Married Male’ Knowledge and Attitude Regarding Family Planning at Soba University Hospital, Khartoum State, Sudan

By

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Examination Committee

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Examination Date: 27/3/2013
Dedication

I dedicate this study to:-

My father, my mother

My brothers, sisters

And all my family
First of all I am thankful and very grateful to the dearest, most beneficial and the most sincere entity to me which is the one and only my Allah subhano talla.

Thanks to mother and all my family for their support and caring throughout my life.

I wish to express my grateful for my main supervisor Dr/ Ietimad Ibrahim Abdelrahman M. Kambal, and my co supervisor Dr. Bothyna Basyoni Alssyed Etewa, for their helpful advices and valuable suggestion to me at the various stages of the research and her ultimate consultation.

My dissertation would not have been successfully completed if I had not found conductive atmosphere of work, includes my gratitude is extended to all members of soba university hospital for their fruitful cooperation and help.
Abstract

Family planning is the voluntary planning and action taken by individuals to prevent, delay or achieve a pregnancy. Men’s support or opposition to their partners’ practice of family planning has a strong impact on contraceptive use in many parts of the world, including Africa. Descriptive hospital based study was done aiming at assessing married male’s knowledge and attitude regarding family planning at Soba University Hospital, Khartoum State, Sudan. The sample size consisted of 120 married males during the period of (August to October 2010). Data were collected by using questionnaire designed for the study. Analysis was performed by statistical package for Social sciences (SPSS). Results revealed that (63.7, 91.7 and 75%) of married males responses with correct answers regarding family planning, coitus interrupts and condom respectively. Only (33.3%) of the study sample responses with correct answers about oral contraceptive pills. only (8.3%) of the study sample responses with correct answers about implantable contraception. (45%) of them stated that the main reason of family planning is to provide better education for the children. (50%) of the study sample their source of knowledge from pharmacist. (77.5%) of married males state that family planning is halal. The study concluded that married males have lack knowledge about family planning. It recommended that continuous education program about family planning for men must be conduct and manual booklet should be design for men about family planning must be available at work place.
ملخص الدراسة

تنظيم الأسرة هو التخطيط الطوعي والتدابير المت阡دة من قبل الأفراد لمنع وتأجيل أو تحقيق الحمل. التأييد أو المعارضة من قبل الازواج لممارسة تنظيم الأسرة له تأثير قوي على استخدام وسائل منع الحمل في أجزاء كثيرة من العالم، بما في ذلك أفريقيا. أجريت هذه الدراسة الوصفية بمختصفي سوبا الجامعي عن تقويم مدى معرفة واتجاهات الرجال المتزوجين عن وسائل تنظيم الأسرة. أجريت الدراسة على عدد 120 من الرجال المتزوجين في الفترة من أغسطس حتى أكتوبر 2010) وهي العينة المتاحة في تلك الفترة. تم جمع البيانات بواسطة استمارة استمارة استبيان تم تصميمها للدراسة وتم التحليل بواسطة الحزمة الإحصائية للعلوم الاجتماعية (Spss). أظهرت النتائج ان (63.7%; 7.9% 75%) من الرجال المتزوجين كانت اجابتهم صحيحة عن تنظيم الأسرة قطع الجماع والواقئ الذكرى على التوالى. (6.7%) من الرجال كانت اجابتهم صحيحة عن الرضاعة الطبيعية (2.2%) من أفراد العينة كانت اجابتهم صحيحة عن حقن منع الحمل (8.3%) فقط من أفراد العينة كانت اجابتهم صحيحة عن حبوب منع الحمل (45%) من الرجال أكدوا على أن الهدف لتنظيم الأسرة تعليم أفضل للأطفال. (50%) من أفراد العينة كان الصيدلي مصدر معلوماتهم عن تنظيم الأسرة. لذلك اوصت الباحثة أن هناك حاجة لزيادة المعلومات عند الرجال حول مفهوم ووسائل تنظيم الأسرة. 77.5% من أفراد العينه أكدوا على أن تنظيم الأسرة حل، وخلصت الدراسة على أن معلومات أفراد العينه عن تنظيم الأسره كانت غير كافية. اوصت الدراسة بعمل برامج مستمرة عن تنظيم الأسرة وتصميم مكتيب عن تنظيم الأسره للرجال يكون متاح في أماكن عملهم.
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### Abbreviations

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<td>FP</td>
<td>family planning</td>
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<td>MCH</td>
<td>maternal and child health</td>
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<td>IUCD</td>
<td>intrauterine contraceptive device</td>
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<td>WHO</td>
<td>world health organization</td>
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<td>IPPF</td>
<td>international Planned Parenthood federation</td>
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<td>PHC</td>
<td>primary health care</td>
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<td>COCs</td>
<td>combined oral contraceptives</td>
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<td>FSH</td>
<td>follicle stimulating hormone</td>
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<td>LH</td>
<td>luteinizing hormone</td>
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<td>POPs</td>
<td>progesterone only pills</td>
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<td>PID</td>
<td>pelvic inflammatory disease</td>
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<tr>
<td>PE</td>
<td>pulmonary embolism</td>
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<td>SPSS</td>
<td>statistical package for social sciences</td>
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<td>GnRH</td>
<td>gonadotropin releasing hormone</td>
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<td>SUH</td>
<td>soba university hospital</td>
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<td>STDs</td>
<td>sexually transmitted diseases</td>
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<td>HIV</td>
<td>human immune deficiency virus</td>
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<td>OCP</td>
<td>oral contraceptive pill</td>
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<tr>
<td>UNFPA</td>
<td>United Nations Fund for Population Agency</td>
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<td>MCFP</td>
<td>maternity centered family planning</td>
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Introduction

1-1 Background:
A national program of family planning was established beginning in the 1950 and multiplied most rapidly from the mid 1960 to the late 1970 when on every five new programs were established each year. In a number of instances national programs expanded the work done by earlier ‘pioneering private programs such as those supported by the international parenthood federation. (A-Buletao2000)

Historically family planning in Sudan was initiated as a voluntary activity in 1964 by the Sudan family planning association SFPA. In the 1978 the ministry of health started a maternity centered family planning clinic in Omdurman maternity hospital ‘sponsored by United Nations Fund for Population Agency and world health organization. The later project was soon expanded into a national maternal and child health, family planning MCH/FP project in 1979. in 1986 the project was institutional within the ministry of health primary health care programme. Family planning commodity distribution was simultaneously strengthened. (Baldo-M- Geris-A-2006)

1-2 Problem statement
The recent attention drawn to the issue of family planning by international bodies like the World Health Organization (WHO2004), United Nations Fund for Population Agency cannot be over-emphasized. This is due to the socio economic implications and health hazards that high population growth rate have increasingly manifested in the economies of Developing Countries. Inadequate family planning strategies have continuously exacerbated the vulnerability of developing countries, culminating into high maternal and infant mortality, increasing hard core poverty, disintegration of the extended family system, high incidence of HIV/AIDS and sexually transmitted infections and a high incidence of morbidity and mortality. At least 25% of all
maternal deaths can be prevented by family planning. One in four infant deaths in developing countries can be prevented by spacing birth at least two years apart (Shane 1996). According to the United State Census Bureau, the world population will increase by 2.5 people every second. This extrapolates up to 152 people per minute, 9,111 per hour, and 218,659 per day. In one month, the world population will increase by 6,650,876 and in one year, it will increase by 79,810,508 people. (U.S. Census Bureau, 2009).

In the past the need for family planning had been rationalized by a significant number of women who state a desire to cease childbearing. However, in spite this apparent unmet need for contraceptive, very little has been achieved in aggregate fertility reduction. The lack of success of the family planning revolution is attributable to the failure of the programmes to recognize the important of male attitudes and attributes in fertility decision making. While women are more likely than men to want to discontinue childbearing however, evidence from including men information of joint preference measure appears to indicate that determining contraceptive demand from women alone leads to gross overestimation of demand due to neglect of men’s role and attitude. (African journal 2006)

1-3 Justification:-

family planning allowes the spacing and timing of their births. A women ability to space and limit her pregnancies has direct impact on her health and wellbeing as well as to the outcomes of each pregnancy but also male involvement of family planning play an important role of decion making and success of family planning programme.
1.4 Objectives:

1.4.1 General objective:
Assessment of married males knowledge and attitude regarding family planning at soba university hospital during (August to October 2010)

1.4.2 Specific objective:
1- To assess married male’s knowledge and attitudes regarding family planning in soba university hospital-Khartoum-Sudan during the period of the study
2- To identify the married male’s knowledge needed regarding family planning at soba university hospital during the period of the study
2-1 Family planning

Family planning is the voluntary planning and action taken by individuals to prevent, delay or achieve a pregnancy. (http://www.health.state.mn.us/)

WHO defined family planning as: “A way of thinking and living that is adopted voluntarily upon the basis of knowledge, attitudes and responsible decision by individuals and couples in order to promote the health and welfare of the family group and thus contributes effectively to the social development of a country. Family planning prevents unwanted pregnancies, brings about wanted births, regulate interval between births, ensure births occur at correct reproductive age and limits the family size. Recent estimates indicate that more than 510million married couples of reproductive age are practicing family planning around the world. Of these about 135million are in developed countries, 185million in the people republic of china and 190million in the rest of the developing world. (.B.Lawson- A.Harrison2001).

As the first pillar of safe motherhood and essential component of primary health care, family planning plays a major role in reducing maternal and newborn morbidity and mortality. Family planning enhances efforts to improve family health. However, traditional beliefs, religious barriers and lack of male involvement have weakened family planning interventions. Research has confirmed high "unmet need" for family planning in sub-Saharan Africa in term of the number or percentage of married women who say they prefer avoid a pregnancy but are not using any method of contraception. Every day, 1,600 women and more than 10,000 newborns die from preventable complications during pregnancy and childbirth. Almost 99% of these maternal and 90% of neonatal deaths occur in the developing countries. (Repositioning Family Planning, Sexual & Reproductive Health (SRH)
Family planning program planners tend to assume that men are opposed to family planning and will, if involve in reproductive decision making, prevent women from regulating their fertility. Available data, however, suggests that the most successful family planning programs target men as well as women and promote communication about contraception between spouses. (Kabwigu S-2001)

2-2 Advantages of Family Planning:
Family planning helps to prevent conception and reduce the risk of pregnancy. The biggest advantage of family planning tools is that they save from the hassles of pregnancy termination and abortion. Adopting a family plan directly affects a woman's health in a good way by preventing unwanted and unplanned pregnancies and subsequent abortions. Restricting the family size allows more resources for bringing up your children and sustaining a family in a balanced way. Adopting family planning methods helps couples to let their children have a more focused upbringing, better education and other amenities. Family planning perspectives are being given serious thought worldwide, and so, important birth control FAQ are being referred more often than ever for effective family planning

2-3 Types of family planning:-
Birth control is an umbrella term for several techniques and methods used to prevent fertilization or to interrupt pregnancy at various stages. Birth control techniques and methods include contraception (the prevention of fertilization), contragestion (preventing the implantation of the blastocyst) and abortion (the removal or expulsion of a fetus or embryo from the uterus). Contraception includes barrier methods, such as condoms or diaphragm, hormonal contraception, also known as oral contraception, and injectable contraceptives. Contraceptives, also known as post-coital birth control, include intrauterine devices and what is known as the morning after pill (Manson E, & Brigham 2009)
2-4 **Qualities of good contraceptive:**
The ideal contraceptive is defined as safe effective, acceptable, inexpensive, reversible, simple to administer, free from side effect and complication. (Clement 2009)

2-5 **Role of husbands towards family planning:**
Women’s roles in family planning are well known as they are the primary career of the child during and after pregnancy. What is less clear is the role and level of Husband’s involvement. Birth control methods involving men such as coitus Interruptus, periodic abstinence and condoms cannot be used without the Complete cooperation of men. With the availability of modern methods (the pill and IUCD) in the 1960s, women gained reliable control of their reproductive Capability (Edwards, 1994). In many societies, men are the primary decision makers regarding the family and family planning practice (Kamal, 2000; Sahin & Sahin, 2003; Al-Riyami, 2004) However, decisions about family planning are sometimes not discussed or made without sufficient communication between husbands and wives. Efforts to improve couples’ communication can help lead to decisions about family planning that reflect the needs of both women and men. Husbands will need relevant information to participate responsibly in making decisions on family planning. The family planning services should also be relevant for husbands to participate. Husbands can learn more about family planning by accompanying their wives on clinic visits and by taking advantage of special clinics hours for men, where available. Husbands also can participate in family planning by helping their wives to remember to take a pill every day or to return to the clinic for regular injections. Husbands also can help their wives by organizing transportation to the clinic, paying for family planning methods and services, and taking care of children during clinic visits (WHO, 2004)
2-6 Methods of family planning:

2-6-1 Natural Family Planning

Natural family planning is a method used to help a couple determine when sexual intercourse can and cannot result in pregnancy. During each menstrual cycle, one of a woman's ovaries releases an egg. This process is called ovulation. The egg moves toward the uterus through the fallopian tubes, where fertilization may take place. An unfertilized egg may live for up to 12 hours. The egg will be shed later during the menstrual period if it isn't fertilized. A woman is most likely to become pregnant if sexual intercourse takes place just before or just after ovulation. During the menstrual cycle, a number of changes occur in a woman's body. By keeping track of these changes, couples can plan when to have intercourse and when to avoid intercourse, depending on whether they are trying to achieve or avoid pregnancy (Mosby E-2007).

2-6-1-1 Coitus Interruptus:

Coitus Interruptus involves withdrawal of the entire penis from the vagina before ejaculation. Fertilization is prevented by lack of contact between spermatozoa and the ovum. This method of contraception remains a significant means of fertility control in the developing world. Effectiveness depends largely on the man's capability to withdraw prior to ejaculation. The failure rate is estimated to be approximately 4% in the first year of perfect use. In typical use, the rate is approximately 19% during the first year of use. Advantages include immediate availability, no devices, no cost, no chemical involvement, and a theoretical reduced risk of transmission of sexually transmitted diseases (STDs). The probability of pregnancy is high with incorrect or inconsistent use. (Jain J, Jakimiuk 2004)

2-6-1-2 Lactational Amenorrhea

Elevated prolactin levels and a reduction of gonadotropin-releasing hormone from the hypothalamus during lactation suppress ovulation. This leads to a reduction in
luteinizing hormone (LH) release and inhibition of follicular maturation. The duration of this suppression varies and is influenced by the frequency and duration of breastfeeding and the length of time since birth. Mothers only need to use breastfeeding to be successful; however, as soon as the first menses occurs, she must begin to use another method of birth control to avoid pregnancy. The perfect-use failure rate within the first 6 months is 0.5%. The typical-use failure rate within the first 6 months is 2%. Involution of the uterus occurs more rapidly. Menses are suppressed. This method can be used immediately after childbirth. This method facilitates postpartum weight loss. Return to fertility is uncertain. Frequent breastfeeding may be inconvenient. This method should not be used if the mother has human immune deficiency virus (HIV) infection. (Beerthuizen R, van Beek A, Massai R, 2000)

2-6-2Hormonal method:
2-6-2-1Oral pill:
At present about 70 million women worldwide are using oral contraceptive pill (OCP). The first contraceptive pill in 1960 contained high doses of estrogen and progesterone. Since then there has been a significant reduction in both the component of OCP, which has led to decrease in adverse effect. The benefits of health apart from pregnancy far outweigh the possible side effect and infrequent complications, which may occur in small number of women. The pill is an easy, safe, effective and reversible contraceptive for the young women wanting to delay her first pregnancy or space the next child. (S Kamdam 2005)
One oral contraceptive pill is to be taken regularly every day by the females. The pill consist of female six hormones, synthetic of estrogen and progesterone, it is a combination of female hormones in various proportions. It suppresses ovulation, makes cervical mucus thick, making the passage for the sperms difficult to enter the uterine cavity and makes the inner lining unsuitable for implantation for fertilized egg.
It is very effective if taken regularly. It is correct menstrual irregularities improve general health and also prevent ovarian and endometrial cancer. One pill is taken daily from the 5th day of onset of menstruation. This regularity is the most important aspect which insures the high efficacy of the method. However if the pill is missed on a particular day the missed tablets should be taken as soon as possible. If missed on more than a couple of occasion it should not be discontinued but another method of contraceptive such as condom should be used, along with it up to the date of next menstruation.( BT Basavantheppa 2008)

**Combined Oral Contraceptives (COCs)**

The primary mechanism of action of combined oral contraceptives is the inhibition of ovulation. The release of an egg, which commonly occurs in the middle of the menstrual cycle, is prevented by combined oral contraceptives. Two hormones produced by the pituitary, a gland located at the base of the brain, coordinate the development and release of an egg from the ovary. One is follicle stimulating hormone, abbreviated FSH, and the other is luteinizing hormone, or LH. A surge in both of these hormones ordinarily occurs in the middle of a woman's menstrual cycle. The surge in LH is the trigger for ovulation. combined oral contraceptives inhibit the production of both follicle stimulating hormone and luteinizing hormone and consequently prevent ovulation. In the very rare cases where ovulation may occur, another contraceptive mechanism of combined oral contraceptives acts to prevent fertilization. combined oral contraceptives have an effect on the cervical mucus. The progestin contained in combined oral contraceptives causes the cervical mucus to become thick and prevents sperm penetration; the sperm cannot pass through the cervix and fertilization cannot take place. Progestin-only pills (POPs) prevent pregnancy through a combination of actions. The amount of progestin in Progestin-only pills is much less than in combined oral contraceptives; because of this, Progestin-only pills do not consistently prevent ovulation. Indeed, about 40 percent of
women using Progestin-only pills may ovulate. When Progestin-only pills inhibit ovulation they do so in the same manner described for combined oral contraceptives. Another mechanism of action accounts for the high efficacy of these pills. This mechanism is the alteration of the cervical mucus. Progestin-only contraceptives cause “hostile” cervical mucus. Progestin-only pills greatly reduce the volume of mucus, increase its viscosity and cell content, and alter its molecular structure. These actions result in little or no sperm entry to the uterine cavity. Even in the rare cases when penetration does occur, sperm motility may be reduced and fertilization is very unlikely to take place. The use of Progestin-only pills is mostly recommended for breastfeeding women, because combined hormonal methods reduce the production of breast milk. During the period of amenorrhea (absence of menstruation) associated with breastfeeding, ovarian function is largely suppressed; ovulation is unlikely to occur and the cervical mucus is hostile to the sperm. These effects greatly enhance the contraceptive action of POPs during breastfeeding. Serious side effects are rare in healthy women who do not smoke cigarettes. In women with certain health problems, however, oral contraceptives may cause problems such as liver cancer, noncancerous liver tumors, blood clot, or stroke. Health care professionals can help women weigh the benefits of being protected against unwanted pregnancy against the risks of possible health problems. The most common minor side effects are nausea; vomiting; abdominal cramping or bloating; breast pain, tenderness or swelling; swollen ankles or feet; tiredness; and acne. These problems usually go away as the body adjusts to the drug and do not need medical attention unless they continue or they interfere with normal activities. Other side effects should be brought to the attention of the physician who prescribed the medicine. Check with the physician as soon as possible if any of the following side effects occur, menstrual changes, such as lighter period or missed periods, longer periods, or bleeding or
spotting between periods, headache vaginal infection itching, or irritation, increased blood pressure. (NJ: Merck and Company1999.)

2-6-2-2 Depo Provera - a Contraceptive Injection

Depo Provera is a hormone used for contraception. It is given by injection and its effects will last for three months at a time. It is similar to progesterone, which is one of the two main hormones made by a woman's ovaries during her normal cycles. (Robert A. (2004)

The mechanism of action of progestogen-only contraceptives depends on the progestogen activity and dose. High-dose progestogen-only contraceptives, such as injectable DMPA, inhibit follicular development and prevent ovulation as their primary mechanism of action. The progestogen decreases the pulse frequency of gonadotropin-releasing hormone (GnRH) release by the hypothalamus, which decreases the release of follicle stimulating hormone and luteinizing hormone by the anterior pituitary. Decreased levels of follicle stimulating hormone inhibit follicular development, preventing an increase in estradiol levels. Progestogen negative feedback and the lack of estrogen positive feedback on luteinizing hormone release prevent a luteinizing hormone surge. Inhibition of follicular development and the absence of a luteinizing hormone surge prevent ovulation. (Philip D. (2005).

A secondary mechanism of action of all progestogen-containing contraceptives is inhibition of sperm penetration by changes in the cervical mucus. Inhibition of ovarian function during DMPA use causes the endometrium to become thin and atrophic. These changes in the endometrium could, theoretically, prevent implantation. However, because DMPA is highly effective in inhibiting ovulation and sperm penetration, the possibility of fertilization is negligible. No available data support prevention of implantation as a mechanism of action of DMPA. (Yacobson I, Grimes D (1999))
Depo-Provera has several advantages

Highly effective at preventing pregnancy. Injected every 12 weeks. The only continuing action is to book subsequent follow-up injections every twelve weeks, and to monitor side effects to ensure that they do not require medical attention. No estrogen No increased risk of deep venous thrombosis, pulmonary embolism (PE), stroke, myocardial infarction, Minimal drug interaction (compared to other hormonal contraceptive, Decreased risk of endometrial cancer Depo-Provera reduces the risk of endometrial cancer by 80%. The reduced risk of endometrial cancer in Depo-Provera users is thought to be due to both the direct anti-proliferative effect of progestogen on the endometrial and the indirect reduction of estrogen levels by suppression of ovarian follicular development, Decreased risk of iron deficiency anemia, pelvic inflammatory disease, (PID), pregnancy and uterine fibroids Decreased symptoms of endometrioses, Decreased incidence of primary dysmenorrhea, ovulation pain, and functional ovarian cyst, Decreased incidence of seizures in women with epilepsy Additionally, unlike most other hormonal contraceptives, Depo-Provera's contraceptive effectiveness is not affected by enzyme-inducing antiepileptic drugs, Decreased incidence and severity of sickle cell crises in women with sickle-cell disease. (Meshell P

Contraindications

History of stroke Multiple risk factors for arterial cardiovascular disease Current deep vein thrombosis(DVT) or pulmonary embolus (PE), Migraine headache with aura while using Depo-Provera, Before evaluation of unexplained vaginal bleeding suspected of being a serious condition, Past history of breast cancer and no evidence of current disease for 5 years, Active liver disease (acute viral hepatitis severe decompensate cirrhosis, benign or malignant liver tumors ), Conditions of concern for hypo-estrogenic effects and reduced HDL levels theoretically increasing cardiovascular risk, Conditions which represent an unacceptable health risk if Depo-Provera is used, Pregnancy (WHO,2004)


**Side effects**

In the largest clinical trial of Depo-Provera, the most frequently reported adverse reactions (which may or may not be related to the use of Depo-Provera) were: menstrual irregularities (bleeding or amenorrhea or both), abdominal pain or discomfort, weight changes, headache, asthenia (weakness or fatigue), hair loss and nervousness. Other, less frequently reported adverse reactions are listed in the patient and physician label information for Depo-Provera. (November 2004 (PDF).

Disadvantage and complication of Depo Provera  
Weight gain. Most women gain an average of 5 - 8 pounds. Other common side effects include menstrual irregularities (bleeding or cessation of periods), abdominal pain and discomfort, dizziness, headache, fatigue, nervousness, most users of Depo-Provera stop menstruating altogether after a year. Depo can cause persistent infertility for up to 22 months after the last injection, although the average is 10 months, Long-term (more than 2 years) use of Depo-Provera can cause loss of bone density. Depo-Provera’s label warns that the decline in bone density increases with duration of use and may not be completely reversible even after the drug is discontinued. The FDA recommends that Depo-Provera should not be used for longer than 2 years unless other birth control methods are inadequate. Some studies indicate that this bone loss may be reversible once Depo-Provera use is discontinued, The injections do not provide protection against sexually transmitted diseases.(Inki P.. 2007-GG, Skjeldestad FE and Hilstad 2007)

**2-6-2-3Implantable contraception**

Single-rod progestin implant (Implanon) is placed subdermally in the inner arm. Contraception is provided by slow release of 68 mg of the progestin etonogestrel, which is initially released at 60 to 70 µg/day, decreasing to 35 to 45 µg/day at the end of the first year, to 30 to 40 µg/day at the end of the second year, and then to 25 to 30 µg/day at the end of the third year. Side effects include spotting, irregular bleeding, and amenorrhea. Irregular bleeding is the primary reason for discontinuation. Fluid
retention, weight gain, and breast tenderness are less common. Potential complications of insertion include infection, hematoma formation, local irritation or rash, expulsion, and allergic reactions. A single case of injury to the branches of the medial antebrachial cutaneous nerve during insertion has been reported. Nerve injury can result in impaired sensibility, severe localized pain, or the formation of painful neuroma. Insertion is an office procedure done with or without local anesthesia. The rod can be removed at any time, but it must be removed at the end of 3 years. Ovulation resumes shortly after removal. Correct insertion technique and timing of insertion play major roles in the effectiveness of Implanon. The FDA has mandated that providers undergo special training to place and remove Implanon. Implanon should be inserted between day 1 and day 5 of the menstrual cycle. If done during other days of the menstrual cycle, a pregnancy test must be done. The patient should be advised to use another method of contraception for at least 1 week after insertion. (Rawlins S, Smith D. Innovative 2002)

2-6-2-4 Transdermal contraception

The transdermal patch consists of three layers. The middle layer contains norelgestromin and ethinyl estradiol. The inner layer is an adhesive and the outer is a protective cover. The patch contains 150 µg of norelgestromin and 20 µg of ethinyl estradiol. The first patch should be applied within the first 5 days of the menstrual cycle, and backup contraceptives should be used concomitantly for 7 days. A new patch should be applied every week for 3 weeks, followed by 1 patch-free week. The patch exposes women to higher levels of estrogen than most oral hormonal contraceptive pills. The FDA has added new warnings that users could have twice the risk of blood clots than users’ oral hormonal contraceptives due to higher levels of estrogen exposure. Application sites include the buttocks, abdomen, outer arms, and torso, except the breasts. The patch may be a good option for women who have difficulty adhering to other hormonal contraceptive regimens. Physicians must balance
the higher estrogen exposure against the chance of pregnancy. The patch completely detaches in 2% to 6% of cases. If it is replaced within 48 hours, no backup contraception is needed. If the patch-free interval exceeds 2 days, pregnancy should be ruled out, a new patch should be placed, and a backup contraceptive method should be used for 7 days. In case of skin irritation, the patch should be removed and a new patch applied to another site. Women weighing more than 198 pounds should not use the patch because its effectiveness is reduced. No protection against STDs. (Rawlins S, Smith D. Burkman2002- Kaunitz AM. 2001Thomas 2001)

2-6-2-5 Intra uterine device
Is a kind of birth control method used by women. The IUD is a T shape device made up of molded polyethylene plastic coated with barium which can be seen on X ray. It is placed into uterus where the base T will be placed over the cervix and the arms of the T are folded down but they then open out from the top of the T. The IUDs is two type, intra uterine contraceptive device (IUCD) and intrauterine system (IUS). IUCD is made of copper and releases copper from a copper wire that is wrapped around the the base where as IUS releases the the hormone progesterone from the vertical part of the T. still it is unknown about how IUDs work however they prevent birth control by causing a localized inflammation that starts about 24 hours after insertion (Shridharan P 2009)

2-6-3 Barrier Methods of Contraception:
Barrier methods have the common characteristic of imposing some type of physical object between the entering sperm and the waiting egg. The best known barrier methods involve the use of condoms and diaphragms. Other methods include the use of creams, gels and sponges
2-6-3-1 Condoms:
Condoms are types of coverings that surround the penis. The most frequently used type of condom is rolled over the penis shortly before sexual intercourse. During the past few years condoms have been manufactured in a variety of forms. For instance, they may be made of lambskin, plastic, or rubber. They may be lubricated or un lubricated. They may, or may not, be covered with spermicide. They also come in different sizes. And they may be edible or no edible. In addition, a female version may be inserted into the vagina and cover the entrance to the uterus as well as the penis. Condoms are one of the most commonly used methods of birth control in the United States. Their popularity derives partly from their relatively high level of effectiveness at preventing the union of sperm with eggs. In addition, they offer the best available protection (i.e., other than abstinence) from sexually transmitted infections. (Hock,R.R. (2007).

2-6-3-2 Diaphrags and Cervical Caps:--
Diaphrags are rubber "caps" that are inserted into the vagina shortly before sexual intercourse and prevent sperm from passing through the cervix. Cervical caps are similar, but smaller. Both Diaphrags and cervical caps generally require a doctor's intervention, primarily to measure the diaphram and prescribe an appropriate size. It they are too small then they may not stay in place or adequately cover the cervix. If they are too large they may be uncomfortable and may not work properly. In addition, both must be left in place for at least six hours to be effective. Although these are about 84 percent effective in preventing unwanted pregnancies, these do not provide protection against infections. On the other hand, it is important to remove diaphrags from the uterus within a relatively short time (i.e., about 24 hours) to avoid toxic shock syndrome, in which the body reacts adversely to the presence of the diaphragm. (Joseph L 2008)
2-6-3-3 Spermicides:—
Spermicides are substances that are toxic to sperm. The general idea behind their use is to kill sperm after ejaculation but before they have a chance to fertilize an egg. There are many different forms of spermicide. These include bio adhesive gels, creams, suppositories, and others. Typically, Spermicides are inserted into the vaginal area 1-2 hours before sexual intercourse and replenished after each "session". They must be left in place for about 6 hours to be most effective. However, despite their relative convenience, Spermicides tend to have an effectiveness rate of only about 75-80 percent. As a result, Spermicides are most commonly used together with other forms of birth control, especially with condoms, diaphragms, and cervical caps. (B., Yarber, W.L., Sayad, B.W., and DeVault, C.

Advantages and Disadvantages of all barrier methods:—
Barrier methods of birth control, Do not affect a woman's or man's future fertility, Are only used at the time of sexual intercourse, Are safe for a woman to use while she is breast-feeding, Do not affect other health conditions, such a high blood pressure or diabetes, Are less expensive than hormonal methods of birth control and some are available without a prescription, Condoms are the best method for reducing the risk of sexually transmitted diseases, including HIV. Failure rates for barrier methods are higher than for most other methods of birth control, Find it embarrassing to use, Some people develop allergies to spermicidal. (Bets Davis, MFA2008 )
Complication of barrier methods:
Latex allergy patient may use polyurethane rather than latex condom, Breakage or permeability oil based lubricants and most intra vaginal medication used with latex condom will increase the risk of these complications, Irritation, urinary tract infection and toxic shock syndrome (if left in place longer than 24 hours) may be seen by diaphragm use, Spermicides cause local irritation or allergic reaction. M.William Schwartz 2002)

2-6-4 Female sterilization:
Female sterilization prevents fertilization by interrupting the fallopian tubes, Sterilization can be performed surgically in the postpartum period with a small transverse infraumbilical incision or during the interval period. Sterilization during the interval period can be performed with laparoscopy, laparotomy, or colpotomy. The methods of fallopian tube sterilization include occlusion with Falope rings, clips, or bands; segmental destruction with electro coagulation; or suture ligation with partial salpingectomy. The latest form of female permanent sterilization is the Essure system. This form of sterilization prevents fertilization by interrupting the fallopian tubes; however, the Essure system does not require surgical incisions and can be performed with the patient under local anesthesia. It is performed hysteroscopically, and a microinsert is placed directly into the fallopian tubes. During the first 3 months after the procedure, the fallopian tube and the microinsert create a tissue barrier that prevents sperm from reaching the egg. After the 3-month period, patients must undergo a hysterosalpingogram to ensure placement. The United States Collaborative Review of Sterilization has examined the failure rate of female sterilization. Rates vary according to the procedure performed. The cumulative 10-year failure rate with each method of tubal ligation is as follows: spring clip method, 3.7%; bipolar coagulation, 2.5%; interval partial salpingectomy, 2%; silicone rubber bands, 2%; and postpartum salpingectomy, 0.8%. The Essure procedure has undergone clinical testing
in the United States, Europe, and Australia. Data from preliminary clinical testing demonstrate that the Essure system was 99.8% effective in preventing pregnancy after 2 years of follow-up. However, approximately 1 of 7 women in the Essure clinical studies did not achieve successful placement of both microinserts during the first placement procedure. Some of these women chose to undergo a second placement procedure, achieved successful placement of both microinserts during the second procedure, and subsequently were able to rely on essure for contraception. Of women who relied on essure, 98% rated their long-term satisfaction with essure as "good" to "excellent." Female sterilization does not involve hormones. It is a permanent form of contraception. No data indicate that change in libido, menstrual cycle, or lactation occurs. Female sterilization is usually a same-day procedure. Female sterilization is a procedure that involves general or regional anesthesia. Patients who undergo the essure system procedure require a backup method of contraception for the first 3 months. It is permanent contraception, and patients may regret the decision later, especially women younger than 30 years. Regret is difficult to measure because it encompasses a complex spectrum of feelings that can change over time. This helps explain that while some studies have reported "regret" in 26% of women, less than 20% seek reversal and less than 10% actually undergo the reversal procedure. If the Essure micro inserts must be removed for any reason, major surgery is necessary, requiring an abdominal incision and, most likely, general anesthesia. No data are available on the safety or effectiveness of in vitro fertilization after the Essure procedure has been performed. Sterilization does not protect the patient from STDs. Sterilization causes short-term discomfort, and it involves all the risks of surgery (Nass SJ, Strauss JF, 2004)
2-6-5 Vasectomy: Vasectomy involves incision of the scrotal sac, transection of the vas deferens, and occlusion of both severed ends by suture ligation or fulguration. The procedure is usually performed with the patient under local anesthesia in an outpatient setting. Complications include hematoma formation and sperm granulomas. Spontaneous resolution is rare. After sterilization, remnant sperm remains in the ejaculatory ducts. The man is not considered sterile until he has produced sperm-free ejaculates as documented by semen analysis. This usually requires 15-20 ejaculations. Vasectomy prevents the passage of sperm into seminal fluid by blocking the vas deferens. The failure rate is approximately 0.1%. Vasectomy involves no hormones, is permanent, is an outpatient procedure, is quick, and carries minimal risk with regard to the procedure. Patients may regret their decision after the procedure. Alternative contraception is required until the ejaculate is deemed free of sperm. Vasectomy does not prevent STDs. Short-term discomfort occurs. (Archer DF.2001)
The GATHER Approach

GATHER is a useful memory aid to help us to remember the basic steps in the counseling process and to add structure to a complex activity. It can be adapted to meet each individual client’s needs.

The following are elements of a successful counseling session:

G=Greet client in a friendly, helpful, and respectful manner.
A=Ask client about family planning needs, concerns, and previous use.
T=Tell client about different contraceptive options and methods.
H=Help client to make decision about choice of method she or he prefers.
E=Explain to client how to use the method.
R=Return: Schedule and carry out return visit and follow-up of client.

Examples of tasks conducted under each step

Greet
- Welcome and register client.
- Prepare chart/record.
- Determine purpose of visit.
- Give clients full attention.
- Assure the client that all information discussed will be confidential.

Ask
- Ask client about her or his needs.
- Write down the client’s: age, marital status, number of previous pregnancies and births, number of living children, basic medical history, previous use of family planning methods, history, and risk for STDs.
- Assess what the client knows about family planning methods.
- Ask the client if there is a particular method she or he is interested in.
- Discuss any client concerns about risks vs. benefits of modern methods (dispel rumors and misconceptions).
Tell

• Tell the client about the available methods.
• Describe how each method works, the advantages, benefits, possible side effects, and disadvantages.
• Answer client concerns and questions. (Watertown, MA: Pathfinder 1998)

2-8 Nursing process of family planning and contraception

2-8-1 Assessment:

1- health history

a) Determine the type of contraception the women or couple desires
b) Obtain through medical, surgical, menstrual and obstetric history to identify any contraindication to the desires method

2- physical examination:- perform a pre contraception physical examination to include breast and pelvic examination, vital signs and other aspects as appropriate.

3- laboratory and diagnostic studies:-

a) A pap smear is used to detect cervical cancer or to validate that lesions from infection are healing
b) Serologic test is used to detect syphilis or gonorrhea
c) Culture are used to detect gonorrhea or other sexually transmitted infection
d) Urinalysis is used to detect urinary tract infection
e) Complete blood count is used to determine anemia or infection and to estimate clotting ability

2-8-2 Nursing diagnosis:

1- Knowledge deficit
2- Decisional conflict
3- Spiritual distress
4- Health- seeking behavior
5- Power less ness
6- Ineffective sexuality pattern

2-8-3 Planning and outcome identification:

1- The women or couple will identify possible methods of contraception that will fit their lifestyle

2- The women or couple will choose an appropriate contraceptive method

2-8-4 Implementation:

1- Provide client and family education
a) Evaluate the women’s or couple’s knowledge of available contraceptive methods, provide information to correct misconceptions
b) Teach the women or couple about the chosen method, including appropriate insertion and removal (diaphragm) Application and removal (condom) Dosage schedule for oral contraceptive techniques for natural methods
c) Discuss possible side effects and steps to take if they occur

2- Assist the women or couple in choosing an appropriate method of contraception
a) Counsel the couple about safer sex practices such as using a condom during intercourse
b) Provide an atmosphere of non-judgmental discussion and information sharing
c) Because this is a highly personal decision, obtain the couple’s view of contraception, and their belief and attitudes
d) Discover the couple’s fears and concerns related to birth control
e) Educate the couple about the correct use of the various methods available.
2-8-5 Outcome evaluation

1- The women or couple explain how to use the selected method and any danger signs associated with the method selected.

2- The women or couple demonstrate the correct use of the contraceptive method chosen.

3- The women or couple verbalized satisfaction with the selected contraceptive method (straight/Barbara R 2004)

2-9 Islam and family planning

There are fundamentally two methods of Contraception or family planning.

(1) Permanent methods.

(2) Temporary methods

(1) Permanent Methods: Permanent methods include Vasectomy in males and Tubectomy in females. All the scholars unanimously agree that permanent methods of family planning are prohibited since they involve changing human physiology.

(2) Temporary Methods: Following are various different temporary methods. a)

(Medical Termination of Pregnancy) or Abortion: All scholars unanimously agree that medical termination of pregnancy or abortion is prohibited.

Islamic perspectives on family planning and contraception are deeply rooted in the teachings of Islam. The Qur'an and the Hadith provide guidance on this matter, emphasizing respect for human life and the sanctity of procreation within the divine plan. Permanent contraceptive methods are generally considered prohibited due to their interference with the natural process of human reproduction, whereas temporary methods, such as those for abortion, are deemed more acceptable as they do not involve altering the human body permanently. However, it is important to note that the Islamic perspective on these matters is complex and context-dependent, with interpretations varying among scholars and cultural contexts.
وقال تعالى: 
ولَا تَقْتُلُوا أَوْلَادَكُمْ خَشْيَةَ إِمْلاَقٍ نَحْنُ نَرْزُقُهُمْ وَإِياكُمْ إِنْ قَتَلْتُمْ كَانَ خَطَّةٌ كَبِيرٌ (١٣) سورة الأسراء

Scholars unanimously agree that any permanent method of family planning, or even abortion, can be done if the life of the mother is in danger. For e.g. if the woman is suffering from certain diseases like heart disease or has undergone multiple caesarean operations and in her case the continuation of pregnancy or another pregnancy may be detrimental to her life, then the woman can be aborted or a permanent method of family planning can be adopted to save the life of the woman.

b) Taking birth control pills: Almost all the scholars including Shaykh Ibn Baaz, Council of the Senior Scholars [of Saudi Arabia] agree that it is not allowed to take birth control pills (Fataawa al-Marah) because of its side effects and changes in the normal physiology.

c) Copper-T: A very common temporary method of family planning or contraception is Copper-T. Though it is known as 'contraception' but technically it is contra-implantation. The sperm fertilizes the ovum but the zygote formed is destroyed by the Copper-T and is prevented from being implanted on the uterine wall (mother's womb). Thus it is a very early abortion, which is prohibited in Islam. Some "scholars" out of ignorance permit this temporary method of family planning without knowing its detail.

d) Coitus Interruptus: Coitus Interruptus is permissible as long as it is performed with mutual consent of both the husband and wife since both of them have equal right to have children.

قال الإمام البخاري في كتاب النكاح. باب العزل.

جُبَرِيَّة. بِعَمَلٍ يُعَذِّبُهُ النَّارُ مَنْ يَقْتُلُ أَوْلَادَهُمْ لِنَخَذُ نَزَرَهُمْ وَيَقْتُلُهُمْ مَنْ قَاتِلُهُمْ.

وَعَنْ جَابِرِ يَزَادَ مُسْلِمَ: لَوْ كَانَ شَيْئًا يُنْهَى عَنْهُ لَنَهَانَا عَنْهُ الْقُرْآنُ.

رَأَى إِسْحَاقُ سَفَيْبَانَ: لَوْ كَانَ شَيْئًا يَنْهَى عَنْهُ الْقُرْآنُ.
Shaykh al-Islam Ibn Taymiyah said: "With regard to coitus interrupts some of the scholars regarded it as haraam, but the view of the four imams is that it is permissible with the wife's permission. And Allah knows best." (Majmoo' al-Fataawa, 32/110) as regarding other temporary methods of family planning like condom etc., the scholars are divided whether their use is permitted or not. Allah has provided a natural method of planning the family, which is medically known as lactation amenorrhea. After the women gives birth to a child, till she breast feeds she does not have her menstrual cycle, thus the chances of pregnancy in this period of lactation is minimal.

Sexuality and family planning

Sexual problem in relation to contraception

The combined pill can cause lowering of testosterone via the effect on sex hormone binding globulin (SHBG) and in some women may be associated with loss of libido. The vaginal ring there is one study which compares oral and intra-vaginal combined contraceptive in relation to sexual function. Interestingly both groups of women had improved sexual functioning compared to the placebo group in both women and partners. Progesterone- only contraception can reduce libido. a few women using an injectable method of contraception may experience loss of libido. the sub dermal progesterone implant and progestogen releasing intra uterine system (IUS) also have theoretical risk of loss of libido. copper intrauterine devices there is a little information about the effect an intra-uterine device on sexual well-being, but none of the publisher studies show a negative effect. The main problem tends to arise when
there is pain or excessive bleeding with an intra-uterine device but otherwise as a non hormonal method they may be a very good choice from the sexual perspective. In some people condom can be a barrier to sexual pleasure and satisfaction to many men it reduces sexual spontaneity and reduces their feeling of masculinity. Female sterilization can lead to significant improvement in sexual satisfaction and sexual drive and a positive impact on sexual life, it has been shown that men how have a vasectomy don’t suffer sexual problem.(A.Glasier-A.Gebbie-2008)

2-11 family planning services
Family planning services are defined as "educational, comprehensive medical or social activities which enable individuals, including minors, to determine freely the number and spacing of their children and to select the means by which this may be achieved” (Philadelphia, Pa: M, Elsevier; 2007)

2-12 previous studies
The study in 1997 in India, The present paper addresses to the knowledge, attitude, belief and practices of rural males towards various aspects of family formation including reproduction and contraceptive use. The study was undertaken in the rural areas of Agra district, located in western parts of Uttar Pradesh. To assess the knowledge and attitude of the males, altogether 517 currently married males, whose wives were in the reproductive age were randomly selected and interviewed., the study shows that while nine out of ten men were exposed to at least one mass media and four out of ten to three or more sources of information,

7. 38 to 52 percent of the men said that in their families all decisions related to reproduction and family planning were taken by husband alone. Another half felt that decisions were generally taken jointly with wife while very few (less than 10 percent) felt that women alone could take such decisions. The study also reveals that most of the men and women are aware of vasectomy, tubectomy, pills and condom. However, only about 44 percent of the men as compared to 72 percent of the women were aware
of the IUD. Except condom, in the case of all other contraceptives, less than half of the male respondents had correct knowledge as to how the method is used. Only 18 percent of the males had correct knowledge of IUD (M. E. Khan-Bella C. Patel-1997). Study in Yemen 2007, the aim of the study is to assess the knowledge, attitude and practice of modern family planning among husbands in Mukalla, Yemen. This study was a cross sectional study involving 400 husbands living in Alamol and Almustagbal quarters in Mukalla. These husbands were selected from households randomly selected from the two quarters. More than 90% of husbands knew about pills, intra-uterine devices and condoms Most of the husbands (89.3%) have positive attitudes towards family planning and agreed that modern methods are more effective than traditional methods About 282 husbands (70.5%) believed that the decision regarding practice of family planning should be decided by husbands and 225 (56.3%) felt the wife only should decide on practicing family planning. Family planning programs in Yemen should also focus on Yemeni husbands to participate as joint decision makers in modern family planning practice. This can be achieved through targeted family planning education and promotion programs to Yemeni husbands. Religious leaders must be involved in clarifying religious issues regarding family planning.( Yahya- K-2007)

Study in 2010 in Nigeria about male involvement in family planning decision making in ile-ife, onus state, the study assessed men’s awareness, attitude, and practice of modern contraceptive methods, determined the level of spousal communication, and investigated the correlates of men’s opinion in family planning decision making in Ile-Ife, Nigeria. Quantitative methodology was employed in this cross-sectional descriptive design using a structured household questionnaire to collect information from 402 male study participants. A multistage sampling procedure was employed. Eighty-nine percent of men approved of the use of family planning while only about 11 percent disapproved of it. Eighty percent of men had ever used contraception while
56 percent of them were current users. Spousal communication about family planning and other family reproductive goals was quite poor. The socio-demographic correlates of men’s opinions included religion, marriage type, educational attainment, and occupation (p<0.05). The study concluded that male involvement in family planning decision making was poor and their patronage of family planning services was low. (Ijadunola M & other 2010)

In 2010 study done in Ethiopia, the objective of this study was to assess the involvement of men in fertility preference and contraceptive use by using of Tran theoretical model of behavior change. Community based cross-sectional survey was done in Wolaita zone, Soddo town Southern Ethiopia, The study found high prevalence of knowledge of contraceptive methods among married men, low utilization of male methods of family planning. Discussion between spouses and their joint decision making on contraceptive use was also found to be high. Most of men behavioural stage of was in maintenance/action stage. Various factors affect the involvement of man in modern contraceptive use the impact of religion on family planning method use was reduce but education, exposure to media, spousal Communication has significant effect on family planning method use. Targeted, stage based IEC intervention should be implemented to change the knowledge and attitude of married men in family planning method. (D. Deresse- 2010)

In 2005 a series of tables from interviews with 250 men concerning male attitudes toward family planning in Khartoum, Sudan are presented, 61 of respondent wanted more children primarily because they are a gift from God or to increase the number of Moslems or Catholics, 39 wanted no more children primarily for economic reasons, 8 felt that fewer could be better raised, and the other 8 had a variety of reasons. 73 believed in limiting family size and 168 did not. The major reasons for limiting were economic reasons and to give better care and the major reason against limiting was religious opposition. 202 believed in child spacing and 46 did not. Major reasons for
approving spacing were for upbringing of child, to help the wife recover her health, economic conditions, and infant health. The main reason against child spacing was religious opposition. The most common sources of family planning information were friends and relatives, radio, pharmacy, newspaper, family planning clinics, and health clinics. 94 stated they had never been exposed to family planning information (Mustafa MA. Mumford SD-2005)
3-Material and Methods

3-1 Study design:
It a descriptive study that describe married male knowledge and attitude regarding to family planning in soba university hospital (august2010- October 2010)

3-2 Study area:-
This study was carried out in the Republic of Sudan in Soba University Hospital It is located in Khartoum State 15 Km from the center of Khartoum. Its boundaries include from the west Madani Street (same soba Alhella street), from the south Faculty of Medical Laboratory Sciences, University of Khartoum, from the north dal golf and from east Soba Alhella.

It was established in 1975, and it is the first training hospital of students of the Faculty of Medicine University of Khartoum and other universities in addition to the training of doctors and after graduation and other medical service providers. It plays a leading role in providing health care at national level.

Department of Soba University Hospital:

   Medicine (endocrine, nephrology, neurology, Cardiology, GIT and chest) both adult and pediatric.

   Surgery (general, GIT, plastic, ENT, urology and orthopedic) also adult & pediatric- Obese and gynecology -Dialysis (adult& pediatric).

   Intensive care units (adult& pediatric).-Nursery unit.-Radiology department.-Palliative care unit.-Endoscopy unit. -Blood bank.

   Laboratory - Out patient’s clinic - Primary health care.

   Infection control - Ambulance department. - Management.

   Nursing department.-Physiotherapy.- Psychology.-Engineering.

   Examination center-Nauru center.-General communications

   Personal management department- Diet Therapy.
General health.-Kitchen.-Embryology unit-Health insurance

- A countment department.-Private unit.
- Theaters(obese, pediatric, gynecology and general surgery)

The total number of beds in hospital (491) and the total worker (1143), 625 males
and 518 female’s

4-0 Distribution of manpower according to jobs

<table>
<thead>
<tr>
<th>Jobs</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacist</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Nursing technicians(sisters)</td>
<td>15</td>
<td>124</td>
</tr>
<tr>
<td>Auxiliary nurse</td>
<td>103</td>
<td>96</td>
</tr>
<tr>
<td>Nurse (diploma)</td>
<td>15</td>
<td>10</td>
</tr>
<tr>
<td>Biomedical engineering</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Head departmental nurse</td>
<td>9</td>
<td>23</td>
</tr>
<tr>
<td>Midwifes</td>
<td>0</td>
<td>30</td>
</tr>
<tr>
<td>Nursing school teachers</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Engineering</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>X RAY technician</td>
<td>11</td>
<td>5</td>
</tr>
<tr>
<td>Statisticians</td>
<td>17</td>
<td>9</td>
</tr>
<tr>
<td>Accountants</td>
<td>29</td>
<td>4</td>
</tr>
<tr>
<td>Anesthesia technician</td>
<td>19</td>
<td>11</td>
</tr>
<tr>
<td>Scrubbing nurses</td>
<td>22</td>
<td>9</td>
</tr>
<tr>
<td>Assistant pharmacist</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>Laboratory technician</td>
<td>19</td>
<td>11</td>
</tr>
<tr>
<td>Secretary</td>
<td>0</td>
<td>9</td>
</tr>
</tbody>
</table>
### Study Population:

The targeted group was married male age not less than 25 years, who are available in the study area at the time of the study.

#### Inclusion Criteria:

- All married male above 25 years age, after two years of marriage and they have children during the period of study and married male less than 25 years old.

---

**Source:** Affairs Department of Manpower – Soba University Hospital

<table>
<thead>
<tr>
<th>Department</th>
<th>N1</th>
<th>N2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training Center</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Nursery</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>General Communications</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Personal Information</td>
<td>13</td>
<td>16</td>
</tr>
<tr>
<td>Cleaners</td>
<td>50</td>
<td>76</td>
</tr>
<tr>
<td>Kitchen</td>
<td>15</td>
<td>3</td>
</tr>
<tr>
<td>Waiters</td>
<td>16</td>
<td>13</td>
</tr>
<tr>
<td>Security</td>
<td>72</td>
<td>0</td>
</tr>
<tr>
<td>Repairing Centre</td>
<td>56</td>
<td>0</td>
</tr>
<tr>
<td>Drivers</td>
<td>26</td>
<td>0</td>
</tr>
<tr>
<td>General Health</td>
<td>9</td>
<td>20</td>
</tr>
<tr>
<td>Gardens</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Mechanics Technician</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Telephone Centre</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Laundry</td>
<td>9</td>
<td>0</td>
</tr>
<tr>
<td>Dilatation</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>Assistance Laboratory</td>
<td>14</td>
<td>4</td>
</tr>
<tr>
<td>Borders</td>
<td>18</td>
<td>11</td>
</tr>
<tr>
<td>Others Departments</td>
<td>19</td>
<td>4</td>
</tr>
</tbody>
</table>
3-3-2 Exclusion criteria:-
Married males who don’t have children, males not available at the time of the study and married male less than 2 years of marriage.

3-4 Sample size:
All married male (120) available at time of the study above 25 years old after two years of marriage and they have children in their family, excluded married male less than 25 years old and married male less than 2 years marriage.

3-5 Data collection tools
The date was collected used questionnaires designed by researcher, every one of respondent applied by himself, the questionnaires contain personal data (age, educational level, occupation, family income), number of children in family, age at marriage and years of marriage, opinion of males about family planning, source of family planning methods and sources of information about it, knowledge about family planning methods (definition, advantage, disadvantage, side effect, follow up)

3-6 Ethical consideration: -
The researcher take permission from the hospital of the study with official letter from the faculty of nursing sciences to director of the hospital, with the agreement of the target population, every individual observed once.

3-7 Data processing and analysis:
The data checked, verified and analyzed using the statistical program statistical package for social science (SPSS) version 15
4- Results

Table (4-1)

Distribution of the study sample according to their age and education

<table>
<thead>
<tr>
<th>Personal characteristic</th>
<th>Numbers</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 25years</td>
<td>14</td>
<td>11.7%</td>
</tr>
<tr>
<td>25-30years</td>
<td>26</td>
<td>21.7%</td>
</tr>
<tr>
<td>30-35years</td>
<td>45</td>
<td>37.5%</td>
</tr>
<tr>
<td>More than 35years</td>
<td>25</td>
<td>20.3%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>120</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Illiterate</td>
<td>12</td>
<td>10%</td>
</tr>
<tr>
<td>Primary</td>
<td>18</td>
<td>15%</td>
</tr>
<tr>
<td>Secondary</td>
<td>60</td>
<td>50%</td>
</tr>
<tr>
<td>Graduated and post-graduated</td>
<td>30</td>
<td>25%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>120</td>
<td>100%</td>
</tr>
</tbody>
</table>

In table (1) show that about 45 (37.5%) of respondent age 30-35 years, half 60 (50%) of them have secondary school
Table (4-2)
Distribution of the study sample according to their occupation and family income

No (120)

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Numbers</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Worker</td>
<td>39</td>
<td>32.5%</td>
</tr>
<tr>
<td>Officer</td>
<td>81</td>
<td>67.5%</td>
</tr>
<tr>
<td>Total</td>
<td>120</td>
<td>100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Family income</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor</td>
<td>17</td>
<td>14.2%</td>
</tr>
<tr>
<td>Average</td>
<td>83</td>
<td>69.2%</td>
</tr>
<tr>
<td>High</td>
<td>20</td>
<td>16.6%</td>
</tr>
<tr>
<td>Total</td>
<td>120</td>
<td>100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Housing</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural</td>
<td>17</td>
<td>14.2%</td>
</tr>
<tr>
<td>Urban</td>
<td>103</td>
<td>85.8%</td>
</tr>
<tr>
<td>Total</td>
<td>120</td>
<td>100%</td>
</tr>
</tbody>
</table>

In table (2) show that about two third 81(67.5%) of respondent were officer, 83(69.2%) were average family income and most 103(85.8%) of them leave in urban area
Table (4-3)
Distribution of the study sample according to age at marriage and years of marriage

No (120)

<table>
<thead>
<tr>
<th>Age at marriage</th>
<th>Numbers</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 25 year</td>
<td>11</td>
<td>9.2%</td>
</tr>
<tr>
<td>25-30 years</td>
<td>29</td>
<td>24.2%</td>
</tr>
<tr>
<td>30-35 years</td>
<td>49</td>
<td>40.8%</td>
</tr>
<tr>
<td>More than 35 years</td>
<td>31</td>
<td>25.8%</td>
</tr>
<tr>
<td>Total</td>
<td>120</td>
<td>100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Years of marriage</th>
<th>Numbers</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 5 years</td>
<td>17</td>
<td>14.2%</td>
</tr>
<tr>
<td>5-9 years</td>
<td>33</td>
<td>27.5%</td>
</tr>
<tr>
<td>10-14 years</td>
<td>50</td>
<td>41.6%</td>
</tr>
<tr>
<td>More than 14 years</td>
<td>20</td>
<td>16.7%</td>
</tr>
<tr>
<td>Total</td>
<td>120</td>
<td>100%</td>
</tr>
</tbody>
</table>

In table (3) show that minority 11(9.2%) of the male in soba university hospital married before 25 years old and 17(14.2%) of them less than five years of marriage.
Figure (1)

No (120)

Distribution of the study sample according to the number of children in the family

In figure (1) show that about 51(42.6%) of respondent have 2 – 4 Childs in his family
**Figure (2)**

No (120)

**Opinion of male in SUH in related to religion about family planning**

In figure (2) show that When the respondent were asked about family planning in related to religious majority 93(77.5%) of the they believe it’s Hallal
**Figure (3)**

No (120)

---

**Husband’s opinion is important in family planning**

In figure (3) show that when the respondent were asked about husbands opinion of family planning all 120(100%) of them said it’s important to take husband opinions
Figure (4)

No (120)

Sources of family planning methods of male in soba university hospital

In figure (4) show that about half 60 (50%) of respondent they take their family planning methods from pharmacy.
Figure (5)

No (120)

Sources of information about family planning in male in soba university hospital

In figure (5) show that half 60(50%) of respondent take information about family planning from pharmacist
In figure (6) show that two third 80(66.7%) of respondent give correct knowledge about definition of family planning.
Knowledge of male in soba university hospital about oral contraceptive pills

About one third 40(33.3%) of respondent give correct complete about definition about the definition of oral contraceptive pills , most 110(91.7%) of them know all advantage of oral contraceptive pills.
knowledge of male in soba university hospital about implantable contraception

When asked the respondent asked about meaning of implantable contraception, minority 10(8.3%) of them mention correct answer as show and figure (8)
Knowledge of male in soba university hospital about contraceptive injection (Depo Provera)

In figure (9) show that majority $100(83.3\%)$ of respondent mention correct answer about the definition of Depo Provera, half $60(50\%)$ of them give correct complete answer about characteristic and all $120(100\%)$ of them don’t know all the disadvantage.
Knowledge of male in soba university hospital about intrauterine device

When the respondent asked about intrauterine device more than half 63(52.5%) give correct incomplete answer about definition also all120(100%) of them didn’t know all the contraindication and side effect as show in figure (10)
Figure (11)

Knowledge of male in soba university hospital about topical contraceptive

This figure (11) show that the majority 70(58.3%) of respondent responses with correct answer when they asked about topical contraception and were same answer about appropriate time to use topical
Knowledge of male in soba university hospital about condom

Figure (12) show that majority 90(75%) of respondent responses with correct answer about condom , half 60(50%) of them mention advantage and also half 60(50%) mention all disadvantage.
Most 110(91.7%) of respondent give correct answer about meaning of coitus interrupts, majority 90(75%) of them mention all advantage of it and 100(83.3%) mention all disadvantage as show in figure (13)
Knowledge of male in soba university hospital about breast feeding as a method of family planning

In figure (14) show that about two third 80(66.7%) of respondent aware by how breast feeding act as method of family planning, majority 98(81.7%) of the didn’t know all the disadvantage of this method.
4-2 Discussion

Most 45(37.5%) of the male under the study in age group 30 – 35 years (most of Sudanese male married after 30 years of age). Half 60(50%) of the respondent complete secondary school, the majority 103(85.8) leave the urban areas because soba is near the capital of the country “Sudan”, 83(69.2%) of male under the study is an average family income, minority 17(14.2) of respondent in relating to years of married are less than 5 years, quarter 30 (25%) of respondent have 4-6 children.

Assessment of married male knowledge in soba university hospital about the meaning of family planning about two third 80(66.7%) of them gave correct answer about it, this result is compared to the study done in kiyeyi-torora district (2000-2001) about obstacles to male participation in family planning, majority 215/300 (71.7%) of respondent knew family planning.

About the male knowledge in soba university hospital about the benefits of family planning, minority 10(8.3%) know all benefit of family planning this result is less compared to a study done in Khartoum –Sudan (2005) about male attitude towards family planning, 202/250 believed in child spacing and the major reason of approving spacing were for upbringing of child to help the wife recover her health and infant health.

The opinion of respondent related to religious regarding to family planning, majority 93(77.5%) of them believed its Hallal.

The assessment of married male knowledge at soba university hospital about husbands opinion regarding to family planning, all 120(100%) said it is important to take the decision by the husband this result is high compared to a study done in Mukalla- yeman(2007) about knowledge, attitude and practice of husbands toward family planning, 282/400(70.5%) believed that the decision of family planning should be decided by husbands.
Related to married male knowledge at soba university hospital about methods of family planning that they know, half 60(50%) of respondent knows all the method, quarter 30 (25%) of them know OCP this result is less compared to a study done in Wolaita- soddo town- south Ethiopia (2009) about the involvement of men in family planning. An application of transtheoretical model, about 96% of respondent heard about family planning and familiar for at least one method and most reported family planning method are pills 389/405(96%).

Assessment of married male knowledge at soba university hospital about the source of information about family planning, 60(50%) of respondent take it from pharmacist while minority 10(8.3%) take it from different media this result is less compared by the study done in Wolaita – soddo town – south Ethiopia (2009) about the involvement of men in family planning. An application of transtheoretical model it found that the source of information 340/405 (83.9%) from radio, 82/405(20.2%) from newspaper.

While assessed married male knowledge at soba university hospital about oral contraceptive pills one third 40(33.3) give correct answer about definition and 110(91.7) they know all the advantage but they didn’t know all the side effect and the importance of follow up after given oral contraceptive pills this result is less compared to a study done in Mukalla – yeman (2007) about attitude and practice of husbands towards modern family planning, more than 90% of husbands knew about pills.

In assessment of male knowledge in SUH about implantable contraception, minority 10(8.3) of the respondent they know it this result is less compared to a study done in Wolaita- soddo town - south Ethiopia (2009) about the involvement of men in family planning. An application of transtheoretical model, the percentage 143/405(35.3%) know about implantable contraception.

In relation married males knowledge at soba university hospital about contraceptive injection (Depo- Provera) majority 100(83.3) of male know the Depo Provera this
result is more compared to a study done in Wolaita-soddo town - south Ethiopia (2009) about the involvement of men in family planning. An application of transtheoretical model about 383/405 (94.5%) of respondent know the injection. While asking married males at soba university hospital about intrauterine device less than half 57(47.5%) of them mention the correct answer about it, 58(48.3%) of them know the correct time to insertion but they didn’t know all the the contraindication and side effect of it this result is less compared to a study done in India(1997) about male involvement in family planning about 18% of respondent had correct knowledge about IUCD.

Regarding the married males knowledge at soba university hospital about topical used as method of family planning 33(27.5%) of them give correct answer. Assessment of married male knowledge at soba university hospital about condom, most 90(75%) of the respondent know the condom and they know the characteristic and disadvantage of it this result is more similar to the study done in Mukalla-yeman (2007) about knowledge, attitude and practice of husband toward family planning, more than 90% of husbands know the condom.

When the married male at soba university hospital were assessed in the knowledge about coitus interrupts majority 110(91.7%) of them answers they know it as a method of family planning this result is less compared to a study done in India(1997) about male involvement of family planning the percentage of male aware about it 11% .

In assessment of male knowledge at soba university hospital about breastfeeding as a method of family planning 80(66.6%) of them know how it prevent pregnancy, but they didn’t know all the advantage and disadvantage of it.
5-1 Conclusion

Knowledge about meaning of family planning by married males in soba university hospital was 70(63.7%) of respondent aware about it, the condom, pill, coitus Interruptus, and breastfeeding are most known methods. There is significant lack of knowledge about other modern methods of family planning such as implantable contraception, topical and intra uterine device. The reason of family planning is to provide better education for every child and pharmacist major sources of information about family planning

5-2 RECOMMENDATIONS

1- There is a great need for information, communication and education for men about family planning. Men friendly programs should be put in place to address this issue

2- Male motivation projects should be under taken to convince males that family Planning is not only for women but men as well.

3- Family planning services should be integrated in the rest of the clinics not to be delivered in only maternal and child health clinic.

4- The government should set up policy about family planning to guide the Community and service providers.

5- Strategies must be put in place to increase on the child survival rate so that People are certain that the few children they deliver will survive after birth.

6- There is a need for more male targeted information in the mass media

7- Must raise awareness among pharmacists about contraceptives without consulting a specialist
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3-involvement of men in family planning An application of transtheortical model Wolaita- soddo town - south Ethiopia -2009- by W. Abraham, A. Adamu and D. Deresse-Faculty of Medical, Addis Ababa University Ethiopia

4-male attitude towards family planning-Khartoum –Sudan -2005-by Mustafa MA

5-obstacles to male participation in family planning kiyeyi-torora district (2000- 2001)
بسم الله الرحمن الرحيم

إستبيان عن تقييم مدموعرة الرجال ووسائل تنظيم الأسرة

البيانات الشخصية (معدل مذكر الأسم) (أ)

1. السن: 
أ/ أقل من 25 سنة (ب) 25 سنة (ج) 30 سنة (د) أكثر من 35 سنة

2. مستوى التعليم: 
أ/ معي (ب) اساس (ج) ثانوي (د) جامعي أو فوق الجامعي

3. المهنة: 
أ/ عامل (ب) موظف (ج) دين

4. الديانة: 
أ/ مسيحي (ب) مسلم (ج) دين

5. دخل الأسرة: 
أ/ ضعيف (ب) متوسط (ج) عالي

6. السكن: 
أ/ داخلي (ب) المدينة (ج) الريف

7. السن عند الزواج: 
أ/ أقل من 25 سنة (ب) 25 سنة (ج) 30 سنة (د) أكثر من 35 سنة

8. عدد سنوات الزواج: 
أ/ أقل من 5 سنوات (ب) 5 سنوات (ج) 10 سنوات (د) أكثر من 14 سنة

9. عدد أفراد الأسرة: 
أ/ أقل من 2 (ب) 2-4 أفراد (ج) 4-6 أفراد (د) أكثر من 6 أفراد

(ب) معلومات الرجال عن تنظيم الأسرة

1. هل تعرف معنى تنظيم الأسرة
أ/ نعم (ب) لا

2. إذا كانت الإجابة بنعم فهل تنظيم الأسرة يعني
أ/ تتخطيط توزيع الألفاظ (ب) تحديد عدد الأطفالي الأسرة (ج) تنظيم الفترة بين ابتداء الحمل كل ما ذكر

3. هل تعقد أن تنظيم الأسرة للوفاء
أ/ نعم (ب) لا
4- إذا كانت الإجابة بنعم فما هي الفوائد 
أ/ خفض المضاعفات الناتجة عن الحمل والولادة ب/ خفض الوفيات بين الأمهات واطفالهن
ج/ (تحسين صحة الأم والطفل) توقف تعليم أفضل لكل طفل
5 - هل تعتقد أن تنظيم الأسيرة من ناحية الدين 
أ/ حرام ب/ حرام
6 - هل أخذ رأى الزوج مهم في تنظيم الأسيرة 
أ/ أدعم ب/ لا
7 - ما هي وسائل منع الحمل التي تعرفها 
أ/ الحبوب (الكبسولات) ووسائل الطبيعية ب/ الوسائل الطبيعية ج/ كل مناذك
8 - في رأيك ما هي أساليب منع الحمل المثلى 
أ/ متوفر ب/ مصادم ج/ امن د/ رخيص
9 - ما مصدر الحصول على وسائل تنظيم الأسيرة 
أ/ عيادات تنظيم الأسيرة ب/ الصيدليات
ج/ الزائرة الصحية او القابلة د/ كل مناذك
10 - ما هي المصادر التي تتحصل بها على معلومات عن تنظيم الأسيرة 
أ/ وسائل الإعلام المختلفة ب/ الطبيب ج/ الصيدلي
(ج) معلومات الرجال عن الوسائل المختلفة لتنظيم الأسيرة
1 حبوب منع الحمل
ث 1 - هل تعرف ما هي حبوب منع الحمل 
أ/ نعم ب/ لا
ج/ إذا كانت الإجابة بنعم فما هي 
أ/ هي أقراس تؤخذ بالفم يوميًا لمنع الحمل ب/ هي أقراس تؤخذ بالمهبل لمنع الحمل
ج/ كلا مناذك
ث 2 - هل تعرف ما هي مميزات حبوب منع الحمل 
أ/ أدعم ب/ لا
ج/ إذا كانت الإجابة بنعم فما هي 
أ/ رخيصة ومتاحة ب/ فعالة ج/ مدة للسيدات أقل من 35 سنة د/ كلا مناذك
ث 3 - هل هناك عيوب لحبوب منع الحمل 
أ/ نعم ب/ لا
ج/ كلا مناذك
ث 4 - هل الإجابة بنعم فما هي العيوب 
أ/ غالبية الأنهار ب/ تحتاج تركيز في عدم نسيان ميعاد اخذها ج/ تقضي قيمتها عند استعمالها مع بعض الأدوية كالمضادات د/ كلا مناذك
هل تعرف أن هناك موانع لاستخدام حبوب منع الحمل؟
أ) نعم
ب) لا

8. لو الإجابة بنعم فلا هنالك الموانع:
أ) ضغط الدم المرتفع (ب) أمراض القلب (ج) الأمراض البليغة في الثدي (د) مرض السكري (ه) الجلطة (و) الرضعات (ت) تدهور وظيفة الكبد (ج) كل ما ذكر

9. هل تعرف أن هناك أعراض جانبية تحدث عند استخدام الحبوب؟
أ) نعم
ب) لا

10. إذا كانت الإجابة بنعم فلا هنالك الأعراض:
أ) صداع (ب) أمراض القلب (ج) تأثيرات نتائج الدم (د) تأثيرات علاج الأمراض (ه) بالثدي (م) بالثدي

11. هل تعتقد أن المتابعة عند الطبيب مهمة بعد إخذ الحبوب؟
أ) نعم
ب) لا

12. إذا كانت الإجابة بنعم فلا أهمية المتابعة:
أ) لا (ب) لا

( كبسولات منع الحمل

1- هل تعرف ما هي كبسولات منع الحمل؟
أ) نعم
ب) لا

2- لو الإجابة بنعم فلا هي كبسولات منع الحمل
أ) هي كبسولات تحتوي على هرمون توزع تحت الجلد في اعلى الذراع بواسطة الطبيب
ب) هي كبسولات توفر لمنع الحمل (ج) كبسولات توزع وقت الزروم

( حقن منع الحمل

1. هل تعرف ما هي حقن منع الحمل؟
أ) نعم
ب) لا

2- لو الإجابة بنعم فلا هي حقن منع الحمل
أ) حقن تعطي بالفضل كل شهرين إلى ثلاثة أشهر حسب نوع الحقن (د) مدة الحقن (د) لمنع الحمل
ب) تحتوي على هرمون يوزع في الدم (ب) تأثيرات نتائج الدم (د) تأثيرات علاج الأمراض (ح) تأثيرات علاج الأمراض (ه) بالثدي (م) بالثدي

3. هل حقن منع الحمل لها معزيات؟
أ) نعم
ب) لا

4- إذا كانت الإجابة بنعم فلا هي هذه المميزات
أ) تكون فعالة لمدة شهرين إلى ثلاثة أشهر (ب) ليس لها علاقة بالجماع (ج) متاحة للنساء مع الرضاعة الطبيعية ومع إيا (س) مناسبة للنساء اللاتي لديهن مشاكل من الحبوب

5. هل تعتقد أن حقن منع الحمل لها عيوب
1- هل تعترف ما هو اللولب

(أ نعم

(ب) لا

2- إذا كانت الإجابة بنعم، فما هو اللولب

(أ) هو جسم صغير عادة يكون من البلاستيك (ب) من الممكن أن يحتوي على نحاس أو هرمون (ج) توضع داخل الرحم لمنع الحمل

(أ) نعم

(ب) لا

3- هل تعترف متى يتم تركيب اللولب بعد الولادة

(أ) نعم

(ب) لا

4- إذا كانت تعترف فمتى يتم ذلك

(أ) بعد الولادة مباشرة

(ب) بعد الولادة بسبع

(ج) بعد أربعين يوم من الولادة

5- هل تعتقد أن هناك موانع لاستخدام اللولب

(أ) نعم

(ب) لا

6- إذا كانت الإجابة بنعم، فما هي هذه الموانع

(أ) الإسهالات المزمنة الحادة (ب) أورام ليفية بالرحم (ج) الحمل (د) غثاءة في الدورة (ه) مشاكل سابقة من اللولب مثل وقوع حمل خارج الرحم (ب) هل تعتقد أن هناك إعراض جانبية عند استخدام اللولب

(أ) نعم

(ب) لا

8- إذا كانت الإجابة بنعم، فما هي هذه الأعراض

(آ) زيادة كمية الدم (ب) نزيف بعد الولادة (ج) تقلصات بالظهر (د) اختلال حوض حمل خارج الرحم

(ب) هل تعتقد أن المشابهة ذات أهمية بعد تركيب اللولب

(أ) نعم

(ب) لا

10- إذا كانت الإجابة بنعم، فما هي هذه الظاهرة

(أ) اكتشاف أي حالة مرضية مبكرة (ب) علاج الحالات المرضية مبكرة (ج) تفاقم المضاعفات والمشاكل المستقبلية

5- الوسائل الموضوعية

1- هل تعترف ما هي الوسائل الموضوعية

(أ) نعم

(ب) لا

2- إذا كانت الإجابة بنعم، فما هي هذه الوسائل

(أ) مواد كيميائية توضع بالحملال تؤثر على حركة الهرمونات المنوية وتقللها (ب) توضع عند اللزوم (ج) كل ما ذكر

(أ) نعم

(ب) لا

(ج) كل ما ذكر

6- لو الإجابة بنعم، فما هي هذه العيوب

أ) إفرازات المهبل (ب) نزيف بعد الولادة (ج) التكلفة (د) الالتهابات (ه) مشاكل سابقة

(أ) نعم

(ب) لا

7- هل تعتقد أن هناك مشاكل ومضاعفات في المستقبل

(أ) نعم

(ب) لا

(ج) كل ما ذكر

6- لو الإجابة بنعم، فما هي هذه العيوب

أ) إفرازات المهبل (ب) نزيف بعد الولادة (ج) التكلفة (د) الالتهابات (ه) مشاكل سابقة

(أ) نعم

(ب) لا

(ج) كل ما ذكر

5- الوسائل الموضوعية

1- هل تعترف ما هي الوسائل الموضوعية

(أ) نعم

(ب) لا

2- إذا كانت الإجابة بنعم، فما هي هذه الوسائل

(أ) مواد كيميائية توضع بالحمل وتؤثر على حركة الهرمونات المنوية وتقللها (ب) توضع عند اللزوم (ج) كل ما ذكر

(أ) نعم

(ب) لا

(ج) كل ما ذكر
3- هل تعرف الوقت المناسب لاستعمال الوسائط الموضعية
أ-نعم
ب-لا
4- لو الإجابة ب، فإن التوقيت المناسب لاستعمالها هو
أ- عشر دقائق قبل الجماع
ب- ساعة قبل الجماع
ج- أكثر من ساعة قبل الجماع
د- كل ماذكر
الواقي الذكري
6- هل تعترف ما هو الواقي الذكري (الحاجز الذكري)
أ- ينعم
ب- لا
2- لو الإجابة ب، فإن فما هو
أ- غشاء مشبعة يستخدم بعد الوراء المنصبة وقت الجماع
ب- هو غشاء مشبعة يغطي بطء من المواد الكيميائية القاتلة للحيوانات المنوية
ج- كل ماذكر
3- هل تعتقد ان الحاجز الذكري له مميزات
أ- ينعم
ب- لا
4- اذا كانت الإجابة ب، فإن فما هذة المميزات
أ-فعال
ب- متوفير دون استشارة الطبيب
ج- ليس له ضرر
د- سهل الاستعمال
ب- يمكن الانتقال للأمراض الجنسية
5- هل تعترف ان الحاجز الذكري عيوب
أ- ينعم
ب- لا
6- لو كانت الإجابة ب، فإن فما هذة العيوب
أ- احتمال حدوث حمل نتيجة حدوث تقب في
ب- يقلل الاشتياج الجنسي لدى بعض الزواجات
ج- يسبب حساسية عند بعض الزواجات
7- قطع الجماع
1- هل تعترف ما هو قطع الجماع
أ- ينعم
ب- لا
2- لو الإجابة ب، فإن فما هو قطع الجماع
أ- يسحب العضو من المهبل قبل الفنف
ب- يسحب العضو من المهبل بعد الجماع
ج- غير ذلك
3- هل تعترف ان لهذه الطريقة مميزات
أ- ينعم
ب- لا
4- اذا كانت الإجابة ب، فإن فما هذة المميزات
أ- للاختلاج (قيد صيحة من الطبيب)
ب- ليس بها مواد كيميائية أو هرمونات
ج- ليست مكلفة
5- هل لهذه الطريقة عيوب
أ- ينعم
ب- لا
6- اذا كانت الإجابة ب، فإن فما هي هذة العيوب
أ- السائل المنوي قبل الفنف يحتوي على حيوانات منوية تسبب الحمل
ب- هذه الوسيلة تحتاج لضبط نفسي
ج- تقلل المتعة لدى بعض الزواجات
8- الرضاعة الطبيعية
 هل تعرف ما هي الرضاعة الطبيعية كوسيلة لتنظيم الأسرة
أ(نعم)  ب(لا)
2- إذا كانت الجواب بنعم فكيفية ذلك
أ) هي طريقة مؤقتة لمنع الحمل تكون فعالة لمدة ستة أشهر الأولى بعد الولادة
ب) الاعتماد على الطفل في غذائه الاعتماد كلي على الرضاعة الطبيعية
ج) عدم رجوع الدورة الشهرية أثناء فترة الرضاعة
3- هل لهذه الطريقة مميزات
أ(نعم)  ب(لا)
4- إذا كانت الإجابة بنعم فما هي هذه المميزات
أ) فعالة لمنع الحمل لمدة ستة أشهر من الولادة
ب) ليست مكلفة  ج) ليست لها اعراض جانبية
د) لها فوائد صحية  ه) كل ما ذكر
5- هل لهذه الطريقة عيوب
أ(نعم)  ب(لا)
6- إذا كانت الإجابة بنعم فما هي هذه العيوب
أ) تقل كفاءة الوسيلة بعد ستة أشهر من الولادة
ب) الرضاعة الطبيعية تكون غير متاحة أو صعبة خاصة مع الأم العاملة
ج) احتمال حدوث حمل  د) كل ما ذكر

شكرًا لحسن تعاونك معنا