, record keeping, and treatment protocols

Women were admitted to see the doctor either by prior appointment, or just on a walk-in basis, upon presentation of their patient cards to the midwife, and payment of the consultation fee. The only requirement for women to receive FP services was payment of a fee, following which a card was issued them during the first visit to the clinic. This was the only service of the four included in this study where FP services were not free.

Upon arrival to the village &/or town, the mobile clinic driver announced through the microphone, that the mobile clinic was available on that day, as he toured the village by bus. The driver explained that this was a more effective way of drawing the local residents' attention to the availability of the clinic, as they tended to forget prior appointments and written schedules. It was noticed that the children playing in the streets usually greeted the mobile clinic with cheers, and ran after it at times, repeating the same announcement that the driver was making, as they had memorised it by heart.

Following the announcement, women started arriving at the clinic, and were admitted on first come, first serve basis. Consequently, the one who arrived there first, were seen promptly, but the women that arrived later, had to wait sometimes for more than an hour to see the doctor, depending on the number of clients available.

Although, the midwife made appointments for women on a previous visit, and registered the date on their client cards, usually, the women did not keep their appointments most probably because of the rarity of the service. Women were sometimes referred to the fixed clinic however it was usually difficult for them to go to Zarqa City, because they did not always have an escort, or the means of transport.

The doctor and midwife counselled women and provided them with health education on an individual basis during consultation. The doctor prescribed OCs, condoms, and vaginal tablets and inserted IUDs.

This clinic had the same score as the MOH clinic for organisational routines and treatment protocols, (5 adequate criteria out of 17). Both clinics had lower scores than SFWC or UNRWA, which were run by international organisations.

7. Facilities, Equipment and Storage of Commodities

The mobile clinic offered the worst facility among the four clinics, whether based at Azraq Women's Association or in the bus. Azraq Women's Association did not have electricity for a long time, and the doctor had to work with a flashlight to insert IUDs. No sheets were available to cover the patients during examination, and many clients were shy and expressed their concern.

The mobile clinic met only one criteria out of eleven for its physical facility, an extremely low score causing a definite barrier to service utilisation. Clients mostly used

the mobile clinic for quick disposable methods such as the condom or vaginal tablets as shown by its service statistics. Hence, this service was not having a positive yield in terms of client recruitment or change of behaviours.

8. Training equipment

No training equipment or material was available at the mobile clinic. Pamphlets were distributed to clients occasionally, without following a set schedule of distribution.

9. Infection prevention practices

Infection control procedures were followed as much as physically possible in this set-up. No sheets were used under the patients, however a sterile technique was followed in IUD insertion and examination. The mobile clinic staff sterilised all used instruments daily, at the fixed clinic of Zarqa, after they returned from the field. The doctor and midwife washed their hands at the beginning and end of the clinic time but not between clients. There were no written procedures and protocols for infection control at this clinic.

III. Service statistics

Similar to the routine of UNRWA, SFWC and the MOH, a monthly report of all the mobile clinic activities was submitted to the JAFPP headquarters in Amman. However, it was only possible to retrieve the yearly reports of the mobile clinic activities, instead of the monthly reports from the JAFPP headquarters in Amman. The yearly reports are from 1992 - the date of the establishment of the mobile clinic of Zarqa - to June 1997.

The studies of UNRWA, JAFPP and Musallam (1998) from the MOH on contraceptive utilisation and discontinuation show that fertility and reproductive behaviour is very similar in the different settings of Zarqa Governorate. This is most

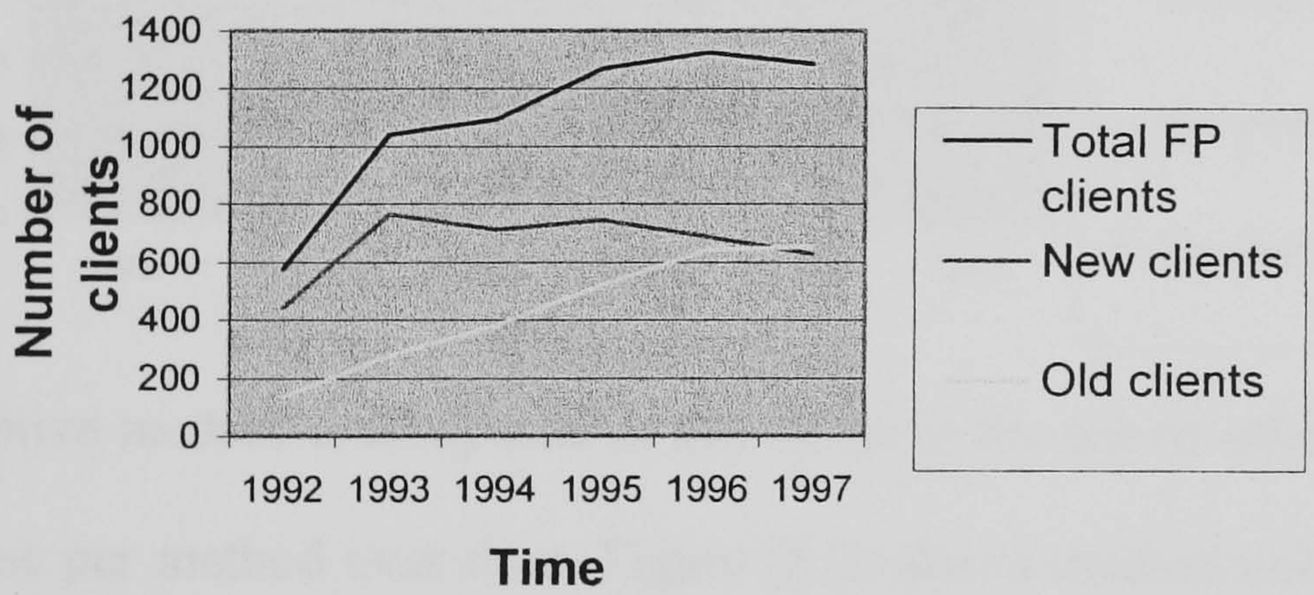
probably related to the common socio-cultural and religious heritage of the clients (Musallam 1998, Madi 1997, and JAFPP 1997).

It was interesting to note however, that method utilisation at this mobile clinic differed somewhat from the three other fixed clinics in the sense that condoms were popular among the users of this clinic.

1. Service utilisation among new, old, and total FP clients of JAFPP mobile clinic

Total 'new users' are the users of the mobile clinic for the first time. Total 'new users' for any given method are clients using the method for the first time or using a

Figure 8.1 Utilisation of services among, new, old and total FP clients of the Zarqa mobile clinic



given method for the first time at the mobile clinic. 'Old users' are the clients that used the mobile clinic more than once. 'Old clients' by method continue using the same method started at the mobile clinic. Figure (8.1) shows that the utilisation of the FP services of the JAFPP mobile clinic of Zarqa amongst the 'old users' and total FP clients has increased in time (1992-1997).

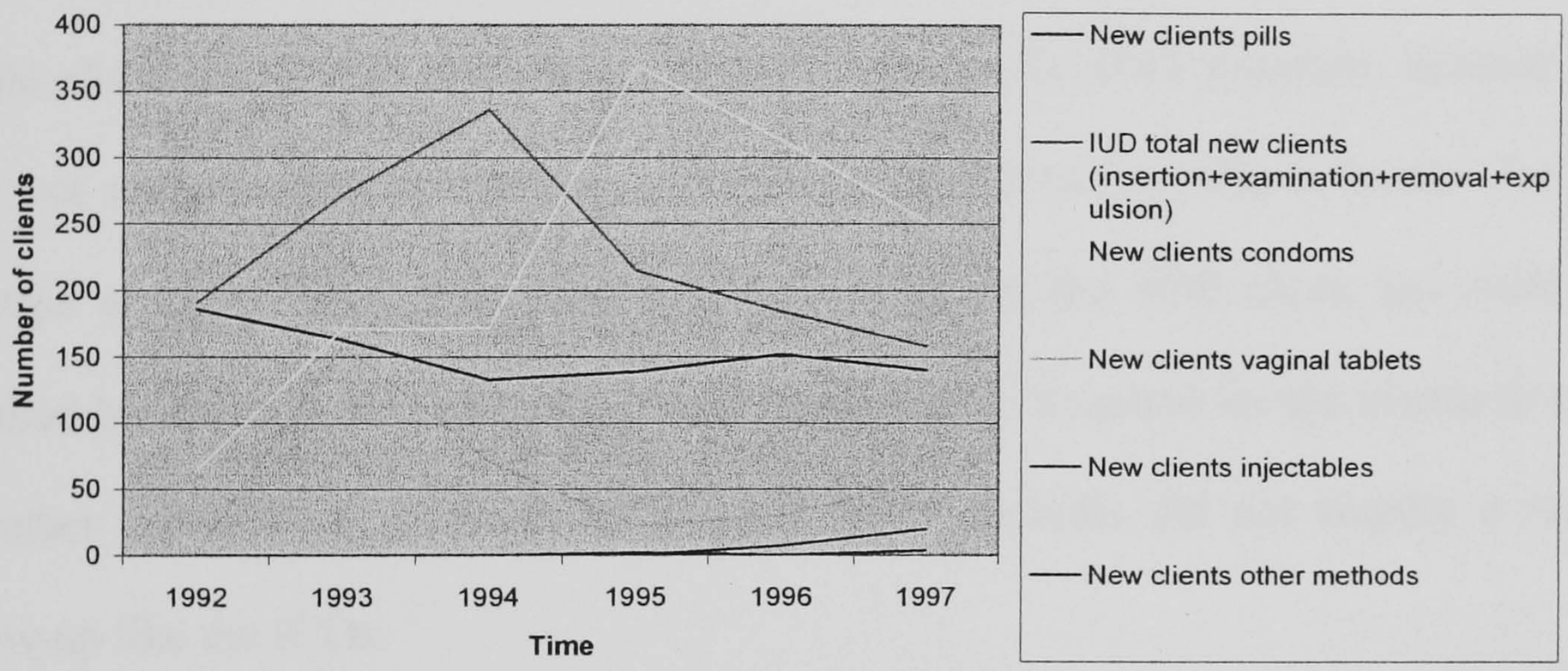
There is also an increase in the recruitment of new clients (1992- mid 1993) after which recruitment decreases slightly (mid 1993–1997) most probably because of the opening of the fixed JAFPP and UNRWA services in mid 1993 as explained by the CEO

of the JAFPP. Now this community had additional options to the mobile clinic to seek FP services.

2. New clients' utilisation of FP methods at the JAFPP mobile clinic

The populations at risk are different and unknown in the different areas of the Zarqa Governorate. Since the denominator remains unknown, the relative use of each

Figure 8.2 Method utilisation among the new FP clients of the Zarqa mobile clinic



contraceptive method is compared in this clinic to the use of other methods, and not the overall use per method over time. Figure (8.2) shows method utilisation among the new FP clients of the Zarqa mobile clinic. The most widely used methods relatively to other methods among the rural and Bedouin clients of this clinic were IUDs between (mid 1992-1995), followed by condoms from mid (1993- 1995).

Earlier (mid 1992- mid 1993), pills were more used than condoms among the new FP clients of this clinic. Condom utilisation then rose markedly between (mid 1994 - mid 1995) to become greater than IUD utilisation at the beginning of 1995. A decrease in condom utilisation is observed after mid 1995 (Figure 8.1). Despite this, the relative take up of condoms amongst new users remains the highest in this mobile clinic in 1997.

The Chief Executive Officer (CEO) of the JAFPP related the relative decrease in IUD utilisation and increase in condom utilisation among the new clients of this clinic to two factors. The expansion of the JAFPP fixed clinics on the one hand (Mafraq in April 93 and Russeifeh in October 93), and the rarity of the services of the mobile clinic (once or twice a month per area) on the other hand. As explained earlier, the female doctors at the JAFPP fixed clinics provided FP services on a daily basis, which might be a better option for the clients who wanted to use the IUD. Furthermore, the days of operation of the mobile clinic were often not suitable to many women for IUD insertion, because they were not menstruating at that time. The rarity of the service was a barrier for IUD insertion at the mobile clinic. Not only IUD insertion, but IUD check ups were also impaired by the rarity of this service, so it became more practical for the clients to either use other services or use condoms because these methods did not require a regular follow-up like the IUDs.

The number of new clients using vaginal tablets increased between (mid 1992-mid 1993), but this method remained the least popular until the end of 1995. Injectables and spermicides in foam and vaginal suppository presentations were introduced towards the end of 1995 and mid 1996 respectively, but remained not popular among the new clients of this clinic.

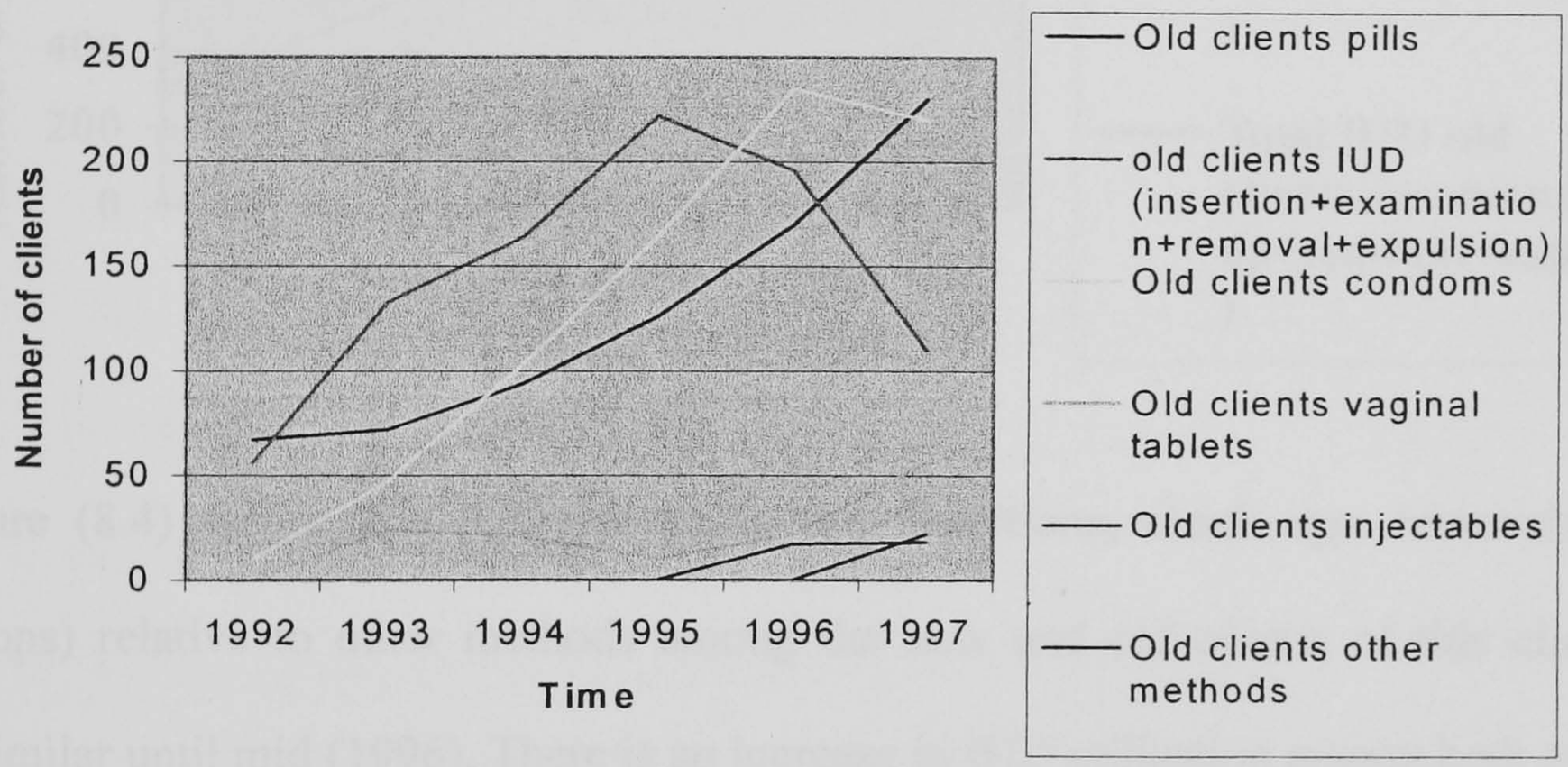
3. Old clients' utilisation of FP methods at the JAFPP mobile clinic

Figure (8.3) shows that IUDs and the pills were the two most popular methods used by the old clients of this clinic before 1994 with IUDs remaining the most popular method until 1996.

In 1996 however, condoms became more popular than IUDs and in mid 1996, a sharp drop is observed in IUD utilisation. Pill utilisation is increasing throughout the period (1993-1997). In mid 1996, when IUD utilisation decreases, pills are the second most widely used method by the old clients of this mobile clinic.

Vaginal tablets were relatively not a popular method although they have been available since the establishment of this clinic (Figure 8.3).

Figure 8.3 Method utilisation among the old clients of the Zarqa mobile clinic



Likewise, injectables are not popular, although utilisation was slightly increasing between (mid 1995 - mid 1996), then decreasing between (mid 1996- mid 1997).

Spermicides, available since mid 1996, increase slightly but their relative take up among the old users of this clinic remains the lowest of all (figure 8.3).

IUD take up among the old clients of this clinic before mid (1996) is in harmony with the findings of the Jordan Population and Family Health Survey (DHS, 1997). IUDs were the most popular method (23%) among all the married women using a contraceptive method in Jordan (DHS, 1997, Table 4.4). Condoms were not a popular method at the national level (2.4% of all FP users) and were also not a popular method in the three fixed

clinics of the MOH, military services and UNRWA (chapters 5, 6, and 7). At this clinic however, the relative take up of condoms among the new users increases markedly since mid (1994) and among the old users since mid (1993).

4. IUD utilisation at the Zarqa mobile clinic

Figure 8.4 IUD utilisation among the new and old clients of the Zarqa mobile clinic

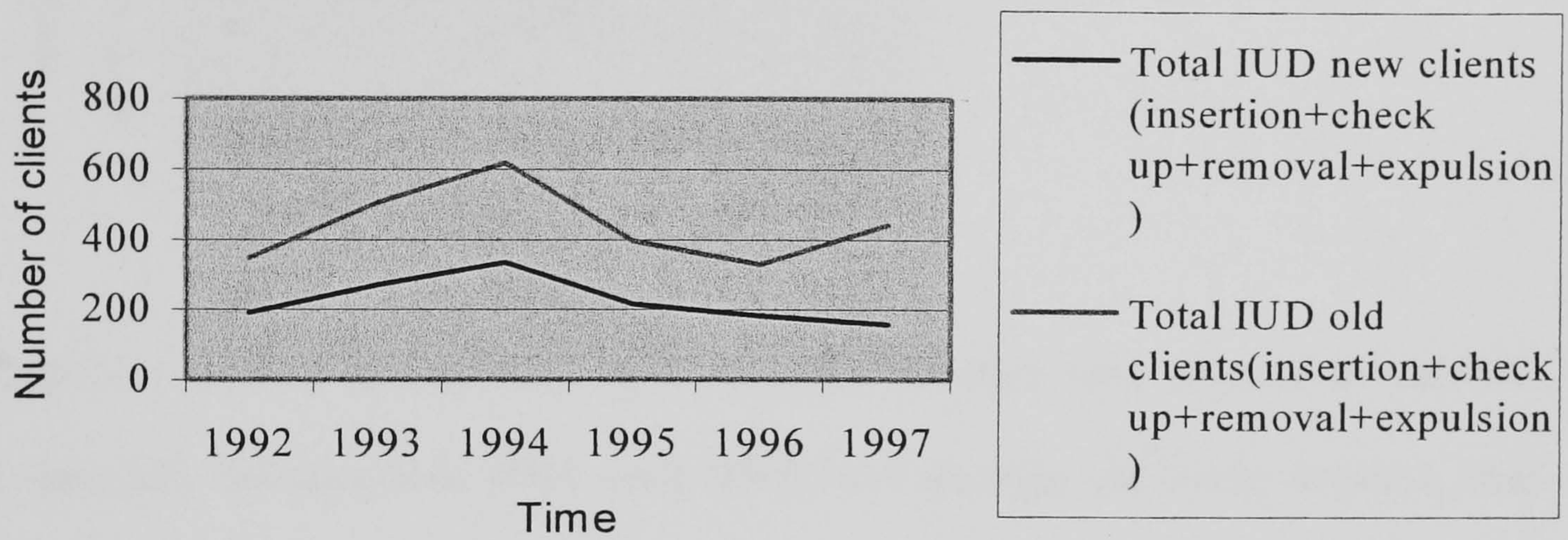
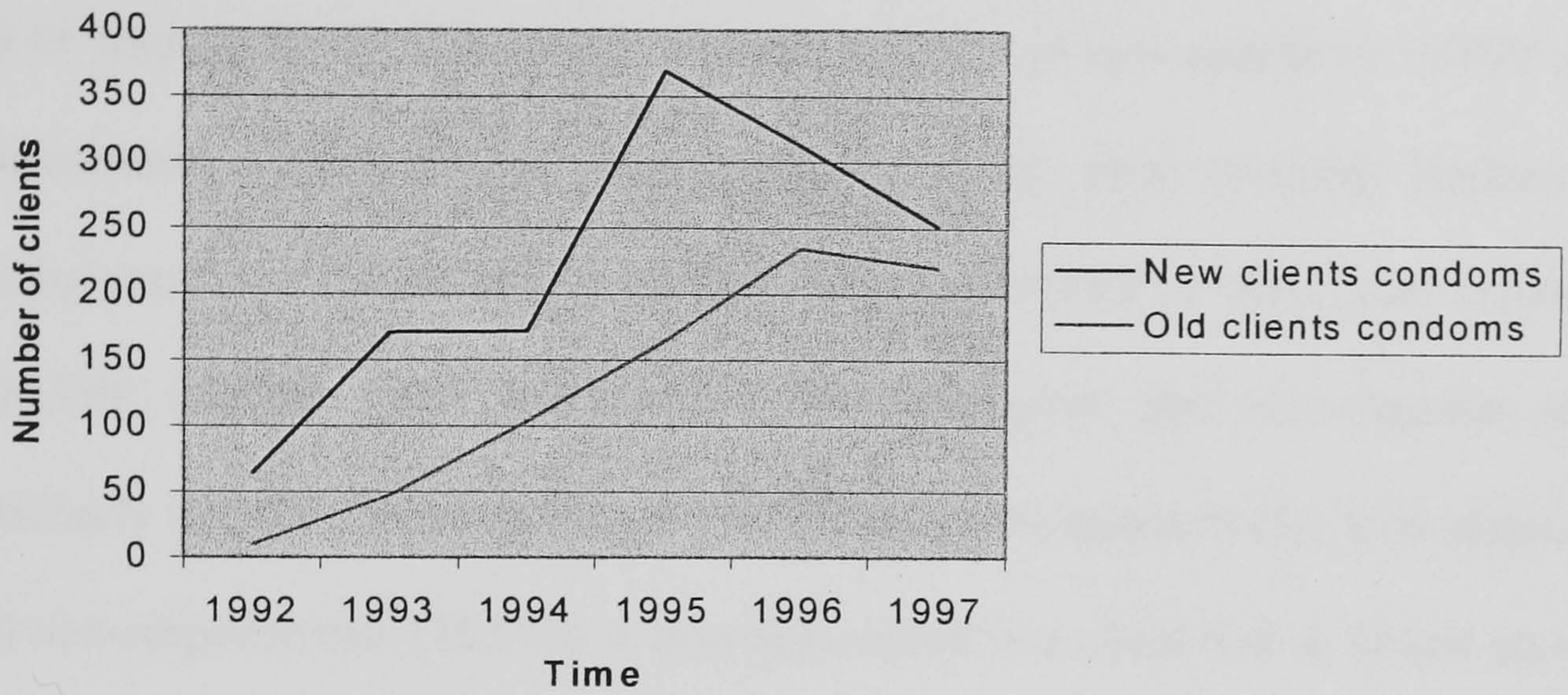


Figure (8.4) shows that IUD utilisation (i.e. insertions, check ups, removals and expulsions) relative to other methods among the new and old clients of this clinic is pretty similar until mid (1996). There is an increase in IUD utilisation among both groups till mid (1994) followed by a decrease in IUD utilisation after that. IUD utilisation increases among old clients after mid (1996), while it continues decreasing in new clients.

As explained earlier, the decrease might be partly related to the opening of the JAFPP fixed clinics in Mafraq and Russeifeh towards the end of (1993), providing better options to receive IUD services than those services offered by the mobile clinic once or twice a month.

5. **Condom utilisation at the Zarqa mobile clinic**

Figure 8.5 Condom utilisation of the new and old FP clients of the Zarqa mobile clinic



There is a relative marked take up of condoms amongst new users of this mobile clinic especially between (mid 1994 –mid 1995), and amongst old clients between (mid 1992-mid 1996). A drop is observed in take up of condoms amongst new clients after mid 1995, less marked amongst old clients effective mid 1996.

IV. JAFPP national study on the loss to follow up among its clients

A study aimed at determining the rate of dropout among the JAFPP clients and the rate of method discontinuation among these dropouts was done (January 1994 – June 1994 inclusive). In addition, the reasons for dropping out and method discontinuation were investigated. Dropout was defined as a client who received a method (IUDs and OC only) and missed her return appointment by one month or more (JAFPP, 1996)

The study population included all women who registered for the first time in any of the JAFPP clinics (11 clinics) between Jan 1994- June 1994. A probability sample (stratified sampling procedure) of dropouts (n=1173) was used. The findings showed that 37% of dropouts had previously used IUD and/ or OC with the latter being more used

than the IUD (53% and 35% respectively) among this group. Most of the time (80%), these contraceptives had been prescribed by doctors (JAFPP, 1996).

Though the overall dropout rate[1] was 61%, it was the highest in Zarqa and Aqaba (South of Jordan)(80%). This means that the majority of new clients of JAFPP in Zarqa will discontinue visiting JAFPP clinics within a year, most probably because of the increasing supply of clinics providing FP services at JAFPP or from other organisations than JAFPP (JAFPP 1996, Musallam 1998). Moreover, the non-response rate was exceptionally high at Zarqa and Aqaba (42.7% and 39% respectively) with respect to the overall non-response rate (16.9%). A non-respondent is a client lost to follow up where it was impossible to obtain an interview with her (JAFPP, 1996).

Musallam (1998) studied clinic visit discontinuation at the MOH clinics of the Zarqa Governorate by using the same formulae for calculations than JAFPP. He found clinic visit discontinuation rates for the Zarqa Governorate MOH clinics to be very close to JAFPP overall rates in Jordan (61.4% and 61% respectively). The most common causes for JAFPP clinic visit discontinuation were:

1) The dropout felt no need to return because she had no problem with the method (25.8%)
2) Dropout was pregnant or wished to become pregnant (20%) (JAFPP, 1998:15).

Almost a fourth of JAFPP dropouts (24.9%) however were unwilling to return to JAFPP clinics because they were:

3) Visiting another medical provider (including another JAFPP clinic) (28% of this group of dropouts that were unwilling to return)

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[1] Dropout rate = $\frac{\text{No. of visit dropout (IUD or pill users on first visit)}}{\text{Total No. of new clients using either method (Jan.94- end June94)}} \times 100$

4) Bad services in the clinic (7.9%)

5) Inconvenient location of the clinic (8.3%)

6) Using a permanent method of contraception (2.5%) (JAFPP, 1998:15).

The most common reasons given by the JAFPP dropouts for method discontinuation on the other hand were:

1) The wish to be pregnant (43.8%)

2) Side effects (28.9%)

3) Husband disapproval of contraceptive method utilisation (9.7%) (JAFPP, 1998:18).

V. Providers' views on method and service utilisation

Like the service providers of MOH, SFWC, and unlike UNRWA providers, the JAFPP mobile and fixed clinic providers perceived utilisation of FP services at JAFPP to be excellent and increasing with time. This perspective is in harmony with the service statistics of the Zarqa mobile clinic that showed an increase in total FP clients (1992-1997) (Figure 8.5).

- ✓ 'An excellent contraceptive prevalence rate' (meaning a high percentage of FP users from total women in reproductive age) (all providers of JAFPP Zarqa fixed clinic in consensus).
- ✓ 'It is increasing and improving and it is not decreasing...a survey on IUD removal showed very low rates compared to the previous years. This proves that there is a continuation in method use and service utilisation' (female providers, mobile clinic of Zarqa, 33 and 38, married, 2 and 3 children).

The providers explained that the utilisation of FP services was excellent because of the increasing interest among the clients, which they perceived as an excellent indicator of a change of behaviour within the community.

- ✓ ' I have been in this field for eighteen years and the situation has changed a lot, especially people's acceptance for the idea of FP has changed 'like the distance between Earth and Sky' (an Arabic saying)(female nurse, fixed clinic, 43, married, 3 children).

In addition to the increase in public awareness, they explained that there were financial motives underlying FP utilisation. Moreover, the quality of FP services at JAFPP, gender and qualifications of the providers all enhanced utilisation.

JAFPP providers believed that women preferred to utilise their services rather than MOH services because they did not have procedural hassles, and they safeguarded their clients' confidentiality:

- ✓ 'The JAFPP is special because of the quality of services it provides... and the qualifications of its personnel... and let us not forget that all our providers are females'(female provider, 34, married , 4 children)
- ✓ 'Let us not forget that the MOH asks for Affidavits and husbands' approval for IUD insertion while us ...no! Because we are convinced that it is her right to choose because she is the one who gets pregnant and delivers... And she has the right to have a confidential choice' (female nurse, fixed clinic, 43, married, 3 children).

An interesting view of the mobile clinic provider was that women put themselves last on their list of priorities, which could account for low utilisation of the services as they kept on postponing their visit to the clinic until their situation was seriously aggravated.

This trend was common among women in underprivileged social settings, not only in Jordan, in other countries of the Middle East as shown by the Giza study of Egypt, where women 'endured silently' because they had acquired and internalised such a low self-esteem over the years (Khattab et al. 1994).

- ✓ 'Women severely neglect their health, because they do not seek care at the beginning of the problem, only when the problem is severely aggravated, because the last thing she thinks of is her health. Her priorities are her husband and children, cooking and the household duties, and that is because she takes everything on herself. And sometimes she does not have the time to seek treatment or does not have the money although the services are available, so she puts herself at the end and does not take care of herself' (mobile clinic provider, female, 33, divorced, 2 boys).

The providers argued that since IUD discontinuation was decreasing in this service, this was a good indicator for the program. They based their views on the above-mentioned JAFPP study (1996) of service and method discontinuation in Jordan.

VI. Providers' views of service barriers to FP utilisation, service needs and strategies to enhance utilisation (FG discussions).

Like MOH, UNRWA and SFWC, the service providers were very much aware that the gender of the service provider was directly related to service utilisation:

- ✓ 'They always like to have a female doctor and not a male doctor... She would rather get pregnant than have a male doctor examine her...'(midwife, mobile clinic, 38, married, 3 children).
- ✓ 'Ok, but the lady wants a female doctor... and let us not forget the social barriers' (RN, female, fixed clinic, 43, married, 3 children).

As seen earlier at SFWC and UNRWA, the providers of the mobile clinic believed that the private sector physicians were acting against FP utilisation. They exposed how the private practitioners were advising women to discontinue FP methods based on a conflict of interest driven by financial motives:

- ✓ 'Sometimes the private sector providers tell the woman to discontinue the method based on the motive of profit only and he spoils my work only for a material purpose...Why? Because when he performs a Caesarean section delivery for 600 dinars, it is more beneficial to him than to insert an IUD for 30 dinars. And he does not understand that for the sake of her health, the woman must practice birth spacing, and is unable to have a child now for health reasons' (female provider, mobile clinic, 33, divorced, 2 boys).

Beliefs concerning fertility

JAFPP providers perceived child demand as being very high in the rural communities based on the concept of *'Ezweh'*, and the *'Sunnah'* (Prophet's tradition). Financial motives also drove people to procreate, in order to get manual help in agriculture however this led to the exploitation of children in their perspective:

- ✓ ' They think that they must have many children in order for their sons to help with agriculture' (midwife, mobile clinic, 38, married, 3 children).
- ✓ '*Ezweh*' and the '*Sunnah*' (Prophet's tradition), and to help their father and mother... and this leads to child exploitation as they have to work when they are 7 years old (child labour)'(mobile clinic provider, female, 33, divorced, 2 boys).

A senior provider explained that child demand was sometimes triggered by women jealousy, which caused peer pressure among them. She deplored hyper fertility because it affected women's health, the quality of their lives and their families' lives:

- ✓ 'Sometimes you find women that are jealous... There is a woman who is fifty that said: "My husband wants me to get pregnant because my neighbour who is fifty one has delivered a boy... With a face like a full moon and his health is excellent... And her health is excellent' (senior provider, female, 34, married, 4 children).
- ✓ 'Yes, in general, hyper fertility affects their overall health and it was evident in that community... and women had many complaints such as infections and uterine prolapsed and severe anaemia in general' (senior provider, female, 34, married, 4 children).
- ✓ 'And of course the most important thing is to reproduce... the principle of a good upbringing and the provision of a good quality of life for their children is irrelevant. I worked in Tafilah and the average number of children that people had was ten children' (senior provider, female, 34, married, 4 children).

Needs and strategies at the service level to enhance utilisation

A few providers believed in targeting remote areas as a strategy to widen access to FP. They thought that carrying out these activities in remote communities required more logistical support from the top management of organisations providing FP services.

- ✓ 'So we need to target the non- users of services, and reach them'.
- ✓ 'If the counsellor comes to give a lecture, she needs to speak to the management to support her by providing the transport and by covering the costs of the workshop completely' (senior provider, female, 34, married, 4 children).

- ✓ 'When the social worker goes to a remote area, how could she reach this remote area without a car…let us not forget the environment of the local community... it could be dangerous for the counsellor to be there on her own' (RN, female, fixed clinic, 43, married, 3 children).

Some of the providers stressed that services must build on clients' perspectives and comfort. That is why they insisted on confidentiality, and treating the clients in a 'proper' manner. JAFPP clinic routine did not to allow anyone in the room with women during consultations. Providers believed that by doing so, they were preserving women's rights for privacy during consultation.

It was clear that JAFPP was addressing confidentiality based on a Western perspective, ignoring the socio-cultural context of this community, where practically women almost never decided on their own on issues of reproduction and fertility.

- ✓ 'We have an environment where the woman feels safe and comfortable with the social worker (counseling). If her mother-in-law comes with her, she is kept in a separate room. In our clinics, it is forbidden for the mother-in-law to attend the consultation. No one is allowed to enter with the woman during consultations. If the woman would like and wants to talk and ventilate about her marital or familial problems, she could do that with total confidentiality provided' (senior provider, female, 34, married, 4 children).
- ✓ '70 % of the cases do not have control over their reproductive decisions' (RN, female, fixed clinic, 43, married, 3 children).

The policy makers who established this policy, and the providers of the JAFPP who were implementing it, did not realise that providing counselling to the woman alone,

without the mother-in-law, was not effective because it was not going to change the attitude of the mother-in-law. Addressing her was an essential strategy, because she was a major decision - maker in the home, in many of the cases. Doan and Bisharat (1986) exploring how female autonomy within the household in Amman, Jordan would influence her ability to provide for the health of her children, found a strong negative influence between female low autonomy within the household and health outcomes. This effect did not disappear with variables such as women age, education, household size and composition and higher household income. Shami and Taminian (1985 cited in Doan and Bisharat, 1986) on the other hand had similar observations concerning the influence of the mother-in-law. The situation was reinforced by the patriarchal household structure, the serious resource constraints leading to financial trade-offs that usually ended up with a gender bias towards boys' interests, and the lack of privacy when the woman was not a co-head in her own household.

Another interesting finding was that sometimes, JAFPP recruited counsellors that were single girls who were not very much trusted by the clients because they were single. One of them related how after two years of working as a counsellor, she married and discovered that she had been demonstrating the use of a condom erroneously, on a carrot which was pointing to the floor.

JAFPP providers stressed consistency in client counselling. They believed it was very important to deliver the same information to clients in different services, in order to establish credibility in those services.

- ✓ 'We all say the same thing and do not contradict each other and we go to the same training sessions, have the same material, the same trainer...The woman being

convinced and with the doctor the conviction becomes complete'(midwife, mobile clinic, 38, married, 3 children)

- ✓ 'Credibility attracts the patient more than other factors... and this is through the administration who organise training sessions and follow-up activities and evaluation activities and training and the changes are disseminated to everybody during the meetings... We are the strongest and most famous organisation, what is said is one and there is no contradiction' (female social worker, fixed clinic, 31, newly married).

Hence, widening providers' expertise, and providing counselling services of good quality were two important general strategies perceived by the policy makers and providers of the MOH, SFWC, and JAFPP, that would promote provider - client interaction. If these two strategies were followed, service utilisation would be increased.

Conclusion

Despite the fact that JAFPP mobile clinic covered remote areas where there were no other providers, there remained a geographic barrier and a social barrier through the use of the bus as a clinic. It was interesting to see how the demand for FP was met by an increase in condoms take up among both the new and old FP clients of this mobile clinic.

The private sector

The private sector physicians denied access to their clinics claiming that they did not keep any records of their patients' files. They only agreed to participate in a FG discussion to discuss their views on FP. Nine married male physicians (40 to 60 years) participated in the FG discussion. In addition, the female matron of a leading private hospital organised and participated in this FG discussion.

1. **Private practitioners' perspectives of FP utilisation in the private sector**

The private practitioners confirmed that women in Zarqa Governorate did not utilise the private sector for FP purposes, but mostly utilised it for antenatal care, because they had many other options to receive free of charge FP services in Zarqa City. In addition, private physicians did not practice in remote areas such as Azraq because they were not affordable to most local residents.

- ✓ 'The ratio of women seeking FP services in the private sector is low ...'(male private physician, 52, married, 4 children)
- ✓ 'In the private clinics, only 10% of the clients come to receive FP services because the public sector and governmental sectors are at present providing these services, and the operation is supported from external sources for the public sector' (private physician, male, 50, married, 2 children).

They perceived these free FP services as being of low quality in safeguarding sterile procedures, which sometimes led to complications, especially with IUDs, and that is why this method was under utilised by women.

- ✓ '...To insert a loop in the private sector is a costly operation, while the GPs insert IUDs without sterile procedure and free of charge. This leads to problems and that is why this FP method is not utilised as expected because of the dissemination of rumours or exchange of experiences between one woman and the other' (male private physician, 46, married, 4 children).
- ✓ 'The costs are high, so the client runs to the public sector although she knows of the poor quality of the IUDs inserted there or the poor procedures for insertion. She

agrees and accepts it when I tell her to remove it' (male private physician, 42, married, 5 children).

These statements agreed with the beliefs of SFWC and JAFFPP providers that private doctors were at times removing IUDs in their clinics. Blaming infections on it, they discouraged women from using IUDs based on a health rationale. In reality, they were driven by financial motives, because they generated more revenue from pregnancies and deliveries (fee per antenatal consultation 5 dinars, fee per ultrasound examination 25 dinars, and fee for delivery between 150 – 300 dinars) than from IUD insertions. IUDs generated single (35 dinars) revenue, and were a long- term method (5 to 8 years).

Since the utilisation statistics of private clinics were inaccessible, the magnitude of this problem was impossible to assess, nor the specific socio-economic background of the private sector users for FP services. The only indicators we have in this study are the providers' opinions about the private sector clients, and what women in the different settings say about private sector utilisation.

Private doctors believed that people were not utilising FP services because they believed that modern FP methods were forbidden by *'Shari'a'* (Islamic legislation), so they utilised traditional methods such as 'coitus interruptus', because they did not want to disobey God. According to their perception, women's fear of becoming infertile deterred them from utilising contraceptive methods. They associated utilisation with socio-economic class, and since most Jordanians were believed to be poor, they were not practising FP.

- ✓ 'From a religious point of view, we all do not have sufficient religious education, and this creates some sort of misuse of FP methods, mistakes in its practice, or sometimes

the wrong information about the way to use contraceptives, or FP methods. The ladies are worried about using contraception and becoming infertile through the use of contraceptives' (male private physician, 43, married, 6 children).

- ✓ 'A good financial status and good education lead to the use of birth control and FP and vice versa. I think that 80% of the people in Jordan are below the poverty level and the other 20% use birth control and spacing very well' (male private physician, 48, married, 3 children).

2. The private practitioners' fertility assessment in Zarqa

In harmony with other service providers' perspectives, private practitioners believed rural communities were more fertile than urban ones, and socio-economic class was a determinant of fertility. Other determinants were thought to be women's education and the achievement of reproductive intentions.

- ✓ 'The more we move away from urban life, fertility increases. In the years that immediately follow marriage there is a lot of reproduction but as the years of marriage pass by, reproduction decreases' (male private physician, 42, married 5 children).
- ✓ 'You go to a house that has three rooms, and you will find that the head of the household marries his sons and lets them live in these rooms. When we live together, we have to behave in a similar way, so if my brother has a lot of children, I have to have a lot of children too' (male private physician, 42, married 5 children).
- ✓ 'When the woman is educated, she starts to think of not having children, and she rather thinks of how to improve the economic situation and takes care of her beauty. But when she wears a *"dishdasheh"* (large dress worn by women at the grassroots), or

casual clothes she will not notice and will only care about her economic situation' (male private physician, 48, married, 3 children).

Jokingly, private physicians sometimes expressed sexist opinions about women however, in reality they believed them.

- ✓ '(Jokingly) If it weren't for jealousy, women wouldn't have become pregnant. This is an old Arabic proverb that is very common' (male private physician, 48, married, 3 children).
- ✓ 'She wishes to keep him broke and in poverty for fear that he will take another wife, and even if her husband has three thousand dinars, it is as if he has a fortune and she becomes afraid' (male private physician, 48, married, 3 children).
- ✓ - I disagree to what is being said, as these women constitute a very small portion of the society (male private physician, 43, married , 6 children)
- ✓ - No, the percentage is very high here in Zarqa' (male private physician, 48, married, 3 children).

There was a consensus that child demand was very high in this community that infertility was stigmatised, and women feared it.

- ✓ 'Infertility is our companion from the first month after marriage, where the woman comes requesting to hyper stimulate ovulation, and if I do not give her what she wants, she will go to another doctor' (male private physician, 46, married, 4 children).
- ✓ 'Although in third world countries, the waiting period is one year, I have decreased it to two months. Also consecutive abortions: three consecutive abortions are allowed worldwide and I have decreased it to one abortion only' (male private physician, 46, married, four children).

Although it was difficult to assess the utilisation of FP services in the private sector, there seemed to be a lack of consensus among the private sector providers on standards of practice and how long they were utilising what method. In addition, they seemed to have a financial conflict of interest in encouraging FP utilisation in their clinics. Their subjective assessments show that this sector was mostly utilised by the rich for FP provision, and used by all other segments primarily for antenatal and infertility services.

Comparison of the modes of FP provision

Chapters five to eight have looked at the full spectrum of FP provision in Zarqa and Jordan. There are five main models and / or providers of FP services: the integrated model (MOH), the vertical model with a pioneer community- based distribution component (SFWC). UNRWA services are organised following the RH model strongly advocated during the ICPD. Provision in the NGO sector is examined by looking at JAFPP, a pioneer in FP provision in Jordan, with focus on its mobile clinic because it is also the first mobile provision for the remote areas of Jordan. The perspectives of the private sector physicians are included.

1. National studies on contraceptive utilisation

Isaac and Maaytah (1994) studied contraceptive utilisation at the national level between (1979 – 1992). Their findings showed that the utilisation of OCs and IUDs had doubled in 1992 among new and old FP users in comparison to the utilisation of these methods in 1980 and 1985. Condom utilisation also increased markedly (1988 – 1992) (Musallam, 1998).

Earlier, the Jordan Fertility Surveys (1976, 1983) had indicated an increase in contraceptive prevalence rates from 23% to 26%. While the JPFHS of 1990 had shown

an increase in the CPR (40% nationally and 38% for the Zarqa Governorate). In 1997, the CPR was 52.6% for all methods and 37.7% for modern methods (JPFHS, 1997 Table 4.4 and figure 4.1).

In harmony with the findings of these studies, this study has shown that the utilisation of FP services at the MOH MCH training centre among the new and old clients had increased between 1990 and 1992 (Figure 5.5). In addition, Isaac and Maaytah (1994) have found that 47% of new FP users were using the pill, followed by 35% using the IUDs, while only 18% were using the condoms. In this study, new users utilised IUDs more than the pills at this MOH clinic, most probably because of the availability of female providers. While the shortage in female providers at the MOH in general might have accounted for the pills being more utilised than the IUDs nationally (1988 – 1992) (Isaac and Maaytah, 1994)

According to the latest Jordan Family Planning and Household Survey (DHS 1997), the Contraceptive Prevalence Rate (CPR) of modern methods at the national level is (37.7%) while traditional methods prevalence (withdrawal and rhythm method) is (14.8%) (DHS, 1997, Table 4.4). In Ghweirieh, the prevalence of modern methods is (35%) and (13%) of couples use traditional methods of contraception according to the basic survey findings (1997).

The DHS (1997) showed that the pill and IUDs were the best known modern methods to all ever-married women (100%). IUDs were the most popular modern method (46% of all ever-married women) followed by the pills (41% of all ever-married women), while condoms and injections were less popular (16% and 3% of all ever-married women respectively) (DHS 1997, Table 4.3). In 1997, the prevalence of pills (6.5% of all users)

is much lower than IUDs (23.1% of all users) at the national level remaining the second most widely used modern method (DHS, 1997, Table 4.4). In Ghweirieh, pills are the second most widely used modern method (22.52% of all users) according to the basic survey findings (1997), and are the most widely used method (47% of all users) at the SFWC according to this study.

Condoms (2.4% of all users), injectables (0.7%of all users), vaginal tablets and jelly (0.5%of all users), are the least used methods in Jordan (DHS1997, Table 4.4). In Ghweirieh, condoms (5.6% of all users), injectables (1.6% of all users) and vaginal tablets (1.5% of all users) are not very popular methods among the FP users according to the basic survey findings (1997). Likewise in this study, (5.9%) of FP clients of this clinic use the condoms, while (11.3%) use injectables and (0.4%) other methods such as vaginal tablets and jelly.

The findings of this study show that FP utilisation is increasing in the four clinics included in this study, matching the findings of JLCS (1998) and the DHS (1997) where Jordan is a country in fertility transition. Utilisation of primary health care services, including FP, are increasing in Jordan, and the (CPR) according to the latest DHS (1997) increased to 37% for modern methods and to 50% for overall contraceptive methods including traditional methods.

During the fieldwork, it was observed that there was a low consensus about FP provision among the different providers and at times among the clinics of the same sector based on the qualitative data from the interviews, service observation and FG discussions with the providers. With the exception of the CPP project (temporary influence), a consistent plan for FP provision did not seem to be clearly disseminated to the front line

providers within the same sector or across the sectors. Standards of practice were not available at the clinics, within and across the sectors, job descriptions and specifications were not readily available, and consistent mechanisms of co-ordination and collaboration such as routine meetings were not established at the micro or intermediate levels. Accountability was diffuse, and in the case of the private sector there was no governance of FP practice whatsoever. With the exception of JAFPP, FP programs remain largely non-sustainable, because there are no mechanisms for cost- sharing or cost- recovery. FP programs and initiatives in the public sector are totally funded by international monies.

Providers in UNRWA and the SFWC project saw room for improvement, but believed that time would improve FP utilisation rather than lobbying for more aggressive measures.

The most important service barriers perceived were the gender of the service providers and the shortage of female physicians. Although they mentioned them, the male doctors in general did not seem very keen on remedying these shortages, for fear of losing their power and prestige. At the clinic level however, this shortage affected the utilisation of contraceptives, especially IUD, and seemed to reduce the workload of the male provider at SFWC. While in UNRWA the male specialist was extremely busy with the Obstetric and Gynaecology clients, in addition to the FP clients. The private physicians on the other hand seemed threatened by FP altogether for fear of losing their business. Even the midwives of MOH were resistant to take over FP provision because it meant more work for them, and they perceived no incentive in shouldering this additional responsibility. In certain sectors there was no consistency in counselling and providers'

training, and some providers remained not really convinced with the economic rationale of FP, believing that *'rizk'* (fortune) was provided by God and came with the child.

The most widely used methods were female methods, namely IUDs and OC, with IUDs being more popular when clients had access to a female service provider. However, when this was not possible, they compensated by utilising OC. Condoms were specifically used in the remote areas where service options were limited. However it remained an unpopular method in the city, because men disliked it.

The findings of this study at the micro level are in harmony with the DHS (1997), and JLCS (1998) findings at the national level, and Ayad et al. (1996), and El Zanaty (1996) at the regional level. All studies show a consistency in contraceptive method utilisation in the sense that IUD and OC were the two most popular methods among the consumers in six Arab countries (Algeria, Egypt, Jordan, Morocco, Tunisia and Yemen). After collecting extensive data on fertility, marriage and contraceptive use patterns in these six Arab countries to study fertility transitions, Ayad ET. Al. (1996) conclude that

> *'A combination of the pill, IUD and female sterilisation accounts for the majority of current use of contraception. The pill predominates in Algeria, Morocco and Yemen, while the IUD is the pre-eminent modern method in Egypt, Jordan and Tunisia' (Ayad et. al. 1996: 498).*

Observation, by using the Maximising Access to Quality (MAQ) check - list criteria showed that the international programmes (UNRWA and SFWC) were more advanced in their physical facilities and better organised in their management information system (MIS) and mechanisms of FP delivery. They also had a more advanced support and continuity system because they had more resources and support, than the public sector, and their programmes had global roots, unlike national organisations.

The mobile clinic was the lowest scoring of the four clinics for its physical facility. Table 8.2 shows a comparative detailed assessment of the four clinics' physical facilities.

Table 8.2 Assessment of the physical facility of four clinics included in observation.

Physical facility	MOH	UNRWA	SFWC	JAFPP
Physical accessibility	Adequate	Adequate	Adequate	Not Adequate
Water in examination and cleaning room	Adequate	Adequate	Adequate	Adequate
Facility clean and tidy Litter or garbage (not adequate)	Adequate	Adequate	Old clinic not adequate, new clinic adequate	Not Adequate
Well ventilated	Not Adequate	Adequate	Adequate	Not adequate
Clear and visible signs for FP services	Not adequate	Not adequate	Old clinic not adequate, new clinic adequate	Not adequate
Inventory of supplies for forecasting (>1 stock out in the last year not adequate)	Adequate	Adequate	Adequate	Not adequate
Register for equipment inventory & maintenance record	Not adequate	Not adequate	Not adequate	Not adequate
Quantity of equipment adequate to work load <than 3 IUD sets per hour , not adequate	Not adequate	Not adequate	Adequate	Not adequate
FIFO storage system of supplies	Not adequate	Not adequate	Not adequate	Not adequate
Privacy for clients receiving services including counselling	Not adequate	Not Adequate	Old clinic not adequate, new clinic adequate	Not adequate
Client's toilet available and clean	Adequate	Adequate	Adequate	Not adequate
Total score adequate out of 11	**5**	**6**	**9**	**1**

SFWC was the highest scoring of the four (9 adequate criteria out of 11) for its physical facility, while the mobile clinic was the lowest (1 adequate criteria out of 11).

In addition, Table 8.3 shows the appropriateness and acceptability of the services support system in the four services included in this research study.

Table 8.3 Assessment of the choice of methods and services support system

Mechanism to encourage continuity	**MOH**	**UNRWA**	**SFWC**	**JAFPP**
Contact of drop-out cases at home	Not adequate	Adequate	Not adequate	Not adequate
Written appointment card system for follow-up cases	Adequate	Adequate	Adequate	Adequate
Reason for clinic drop-out documented	Not adequate	Adequate	Not adequate	Not adequate
Mechanism to encourage continuity	**MOH**	**UNRWA**	**SFWC**	**JAFPP**
High technical staff turnover (>than 2 persons /last year not adequate	Adequate	Adequate	Adequate	Adequate
Choice of methods				
Number of methods 4 methods adequate	Adequate	Adequate	Adequate	Adequate
Clinical provider guidebooks	Not adequate	Not adequate	Not adequate	Not adequate
Provider bias	Adequate	Adequate	Not adequate (pushing injectables, and tubal legation)	Not adequate (pushing screening)
Administrative barriers to receiving method of choice	Not adequate (client referred to rural clinic for IUD insertion)	Adequate	Adequate	Not adequate (refused IUD insertion because of previous c-section)
Total score from 8	**4**	**7**	**4**	**3**

UNRWA scored highest among the four clinics (7 out of 8) in their choice of methods and mechanisms of continuity because they followed standards set by the WHO. The mobile clinic had the lowest score in their mechanisms of continuity and support system.

SFWC seemed to have the best yield of the four programs included in this study in terms of client behaviour. The findings showed that IUD discontinuation decreased with time while pill utilisation increased steadily.

However, IUD discontinuation also decreased with time at the MOH centre, which was the most popular centre for IUD utilisation, because of its totally female staff and its

long history. This centre however lacked political support and co-ordination efforts with funding agencies, because of the political debate between them and officials of the MOH.

The mobile clinic was the least utilised clinic where IUDs were not a popular method, because of the follow-up required. There were geographic and social barriers to access this clinic, along with continuity of service problems.

2. Determinants of contraceptive utilisation

The findings of this study show that fertility and reproductive behaviour are quite similar in the different settings of Zarqa, because people share a common socio- cultural and religious heritage. This finding is confirmed in the JLCS (1998) where rural -urban differentials and refugee non-refugee status differentials are minimal with respect to fertility, reproductive behaviour, and contraceptive utilisation. In the studies of JAFPP (1996), Musallam (1998) and Madi (1997) on contraceptive utilisation in Jordan, the mean age at marriage for JAFPP, UNRWA and MOH clients was very similar (19.7, 19.2, and 19.6 years respectively). The mean number of living children for JAFPP, UNRWA, and MOH clients was also very similar (4.1, 3.89 and 3.9 respectively). Most women utilising JAFPP, UNRWA and MOH services were housewives (JAFPP 1996, Madi 1997, Musallam 1998).

JAFPP clients were on the whole more educated than clients of the MOH: more than 50% of the JAFPP clients had 9 to 12 years of formal education (JAFPP 1996), while only 30.6% of the MOH clients had 12 years of education (Musallam 1998).

In her analysis, Madi (1997) explains how young women have the lowest contraceptive prevalence rates, because they believed that contraceptive use might result in infertility. While mothers who were older than 45 years of age had lower contraceptive

prevalence too, because they believed that they would not get pregnant at their age (Madi 1997). Therefore, contraceptive prevalence rates among clients of the UNRWA clinics were related to age and parity, and the highest contraceptive prevalence for Jordan was among mothers of 7-9 children because they had already achieved their reproductive intentions. On the other hand, lactation was the main reason behind not using modern contraceptives in the Palestinian refugee camps, and more than (56%) of mothers who had infants below 1 year of age were using lactation as the only method of contraception (Madi 1997:25).

If one compares the age structure of continuers and discontinuers of contraceptives in all UNRWA clinics, one finds that women between 20 and 34 years of age are more likely to stop using contraceptives because they have not yet reached their reproductive goals. (83.5%) of this age group have 3 children or less, while women between 35-39 years of age are less likely to discontinue contraceptives, because (67.7%) of this age group have already more than 5 children (Madi 1996).

Musallam (1998) and Madi (1997) agreed that age and the number of children were two determinants of contraceptive utilisation, along with the gender of the living children. Contraceptive utilisation was only (16.3%) for women who had no living males, regardless of the number of females. However, this rate increased to (24.6%) for women who had no living females, regardless of the number of males (Madi 1997). The highest prevalence of contraceptive use was among families with 3 male children in Jordan. Therefore, gender bias is a determinant of contraceptive utilisation in this refugee community, as in the other communities of the Zarqa Governorate.

3. Reasons for contraceptive discontinuation and clinic visit dropout

The most important reason for method discontinuation at JAFPP, MOH and UNRWA, was the wish to become pregnant, among (43.8%, 46.4% and 35.6%) of the clients respectively (JAFPP 1996, Madi 1997, Musallam 1998). These findings agree with those of other national studies (DHS 1997, JLCS 1998).

According to Madi (1997) IUDs were the most popular method, with the lowest discontinuation rates. According to Madi (1997), the highest discontinuation rate by method at UNRWA clinics was among spermicides (21.5% of total method discontinuation) followed by OC (18.2% of total method discontinuation), condoms (17.3% of total method discontinuation) and the lowest discontinuation rate was among IUD users (4.6% of total method discontinuation). And the majority of women (80.6% of total clinic visit discontinuation) who wanted to get pregnant discontinued contraceptive use within nine months of starting the method (UNRWA Agency-wide rate). The second reason for discontinuation of contraceptives differed however, between MOH clinic users where women 'did not see any reason for visiting the clinic' (18.1% of total clinic dropout), and UNRWA clinic users were family pressure (13.2% of total clinic dropout) forced them to discontinue utilisation. The third reason for discontinuing contraceptive methods among UNRWA defaulters was side -effects (12.3% of total clinic dropout), and the fourth reason was dissatisfaction with UNRWA services (9.1% of total clinic dropout) Agency-wide. In Jordan, the rate of dissatisfaction with UNRWA services was higher: (14.6% of total clinic dropout) (Madi 1996:10). This was most probably related to the wide supply of other sectors providing FP services in Jordan (JAFPP, Royal Medical Services and MOH). Women expressed their preference for female providers (2.8% of

total clinic visit dropout) which was confirmed by the qualitative data of this research study in the camps, where people expressed the same preference. While (5.9% of total clinic visit dropout) of clients sought other health providers such as the JAFPP, MOH, or SFWC (Madi 1996). There were other variables that seemed associated with a low risk of discontinuation of FP methods at the JAFPP clinics, according to their study. These variables are higher education, a long duration of marriage, using the IUD, having at least one male child, previous use of contraceptives, infrequent visits to the clinic, and good quality counselling (JAFPP 1996).

The reasons for discontinuing clinic visits in UNRWA and MOH clinics were pretty similar, 'Wanting to have more children' (35.6% and 46.4% of total clinic visit dropouts respectively) (Madi 1997, Musallam 1998). The most important reason stated for clinic visit dropout by JAFPP clients was that the client 'felt no need to return because she had no problem with the method' (25.8% of total clinic visit dropout). The second most important reason was 'being pregnant or wanting more children' (20% of total clinic visit dropout) and the third was 'the use of other services' (14.3% of total clinic visit dropout) (JAFPP, 1996). At the MOH the second reason for clinic dropout was 'using other services' (14.5% of total clinic visit dropout), and the third reason was 'side-effects' (13.6% of total clinic visit dropout) (Musallam, 1998).

The presence of these multiple providers and models of care in one city meant that the community had a choice of FP provision almost all of which was free. The question that remains is what did they think of FP service provision?

Chapter Nine

Men and women's views on family planning and provision

Introduction

This chapter is an analysis of community views on family planning. Ten natural group discussions - one per gender per setting - were organised with fifty-eight men and women. In addition, eleven household interviews with four couples, six individual women and one man were done in the different settings of the Zarqa Governorate, i.e. the low, middle, and high urban socio-economic class, the Palestinian refugee camps, and Bedouin and rural communities (see chapter 3 for details). These community views are compared and contrasted with the service providers' views.

Qualitative research methods were used to explore the beliefs, perceptions and attitudes influencing the decision-making for FP service and method utilisation. To what extent did men and women see family planning as meeting their own needs? What factors affected child demand and how did the gender of the offspring shape this demand? Were the FP services accessible in the different settings, and were the models of provision used acceptable to them? What were the service barriers and personal and household barriers to service and method utilisation?

During the interviews, men were addressed as key players in family planning. An assessment of the degree of common agreement at the household level concerning family planning was deduced from the discussions with men and women. Views on high fertility as a tool for informal power, its impact and other multiple pressures on their daily lives were examined. Strategies were put forward concerning how to widen access to FP.

1. Natural group discussions and household interviews with men and women

In March 1998, ten natural group discussions with men and women within their social networks were organised. Two natural group discussions were carried out per setting, one for men and the other for women. However, the men of Al Azraq were difficult to access, instead, a natural group discussion with men teaching in the public sector was done in the city of Zarqa. The five settings were New Zarqa (high socio-economic, urban), Ghweirieh (low middle- class, urban), Zarqa camp (Palestinian refugee camp), Hashemieh (settled Bedouin) and Azraq (rural).

In June 1998, eleven household interviews with six individual women, one man and four couples followed the natural group discussions. These in-depth interviews were carried out in the same settings, and consent for household interviewing was obtained from participants in the natural group discussions. Women currently using family planning and those that did not were identified and asked whether they were willing to be interviewed. If they agreed, they were then asked to approach their husbands. If the husbands agreed, a couple's interview was done otherwise women were interviewed individually. Table 9.1 shows the details of natural group discussions and household interviews.

Table 9.1 Natural group discussions & household interviews in the Zarqa Governorate

Type of interview	Men	Women	Couples	Total	Participants (N)
Natural groups discussions	5	5		10	64
Couple and individual interviews	1	6	4	11	15

For further details of the data collection in the community refer to chapter 3.

2. The community's knowledge of FP methods and the sources of information

The questions asked to men and women to assess their knowledge were the following: What is FP? What do you think of it? What are the FP methods? Why do people use FP? From where did you get your information and are you satisfied with this information? Men and women in all the settings knew at least three modern contraceptive methods, and listed them. They also knew traditional family planning methods as well, but their knowledge remained superficial. In the camp, a few men described the monthly cycle of fertility, and many of them were aware that their wives might become pregnant while breast-feeding, while women mentioned in consensus all the modern and natural FP methods, except for the implants.

- ✓ 'After the period stops for four or maximum in some women five days...It is ok if you have intercourse and you have the evacuation of sperms vaginally. Because the male sperms live for three days, at the end of the period also you have five days where the egg is dead and you can have intercourse safely. Each couple knows their own cycle and can regulate themselves.' (man, Zarqa camp, 28, driver, married, 10 children, living with his parents)
- ✓ 'The loop, the pills, the suppositories (meaning vaginal suppositories), *al Azl* (coitus interruptus), the rhythm method, the bags (meaning condoms), breast feeding, injections' (Women, Zarqa camp, enumerating these methods in consensus).

According to men, women and the service providers, the media, especially the TV, and newspapers were the most important sources of information. Other sources mentioned were counselling sessions, lectures, brochures given by the providers and women's personal networks and neighbours, especially older women.

To be specific by region, women in Azraq mentioned that they got their information about FP methods from JAFPP and other women. In the Bedouin community and Zarqa camp (refugee), information was obtained in a pretty similar way: men got it from each other, while women got it from the TV and health services. In Ghweirieh women had heard about FP methods from providers (SFWC, CBDs, and the brochures they distributed), while women in New Zarqa (high socio-economic strata) got their information from the TV, radio, books, magazines, and doctors. The community and service providers agreed on the sources of information about FP.

- ✓ 'The Association for FP (meaning the SFWC and the CBD project), and they offered the pills to me and until now they visit me at home' (woman, Ghweirieh, 22 married, 1 girl).
- ✓ 'From the TV and the clinics (women, Zarqa camp in consensus).
- ✓ 'Mostly from women's talk, and the TV adds, the radio, books, the magazine '*your doctor*' and the doctors' (Woman, New Zarqa, 30, married, 4 girls, non-user).

However, some of the providers criticised the FP messages on TV for being simplistic in their content, and for overemphasising the benefits of FP methods without mentioning their side effects.

- ✓ 'FP methods are presented on TV including the Depo-Provera injection as if they are sweets or chocolates without talking about side effects...We had a visiting physician from abroad and he did not mention side effects and he said that it is like a sweet. I think that he is underestimating his colleagues when he says that FP is like a sweet' (Male private physician, 48, married, 3 children).

3. Men and women's views on FP

Questions asked to men and women were Why do some people use FP and others not?' Most people perceived FP as being a synonym of birth spacing. They believed in birth spacing, and supported it, because it was beneficial to the family, as a whole, and to the mother and child individually. An 'acceptable' interval for birth spacing was usually perceived as two to three years, however most people did not believe it should exceed three years.

It was striking how most of the participants in natural group discussions and in-depth interviews from both genders analysed in great detail the relationship between family size and the quality of life. This association seemed however more subtly felt by men when they gave examples of the difficulties in keeping two ends meet, most probably because of their defined gender role in this society where they were held fully responsible for the financial support of the family, based on Islamic tradition. Effectively, since the beginning of the economic restructuring in the late 80s and throughout the 90s, Jordan was facing an increased thinning of subsidised services and resources, a gradual devaluation of the dinar, and the inflation in price of commodities. The impact on consumers at the grassroots - men, women and front line providers in this study – was devastating. Times had changed, and the demands of life had changed with time, hence fertility behaviour had to change by necessity rather than by conviction.

✓ 'I think that it is necessary to have FP. The number of people in the family, keeping in mind the father's and mother's situation, the income that they get. How will they distribute this income, how will they divide it? What will happen tomorrow?'(man, Ghweirieh, 26, married, civil service, 2 children)

- ✓ 'I expect now that people might even utilise birth control and not birth spacing, based on a financial motive. An employee whose salary is only 150 dinars and has to pay a rent of 70 dinars and water and electricity, pampers, potatoes, you are always short of money, so the human being gets convinced with family planning' (man, Ghweirieh, soldier, 27, 4 boys, living with parents).

As mentioned earlier, men in the camp seemed ideologically mobilised against FP program delivery and not FP itself. In their analysis, FP practised at the emergence of Islam by the Prophets' companions, and FP programmes provided today were two different things; while the earlier practice was perceived as culturally sound, based on tradition, and individual choice, hence acceptable. The latter i.e., the FP programmes as they were delivered today by UNRWA and other services were perceived as alien, aggressive, and coercive.

Men in this group believed that coercion was a feature of FP programmes in many countries of the third world and not only in Jordan. Using the examples of Argentina, Brazil, Asian, and Arab countries, they viewed these FP programs as specifically targeting women. Referring to them as 'campaigns' and 'aggression', they perceived these programmes as a Zionist, anti-Islamic campaign in the Middle East aimed at further dispossessing them.

At the individual level, men felt threatened by these 'campaigns' because they resulted in a decreased progeny, one of the bases of the patriarchal system in which they grew, and in which they believed very strongly in their collective mind.

Basing their argument on a *'Hadeeth'* interpretation (tradition of the Prophet) and using a prophetic quote that might have encouraged Muslims to multiply, they firmly

believed that numbers would retrieve them the power that they had lost. They had lost their power as a group when they were dispossessed of their country and identity (Palestinian), and became politically marginalised in camps; in addition they remained socially marginalised because of their poverty.

The compensation for this lost 'status' was now seen as being beyond the return of Palestine, which was very acute in the psyche of the first generation of refugees (their fathers). Following half a century of Diaspora, this generation had realised that in the recent balance of power, Palestine was lost, and with it their hopes of regaining their original 'status'. After the Gulf War and the Peace Process, they realised that even if there were a Palestinian state, it was going to be so small that it could not assimilate all the refugees in Diaspora.

As their hopes of returning to their country were thinning by the day, men instead identified other sources to retrieve their lost power as emanating from an Islamic identity rather than a national identity. And to satiate an immediate need for power and status, they concentrated on the realm of their individual households and progeny, which were the only accessible spaces where they could still practise their power, and feel 'status', by exerting control over their wives and children. Their families became the platform of fulfilment of their need for power, status, and progeny became the fuel for the re-acquisition of 'status'. Men used their interpretations of Islamic tradition as a convenience to them in that respect.

They viewed FP projects as aiming at further dispossessing and eradicating them, by targeting their religion, Islam; to them, it was a struggle for survival. They also rejected FP projects because they perceived them as mechanisms of war between the North and

the South, because Southern states would outgrow Northern states in numbers, in the 21st century.

- ✓ 'Family planning is being imposed, and becoming very similar to birth control, imposed from abroad... as much as one is exposed to the publicity regarding family planning... One is disgusted... the foreigners perceive the third world countries as if population growth in those countries is stronger than the hydrogen or atomic bomb' (man, Zarqa camp, 37, teacher, 3 children).
- ✓ 'The view about family planning is that it is 'ferocious' (and he giggles)...We know what is their plan...It is not that they want to help the poor people no! Family planning is a failure and I will repeat it again to you it is a failure!' (Man, Zarqa camp, 38, civil servant, 9 children).
- ✓ 'Very far from the publicity and media campaigns for FP...these are missionary, ideas and Zionist ideas...and it is very clear. It is coming from the west and it is a Zionist publicity campaign for FP...We are against it till doomsday' (man, Zarqa camp 36, driver, two children).

Many stories were told by men to expose the motives underlying FP 'campaigns'. This seemed to be the most emotionally charged issue of the whole discussion with them. It was apparent that women in the camp whether in a group or individually did not express the same suspicion and hatred of these programs, and this strong reaction seemed exclusively prevalent among men:

- ✓ 'Two years ago, they have promoted contraceptive pills. Working women used it in Argentina, Brazil and the Philippines... The TV ads were very brilliant and tempting of course... after few months, they were unable to work because of joint pain and

they could not even move. These contraceptive pills and the IUDs made them unable to work, it would have been better for these women to work when they were pregnant!'(Man Zarqa camp, 38, civil servant, 9 children).

- ✓ 'Tetanus immunisations were given once for males and three to four times for females in the schools... They noticed that infertility was on the increase among the female population... So they sent educated people to investigate why there was this high rate of infertility among girls of 15. These researchers analysed tetanus vaccines in the laboratory, and they found that they contained substances, which caused infertility, given to young children in nurseries and schools, when they were 7 or 8 years... This is the harm caused by Zionism and Masons, FP's aims are colonialist!'(man Zarqa camp, 38, civil servant, 9 children)

4. Men and women's interpretation of the position of Islam on FP

Generally, men and women perceived Islamic legislation as permitting *' Tanzeem el Usra'* (birth spacing) by using reversible methods for contraception at the individual level. However, when it came to *'Tahdeed el Nasl'* (birth control) by using irreversible sterilisation methods such as tubal ligation or vasectomy, it was a different story. The latter was forbidden by '*Fatwas'* (rulings), and rejected by the people.

- ✓ 'I understand it through the concept of Islam, it is not reproduction control but it is birth spacing. The *Quran* recommends *'breast feeding and weaning after two years'*. And so there is no *' Gheela'* (killing of a soul) (businessman, 46, married, 6 children)

As mentioned earlier, people often referred to Islam in their conversation; their subjective understanding of Islamic jurisdiction on FP seemed to determine their practice. Gender and socio-economic background affected these perceptions of Islamic

jurisdiction. In the Zarqa camp, modern contraceptive methods were mostly perceived as '*Haram*' (forbidden by Islamic jurisdiction), while traditional methods such as breast-feeding and coitus interruptus were seen as encouraged by the *Quran.*

- ✓ 'Islam said that the woman must breast feed for two years and also the companions of the Prophet used to ejaculate outside the vagina, not have intercourse when the woman was in her fertile period' (Teacher, Zarqa camp, 27, married, 1 girl).

Rich men and women had different perspectives of the position of Islam towards FP. While men believed Islam was against it, women believed Islam encouraged it; in Ghweirieh, both men and women agreed that Islam had permitted and encouraged FP. Verses from the '*Quran*', and '*Hadeeth*' (Prophet's tradition) were used to support this view. In Hashemieh, Bedouin women did not know whether Islam had encouraged it or not, while the women of Azraq were definite that religion was against FP.

- ✓ 'Pregnancy and breast feeding for 30 months' (verse from *Quran*), so 9 months pregnancy and 21 months breast feeding, or 30 months of breast-feeding, and a pregnancy of 9 months it means three years and a bit'.(woman, New Zarqa, 35, married, 2 children)
- ✓ 'Islam encourages FP. The Prophet said *'The worse trouble is a lot of children with little resources'*. God does not surprise people with magic, I live in a certain situation, I have to adapt to my situation' (woman, Ghweirieh, 28, married, 3 children).

This lack of consistence within the community in the '*Fatwas*' (rulings) on FP was due to a lack of knowledge about the position of Islam on this matter. The Higher Judge of the Islamic court had identified the necessity for the Muslim public to associate

between Islamic *'Aqeeda'* (the doctrine of Islam) and the daily practices in a consistent manner. He insisted that this information needed to be disseminated to the grassroots to help them in their daily lives.

5. Men and women's perspectives of the benefits of FP

When asked 'What are the benefits and harms of FP?' men and women in the different settings seemed well aware of the benefits of FP. As mentioned earlier, there were several descriptions of how FP improved the quality of their lives, by decreasing their family expenses and the health risks that were caused by numerous pregnancies.

Another view prevalent among both genders but expressed more by women was that FP helped to decrease women's load, and improved the quality of her life and her children's life. They were specifically aware that FP enhanced the well-being of the mother and the quality of time women would spend with their husbands, hence increasing intimacy between them, and improving the quality of care and attention given to their children.

- ✓ ' You cannot divide your time and affection over 12 children, it is not only a financial consideration' (Bedouin woman, 34, married, 4 children).
- ✓ 'Sometimes I do not even have time to comb my hair because my time is all busy' (Ghweirieh woman, 28, married, 3 children)

An interesting perspective among men of the high socio-economic group and the teachers (educated) was that FP was a process that enhanced the overall organisation of the household, and not only the number of children in it, they perceived the comprehensive aspects of family planning:

- ✓ 'FP is a comprehensive concept. It is not how many children I want to have, but rather it has to do with counselling, financial income, birth spacing and the environment. So FP provides lessons about everything' (man, New Zarqa, 45, married, contractor, 4 children).

In general most men and women in all the settings perceived and analysed the benefits of FP, except for men in the Zarqa camp and a few teachers. A portion of the non-users usually referred to the will of God that was always above all FP. Other women not using FP mentioned that their husbands insisted on having more children and in one case they had not yet had a male child. It was noticeable that men and women often referred to religion to justify their positions, or to support their concepts, and this dimension was always present at the back of their minds.

- ✓ 'The Moslems specifically do not consider poverty in family planning. 'We provide you and them (children) with *rizk* (meaning fortune)'... We find that a lot of families have *mashallah* 10 or 12 children and then he gets is 16th child or more and then you find that from the *rizk* of this new child all the family status improves. God provides *rizk* for a whole country because of one individual (male teacher, Zarqa camp, 37, married, 3 children)
- ✓ ' FP depends on the will of God. If you have many children sometimes, your wife puts a loop and she still gets pregnant despite the loop, this is what God wants... True or not?' (man, Zarqa camp, 33, married, janitor, non-user of FP, 4 children)

Some women in Azraq and Ghweirieh mentioned that FP solved a problem of lack of space.

- ✓ 'The house is a very important determinant, if he has a big house, it would make many things easier, but we cannot even buy them beds' (couple, Ghweirieh, 5 children, husband is a soldier).

Women in most settings were pleased because the interviews provided them with the platform to express their opinions. They complained that the service providers did not give them enough time, and were always in a hurry, rushing them without allowing them to express themselves.

6. Men and women utilisation of FP services

The information obtained from men and women during the natural group discussions and household interviews about FP service and method utilisation was consistent with the service observation findings, statistics, and FG discussions with the providers.

Women in Azraq (rural region) mostly utilised JAFPP mobile clinic. However, they had a problem with the rarity of this service (once a month), and used JAFPP fixed clinic of Zarqa instead (two hours drive from Azraq). There weren't any doctors available at the MOH health centre of Azraq, nor private doctors either.

In Hashemieh (Bedouin), people were dissatisfied with the MOH health centre and JAFPP mobile clinic services, because the former had a male provider and the latter used the bus for FP provision. This community used the JAFPP fixed clinic in Zarqa and the SFWC however, one woman explained how she stopped utilising the SFWC when the female doctor was replaced with a male doctor, and utilised the JAFPP fixed clinic instead.

- ✓ 'At the beginning, I used to go to the Soldiers Welfare Society. When I returned for a check up, there was a male doctor instead of a female one and I refused to be

examined by him. I now use JAFPP in Zarqa, and not the mobile clinic because it is in a bus, and this is an idea we all reject, to get examined in a bus, because everybody is watching and knows you, and they know why you are going there' (woman, Al Hashemieh, 35, married, wife of retired soldier, 4 children).

In Ghweirieh, the two most popular services were the SFWC, and the MOH MCH training centre in the same neighbourhood. Half of the participants utilised SFWC, while the other half utilised the MOH MCH training centre. Two participants (a woman and a man) claimed that they utilised the private sector, while most men said their wives were utilising SFWC because their services were free.

In the camp, women utilised the MOH or JAFPP services (IUD users) because the providers were female, and when they wanted oral contraceptives (OC), they used UNRWA. Four women were utilising IUDs that they had inserted at the SFWC, the worker's union, JAFPP, and a private clinic respectively.

Rich men and women utilised the private sector only, while there were two contrasting positions among the teachers: some of them claimed that they used the private sector because the public services were bad, while other teachers utilised MOH services because they thought that they were very good.

7. Factors perceived by men and women to promote FP utilisation

Women in Azraq and Zarqa camp rejected the providers' view that the influence of neighbours was a major determinant of women's decisions to utilise FP services and methods. They argued that FP utilisation had increased because unlike the old days, women filled their time with other things than taking care of their children.

Some men and women of Azraq and New Zarqa related the increase in FP utilisation to an increase in awareness, and education among the people. According to their perspective, the media, medical conferences and lectures, awareness- raising campaigns, and school programs had raised awareness and knowledge, especially in the remote areas. People who could read the newspapers, watch TV, or simply listen to the radio became more aware of FP.

- ✓ 'No, each one is depending on her opinion and conviction. And it is not necessary that one be tied with her neighbour. Maybe one would like to have ten children, so why should she be committed to her neighbour?' (woman Azraq, 23, married, 2 boys)
- ✓ 'No, each one does whatever makes her comfortable, each one has her own personality'(woman, Zarqa camp, 26, married, 1 girl)

As mentioned earlier, the financial situation was perceived as a major determinant of FP utilisation for most people in Azraq, Hashemieh, Ghweirieh, and the Zarqa camp. Often, it was the '*leitmotiv*' of men and women of the different settings. In the Bedouin community, one man analysed how the size of his family had deprived him of many things in his childhood, so he did not want the same thing for his children. However, another man from the camp strongly objected to this view, because it meant that one did not trust in God.

- ✓ 'My family is very large, and I lived in an environment where I was deprived of many things. I do not want my sons to grow up in the same conditions' (Bedouin man, 33, retired soldier, married, 4 children).
- ✓ 'The financial situation plays a big role especially the bad financial situation' (few women, Zarqa camp, married).

Men and women's perceptions of an increase in FP utilisation over time were in total harmony with the service providers' perceptions and the service statistics. Men and women in the different settings related the increase in FP utilisation to health considerations and to the lack of space in accommodating large families. Some of them however perceived that FP utilisation had decreased recently, because of the religious misinterpretations that Islam forbade FP.

- ✓ 'I went to the hospital to deliver and I only found one lady in five hours. It means that there is FP utilisation!' (woman, Ghweirieh, 32, married, 5 children)
- ✓ 'Money is important but there is something which is more important and that is the mother's and child's health '(woman, Azraq, 32, married, 2 boys).
- ✓ 'We are suffocating and there is nowhere for them to play except in the street' (woman, Ghweirieh, 32, married, 5 children).

Women in Zarqa camp believed that the cost of the service, the way they were treated, and the doctors' qualifications were factors encouraging FP utilisation. Women in Ghweirieh mentioned that FP utilisation became easier now because the CBDs provided FP services in their own homes.

- ✓ Women were unable to leave their homes but now the service of FP is offered in their homes, and it is easier, so why should we not use FP?'(Woman, Ghweirieh, 22, married, 1 girl).

8. Utilisation of FP methods among men and women

Confirming the service statistics findings and the providers' perspectives, most men and women said that they utilised the IUD because it was their preferred FP method. Most rural women in Al Azraq and Al Hashemieh were comfortable with the loop, and a

Bedouin man from Al Hashemieh praised the loop because it did not have any side-effects, while a few women used OCs, and one woman used coitus interruptus. In Ghweirieh, a man was using the rhythm method and condoms, while two women were using IUDs (one of them for six years) because it did not have any side- effects. In the camp, half of the women participating in the discussion were utilising the loop, and a few of them OCs, and one woman had undergone a tubal ligation. Rich women mostly utilised the loop, because they believed that it was the best method and three men in the city said their wives were utilising it. Teachers expressed their dislike of the condom, pills, and loop, while one of them thought that the IUD was the best method. It seems that the IUD is the most popular method among men and women themselves in the different settings, because it is not a 'chemical'.

- ✓ 'I have been using the IUD for eleven years, and I have no complaints'(woman, Zarqa camp, 46, married, 9 children)
- ✓ 'The condom is an uncomfortable method for the husband and wife' (Bedouin woman, 35, married, 4 children)

9. Side-effects of FP methods as perceived by men and women

Men and women in the different settings were afraid of the side -effects of modern contraceptives. Despite the popularity of the IUD, a woman in Ghweirieh described how it had caused her many side -effects like nervousness, bad luck, and three other women also complained of its side -effects. Likewise, one woman in the camp described the many calamities that she had following IUD utilisation, such as 'the raising up' of the IUD in the uterus and damaging it. She mentioned that it was a private physician that had discovered all these complications.

Men and women were very cautious to use Norplant (implants), or contraceptive injections because they feared that they were carcinogenic, and not yet approved internationally.

In the city of Zarqa, a rich man said contraceptives were 'full of problems', while a few men described IUDs and pills as 'one being worse than the other'. Another man perceived that coitus interruptus and condoms were the best, because they had less side-effects for the woman however, they were difficult for the man.

- ✓ 'The best thing is the loop and the bag caused me infections and I was not happy with it (meaning the condom) neither was my husband and with the withdrawal method, I had back pain' (woman, Azraq, 32, married, 2 boys).
- ✓ 'The pills affect the eyesight or the body weight and cause over or underweight' (woman, Hashemieh, 32, married, 6 children).
- ✓ 'I do not believe in anything except the loop. I have tried the vaginal suppositories and it came out to be a lie and I got pregnant despite using them' (woman, Ghweirieh, 28, married, 4 children).

Utilisation criteria are highly subjective however, IUDs remained the most popular and condoms, injections and implants were the least popular methods in the community. Table 9.2 presents the most important drawbacks of FP methods as perceived by men and women in the community

Table 9.2 Drawbacks of contraceptive methods as perceived by men and women

Contraceptive method	Perceived drawbacks Men	Perceived drawbacks Women
Condoms	Decreasing sexual pleasure (mentioned frequently) Annoying and not comfortable (mentioned frequently) Used in America (mentioned once) Used by the foreigners (mentioned once)	Cause itchiness and infections (mentioned frequently) Annoying and not comfortable (mentioned sometimes)

OC	Weight gain (mentioned frequently) Nervousness (mentioned frequently) Cause fibroids (mentioned at times) Cause cancer of the breast and the reproductive system (mentioned rarely) Women might forget to take them (mentioned once)	Weight gain (mentioned frequently) Nervousness (mentioned frequently) Affect eyesight (mentioned sometimes) Weight loss (mentioned once) Cause hypertension (mentioned once)
IUD	causes infections (mentioned frequently) Are not effective and often women get pregnant with the loop (mentioned at times)	Cause infections (mentioned frequently) Back pain (mentioned frequently) Heavier and longer menstruation (mentioned frequently) Impatience and nervousness (mentioned at times) weight gain or loss (mentioned at times) are not effective and often women get pregnant with the loop (mentioned at times) Might cause infertility (mentioned at times) Moved up and wounded uterus (mentioned once) Cause mass (mentioned once) Profuse vaginal discharges (mentioned once)
Injections	Bleeding (mentioned often) Causes cancer (mentioned at times) Still being tested (mentioned at times)	Long periods of bleeding (mentioned often) Harm the ovaries (mentioned at times) No period for a long time (mentioned at times) Irregular menstruation (mentioned at times) Causes cancer (mentioned rarely)
Vaginal suppositories:		Useless (mentioned at times) Harm the man (mentioned rarely)
Rhythm method	not guaranteed (mentioned at times) Not practical for the man and woman because requires a lot of self-control (mentioned at times).	
Breastfeeding	neither guaranteed nor practical (mentioned at times)	
Withdrawal method (coitus interruptus) ***'Azl, Wasita'***	Not guaranteed (mentioned often) Tiring for the man (mentioned often)	Causes back pain (mentioned at times) Disgusting (mentioned once) Causes dryness in the woman vagina (mentioned once)
Implants:	Still being tested , might be carcinogenic (mentioned at times) cause infertility (mentioned once) cause hirsutism (mentioned once)	Light periods (mentioned once) If pregnancy occurs during usage, 90% chance of mental retardation of offspring (mentioned once)

10. Men and women's perspectives of the ideal family size

In agreement with the service providers' perspective of an ideal family, most men and women in the different communities believed that a family of four children with two boys and two girls was ideal because it would mean that the boy had a brother and the girl had a sister. Traditionally, children were perceived as an asset, and a source of pride and pleasure in this culture.

It became clear from the qualitative data that men and women were utilising FP services and methods out of immediate necessity, mostly a financial pressure, rather than out of a deep conviction with FP and with a family size of two children or less being an ideal family size. In western societies the notion of smaller size families was prevalent, and a family of four children would be perceived as a large family, whereas the ideal family size norm here was four children. In support of these findings, the Jordan Living Conditions Survey (1998) found that all the educational groupings except for (no education) of both genders have a modal ideal family size of four children (Randall and Kalaldeh 1998, Figures 2.22, 2.23 and 2.24).

It was observed that when men and women spoke of FP during the natural group discussions and in-depth interviews, there was a tone of melancholy in their voices, as if they were grieving an important loss, the loss of their progeny. In Azraq only one woman wanted a family of two, while all others wanted more with a bias towards boys. In the Bedouin community, most of the participants agreed that four seemed to be an adequate number, and all men recognised the importance of males. In Ghweirieh, men agreed that the male child had a big effect on family size.

- ✓ 'Six with five males and one female' (woman, Azraq, 23, married, non-user of FP, 2 boys)
- ✓ 'Five at least and that they are all male'(woman, Bedouin, 35, married, 1 boy and three girls)
- ✓ 'A male child in the family is comforting so that one does not have to continue to reproduce. The ideal number to have is 4-5. I have many friends that have many girls and they continue to have children until they have the boy' (2 Bedouin men in consensus, married, 33 and 35 years, with 4 and 5 children respectively, non users).

In the camp, the majority of women believed that five or six children were ideal, while most rich men and women, and teachers preferred a family of four children, with two boys and two girls. It was obvious that child demand was high in most communities, and to have a family of less than four was not perceived as the 'norm'.

11. The decision-making process about reproduction and FP

In most settings, half of the couples interviewed discussed reproductive and FP issues together, and usually made a joint decision based on both perspectives. Among the other half however, men made these decisions alone for the couple, while the wives did what men wanted out of fear, or because they were too shy to contradict him.

- ✓ 'Do you believe in FP?

Husband: no Wife: Yes (couple, Zarqa camp, husband 33, wife 29, non users, 4 children)

- ✓ 'We believe in a joint decision between the man and wife' (couple, Zarqa camp, users of FP, husband 27, teacher, wife 26, university student, 1 girl).

- ✓ 'Whoever plants a tree in his house, has to eat from its fruits. And if I want to birth space, I might get too old to enjoy my children... One must continue to have children as much as God gives him, to see his production' (Man, Zarqa camp, 33 married, non-user, 4 children).

In New Zarqa (high socio-economic status), women believed in joint decision-making however, their husbands were in control of reproductive decisions in both households.

- ✓ 'I believe in dialogue between husband and wife. Women constitute half of society, and this is true, having children concerns her because there is an increase in the load at home, and for health reasons' (male engineer, New Zarqa, 45, married, 4 children).

In Ghweirieh, one couple made decisions jointly, while in the other household, the man's decision was followed: he wished to utilise FP, and his wife did not. According to him, women had the same desire for children however it was the husband who bore all the financial responsibility. He explained that he wanted FP because he wanted to enjoy his wife's attention and intimacy. His wife explained how in her view, it is the man that built the woman's personality.

- ✓ 'Who decided FP utilisation? Me of course! (laughing) (Husband, Ghweirieh, 26, married, 2 boys, user of FP, civil servant).
- ✓ 'He pushed me to use FP from the third day, I was still tired from the delivery, and of course there was no time for discussion' (wife, Ghweirieh, 25, married, user of FP, 2 boys).

In Hashemieh (Bedouin), one woman said she never discussed such matters with her husband, but rather left it up to God. In the other household, the woman, a mother of nine, described how she had suffered from health problems because of her nine children.

Her husband had pressured her to have more children however, after her health deteriorated, she ignored his requests completely. This woman fervently believed that reproductive and FP decisions must be made jointly. In Azraq (rural community followers of Druze faith), both women were making joint decisions with their husbands.

- ✓ 'I am using FP because I am tired, my chest is tired… He was refusing to let me use FP methods, and I used to deliver against my wish…He even wants me to have children now, but I ignore his request. He fights with me and shouts at me for two three days and then he keeps quiet. My husband is now convinced about using FP because the doctor told him to' (Bedouin woman, 35 married for twenty years, 9 children, 4 boys and 5 girls).

12. Quality of services as perceived by the community

Most men and women were unhappy from the service providers' attitude towards them. They were perceived to be 'always in a hurry', and men and women felt that they had many information needs that were not being met by the providers.

In Ghweirieh and the Zarqa camp, women had more complaints about the attitude of the service providers of SFWC and UNRWA. They perceived them as arrogant and 'belittling' their clients. They felt that favouritism (*Wasita*) was practised in the public services and UNRWA clinic, despite the system of colour-coded cards established by the management to evenly distribute the client load during the clinic hours.

The private sector providers were generally perceived as paying more attention to their clients, and having 'sweeter tongues', because they were paid for their services. Men and women unanimously associated the quality of care they received in that sector with the fees they paid. Consequently, this sector was perceived as being the best in terms

of quality of care, and that is why the rich people utilised it exclusively because they believed that the public sector was not safe.

Azraq (rural)

Women in Azraq were generally satisfied with the services provided by JAFPP, despite an estimation of a waiting time of two hours to receive services in both the mobile and fixed clinics. The providers did not visit them at home, but were perceived to be qualified, and women said they had a good rapport with the doctor of the mobile clinic. However, they expressed the need for counselling sessions and awareness- raising activities. They were dissatisfied with the time provided for medical consultations, though the providers answered their questions and gave them the choice of more than one FP method. During the household interviews, one woman said that the service providers had not respected her privacy, and had examined her uncovered.

- ✓ 'There is not much counselling and awareness raising' (woman, Azraq, 23, married, 2 boys).
- ✓ 'I felt that her answer was clear and understood really, and she explained to me about the ulcer and I was afraid and she reassured me'(woman, Azraq, 27, married, 1 boy)
- ✓ 'In terms of qualifications they are ok… better than nothing, because there is no one else but her, whether she is good or no good we are obliged to go to her' (woman, Azraq, 32, married, 2 boys).

Hashemieh (Bedouin)

In Hashemieh, men were unhappy with the services provided at the MOH centre. On the other hand, some women used SFWC of Ghweirieh (about 20 minutes drive by car from Hashemieh), and they claimed that they only waited for ten to fifteen minutes to

receive the services there, and the providers explained 'a lot of things' to them. Women complained about the bus service of JAFPP, but were generally happy with the fixed JAFPP clinic in Zarqa.

- ✓ 'There is also a very thorough explanation before receiving the service at the counsellor's office (JAFPP fixed clinic) and she gives booklets and brochures about FP methods and their benefits and drawbacks' (woman, Bedouin, 35, married, 4 children).
- ✓ 'No, the important thing is to finish. So they treat you in a hurried manner'(woman, Bedouin, 32, married, 4 boys)
- ✓ 'Even the doctor tries to know if the method is suitable, especially when you are using it for the first time... And especially with the IUD' (woman, Bedouin, 32, married, 6 children).

Ghweirieh (urban low socio- economic)

Some women acknowledged that JAFPP fixed clinic of Zarqa had better counselling services than other clinics and the users of this clinic expressed their appreciation of the social worker's role. Few of them however perceived that the providers were 'desperate to gain customers', so they did their best to market their services. The counseling was good at JAFPP clinic, but there was a long queue and the providers sometimes forced women to take contraceptive injections, and one had to pay a 'little bit of money'. Other women from Ghweirieh and New Zarqa were not satisfied with the way JAFPP providers had treated them.

On the other hand, women in Ghweirieh found the site of SFWC adequate, but they were not satisfied with the way that the clinic providers had treated them. They

complained how they had to wait at SFWC, because the doctor refused to see them claiming he was 'tired', or dismissed them quickly. Men were aware that the CBDs were visiting their wives at home and that privacy was respected.

- ✓ 'At JAFPP the treatment is excellent. It's very different from the other places because they want to attract clients. For heaven's sake just come. But there is a queue' (woman, Ghweirieh, 28, married, 3 children).
- ✓ 'However in JAFPP they force one method on you, I have been there twice and I do not plan to return' (woman, Ghweirieh, 25, married, 2 boys, non-user of FP now).
- ✓ 'The doctor is tired, apologises, then declines to see us although one would have waited for a long time for her turn... it is his duty to treat us. Not considering the talk and humiliation that they give the women. But still the doctors are better than the nurses' (woman, Ghweirieh, 28, married, 4 boys).

Zarqa camp (Palestinian refugees)

In Zarqa camp, all the men that participated in this study were dissatisfied with UNRWA and MOH services, which they perceived to be below standard. They compared them to the private sector where individualised attention was provided to clients. Men complained how most of the important drugs were not available, while all the FP methods were provided for free. The providers were qualified, and visited them at home when they were late to come to the clinic and distributed brochures however, not everybody liked them because people did not read. According to them, the providers did not respect them and treated them as if they were 'ignorant'.

- ✓ 'As if the woman is ignorant and there is some arrogance in their way' (woman, Zarqa camp, 26, married, university student, 1 girl).

- ✓ 'There is a belittling of the older women that are pregnant. As if she has done something shameful' (woman, Zarqa camp, 29, married, 4 children, non-user now).

Women in the camp were unhappy and found the nurses rough and lacking empathy, hurrying them and pushing them around. Waiting time and the gender of the doctor were two service barriers mentioned by couples during the household interviews?

- ✓ 'The coloured cards are all a bunch of lies, it is just for appearances, and whoever comes after 12 noon is kicked out' (non user couple, Zarqa camp, 4 children, husband 33, wife 29).
- ✓ 'The woman comes at 8, waits for the doctor to have breakfast until 9:30, and then someone comes with the number 100 and has '*wasita*' (favouring kins) and enters first' (user couple, Zarqa camp, husband 27, wife 26 with 1 girl).
- ✓ 'If a lady has inserted an IUD at a private clinic and wants to have the IUD examined at their clinic they do not accept her. They only accept the ones that have inserted the IUDs at their clinic' (woman, non- user, Zarqa camp, 29, married, 4 children).

New Zarqa (rich urban)

Rich women were also not satisfied with JAFPP providers because they found them rough and lacking respect. They also complained that they were not given enough time, and were not allowed to express themselves. They concluded that the quality of care depended on the fee of the service and that was why the private sector was better than the other services.

- ✓ 'They do not allow us to ask questions because they want to finish quickly and they want to go' (woman, New Zarqa, 50, married, 5 children).

- ✓ 'I go to a private physician in Zarqa, and I do not go to the public sector or to the Army. Their services are like a slaughterhouse. I utilise the private sector because their services are better and I deliver in the private sector' (woman, New Zarqa, 30 married, 4 girls).

Most of the community's complaints about the quality of services focused on the providers' attitude. Men and women, with the exception of rich women, did not usually differentiate between the private sector practitioners and other practitioners in terms of qualifications or equipment used, but only stressed the time spent with clients, and the way they treated them. Changing the providers' attitudes, and their perspectives of the community, were given priority by men and women in the community.

13. Service providers' views of clients' knowledge

Generally, service providers were not satisfied with the clients' current knowledge of RH and FP. Their opinions varied but there were very few positive perspectives. Providers expressed varying degrees of dissatisfaction from mild to severe.

On the other hand, some providers in all sectors except the private sector perceived clients' knowledge as average and improving with time. They associated this improvement with educational programs, the media, school curricula, and providers' efforts.

- ✓ 'The level of information is better because of the media education and school curricula that include information on RH concepts… and so we find that women have a background and experience about what FP methods they want to use' (female doctor MOH MCH training centre, 43, married, 3 children)

- ✓ 'But lately, as a result of lectures and of the efforts of the CBDs, the level of awareness is better than before, but we are until now not satisfied but there is a visible improvement' (1 male specialist and 2 female nurses in consensus, SFWC)

Except for UNRWA and the private practitioners who were pessimistic in their views of the community, the providers of MOH, SFWC and JAFPP were convinced that women were co-operative. Many realised that women had a variety of needs, which they tried to provide for individually because they were proactive in their quest to know more. The community- based distributors (CBDs), who were fairly new in outreach service delivery, were particularly excited about women and men co-operation within their outreach community (Ghweirieh). Could this be related to the fact that CBDs were recruited from the same community that they served, hence people co-operated better with them because they knew them well. Community-based distribution in Jordan is a pioneer initiative within the CPP project that is ongoing for five years. It would be useful to investigate (research) the effect of the CBDs being recruited from the same community that they served on change in utilisation behaviours or on widening access to FP services based on providers (CBDs) experiences and the clients views in the community.

- ✓ 'They wait for us and welcome us cheerfully and we find acceptance from them ... Even if they see us for the first time, they used to accept the subject immediately ...And when we started going to them time after time, they used to accept us more and listened to us more'(CBD, 24, married, 3 children)

Many providers believed that the level of their clients' knowledge was varied, and generally determined by their educational level. However, not all of them agreed that education was a determinant of knowledge. Private practitioners perceived their clients as

being of different social backgrounds, unlike the public sector clients who were usually from the same background, resulting in a uniform level of knowledge of RH and FP.

- ✓ 'Even the ladies who hold a university degree or diploma do not have any sexual education or information' (female nurse, UNRWA, 48, married, 4 children).
- ✓ 'I received a woman with university education, and she told me that the '*Daya*' (TBA) told her that the uterus has risen up, and that we (doctors) do not know about these conditions, and that only the '*Dayas*' know about these conditions' (male private physician, 46, married, 4 children).

The majority of providers agreed however that their clients were lacking knowledge of FP, and were unable to make choices. Some women did not even know of contraceptive pills safe for breast feeding women, and according to them, only about 40% of women had satisfactory information about RH and FP.

- ✓ 'Some women come to us at a loss, and they do not know what are FP methods' (female nurse, MOH, 24, married, pregnant)
- ✓ 'People's information of FP methods is insufficient and incomplete and let us not forget that the society that we serve is a society with a moderate level of education' (male specialist, SFWC, 38, married, 3children)

Many providers were completely dissatisfied with their clients' knowledge, and believed that they did not know many aspects of health and prevention of disease. They used the word 'ignorant' often to describe people and express their frustration with their clients' knowledge.

- ✓ 'The level of information is very low, it is below zero' (male doctor, MOH, 40, married, 2 children).

- ✓ 'The problem lies in ignorance and people's lack of education, the basis is ignorance' (three providers, SFWC, 1 male doctor and 2 female nurses mentioned this description during the FG discussion, all married, 38, 37 and 32 with 3, 5 and 4 children respectively).
- ✓ 'All the information emanates from the neighbours and the wrong information keeps on being exchanged and we cannot call it ignorance or lack of education because it is a case of extreme ignorance and total lack of education… And this is not a feature of women only, for men are the same' (male specialist, UNRWA, 45, married, 3 children).

Men and women in the community saw lieu for improvement in the providers' attitudes towards them, while the providers themselves were not satisfied from the level of knowledge in the community concerning RH and FP. The next section explores community strategies to help bridge the gap between both parties to widen access to RH and FP knowledge and promote the utilisation of FP methods and services.

14. Community strategies to widen access to FP

Men and women focused on utilising the economic rationale in harmony with the service providers' and policy makers' perspectives. The providers of UNRWA suggested using the economic rationale for utilising FP because they believed that it was an effective strategy at the household level, while the private practitioners focused on utilising the health rationale for FP utilisation. A few men suggested introducing a social welfare system at the national level, while others suggested providing financial incentives to smaller families like free education for families with two children.

- ✓ 'I think that the bad economic situation of people has to become a positive element that motivates people to use FP' (male teacher, Zarqa, 38, married, 2 children).
- ✓ ' The husband must understand also that the woman must not have too many children to maintain her health, her body and fitness, and personality' (male doctor, UNRWA, 36, married, 2 boys).

The group of teachers mostly focused on awareness- raising campaigns, home visiting and counselling. However, they were against targeting men because they believed that society was not ready for such a strategy. On the other hand, they disagreed on mobilising religious preachers in advocacy campaigns.

- ✓ ' Having a religious preacher with a male or female doctor on TV in a seminar' (Male doctor, MOH, 40, married, 2 children).
- ✓ ' Including men is a must but before that, society must be ready through awareness – raising campaigns targeted at women because they listen to rumours and disseminate them' (male retired teacher, 48, married, 8 children with 5 boys and 3 girls).
- ✓ 'Some *sheikhs* advocate reproduction and the increase in numbers, while others encourage FP because the conditions have changed' (man, Bedouin, 35, married, 5 children with 4 boys).

Providers in all the sectors, unlike the teachers believed that addressing men was a major strategy to widen access to FP. This matched the perspective of the policy makers. The private physicians, a few front line providers in JAFPP, and CBDs in Ghweirieh stressed that targeting mothers-in-law was a key to change within the community, because she was an effective decision-maker at the household level, and influenced her son's fertility and reproductive decisions. Many providers believed that men and

mothers-in-law must specifically be targeted at the household level for a change to happen within the community.

- ✓ 'As long as it is the mother-in-law and the husband that decide, it is better for us to address men' (female CBD, 37, married, 4 children and a JAFPP female nurse, 43, married, 3 children).

Despite the consensus among providers to address men, there was a disagreement among them on how to do that. Some of them preferred the indirect approach through the media (TV and newspapers), rather than directly addressing them in the clinics, which were perceived to be the realm of women. Others focused on the repetition of messages on the TV, as an important strategy while using publicity techniques.

- ✓ ' You must concentrate on the TV because it has caught people's thoughts' (female doctor, MOH, 40, married, 3 children)
- ✓ 'Repetition is necessary because repetition teaches the donkey (an Arab proverb). For example you can say, 'conceive slowly, slowly' and people start grasping the word' (male specialist, UNRWA, 45, married, 3 children).

Most providers however believed in the direct approach to mobilise men. Organising multi-disciplinary teams of providers, professionals from the media and religious men were suggested. Using men spaces such as the work place, factories and the Mosque after the evening prayers and the Friday sermons were emphasised.

- ✓ ' Trained young men should go to the factories or companies and educate men'(male specialist doctor, SFWC, 38, married, 3 children)
- ✓ 'It is important to insist that FP is a religious practice *('Ibada')*. We want the doctors to work with the religious authorities and preachers on building a health education

and religious education whose effect would be much stronger' (Male private physician, 50, married, 2 children).

Addressing youth was equally important for change to occur in the values and norms of this community. Providers from SFWC, JAFPP and the private sector suggested targeting schools, clubs, rehabilitation centres and prisons to reach the youth group. Information, education and communication campaigns on RH and FP were suggested by the senior providers of UNRWA and SFWC who insisted on quality as being essential in changing women's convictions about FP.

- ✓ 'Education is very important and we must concentrate on the youths in schools, through the curricula and at the university on a monthly basis, have lectures given by a specialist' (2 male specialist doctors, UNRWA, 45 & 42, married with 3 children)

Conclusion

This chapter has presented men and women's views on FP, explored the determinants of FP services and method utilisation and the barriers deterring such utilisation in the different settings. In general, men and women seemed well aware of the benefits of FP, and knew the various methods of contraception, although they feared their side effects. The providers were generally dissatisfied with the community's knowledge, while the community complained of the providers' attitudes towards them. The providers and men and women's views agreed however on the sources of information used and on the trend of increasing FP utilisation in time. Addressing men seemed an important priority to all, however, there was a lack of clarity and consensus among the providers, and the community on how to do that, and where and when to do that in order to obtain the best results.

Chapter Ten

Discussion and conclusions

Introduction

This chapter reviews the main findings at the policy, service, community and household levels, and suggests strategies at those four levels to improve access to FP and utilisation. The findings of this thesis are common to other countries of the region and the world, and the strategies transferable to countries with similar socio-cultural and political contexts.

1. Findings at the policy level

In this thesis, the population policy environment of Jordan was explored to assess the degree to which this environment was facilitating or deterring FP utilisation. The perspectives of the policy makers in international organisations (United States Agency for International Development, UNFPA), national organisations (National Population Commission and MOH), and the directors of FP programs and services and the Higher Religious Islamic Authorities differed.

Lack of appreciation of the nuances in the international population movement

The policy makers in Jordan were concerned with capacity building, sustainability, and establishing mechanisms for it. Their justifiable argument was that empowerment and national capacity building cannot be achieved and maintained without sustainability. The interviews with them suggest that they did not clearly understand the nuances between the conservative and progressive streams of the international population movement.

The literature review shows that this situation is not unique to Jordan (Population Council, 1994). Many policy makers in the Middle East do not differentiate between the different streams of the international population movement because of the similarity of their discourse at the regional and national levels.

The traditional population movements (USAID, World Bank, ODA) and progressive movements (feminists and human rights activists) advocate a population policy based on individual 'rights' and 'choice'. They base their approach to population control on the same assumptions regarding women, and assume that Islam is a barrier to women's empowerment (Population Council 1994). This conditional linkage between women empowerment and population control is used in other regions of the world as well (Africa, Latin America, and Asia).

Historically, FP programmes that were internationally funded used FP technology that was mostly delivered within biomedical frameworks in Jordan and the other countries of the region, while addressing the public with a progressive discourse. These 'joint ventures' between conservative (USAID, World Bank, ODA) and progressive population movements (feminists, human right activists, environmental activists) in preparing and delivering FP programmes, have made it difficult for governments and religious authorities to clearly differentiate between them.

Lack of co-ordination between the policy formulation and implementation levels

The lack of optimal co-ordination between the population policy formulation and population policy and program implementation levels in Jordan has further contributed to this lack of differentiation.

Funding agencies in Jordan were dealing directly with the non-governmental organisations (NGOs) without passing by the National Population Commission. This caused discomfort among some of the Jordanian officials who perceived the NGOs as 'cantons' (interview with NPC secretary general). Other national policy makers felt 'marginalised' from defining their own needs, by having imposed policy agendas (ICPD conference, Beijing conference), that were 'pasted' to their reality (using their own words)(MOH official). On the other hand the funding agencies perceived their roles as 'catalysts' of the population policy environment in Jordan. By working with the NGOs, they were primarily implementing the recommendations of the ICPD, and were dealing directly with them to avoid the delays and hassles caused by bureaucracy in official procedures and to avoid political scrutiny by local governments (Chief of Party, CPP project, Jordan).

Lack of fit between the international and local population policy

This lack of fit between international and local population policy agendas in Jordan deduced from the interviews with the policy makers and religious authorities are not unique to Jordan. Cohen and Richards (1994) analyse the gap between the religious authorities of Islam and Catholicism and the new International Population Movement (consisting mostly of feminists and human right activists) during the International Conference on Population and Development (ICPD, 1994). This gap is widened by the unconditional advocacy for sexual rights and gender rights.

The findings of this study show that the higher religious authorities of Jordan support FP advocacy in the community, but are against the inclusion of reproductive rights in the advocacy for gender equity, and are absolutely opposed to the advocacy of abortion, and

homosexuality as part of reproductive rights. They perceive this advocacy for sexual rights as carrying with it a threat of social corruption.

The descriptions of Basu (1997), Sundari Ravindran (1993), Kamran (1996), Morsy and El Bayyoumi (1998) and Greenhalgh (1995) of how international approaches are questioned and challenged by local perspectives support these findings. Population and FP programmes are specifically critiqued for having a uniform design across the globe, ignoring the local context. Green (1992) and Kamran (1996) on the other hand view this unilateral approach as a sign of the economic and political struggle between the North and South. Morsy and El Bayyoumi (1998) represent a rather extremist interpretation of the struggle between the North and the South in her writings about the situation in Egypt.

> *'As such "co-operation" related to women's reproductive health is judged as reminiscent of the exercise of power by colonial educators who sought to denationalise local women, rendering them intermediaries in transmitting colonial culture to local society (Morsy and El Bayyoumi 1998: 292).*

In many regions of the South including the Middle East, the rationale, agenda, and solutions suggested by the international population movements for population control are perceived as being unilaterally and uniformly shifted towards the interests of the North, at the expense of the interests of the South. Likewise, the religious authorities in Jordan deplore the approach adopted in international population policy, and doubt that this advocacy is motivated by the 'genuine' wellbeing of the countries of the region (using their own words).

Even in Japan, suspicion of and local resistance to international population agendas emerged because they were perceived as being imposed in a society where the family and community life were highly honoured, despite industrial and economic development

(Lock, 1998). Likewise, the focus on the advocacy for reproductive rights in the Middle East gives rise to an important question: how could policies that were based on individuality, fit in societies where both culture and religion value community life (*umma)* and the family (*hamula)* so highly?

Another critique of the current international population movement is that the Reproductive Health model, advocated during the ICPD, focuses on FP services to be mostly delivered within a bio-medical set-up, resulting in FP services, supposedly 'health - promoting services', to be provided within 'bio-power frameworks' (Berer 1993). This type of provision is dis-empowering and keeps FP utilisation in the hands of the providers instead of building the strengths of the clients (Morsy & El Bayyoumi, 1998).

Other external political factors encouraging national population policy in Jordan according to the policy makers interviewed were the Gulf War (1990) and Peace Process with Israel (1993). Supporting these findings, DeJong (1994), Al Masarweh (1997), NPC (1997) and Gilbar (1997) believed that the demographic increase resulting from the return migration of Jordanian nationals from Kuwait and Saudi Arabia in 1991, following the Gulf war burdened Jordan's infrastructure. Consequently, population policy became a top priority on the national agenda. The officials of UNRWA believed that the Peace Process with Israel (1993) brought promises of political stability. Discourses about quality of life improvements were replacing earlier discourses about the demographic struggle. The results of the latest 'General Census of Population and Housing of Jordan' (DOS, 1997), DHS (1997) and 'Living Conditions Survey' (Hanssen-Bauer & Kharabsheh, 1998) are in agreement with Al Masarweh (1997), that a growing demand for a quality of life is now

associated with changing ideas concerning ideal family size among young couples, and women in the different Jordanian settings.

The gap between the policy makers and the grassroots

This assertion of the policy makers that the Peace Process brought stability to the region however is different from the views of men in the camps as shown by the results of this thesis. There seems to be a wide gap between the policy makers' perspectives, based on a political regional approach to the Palestinian refugee problem and the position of the refugee men themselves which interpret this FP advocacy as politically targeting their existence.

This gap between the policy makers' perspectives and grassroots perspectives seems less marked and certainly less 'politicised' outside of the Palestinian refugee camps. There is a gap between population policy in Jordan and the local mentality built on kinship and familial networks and the Bedouin norms and values surrounding the tribe and children, however this gap is more subtle. The findings of the 'Jordan Living Conditions Survey' (Hanssen-Bauer & Kharabsheh, 1998) are showing marked fertility differentials by education and also some differentials in the 'ideal family size' because women in Jordan are already significantly more educated over the last decades. This increase in education however has not been accompanied by an increase in women's employment (UNFPA 1994, Al Masarweh 1997). This is related to the local mentality where the man is responsible for providing. The findings of this study have shown that only a minority of women worked while most of them still did not value their own employment because they perceived it as a burden that would add to their domestic responsibilities (natural group discussions, household interviews).

2. Strategies at the policy level

Co-ordination as a preliminary for sustainability

A top regional and national priority identified by the policy makers and service providers of Jordan was to develop more co-ordination rather than the existing competition among the different funding agencies between them and the national organisations in Jordan. The policy makers at the Ministry of Health (MOH) acknowledged that mechanisms were established to promote the co-ordination between internationally funded projects such as the project co-ordinating unit of the MOH in Jordan established in 1996. They were however concerned with the sustainability of this unit because it is currently totally funded by United States Agency for International Development (USAID). In addition, they expressed concern that this co-ordinating unit might become politically tied to the USAID political agenda at the expense of the national policy agenda. Co-ordination is also important between the funding agencies and the national organisations, mainly the National Population Commission and the MOH. The situation is further aggravated by the competing political agendas of the NGOs themselves.

National funding of the NPC

In addition, national funding of the National Population Commission would secure its political 'neutrality' instead of complicating the process of policy formulation with the conflicting political interests of the funding agencies. The Population Information Centre, now developing at the National Population Commission would become more sustainable with national sources of funding, and training staff in medical information systems

technologies, policy formulation, development, and analysis would also become possible (Al Masarweh, 1997).

The National Population Commission is highly supported by the Jordanian government and financially and politically supported by the Queen Alia Fund, a major Jordanian non-governmental organisation headed by Princess Basma (Jordanian Royal Family). In addition, many of the policy makers interviewed said they would like to see the National Population Commission as a 'reference body' for population policy, programs and activities in Jordan. A government decree (1997) has declared Princess Basma Bint Talal (the political mentor of the National Population Commission) as the authority on all women affairs and activities in Jordan (population and FP activities included). It would seem then a politically relevant strategy to channel all international funding for the non-governmental organisations through the National Population Commission. Furthermore, it seems important to train non-governmental organisations in fundraising techniques to promote their institutional capacity and financial sustainability.

Linking the policy formulation and implementation levels

Linking the formulation and implementation levels within the National Population Commission is an important strategy that translates official commitment to population policy. The Population Council (1994) in an evaluation of 30 years of population policy in Egypt, found that the decision-makers directly below the president were not very committed to population policy, while middle managers and doctors believed that Egypt's problems lay elsewhere. The findings of the comparative policy analysis of Lee et al. (1998) in eight low-income countries support this strategy.

> *'The fragmentation of the policy process among different institutions only weakened FP programmes' (Lee et al 1998:956)*

Pakistan and Zambia share common features with Jordan in terms of FP policy implementation. In Pakistan, there was a struggle between the government and the non-governmental organisations responsible for FP delivery (the equivalent of the Jordanian Association for Family Planning and Protection) over the control of objectives, monitoring, and evaluation of activities and funding. In Zambia, there was a gap between the National Commission for Development Planning (an equivalent of the National Population Commission in Jordan) responsible for policy formulation, and the MOH in charge of the implementation of policy decisions. What made FP programmes stronger in the other countries with similarities in socio-cultural and economic contexts, is the fact of having

> *'The institutions responsible for policy formulation and implementation closely linked in the policy process, and where the responsibility for implementation was clearly demarcated' (Lee et al 1998:956).*

Al Masarweh (1997) is recommending the establishment of a national policy sub-committee of four governmental organisations: the National Population Commission, the Ministry of Health, the Department of Statistics and the Ministry of Planning in Jordan.

3. Findings at the service provision level

This study shows that the environment in which FP services are delivered in Jordan is complex, and characterised by fragmented efforts and resource constraints. This situation is common in other countries of the region, and the developing world (Thaddeus & Maine, 1994). Information on the exact amount of dollars invested in family planning programs is available but restricted to senior officials only (confidential). The interviews

with the policy makers and service providers however shows that family planning service delivery in Jordan is still non-sustainable, because it is largely dependent on donor money (chapters 4-8). This situation is almost universal in the developing world. Diaz & Diaz (1993) explains how

> *' Most services and programs in Latin America depend heavily on donated commodities, and managers cannot freely decide which methods will be offered to their clients' (Diaz & Diaz 1993:119)*

There are many types of FP services available, except in the remote regions (NPC 1997, Al Masarweh 1997, DeJong 1994).

Lack of co-ordination

It was extremely difficult to retrieve client FP utilisation history and impossible to know the exact client population per family planning service at any time because the clients were registered in more than one clinic, and utilised them both at the same time. That is why service statistics provide an overall view of service utilisation but cannot be used to make definite conclusions concerning family planning utilisation. It is not uncommon for clients to have an IUD inserted in one clinic, and removed in another, if the first clinic had restrictive procedures for discontinuing the IUD or did not have a female physician. Some of the service providers are aware of this haphazard pattern of service utilisation, yet no substantial measures are being taken to remedy the situation by improving co-ordination (chapter 5). Access to the clinics is still unrestricted even to women that shop around for services, and each service seems mostly interested in its own individual yield and recruitment of new FP users, rather than in changing FP utilisation in the community as a whole. At times, contradicting information, different policies and routines in the different clinics puzzle women, and decrease the credibility of the service

providers (chapter 9). This situation is found in other developing countries such as India and Pakistan (Guldan, 1996).

Resource constraints

Although policy makers perceive co-ordination as a top priority for improving the yield of FP programmes, service providers and community members do not. Most providers focus on the resource constraints, while men and women concentrate on the quality of care and providers' attitudes. All groups focused on the socio-economic pressures in their daily lives.

Discrepancy between the providers and the community

The findings of this thesis suggest that there is a discrepancy between the perceptions of service providers and local communities concerning their assessment of the community's knowledge of RH and FP, and the community's experience of service delivery. Most providers underestimate the community's knowledge of RH and FP methods: during the natural group discussions, and the in-depth household interviews, the findings show that men and women actually know much more than what the service providers think that they know about RH and FP.

In addition, men and women at the grassroots complain that the providers treat them as if they were 'ignorant' (chapter 9), and the service providers actually used this term in describing men and women in the community (chapters 5-8). These findings match the KAP study findings on FP needs assessment in Jordan in 1997, where service providers perceived 'ignorant or uncooperative clients' (using their own words), as obstacles to quality service delivery.

This discrepancy between service providers and the community is widespread in other countries. Diaz & Diaz (1993) elaborates on how providers of FP in Latin America firmly believed that they know what is best for their clients, and hence decide what contraceptive methods they are supposed to use. Inhorn (1994), Abdel-Tawab and Roter (1996) describe the common belief among Egyptian service providers that client – centred counselling might not be effective or acceptable to clients because of the hierarchical structure of society. This belief proved to be unfounded; the Egyptian clients expressed their need to be listened to and treated nicely while given enough time. The Jordanian men and women in this study express similar needs. WHO (1991) describes how policy-makers and providers may make incorrect assumptions about what is acceptable to women and men. Whether integrated with MCH services (public sector), or delivered using the RH model (Jordanian Association for Family Planning and Protection, UNRWA), in all the models of FP provision in this study, the mode of delivery, mentality, and attitude of service providers remains deeply rooted in hierarchical biomedical structures (chapters 5-9).

Studies from Egypt and Peru relate how the attitudes of service providers (rushing their clients and treating them with hostility) and their perceptions of their local communities are very similar to those of Jordanian providers (Fort 1989, Inhorn 1994).

Even the community-based distribution program (Soldiers' Families Welfare Clinic), initiated recently by USAID remains trapped within the same boundaries. After their training, the CBDs' main objective is to attach clients through referrals to the clinic - the base for all the programme activities. The computerised Management Information System was installed at the clinic for the measurement of changes in utilisation rates, rather than

for focusing on understanding the context of utilisation behaviour within the community and at the household level (chapter 6).

Family planning service delivery is 'techno-patriarchal' in Jordan, where female contraceptive methods are the norm (IUDs, pills) and favoured options of the service providers as well, and where utilisation is initiated and monitored around a lot of technical laboratory investigations. In Egypt, Inhorn (1994, 1996) describes how the provision of services for infertility are 'techno- patriarchal' i.e., reinforce patriarchy because they mostly address infertility as a woman's problem, and are embedded into biomedicine. Vasectomy isn't even considered an option in FP provision in any of the Arab countries except Lebanon, where it has proved to be extremely unpopular. In Jordan, the female contraceptive technology marketed ranges from traditional non-invasive methods such as the LAM (Lactation Amenorrhea Method), to experimental highly invasive methods such as Norplant or Depo-Provera (hormonal contraception in the forms of injections or subcutaneous transplants). This latter technology is widely feared by women and men at the grassroots, who resist it through local narratives about how it might cause cancer and infertility (chapter 5-9).

Similarly, a common perception that modern methods are dangerous to women's health and might cause cancer, is a major barrier to contraceptive use among the Mayans of Guatemala (Ward et. al.1992). Kabir describes how in Bangladesh, women avoid methods believed to cause cancer, or cause infections such as IUDs inserted under non-sterile conditions (WHO 1991).

Providers' fears

Even the providers themselves are reluctant to use Norplant and Depo-Provera, because they are not familiar with them, and are afraid to use them (chapters 5-8). These findings match those of a survey conducted in 1996 in Jordan with 31 providers of family planning. Providers were afraid of infertility perceived as a side effect of the method, and did not consider oral contraceptives to be a suitable long-term family planning option (NPC 1997). Diaz & Diaz (1993) relates a similar belief among the family planning providers in Latin American countries. WHO (1994c,d) deduces

> *'Empirically, women's perceptions of the health risks associated with contraceptive use are greater than the perceived benefits of using them (WHOc,d 1994:12)'.*

Shortage of female physicians

The chronic shortage of female physicians in Jordan is deplored by policy makers, providers, and the community alike and affects utilisation decisions, especially since the most favoured contraceptive method in this community is IUD (chapters 5-9). UNFPA, Jordan identifies female physician shortage as a serious constraint to access

> *'Also related to the issue of demand for RH/FP services, is the empirical evidence that seems to indicate a strong preference for female physicians/ gynaecologists particularly in poor more conservative communities...*
> *If this situation is validated through more in-depth research it presents a serious constraint to accessibility of RH/FP services in view of the shortage of female physicians/ gynaecologists. This is further compounded by the shortage of nurses' (UNFPA 1998:12).*

This situation is not unique to Jordan, and Inhorn and Buss (1993) relate how Egyptian women are often reluctant to discuss sexual behaviour and problems with male physicians. In addition to the gender constraint, the service providers' attitude further

affects service utilisation in Jordan and long waiting hours, lack of empathy and respect, and paternalistic attitudes are common constraints (chapter 9). Haddad et al. (1998) relate how the users of Primary Health Care services in Guinea are mostly sensitive to aspects of interpersonal relations with providers, and the technical quality of care provided.

In addition, policy makers, providers, and the community agree that the lack of training of service providers, and at times their lack of conviction in FP are barriers to service utilisation. Likewise, in Latin America (Diaz & Diaz 1993) and Egypt (Abdel-Tawab and Roter 1996), FP providers' training is a major impediment to quality of care.

Inadequate service supply for remote regions

There is a wide supply of family planning services at no cost in the city but almost no family planning services in the remote areas, except for the mobile clinic that operates for one or two days a month. This discrepancy between rural and urban areas is universal in developing countries (Thaddeus & Maine 1994, Fort 1989).

4. Strategies at the provision level to increase FP utilisation

Moving away from the bio-medical model in family planning provision

In order for family planning services to become 'health promoting', health promotion being

> *'The process of enabling people to increase control over and improve their health'* (Guldan 1996)

a major long-term strategy would be to de-medicalise FP provision. An important feature of biomedical FP provision in Jordan is its restriction to physicians only. In view of the lack of supply in female physicians, it would be advisable to train other categories of health personnel, apart from doctors to fill this gap. In-service training must aim at changing the providers' attitudes towards their clients and other health professions.

It seems important to note however, that working in the community rather than in a clinic is a necessary, but not sufficient condition, to move away from the biomedical model. The Community-Based Distribution (CBD) program in this study shows how provision is still embedded in the biomedical system, despite the fact that they are operating within the community. The discourse, attitude, and approach of service providers are key determinants in moving away from biomedical FP provision.

Diaz & Diaz (1993) relates how in Latin America, physicians do not always respect the counsellors' decisions based on a concept that contraceptive choice is a medical activity. This hierarchy among health professionals is also common in Jordan, and reinforces biomedical structure.

In another attempt to move away from the bio-medical model in Egypt, Abdel-Tawab and Roter (1996) suggest to support medical education with behavioural sciences and interpersonal communication training. This strategy is relevant to medical education in Jordan and might contribute a supply of health-promoting physicians. According to Guldan (1996), this quality of medical education is still non-existent.

Involving gatekeepers in family planning advocacy and provision

Mobilising community gatekeepers and non medical personnel in family planning advocacy and provision might enable men and women to increase control over their reproductive and fertility decisions without compromising the quality of information, counselling and services provided. Utilising these community resources fills the shortages in human and financial resources and might move family planning provision away from the biomedical framework. UNFPA in its assessment of the National Population Strategy (1998) recommends to:

> *'Improve the outreach capacity of RH/ FP service providers by involving community-based health workers such as TBA's and midwives' (UNFPA 1998:3).*

Integrating men in family planning provision

Men in Jordan are widely involved in family planning decisions. Hence, addressing men is a major strategy to increase family planning utilisation, as they are major determinants of this utilisation. To the exception of one advocacy programme of the National Population Strategy 'Together towards a happy family' (1998 onwards), most advocacy programmes in Jordan do not address men.

Moreover owing to the fragmentation between the policy and implementation levels, this new strategy of addressing men is still not translated into changes at the service level (Ministry of Health, UNRWA, Jordanian Association of Family Planning and Protection). Men are denied access to most family planning services because these services remain integrated with MCH services; even the Comprehensive Postpartum project mostly addresses women in the postpartum period.

During their assessment of the National Population Strategy of Jordan in 1998, UNFPA recommends to increase the accessibility of RH/FP information and services beyond MCH centres.

Improving quality of counselling

Quality counselling in family planning is now a universal issue. Verme et al (1993) relate how policy makers still view counselling as a luxury, because in the current models of provision, heavy client load, lack of private space, and understaffing impair counselling activities. In addition, Diaz & Diaz (1993) explains how in Latin America, most providers are convinced that they are in a better position to choose the most

appropriate method for each client, and therefore refrain from providing information on all options available. The findings of this study show similar constraints for effective counselling and similar attitudes and beliefs among Jordanian providers (chapters 5-8).

Setting standards of practice and unifying procedures

Meanwhile, another important strategy at the provision level is the setting of standards of practice, and protocols at the national level and unifying routines and procedures.

Reinforcing co-ordination mechanisms

Improved co-ordination is a major strategy to widen access to FP at the service level. Co-ordination mechanisms between the different services providing FP and among the different clinics of one organisation would lead to increased utilisation. This co-ordination helps clients to have more control of their environment by decreasing their bewilderment, and might improve the image of service providers by promoting their credibility.

Special attention needs to be geared to the rural and remote areas of Jordan where service delivery is minimal and discontinuous. The findings of this research show a great need for family planning expressed by men and women in rural communities. This situation is not unique to Jordan: a qualitative study in Peru typically indicated that no family planning services are available in rural areas (Fort 1989).

5. Findings at the community level

Traditional norms and patriarchal networks as determinants of fertility

Jordanian society like many others valorises 'corporateness' (the sense of inviolability of the social group), at the expense of 'individualism' (Inhorn 1996). In most

Middle-Eastern societies, individuals sacrifice their individual needs for the group, usually the extended family.

> *'The persons are thus embedded in familial relational matrices that shape their deepest sense of self, and serve as a source of security when the external, social, economic and political situation is uncertain' (Inhorn 1996:8).*

Historically, Islam emerged in a tribal society largely patriarchal and patri-lineal. To date, many Arab societies of Bedouin tradition, Jordan included are still shaped by patri-lineal (marrying into the father's families, carrying father's name, identification through father's lineage and kin), and patri-local networks (living within the same location as father's lineage and kin). In Nigeria and many African cultures as well, patri-lineal linkages shape reproductive behaviour (Pearce 1995, Inhorn 1996, Renne 1997, Hollos and Larsen 1997). This determines male child demand, and FP utilisation. It seems important to note however that

> *'Islam and especially modern extremist versions of it, plays a role in the perpetuation of patriarchy in the Middle East. But Islam* ***is not*** *patriarchy, nor is Islam particularly patriarchal' (Inhorn 1996:33)*

Fertility is associated with the marital bond, femininity, and power by both men and women (chapter 9). The providers and community members alike use many justifications to advocate the value of children, and when asked about their perception of the ideal family size, they agreed that the ideal family size is a family of four children (chapters 5-9). This preference for a family of four children is found in the Jordan Living Conditions Survey (Hanssen-Bauer et. al 1998) with no difference in family size preference between the refugee and the non-refugee population.

Men and women justify their value of children with economic (a security for old age), religious (a duty for good Muslims), national (the continuation of the Palestinian identity), social (carrying one's name), or simple physical reasons (a pleasure and a continuation of the species). Inhorn (1994) relates a similar intense desire for children among the Egyptian poor.

> *'They visualise them as one's primary capital and perpetuity after death, they are a compensation for all that is lacking in their lives of hardship and despair' (Inhorn 1994).*

Changes in social networks brought about by urbanisation and the economic constraints

The findings of this thesis show that the Bedouin norm of 'Ezweh' (children as a support), is now mentioned with 'nostalgia' and remembered as 'nice and valuable', by most people (using their own words). However, it is often perceived as 'a thing of the past' because times have changed, and because of economic hardships, and habitat constraints (lack of space) which have made it very difficult to keep large families (chapter 9). Inhorn (1996) describes a similar trend in concentration on the nuclear family *'usra'* as opposed to the extended family *'aai'la'* following urbanisation in Egypt.

Notions such as quality of life, and the valuing of intimacy between couples, emerged in the current discourse, especially among young urban couples, and affluent men and women (chapter 9). Shneider and Shneider (1995) relate a similar change in discourse among the Villamaura population (Sicily) between the turn of the twentieth century and the 60s, when new ideas about family respectability, became closely linked to the value of partnership in marriage, and the importance of privacy. This discourse preceded fertility decline that resulted from the mass use of coitus interruptus, because it did not antagonise the teachings of the Catholic Church. Nowadays, most men and women in

Western societies practise family planning out of conviction because they want smaller families.

The gap between family planning programmes and the local mentality

The qualitative findings of this study show that men and women in the different settings of Jordan feel the need for and are convinced with the importance of reproductive health and family planning services. Jordan is currently in a fertility transition with a marked change in TFR (dropped from 7.41 in 1976 to 4.38 in 1996) and CPR of modern methods (increased from 24% to 37% for the same time interval (DHS 1997, Hanssen-Bauer et. al 1998). Despite this change in reproductive health indicators, men and women according to this study and to the Jordan Living Conditions Survey (1998) remain convinced that the ideal family size is a family of four children. The increase in family planning utilisation might therefore be more due to an economic imperative of the cost of having children than to a change in people's convictions regarding the ideal family size. In addition, the findings show a widespread concern about the permissibility of family planning utilisation in Islam. Only a minority of men and women believe that family planning is an absolute benefit to them, and although they have smaller families than their parents, they are still far from reaching the replacement levels advocated by demographers. Men and women statements concerning children bear a tone of deprivation, even when they have three or four of them.

Excluding men from the process of family planning delivery in a patriarchal society like Jordan, where women are totally economically dependent on men, and where children are so much valued, is another illustration of the gap between services and the community. This situation is not unique to Jordan: the majority of population

programmes historically ignored men, because they either assumed that they were against family planning, or at best indifferent (Mc Ginn et al. 1989).

Finally, there seems to be a lack of fit between most family planning programmes whose design is based on an individualistic perspective, and the mentality of the people at the grassroots of the Middle Eastern countries that favour the collective good to the individual good.

The gap between the religious authorities and the community

The doctrine of Islam is egalitarian in nature, while the tradition stresses fundamental differences between men and women (Tamimi 1998, Seestani 1997, and Obermeyer & Potter 1991). There is often confusion between Islamic doctrine and tradition at the grassroots.

Islam includes a comprehensive social system, and the role of *'Imams'* (Islamic authorities) is to initiate people into this social system, including family planning. The *'Imams'* role became strictly censored in the second half of the twentieth century, following political frictions between most Arab governments following 'nationalism', and the emerging fundamentalist *'Islamist'* movements mainly represented by the Moslem Brotherhood (Egypt, Syria and Jordan, lately Lebanon and Palestine). Free Islamic expression, targeted against fundamentalist movements, was almost completely censored by Arab governments. This censorship however, also affected moderate Islamic authorities, leaving a gap between religious authorities and the community.

Owing to this gap, there is a lack of information about Islamic doctrine and rulings of daily activities including family planning in Jordan and many other Arab countries.

In addition, population policy was dormant for a long time in Jordan, being a sensitive political issue, so religious authorities rarely addressed it in their discourse.

The qualitative findings show a lack of consensus regarding the interpretation of the position of Islam towards family planning in different Jordanian settings (chapter 9). Earlier a knowledge attitudes perspectives survey (1997) in Jordan has shown that most men did not talk about family planning with their religious leaders, and were not sure whether they approved or disapproved utilisation of family planning methods based on Islamic jurisprudence (NPC 1997). According to the Higher Judge of the Islamic court however, the position of Islam towards family planning is clear (chapter 4).

This gap between the Moslems and their doctrine is detrimental for community life, because people become gradually alienated from Islamic doctrine, and concentrate on 'social Islam' and 'rites of passage' e.g. weddings, funerals, feasts.

For differentiation purposes, the fundamentalists are referred to as *'Islamist'*. Led by purely political motives, Islamist movements high jacked the grassroots arena and concentrated on following distorted interpretations of Islamic tradition at the expense of the substance of Islamic doctrine. Inhorn (1996) describes a situation in Egypt

> *' It appears that Islamist elements within Egyptian society have targeted their efforts in large part towards religiously illiterate, poor urban Egyptian men and women through a number of inherently political strategies' (Inhorn 1996: 257).*

Furthermore, the fundamentalist movements attacked family planning, driven by purely political motives, using people's lack of knowledge of the position of Islam towards it to mobilise them against it, totally ignoring Islamic jurisdiction. Another drawback of this lack of knowledge of Islamic doctrine is overlooking mutual consent -

the basis for gender relations - much emphasised in the *Quran* (Obermeyer & Potter 1991).

In Egypt, eighty five percent (85%) of religious leaders in the community that were included in a knowledge, attitudes and perspectives survey perceived population policy and the use of contraceptives negatively (Population Council 1994).

One illustration of this situation is the *'Islamist'* opinions expressed exclusively by men in the camps during natural group discussion. However, these opinions became diluted during household interviews, when some of these men were approached with their wives (chapter 9).

It is interesting to note that women in the camps (their wives) did not express any *'Islamist'* opinions, and were more flexible towards family planning utilisation. However, many of them, cannot act independently, and fall in with their men's decisions.

6. Community strategies for family planning utilisation

Culturally-sensitive approach

These findings show a need for family planning programmes to address men and women in a comprehensive and culturally sensitive manner. In Jordan, the National Population Commission wants to address mothers and mothers-in-law, because they exert considerable influence on the decision-making process at the household level. In addition, husbands are perceived as the protector of, provider for, and decision- maker of the household.

In Guatemala, research indicates that community and religious leaders, and husbands exert considerable influence on family planning decisions, and usually oppose the use of contraceptives (Ward et. al.1992). While in a study of five cities in Indonesia, husbands'

approval is the most important factor in whether or not wives use contraception (Eschen and Whittaker 1993:109). Even in other cultures in Sub-Saharan Africa, males play a dominant role in decisions regarding childbearing and fertility regulation (Caldwell and Caldwell 1987, Magnani et al. 1995).

Since most men in Jordan, other countries of the Middle East and the developing world shape reproductive decisions in the public and private spheres. It is therefore argued that if men were more pro-actively involved in family planning awareness campaigns, there might be a transformation of values and perceptions around fertility and family planning in the Jordanian society.

The need to address men in family planning programmes and services is now universally recognised (Mc Ginn et. al 1989, DHS 1996). Fertility decline happened in Turkey not because of development, but because men had approved family planning utilisation in their homes (Population Council 1994, Greenhalgh1995, Angin and Shorter 1998).

In harmony with global trends, UNFPA, is recommending mechanisms to involve men in reproductive and sexual health in Jordan, focusing on

> *'Understanding the process of decision-making regarding the RH/FP at the household level and its effects on acceptance and practice' (UNFPA 1998:2).*

Using local resources

Using local resources (religious men) in advocacy for family planning based on a cultural context (Islamic jurisdiction) seems effective in changing reproductive behaviour of men. The argument is based on the empirical assumption and findings of this thesis that show that local resources, especially religious men are instrumental in promoting the

political trust in and a sense of ownership of family planning programs in Jordan. Men at the grassroots generally perceive religious men as being primarily 'role models' and 'a reference for Islamic jurisdiction'. Since many men at the grassroots are unclear about the rulings of Islam concerning FP, *'Sheikhs'* (religious men) would be trusted sources to clear this dilemma. Furthermore, policy makers are now acknowledging the importance of religious leaders as 'key social actors' because they are intimately involved with social networks at the local level (NPC1997).

Advocacy based on religious tradition

While participating in discussion groups, community meetings and or media presentations, religious leaders might reassure the community that practising family planning and using modern methods is acceptable in Islam. The efficacy of this strategy is validated by a knowledge attitudes perspectives (KAP) survey findings (1997) showing that religious programmes on TV are very popular among men who are thirty and older especially in the Northern and Southern regions of Jordan (higher fertility) (NPC 1997).

Warwick's (1988) recommendations for countries with dominant religious tradition have an impact on family planning acceptance and might be pertinent to Jordan.

> *'Religious leaders are consulted about program design, the programs avoid elements offensive to the religious tradition and the program includes methods favoured by the religion or otherwise makes concessions in that direction (Warwick 1988:5)*

The Islamic regime in Iran has popularised the fundamental importance of practising family planning, through the Friday sermon and other media. Consistent communication and education campaigns that address men and build on '*Aqeeda*' (i.e. the ideological tenants of Islam) prepared by the '*Sheikhs*' (religious men), might transform the culture at

the grassroots, by clarifying the position of Islam towards family planning. These official religious resources can effectively answer the propaganda against family planning that certain *Islamist* groups are disseminating at the grassroots.

Furthermore, it might be useful to promote coitus interruptus, traditionally used by the companions of the Prophet, as a culturally–sensitive method. Widely used in Italy and France at the turn of the century and during the first half of the twentieth century, coitus interruptus has been quoted to reduce fertility, without antagonising the Roman Catholic Church (Shneider & Shneider 1995).

Warwick (1988) describes how dominant religious traditions have played a crucial part in the development of national family planning programs in Mexico, Egypt, Indonesia, and the Philippines. Islamic and local traditions can also be used to train providers about confidentiality, relating to clients', and to clarify their views about family planning and the ideal family size. It follows that the use of these local resources seems more effective in increasing family planning utilisation rather than using non-Jordanian 'experts' or Jordanian 'non-religious' experts to advocate the benefits of family planning at the grassroots.

Combining religious discourse with modern rationales for family planning utilisation

The national population policy was successful in Iran because it combined Islamic discourse with modern population discussion in a very accessible format (Hoodfar 1995).

Building on economic constraints to mobilise the community is a useful strategy whereby family planning is presented as an advantage because it relieves households of economic burdens. In harmony with this strategy, UNFPA in its assessment of the

National Population Strategy is recommending the reinforcement of the link between family size and environmental resources (UNFPA 1998).

It seems equally important for family planning programmes and services to build their approach and discourse on the economic and health imperatives as well as to inspire from the local Islamic and Bedouin tradition. Using the value of children rationale in 'Ezweh' but matching it with the new demand for 'quality' rather than 'quantity' might be a useful strategy in advocacy of family planning in Jordan.

Acknowledging the complexity of determinants perpetuating child demand and affecting utilisation in the Jordanian community, UNFPA is now recommending

> *'To undertake research establishing correlations between socio-cultural perceptions and practices and i.e. son preference, value placed on reproductive role of women and large family size and use of RH/FP services' (UNFPA 1998:4).*

7. Value of methods used

Qualitative methods used in this research were very helpful in understanding how economic, social, political, cultural, and other environmental factors affect peoples' behaviour in seeking family planning services, and their utilisation of those services. Hence the methodology used is a contribution to the debate on the value of multi-disciplinary approaches in understanding health seeking and utilisation behaviours in public health (Inhorn 1993, 1995, Baum 1995, Bryman 1996, Lewando – Hundt 1993,1999, Loos 1995, Stone and Lewando-Hundt 1987, Trostle and Sommerfield 1996, DeJong 1994)

A matrix of factors shapes other health seeking behaviours in Jordan, and is applicable to other countries of the region, and developing countries as well. The

methods used unfolded the various discrepancies between policy and implementation levels, between service providers and the community, and between religious authorities and the community.

This thesis shows that it is not only environmental factors such as socio-economic and political factors, or cultural factors such as social construction of fertility, reproductive roles, and the meaning of progeny that determine utilisation patterns. Instead of using a *reductionist* approach, *interactionist* and *constructivist* approaches are adopted in researching the matrix of barriers deterring FP utilisation at the policy, service, and community levels.

> *' The approach stresses holistic understanding and the importance of context. The emphasis is not measurement but rather understanding' (Baum 1995:461).*

The qualitative methods used contribute to understanding the subtle processes of power and negotiation relating to family planning provision among the different players, and the various interpretations of reproductive health and family planning.

8. Contribution to knowledge

The findings of this thesis are relevant to other countries of the Middle East and developing world, as are the recommended strategies.

At the policy level, there is a dichotomy between the perceptions and expectations of policy makers in funding and international organisations and the policy makers in the public sector of Jordan. In addition, family planning provision in Jordan remains non-sustainable, because it is largely dependent on international donor money. The findings of this thesis show that embedding family planning programs in their local context is an important determinant of their sustainability (Warwick 1988, Airhihenbuwa 1995). An

approach of a 'cultural and political economy of fertility' developed by Greenhalgh (1995) is highly applicable to the context of Jordan.

The nuances among the different streams of the international population movement are perceived without much differentiation at the local level, mostly because of the uniform design of implementation of population policies and family planning programmes at the regional level.

At the service level, family planning provision in Jordan as in many other places remains trapped into biomedicine. Hormonal contraceptive technology is widely feared by providers, women and men at the grassroots. The chronic and severe shortage in human and financial resources, and the chronic shortage of female physicians are service barriers to access, especially that the IUD is the most popular method in this context. Other service barriers are the providers' attitudes and inequity in service distribution between the rural and urban areas.

In Jordan, the political environment (Palestinian –Israeli conflict) that deterred population policy formulation has lately changed in favour of a population policy formulation (Peace Process). The social environment however remains an impediment to such an implementation. Women's education and employment are not determining fertility decline in the Jordanian context because of the social environment (Basu 1997).

Reproduction, fertility, and children are still highly valued in the different settings of Jordan, and most countries of the Middle East, because of religious interpretations and socio-cultural tradition - patrilineal, patrilocal kin networks (Population Council 1994, Inhorn 1994, 1996). However, traditional networks are gradually eroding with the rapid urbanisation of Jordanian society, and economic pressures mostly induced by the

structural adjustment programme, are reducing the value of large families. Pragmatic decisions induced by the necessities of life have influenced this love of children to become more of an ideal, being replaced by notions of quality of life, and the valuing of intimacy between couples. Yet, contraception is still rarely seen as more than a 'necessity of life', because of the 'cost' of having children.

Historically, the political friction between religious fundamentalist groups and Arab governments had unfortunate consequences on the formal religious authorities. As the governments censored formal religious activities in the community for fear of the fundamentalist movements high jacking the public arena, a gap in information about Islamic doctrine, and its verdicts on daily activities, including family planning has developed. There is now a lack of consensus about the interpretations of Islam concerning family planning in Jordan and other Arab countries. The fundamentalist movements have attacked family planning, accentuating the gap between family planning programmes, the services provided, and the community in Jordan, and elsewhere in the region.

Moving provision away from biomedicine by utilising community resources to remedy shortages in human and financial resources, and addressing men are instrumental strategies. Using official religious authorities, is one culturally- sensitive strategy to widen access to family planning in Jordan, by matching Islamic doctrine and family planning practice. Using the value of children rationale in *'Ezweh'* and matching it with the demand for 'quality' rather than 'quantity', and building on economic constraints might be other useful community strategies to widen access to family planning.

Conclusion

This chapter has linked the findings of this research with the contrasts in population policy at the global, regional and national levels. Factors affecting the provision and utilisation of family planning at the policy, service and community levels have been identified. Possible strategies have also been identified to diminish barriers to family planning provision. This thesis advocates a cultural economic approach to demography and population policy an illustration of which is using the official religious infrastructure in advocating fertility behaviour changes based on Islamic doctrine. The approach developed in this thesis is transferable and not unique to Jordan, because the issues identified exist in other places.

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Appendix 2.1 Strategic objectives of NGOs for women's health for the year 2000:

1. Lifetime access to quality and affordable health services for all Jordanian women.

2. Reinforcing prevention programs that promote women's health

3. Encouraging research and disseminating information about women's health.

4. Increasing resources allocated for women's health

5. Promoting gender oriented education, and programs that prevent sexually transmitted diseases.

The National Strategy for Women:

The Jordanian National Committee for Women was established in 1992. It is presided by HRH Princess Basma Bint Talal, and includes representatives of public and private organisations dealing with women.

The Committee prepared the National Strategy for Women, which has resulted in the active participation of the Jordanian women in the Beijing conference in 1995. Following the conference a platform for action was to be implemented by the governments and NGO'S by the year 2000 with a landmark of implementation strategies by the end of the year 1996. A regional forum for Arab NGO's followed by a regional meeting of Arab governments was held in Amman from September 22-23, 1996 (for NGO's) and September 28-29 for Ministers of Social affairs under the patronage of HRH Princess Basma and recommendations were achieved concerning the plan for the year 2000.

The Jordanian NGO's have decided to address the following priorities [1]from the platform of action by the year 2000:

1997:
Women and poverty
Women and armed conflicts
Education and training of women
Women in power and decision making
1998
Women and human rights
Violence against women
Women and health
Women and the environment
1999
Women and economy
Organisational mechanisms for the enhancement of women
The girl child
Women and information
2000
Evaluation of the implementation of the platform of action after 5 years
Other recent issues

[1] Platform for action of the Jordanian NGO's concerning women for the year 2000, Amman, 1996.

Appendix 3.1 List of policy makers interviewed:

Organisation	Position	Date and number of interviews:
Ministry of Health Directorate of PHC services	Technical Assistant Director	August 9th, 1997, 2-4pm (four cancelled appointments).
Directorate of MCH services	Assistant Director	August 7th, 1997, 10-12noon (one cancelled appointment).
Directorate of planning- Program and projects co-ordinating unit	Director	August 10th, 1997, 2-4pm
Directorate of health- Zarqa Governorate	Director	August 3rd, 1997 August 10th, 1997 August 24th, 1997
National Population Commission General Secretariat	Secretary General	June 28th, 1997, 10-12noon
The policy project	The Jordan resident advisor	September 18th, 1997, 9-11:30am
UNRWA Headquarters- Family Health Division	Director	August 5th, 1997, 12-2pm
Jordan Field	Health Officer and Deputy	August 11th, 1997, 8-10am
Jordan Field	Family health officer	August 25th, 1997, 8-10am
UNFPA Country Support Team (CST)	Regional and Jordan Advisor for RH	July 22nd, 1997, 11-1pm
Jordan office	Senior program officer	September 9th, 1997,1-2:30pm (ten cancelled appointments)
UNFPA consultant at NPC.	Gender mainstreaming consultant for the national population strategy	September 22nd, 1997, 9-11am
USAID CPP project	Chief of Party	July 30th, 1997,1:30-2:30pm July 31st, 1997, 2:30-4pm
JAFPP	Director of patient services	October 1st, 1997, 8-9am October 2nd, 1997, 8-9:30am (one cancelled appointment)
The Family Counselling Centre Sear	Director	June 29th, 1997, 12-2:30pm
The Islamic Court	The Higher Judge	October 4th, 1997, 12noon October 8th (cancelled) October 29th, 1997, 12:30noon November 12th,

1) The Assistant Director for Technical Affairs of the Primary Health Care services, at the Ministry of Health. Originally, the researcher had planned to interview the director of the PHC services but upon contacting him, the Director General of the PHC Directorate referred the investigator to his technical assistant.

2) The Assistant Director of the MCH/FP Directorate, MoH. Again, the researcher had organised three interview dates with the Director of MCH/FP services who failed to show up and suggested through the phone to interview his assistant instead.

3) The Director of the Project Co-ordinating Unit, Directorate of Planning, MoH. This Director was suddenly transferred to Salt (one of the Governorates of Jordan) during the year 1997-1998 and was replaced by two junior General Practitioners following difficulties with the Director of the Directorate of Planning.

4) The Director General of Health of the Zarqa Governorate, MoH.

5) The CEO of the Comprehensive Post Partum Project (USAID project) in Jordan.

6) The Secretary General of the National Population Commission (NPC).

7) The Policy Advisor on the Population Policy Project (USAID project), adjunct to the NPC.

8) The Director of the JAFPP clinics and services.

9) The Director and Deputy Director of health for the Jordan Field, UNRWA

10) The Jordan field health officer, UNRWA

11) The Senior Program Officer for the UNFPA programs in Jordan.

12) The UNFPA Country Support Team Regional Advisor and advisor for Jordan.

13) The UNFPA visiting consultant for integration of the gender mainstream in the National Population Strategy.

14) The president of a local women NGO in Zarqa, also a candidate to the parliamentary elections of 1997, and an executive member of the Jordanian Union for Women, and the Union Representative for the Zarqa Governorate.

15) The 'Qadi el Qudah' (The Higher Judge of the Islamic Jurisprudence in Jordan).

Appendix 3 .2 Time frame of the research study

The fieldwork of this research study started in June 1997, and finished by the end of June 1998.

Activity	J 97	J	A	S	O	N	D	Jan 98	F	M	A	M	J
Access													
Interviews with policymaker													
Service observation													
Service statistics													
FG discussions with providers													
Natural group discussions													
In-depth household interviews													
Quantitative analysis													
Qualitative analysis													

Appendix 3.3 The research protocol

Dear Dr.

Please find enclosed a summary of the fieldwork in Zarqa:

Duration: July 1997- December 1998.

Location: Zarqa Governorate

Sites: One Bedouin community in South Azraq accessed through the mobile clinic of the JAFPP.
Two urban communities (1 high socio-economic accessed through the private sector and one low socio-economic accessed through the MoH clinic). Match both communities.
One community of families of militaries accessed through the Royal Medical services (The Soldiers' Families Welfare Society).
One community of Palestinian Refugee origin (accessed through the UNRWA clinic).

Services:
MoH
Royal Medical Services
UNRWA
JAFPP
Private sector

Methods:

1) **Interviews** with policy makers: 10 (See appendix I) (qualitative)
2) **Participant observation** of service facility, provision and provider client interaction in the five services(qualitative)
3) **Document analysis:** of clinic records for service utilisation and coverage for the five services (quantitative).
4) **Focus group discussions:** 10 with providers in clinics to identify barriers to access and strategies to widen access (qualitative).
5) **Natural group discussions:** 10 in the homes within the five types of communities to identify perceptions of women concerning reproductive health, fertility and contraception. Perceptions on quality of service provision and service providers will also be explored along with identification of barriers to access (qualitative).
6) **In-depth interviews:** with service users, non-users and their partners (40 interviews, 10 users, 10 non-users and 20 partners) will be carried out to identify community perceptions of reproductive roles, fertility and contraception. Identify barriers to access and community-based strategies to widen access (qualitative).
7) **Dissemination of results:** to policy makers (through progress papers and reports), providers (workshops and meetings) and men and women in the community (home visits, natural groups).

1) Interviews with Policy Makers:

1.The Director General of the PHC services, MOH.
2.The Director of the MCH/ FP services, MOH
3.The Director of the PHC/MCH/ FP services of the Governorate of Zarqa, MOH
4.The Director of the MCH /FP services at the Royal Medical Services
5.The Secretary General of the National Population Commission
6.The President of the JAFPP and the Regional IPPF.
7.The Director of the UNRWA PHC/MCH/FP services.
8.The National Officer for UNFPA programs in Jordan.
9.The 'Qadi el Qudah' (Director of Islamic Jurisprudence in Jordan)
10.The Medical Director of the CPP project

Appendix 3.4 Policy makers' interview guide

Interview questions for policy makers:

1.What are the historical determinants of FP policies in terms of actors, processes and contexts?

2.What are the current population policies, who are the most important policy players and within which contexts in Jordan?

3.Who and how are priorities coordinated between the different players?

4.Any link between population policy making at the global level and national level?

5.To what extent do these global level efforts influence national policy makers? If yes, under what circumstances?

6.What is the influence of economic circumstances on FP policy support and what is the relationship between the perception of economic problems (development strategy based on economic growth) and support for FP policies and population growth limitation?

7.What are the perceived difficulties in population policy formulation and implementation in the different Jordanian contexts?

8.What are important priorities to bridge the gap between ideal service provision versus actual provision, between the services and the community's reproductive health needs?

Appendix 3.5 Services included and methods of data collection by service

Clinic	Model of provision	Service statistics	Observation	Focus Group discussion with service providers
I. MOH (Public) 1. MCH training centre 2. Prince Mohammed centre	✓ Integrated with MCH services ✓ Integrated with MCH services	(1989-1997) ======	✓ Non-participant 3 clinic days ======	✓ 4 nurses and 2 doctors female) ✓ 5 female nurses and 1 male doctor **Total**: 2 FG discussions **Total** participants: 12
II. SFWC (military) 1. Fixed clinic	✓ Vertical provision ✓ Community-based distribution. Outreach (CPP project)	(1990-1997) Baseline survey	✓ Non-participant 3 clinic days 1 day CBDs	✓ 2 female nurses and 1 male doctor ✓ 10 female CBDs **Total** : 2 FG discussions **Total** participants: 13
III. UNRWA (UN organisation) 1. Zarqa MCH clinic 2. Msheirfeh MCH clinic	✓ RH model (Family Health model) ✓ RH model (Family Health model)	(1996-1997) ======	✓ Non-participant 3 clinic days ==========	✓ 5 female nurses and 1 male doctor ✓ 4 female nurses and 3 male doctors **Total** : 2 FG discussions **Total** participants: 13
IV. JAFPP (NGO sector) 1. Mobile clinic 2. Zarqa fixed clinic	✓ RH model, outreach ✓ RH model	(1992-1997) ======	✓ Non-participant 3 clinic days ==========	✓ 1 nurse and 1 doctor (females) and 1 male driver ✓ 2 nurses, 2 social workers and 1 doctor (all females) **Total** : 2 FG discussions **Total** participants: 8
V. Private sector	==========	==========	==========	✓ 8 male doctor and 1 female nurse **Total** : 1 FG discussions **Total** participants: 9
Grand total:				**9 FG discussions** **54 participants**

Appendix 3.6 Observation criteria of FP service/ program

Physical set-up

- Location and access
- Buildings status: new, old?
- Clinics: Signs for working hours
- Cleanliness
- Water and electricity
- Toilets for clients
- Clear signs to direct clients
- Waiting room status
- Examination room status
- Privacy : Partition for women to undress, privacy to talk.
- Trash containers and sink with running water and soap
- Curtained windows
- Convenient working hours for women
- Waiting time??
- Pregnant women, women/ per workload of midwife
- Availability of equipment and its status
- Job descriptions
- Health education sessions

Qualifications of personnel

- Gynecologists or GP's
- Level of education of nurses
- Level of education of social workers
- How many had on the job training ? In what? Duration and content of training?
- Date of training
- Availability of instruments and equipment

Provision of care:

- What is done to the woman. Describe sequence of events.
- Provider histories : life-histories
- Medical investigations
- Instructions given prior to procedures, examinations?
- Providers use gloves? Without gloves?
- Handwashing routine?
- Sterilisation techniques in procedures?
- How are sterilised instruments handled?
- Women are more satisfied with technical competence?
- What about human interaction?
- Information exchange ?

Health education:

- Is there a system of standardising training of providers for health education? How describe?
- Is ample time given to providers for health education sessions? Describe?
- Quality of information provided?
- Content and methods used ?
- Language? clarity of explanations? Allowing enough time for questions?
- Follow up?

Human Interaction:

- Are women greeted?
- Are they asked to be seated?
- Are they provided with privacy while undressing and during physical exam?
- Are they allowed time to express their concerns, fears , anxieties?
- Are they treated with respect?

- Are they treated with dignity?

Continuity and follow up:

- Is there a system in the service of reviewing statistics?
- Any home visiting? Describe system.
- Status of medical records documentation: completeness, clarity, specificity of information?
- Any follow-up of drop out clients?
- Is there an IUD check up return visit scheduled?
- Describe counselling status.

Appendix 3.8 Focus Group discussion guide with the service providers

Upon his request, the following guidelines were forwarded to the under secretary of the MoH to obtain access.

1. From your experience, how do you assess the community's knowledge of reproductive health?

2. In your opinion and from your observations what do you think are the determinants of this knowledge of reproductive health?

3. What are current household behaviours that promote reproductive health for women, men and adolescents? What are current household behaviours that are risky or deter reproductive health promotion? What are the determinants of these health promoting or health deterring behaviours?

4. In your service, what are the current health provider behaviours that promote reproductive health?

5. What is your assessment of the community's utilisation of reproductive health, FP services? State reasons for your opinion?

6. In your opinion and from your experience what are the major reproductive health needs in the community for women, adolescent girls, boys, men, married women and men, old women and men?

7. Can we explore together what are the major barriers to service access and utilisation? Are they service or community-based or both and specify?

8. What are the clinic and community conditions that widen access or reproductive health, FP service promotion?

9. Can you assess the quality of service provision provided in your service and what are the major constraints, if any?

Appendix 3.9 Phases of data collection in the community

Clinic	Matched Community characteristics	Data collection
Soldiers' Families Welfare clinic	Military, poor urban	1 user of MCH Select 1 user of MCH and visit at home during 40 day postpartum period 2 natural group discussions 1 with women and one with their husbands. **Total : 10 (5 women and 5 men)** **In-depth interviews: 2 couples** 1 couple users and one non-users of FP Total **14**
UNRWA	Palestinian refugee camps	1 user of UNRWA clinic Select 1 user of clinic and visit at home during 40 day postpartum period 2 natural group discussions 1 with women and one with their husbands. **Total : 19 (10 women and 9 men)** In-depth interviews: **2 couples** 1 couple users and one non-users of FP Total: **23**
JAFPP	Rural (Azraq) Bedouin community (Hashemieh)	1 woman using the mobile clinic in Azraq Postpartum visit at home and natural group discussion with women **Azraq: 6** **In-depth interviews** with women **Azraq: 2 women** (1 user and one non-user) Total 8 women Natural group discussion with a group of male teachers in Zarqa: **6** 1 woman using the mobile clinic in Hashemieh Postpartum visit at home and natural group discussion with women **Hashemieh: 8 women** Natural group discussion with husbands in **Hashemieh: 3 men** Total participants in natural group discussions: In-depth interviews with women **In Hashemieh: 2 women** (one user and one non-user) Total : **27**
Private sector New Zarqa	Urban, high and middle socio-economic	1 woman using private hospital (Jebel Al Zaitoun) Postpartum visit at home and natural group discussion with women New Zarqa: **6** Natural group discussion with businessmen from New Zarqa: **6** In depth interview with **2** women in New Zarqa (1 user and one non-user) In-depth interview with **one** businessman Total:**15**
Total	Natural group discussion participants	**64**
	Household in-depth interviews	**15**

Appendix 3.10 Natural group discussion themes

1. To you, what is reproductive health, and what are its components? Where would you go for more information on reproductive health?

2. Describe an important problem you had relating to reproductive health. What happened? What did you do? How did you feel about it? What made you feel that way?

3. When you experience fears and anxieties (define), or symptoms (define) (pain, discharges, etc...) how do you respond? What persuades you or dissuades you from going to see the doctor? What are your major concerns at this time? What would help most at this stage? How do you cope with your fears?

4. Assessment of their reproductive health practices. Their perceptions of risk factors, behaviours and what do they do about it?

5. What are your reproductive health needs as you see them? Why are they important to you? What are the most important ones? Why?

6. In your opinion can the services be reorganised to respond to these needs? State reasons for your view.

7. Are you satisfied with the family planning method you are using? If yes, why and if not, why not?

8. Are you satisfied from the services provided by the clinic? How can they be improved? Do you think that they can be improved? State reasons.

9. What are the benefits expected from such changes in service provision?
Are they willing to share in cost in return for a more comprehensive scope of reproductive health services? If yes why? And if not why?

10. What is your preferred flow of information concerning reproductive health and do they like to address this field as a field that concerns all family members from all age groups? If yes why? And if not why not? What are their barriers?

11. How can users of services motivate non-users in the community and promote future utilisation of this clinic that will be providing reproductive health services?

Appendix 3.11 Natural Group discussion guide

At the beginning of the session please record participants name (does not have to be real name but what he wants to be called in that session) and ask for permission to tape after explaining purpose and objectives of the session., the age, number of children, occupation if any or unemployed if not working and the type of housing whether with parents or no, ..Thank you!

Knowledge about FP and its determinants:

1) What is FP?

If they speak of birth control ask about difference with planning or spacing do not give any comments if they say "Haram" you can just ask why is it "Haram" If they say it is important ask: Why do you think it is important If they do not answer thoroughly, comments are asked about these subjects: Neighbours influence Women like to share their experiences Rumours Ignorance Religious influence Religion encourages reproduction No decision for the woman Women like to deliver to keep their chair Mother in law's influence and relatives Economic situation and FP

Barriers to access:

2) Why do some people use FP and why others don't?

If they do not answer thoroughly, you can initiate the discussion by asking comments about these topics: Geographic Lack of continuity of service Husbands approval Gender of provider Fear of FP complications Rumours Financial

3) What is the ideal family size in your opinion?
4) And what is the effect of male children on the family size?

Probe questions: Why the demand for children Woman keeps on delivering to get the boy especially if many girls The male child Arab society cherishes males more than females What is Ezweh The child comes and his rizk (fortune) with him Religious Barriers to FP Displacement and poverty The husband disapproves of FP? The man decides for everything The woman does not make her own decisions The in-laws influence

Needs and strategies:

5) Do you think that you need FP or not?
If yes, why and if no why?

Service utilisation:

6) Do you use FP services? Yes or no? If yes why and if not why not?

Where do you go and why? Do you think that people are utilising FP more, less or the same explain why? What are factors that encourage utilisation? What do you think of the private sector? MoH? UNRWA? Soldiers welfare? JAFPP? What was your impression building on your experience? Waiting time Physical access Privacy Cleanliness What do you think of the service providers? How do you feel about them? How are the providers? Do they contact you at home? Do you feel that they know what they are doing? Do the people who visit you have IEC material? Do they treat you well? Do they respect you? Do they give you enough time? Do they answer your questions? Do they encourage you to talk? Are their answers clear and understood? Do they offer more than one method or do they impose one method?

Appendix 3.12 In-depth household interview questions

Non Users of FP methods

Users of FP methods

Appendix 3.13 Request for the ethical approval of the research study- The LSHTM

Appendix 3.14 Letter of access to the field- The MOH

Appendix 3.15 Affidavit for UNRWA

Appendix 3.16 Data (indicators) of target group research in the community

Type of data	About FP
Knowledge of FP(what they know, what they do not know and what they want to know)	1. Whether men and women are aware of the health risks associated with early pregnancy and or many pregnancies > 6 pregnancies 2. Whether women and men want to learn more about modern methods of FP
Attitudes and perceptions (what they think or believe and what their views are)	3. Whether husbands and wives have the same attitudes towards family planning and want the same number of children 4. What women think about the side effects of various contraceptive methods
Practices (What they do about key health issues relating to contraception)	5. Whether couples are using FP methods and where they get them from
Obstacles, barriers (influences that prevents them from using FP methods and services)	6. Whether religion or cultural beliefs prohibit the use of contraception 7. Whether FP services are available in local health facilities 8. What women and men think of FP services available and the FP providers
Sources of information and how much trust they have in these sources	9. Whether there are H workers or other community workers who provide information on health issues relating to FP 10. Who in the family or community has the most influence on women and men? 11. How often do women and men listen to the radio, watch television, read newspapers and magazines 12. How much attention do men and women pay attention to their information sources , and how much respect do they have for health workers

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