

**An-Najah National University
Faculty of Graduate Studies**

**The Effect of Health Promotion Education Program on
Reproductive Health Knowledge Attitudes and Practices
(KAP) Among Reproductive Age Women in
Rural Palestinian Community**

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2005



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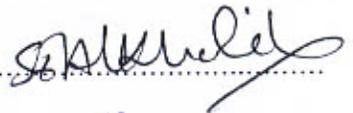
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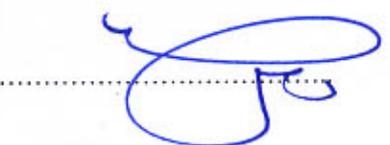
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Dedication

**Humbly I Dedicate this Effort to
My Beloved Family for their Patience and Encouragements**

And

To The Soul of My Last Grand Parents

**With Gratitude, Respect
And Love**

Acknowledgement

I would like to express my deep thanks for my supervisors Dr. Suleiman Khalil and Dr. Ali Sha'ar for their efforts, encouragements and continuous support through out this study. Thanks are also due to Save the Children Federation, Palestinian Ministry of Health and Union of Palestinian Medical Relief Committees for their help and support. Thanks are also due to my colleagues and friends for their emotional support.

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List of Abbreviations

F	Female
FP	Family Planning
GS	Gaza Strip
ICPD	International Conference on Population and Development
IMR	Infant Mortality Rate
IUD	Intra Uterine Device
KAP	Knowledge, Attitudes, and Practices
M	Male
MCH	Mother and Child Health
MOH	Ministry of Health
OBGYN	Obstetrics and Gynecologists
OPT	Occupied Palestinian Territory
PCBS	Palestinian Census Bureau for Statistics
PMID	Pub Med Indexed for MEDLINE
PMOH	Palestinian Ministry of Health
PT	Palestinian Territory
RH	Reproductive Health
SPSS	Statistical Package of Social Science
STD	Sexually Transmitted Disease
STIs	Sexually Transmitted Infections
TFR	Total Fertility Rate
UNFPA	United Nation and Population Fund
UNRWA	United Nation Relief and Work Agency
WB	West Bank
WHO	World Health Organization

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Abstract

The current study aimed at evaluating the effect of health promotion education program on reproductive health knowledge, attitudes and practices among reproductive age women in rural Palestinian community in Gaza and northern and southern regions of the West Bank area. To achieve our goals a specially designed questionnaire was prepared and the study was conducted at two phases. The first phase was carried out prior to the intervention of the health promotion educational program and the second was carried out after this intervention program. The study was conducted during the period 2001-2002. Data was collected through personal interview with the targeted groups and included 1,347 women (743 first phase and 604-second phase). In the pre phase, Gaza region was represented by 107 (14.4%) women while the southern and northern regions were represented by 291 (39.2%) and 345 (46.4%) cases, respectively. The sample was selected using simple random stratified method and the data was analyzed using the software SPSS (Statistical Package for Social Sciences).

Similar age mean was found among the participants in both phases (29.9 year, for pre intervention and 30.3 for post phase). It was found that 55.2% were less than 18 years of age among the first phase group and the rate of 57.3% among the second group. This indicates a high percentage of

early marriage in the rural areas and the mean age at marriage among both groups was 18.8 years. The findings of the study also showed a very low level of education in these areas as the average number of years of education was 7.83 and 8.84 for the pre and post intervention groups, respectively. It was also found that 93% of the study population in both phases did not exceed the secondary stage of education.

The findings of the study showed a very low level of knowledge with respect to postnatal health care and it seems that the health promotion educational program did not improve knowledge in this field. Attitudes were highly positive and improvements in practices were also noted with the exception of practices concerning routine check up of new the born.

With respect to family planning issue, noticeable improvements was observed among the second phase participants, however, low level of knowledge concerning the concept of family planning was observed among both study groups (below 50%). Higher levels of positive attitudes with respect to use of family planning methods were observed among the first phase group (75.9%) compared to the second phase group (72.2%) indicating a limited use of family planning methods and this is also clear from the findings on number of pregnant women during the study period (79.3% and 78.1%) for pre and post phases, respectively. With respect to availability of family planning services, 93% (post phase) and 64.1% (pre phase) reported easy access to such services.

Low level of improvement was observed with respect to knowledge concerning sexually transmitted infections among participants of the second phase as 90% were unable to recognize disease symptoms, 85% were unable to provide two examples of such diseases, 70% did no know

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preventive methods and 50% were unable to name three organs of the female reproductive system. Practices in this field seem to be acceptable among both study groups.

With respect to regional differences, low knowledge levels were observed with respect to postnatal care in all regions, while highly positive attitudes were reported in the various regions concerning all studied variables in this field. This was very clear in Gaza region with respect to giving birth in hospitals (61.6% pre; 86.1% post), however, both the northern (90% pre; 84.8% post) and southern regions (89% pre; 83.1% post) showed low levels of positive attitudes towards giving birth in hospitals under medical care. Improvement in practices in this field was reported in all studied regions.

Low knowledge levels concerning family planning was found in Gaza with respect to all studied variables among participant of the second phase and levels did not exceed 52%. Attitudes were highly positive in all regions.

The findings also indicates improvements in practices concerning family planning and the highest reported rates of use of family planning methods was found among participants of northern region of the West Bank and lowest levels were reported by participants from Gaza region. This was evident form the number of children under the age of five years as the northern region was with the lowest mean value compared to the other two regions.

Low knowledge levels were also found among participants from Gaza region with respect to sexually transmitted infections as only 3.7% were able to identify symptoms associated with such diseases. Improvement

among second phase participants in the southern region was noted especially with respect to the need of treating affected partners, organs of female reproductive system, however limited knowledge was observed concerning other tested variables. With respect to attitudes towards sexually transmitted infections, highly positive attitudes were noted in all studied regions. Practices in this field were within acceptable levels in all regions. In general, these highly positive attitudes did not reflect on neither the poor practices nor the poor knowledge level in all studied regions and among both study groups.

Although some improvements were observed in the post intervention group was found compared to the pre intervention phase of the educational program, the findings clearly indicate the need for further studies concerning priorities in health education programs.

Chapter One

Introduction

1.1 Reproductive health

Reproductive health is defined by World Health Organization (WHO) as a state of physical, mental, and social well-being in all matters relating to the reproductive system at all stages of life. This definition implies that people should be able to have a satisfying and safe sexual life and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so. Implicit in this are the right of men and women to be informed and to have access to safe, effective, affordable, acceptable methods of family planning, and the right to appropriate health care services that enable women to safely go through pregnancy and childbirth (WHO, 1998).

1.1.1 Concepts of reproductive health care

The concepts of reproductive care are centered on human needs and development throughout the life cycle (WHO/AFRO, 2002). It includes:

1. The well-being of men, women and young people as concerns their reproductive functions throughout the life span.
2. Women's ability to go through pregnancy and childbirth without danger to themselves or their children.
3. Prevention of unintended pregnancies and diseases spread through sexual intercourse.

1.1.2 Challenges in reproductive health

One of the fundamental principles of Primary Health Care is equitable access to quality health care at all levels. To respond to this, the following issues need consideration (WHO/AFRO, 2002):

A. Minimum package of services

Reproductive health embraces a wide range of health services far beyond the traditional maternal and child health services. Traditional maternal and child health focused on pregnant women and children. Reproductive Health brings in other non-traditional target groups such as men and adolescents.

B. Availability and quality of care

The unacceptably high maternal mortality underscores the need for the availability of and access to essential and obstetric care at primary health care level, the key element being the availability of skilled attendance at childbirth. This is in line with the guiding principle of the Health-for-All Policy for the 21st century based on equity in the availability of essential health services. The speed at which Sexually Transmitted Infections (STIs)/ and Human Immuno Deficiency Virus (HIV)/ AIDS is spreading has left more and more women being infected. As a result, the maternal to child transmission of HIV infection is on the increase. Another major problem is complications from unsafe abortions; all these factors have considerably modified the demands on health systems.

C. Functional referral systems

Most of maternal and neonatal deaths could be prevented if only functional referral systems could be put in place to allow pregnant women to reach the appropriate health services when complications occur.

1.1.3 Reproductive health approach

The International Conference on Population and Development (ICPD) held in Cairo in 1994 was a landmark by clearly defining for the first time the concept of reproductive health and the reproductive rights. The

concerns of gender equality and women's improvements were recognized as essential components of reproductive health rights (Obermyer, C.M, 1995). Population policies thus, must be adopted and taken in parallel with other interventions aiming at improving the status of women through education and employment, removing unnecessary barriers to information and ensuring access to an acceptable mix of contraceptive technology, which helps women to take informed reproductive decisions (Nataraj, 1994).

Despite rapid expansion of family planning programs and recent changes in the approach to fertility regulation, it is estimated that in Africa and Middle East alone, out of 11.6 million pregnancies occurring yearly, 58% are wanted, 12% are mistimed, 18% are unwanted and 12% end in abortion (Zatucchini, 1994). Improving access to family planning, a broader range of culturally acceptable methods, better quality services, better counseling and information on side effects, free choice of methods and increased male involvement are all factors population programmers need to address in the future. But only with improvement in the status of women, better access to education and employment and improvement in socio-economic conditions will population programs achieve to improve reproductive health behaviors.

1.2 Reproductive health care

Reproductive health care is the constellation of methods, techniques and services that contribute to reproductive health and well being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted diseases (Earth Negotiations Bulletin, 1994).

1.2.1 Component of reproductive health care

Since Alma-Ata conference on public health in 1978, the maternal health component of Primary Health Care has greatly evolved. The traditional maternal health services, which comprised primarily antenatal care, safe delivery and postnatal care, has included since a much wider spectrum of services today (WHO/AFRO, 2002). The components included (Earth Negotiations Bulletin, 1994; Family Care International, 2000):

1. Safe Motherhood.
2. Adolescent Reproductive Health and Sexual Health.
3. Gender equity.
4. Prevention of harmful traditional practices.
5. Reproductive health needs associated with menopause and andropause, including reproductive tract cancers, and breast cancer.
6. Family planning information, counseling and services.
7. Prenatal, postnatal and delivery care.
8. Health care for infants.
9. Prevention of treatment Sexually Transmitted Diseases (STDs) and Reproductive Tract Infections (RTIs).
10. Safe abortion services and management.
11. Prevention and treatment of infertility.
12. Information, education and counseling on human sexuality, reproductive health and parenthood.

1.3 Reproductive health indicators in Palestinian community

The Palestinian population in Occupied Palestinian Territories (OPT) was estimated by Palestinian Census Bureau for Statistics (PCBS) to be approximately 3.648 million people in middle of 2003 (PCBS 2000). Males comprise 1.848 million while females comprise 1.800 million. Out of 3.648 million inhabitants, 2.314 million live in West Bank (WB) and 1.334 million live in Gaza Strip (GS). City inhabitation constituted 56.4%, while inhabitation of rural areas and refugee camps were represented by 28.5% and 15.1%, respectively (ICPD, 2004).

The Palestinian Census Bureau for Statistics, Labor Force Survey 2002 indicated a literacy rate (knowledge of reading and writing) of 91% (91.2% WB and 90.7% GS), in Palestine for those 15 years and above (95.7% for males and 86.45% for females). For those 15 years and above, 16.8% have not completed any educational level, (12% male and 21.45% female), 20% completed the primary education level (grade 6) (21% male and 19% female) 32.9% completed grade 9 (33.6% male and 32.3% female), 19.1% obtained the high school certificate, 4.8% a middle diploma, and 6.4% a bachelors degree and above (8.8% male, 4.1 % female) (PCBS, 2002). The percentage of females and males enrolled in school is almost equal 50.23% males compared to 49.68% females.

Palestinian rural women constitute 14.6% of Palestinian women in the Palestinian territories (PCBS- A, 2002). 65% of rural Palestinian women are illiterate or had primary school education. This has a negative impact on their economic, social, and educational life. There is a drop in the percentage of rural Palestinian women who complete their high or graduate education; they are registered 7.9% and 1.3%, respectively (Center for Reproductive Rights, 1999).

In Palestine, there are four providers of health services inclusive of Reproductive Health (RH) services; these include governmental sector; United Nation Relief and Work Agency (UNRWA); non-governmental sector and private sector (ICPD, 2004). Data presented in tables 1.1 and 1.2 represent the various reproductive health indicators and services in Palestinian community (ICPD, 2004).

Table 1.1 Reproductive health indicators in Palestinian community

Reproductive health indicators	1994-1997	2000	2001-2003
Total fertility rate	6.1	5.9 (1999)	
Median age at 1 st marriage	M=23 F =18	M 24.1 F 18.9	M= 24.2 F = 19.0
Contraceptive use	45.2%	51.4%	
HIV/AIDS		1.8/100,00	
Immunization coverage	95.7 (94-97)	98.3 (2000)	
Polio (3 doses)	48.9	92.7	
Measles	84.6	74.7	
MMR	96.4	98.7	
DPT (3 doses)	-	-	
% Deliveries in hospitals	70.9	83.0	67%
% Receiving antenatal care	94.6	95.6	
% Receiving postnatal care	19.7	26.3	
% of pregnant women 15-49 with no health care during pregnancy		4.4	19.6
% Tetanus immunized women	33.5	27.5	
Prevalence of anemia in pregnant women		31.1	
Deliveries by trained personnel	94.9	96.8	
% Home births	10.2	5.2	30%
% Breastfeeding	96	96.8	
Incidence rate of STDs/100,000		123.2	

Table 1.2 Reproductive health services and resources in Palestinian community

Resources Indicators	1994-1997	2000	2001-2003
Maternity beds - 10,000		6.3	
Midwives		1.4/10,000	
No. of Obstetrics and Gynecologists (OBGYN) Specialist		156	
No. of Primary Health Care (PHC) clinics	454	595	609
No. of centers providing Family Planning (FP) services		175	
of health centers providing 3 or more RH services		175	
% of insured persons			76%

1.3.1 Maternal mortality rate in Palestine

Maternal mortality is one of the most important indicators to determine the health status for women. In Palestine, although institutionalized deliveries are improved but many risk factors including unrest of the political situation, repeated curfews and frequent closures and separation of Palestinian areas are determinant factors that increase the risk of maternal mortality. Underestimation and poor reporting of mortality and morbidity maternal cases is a continuous problem in both Gaza Strip and West Bank, where proper attention needs to be paid in reporting the cause of death among women within the age group between 15-49 years old. A study conducted in Gaza Strip in 1998 showed that maternal mortality rate in 1998 was 42 per 100,000 live births (MOH-HMIS, 2001). The Palestinian Ministry of Health (2004) reported that maternal mortality was 10.6/100,000 in Palestine (20 in Gaza and 3.4 in the West Bank) (PMOH, 2004).

1.3.2 Total fertility rate in Palestine (TFR)

TFR in Palestine is one of the highest rates in the world. Reasons for reported high fertility were attributed to early marriage especially for

females; desire to have children; culture and traditions. The fertility peak is between the ages 20-29 years then by increased age fertility decreases (MOH-HMIS, 2001). The PCBS Population, Housing and Establishments Census of 1997 indicated a total fertility rate of 6.04 (6.5 in WB and 6.9 in GS) (PCBS, 1997). In 2004, the Palestinian Ministry of Health reported that the total fertility rate as 4.19 (5.5 in Gaza and 3.7 in the WB) (PMOH, 2004). This rate is much higher than reported rates in several neighboring countries (PCBS, 2000). Over the past ten years, the fertility rate decreased progressively and this drop might be related to the efforts of both governmental and NGO's programs with respect to family planning and reproductive health in Palestine (ICPD, 2004).

The median age at first birth for women with 13 year and more schooling was 24 years compared to 19 years for women with 1-6 years of schooling (PCBS, 2000). FAFO (1993) conducted a survey on living condition of Palestinians which revealed that 81% of women have had less than 6 years of schooling, 55% had 10 years or more whilst 2% completed university education (FAFO, 1993).

1.3.3 Family Planning in Palestine (FP)

Family planning has been identified by the World Health Organization (WHO) as one of the six essential health interventions needed to achieve safe motherhood. WHO, define family planning as "The women's ability to experience a safe and healthy pregnancy and delivery" (Shiffman, *et al.*, 2004).

According to Palestinian Ministry of Health data on family planning shows steadily increasing in the number of FP clinics in Palestine. The total number has increased from 97 FP clinics in 1997 to 175 in 2000. The

increase in the number of family planning clinics was accompanied with significant increase in the use of contraceptive methods and the number of women utilizing these services in Palestine over the last 4 years. The current rate of contraception methods use is 51.4 % of currently married women in Palestine and was reported to be higher in West Bank (54.3%) compared to Gaza Strip (46.1%) (MOH-HMIS, 2001).

According to PCBS report, the most commonly used method is Intra Uterine Device (IUD), which is used by 24.6% of married women followed by pills, which account for 5.8%. According to PMOH, the commonly used method in governmental FP clinics is pills and its use was reported by 48.5% of married women (42.5% in GS and 50.7 in WB), followed by IUDs with percentage 26.5% (22.3% in GS and 28.1% in WB), and male condom 23% (28.1% in GS and 21.1% in WB) (MOH-HMIS, 2001). PCBS health surveys (PCBS, 2000; 1996) indicate a high level of awareness with respect of contraceptive methods (modern and traditional types). The level of contraceptive use, estimated at 35.3% for modern methods and 46.2% for all methods. Such high level of use of contraceptive methods is contradictory to the high previously mentioned fertility level (PCBS, 2000). The high percentage of contraceptive use is attributed to the widespread practice of early marriage and to general attitudes that tend to favor large families for a number of reasons, including social security in crisis and old age. As a result, women tend to use contraception as a means of spacing their children or adopt it later in their reproductive years after they have had the desired number of children. The gap between the high knowledge of family planning (99.4%) and relatively moderate use of contraceptives is attributed to fears of side effects of contraceptives, religious prejudice, husband and family opposition (PCBS, 2000- A).

UNRWA conducted an Agency-wide cross-sectional study to assess the current contraceptive practices among 8,309 mothers attending mother and child health clinics in Jordan, the West Bank and Gaza Strip, Lebanon and Syria, the data showed that the mean age of mothers in the sample was 27.1 years. The mean age at first marriage was 19.2 years. Of the mothers surveyed, 47.3% had a birth interval of less than two years. The overall prevalence rate of contraceptive use was 32.12%. The most popular method was the IUD that accounted for 57.9% of all contraceptives used. Women between the ages of 20 and 40, who had four or more living children, showed the highest prevalence rate of contraceptive use. Results also seemed to indicate that the sex of the youngest child affected contraceptive use. Mothers whose youngest child is male were more likely to use the IUD (El-Yahya, 1997).

Family Planning knowledge attitudes and practices (KAP) survey in Gaza (Donati, Hamam and Medda, 2002) showed that 98% of the interviewees favor family planning and 88% plan to use a contraceptive in the future. However, 52% of the women not using contraceptives refuse to do so because of their husband's opposition, fear of side effects or lack of knowledge. The risk of having seven or more children is positively associated with a woman's low educational level and husband's desire for more than seven children. Despite favorable attitudes regarding family planning, there is ignorance and the prevalence of contraception use is low. There is a gap between fertility preference (attitudes) and achievement (practices).

Review of Palestinian literature by the population initiative for Peace in (1995) on the status of reproductive health, gender issues and KAP regarding reproductive health and family planning and main attitudes

towards fertility indicated a lack of knowledge regarding family planning clinics or sites of service provision, additionally noted were financial or psychological barriers for receiving services, limited family planning services offered, early marriage and the yearning of large families (FAFO, 1993).

1.3.4 Antenatal care in Palestine

According to Palestinian Ministry of Health reports 2001, about 94.3% of births take place in health institutions and 5.7% at homes and about 94.8% of deliveries are attended by trained personnel (MOH-HMIS, 2001). Figure 1.1 shows a sharp drop in the percentage of deliveries at home (10% in 1996 to 5% in 2000). A similar drop was registered among deliveries taking place at UNRWA run health institutions from 8% in 1996 to 7% in 2000. On the other hand, Figure 1.1 shows that there was an increase in the percentage of deliveries at private hospitals from 22% in 1996 to 28% in 2000. Percentages of deliveries at governmental hospitals and private clinics remained almost the same (PCBS, 2000- B).

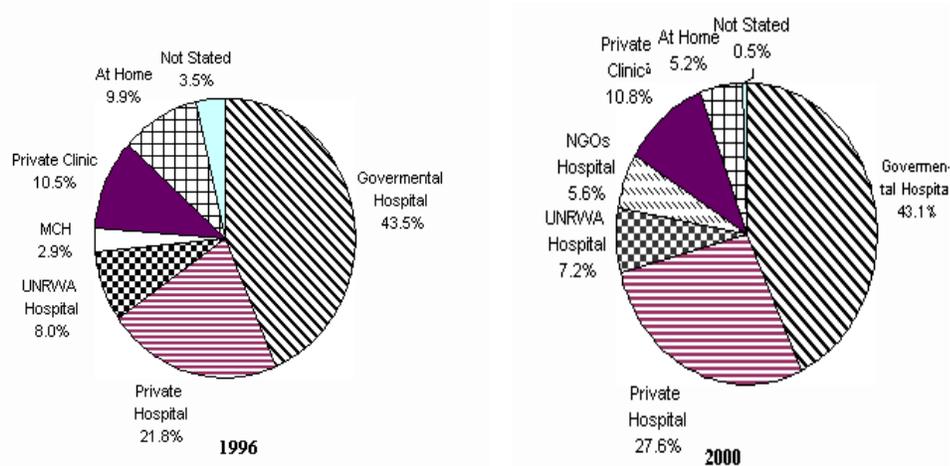


Figure 1.1 Distribution of births in Palestine territory by place of delivery

The comparison of maternal care indicators of the health surveys of 1996 and 2000 shows a development in maternal care in the Palestinian territory, such development appears in early pregnancy follow-up and in a rise in the average number of visits paid to a physician during pregnancy and the number of deliveries at healthcare institutions. However, such rise remains below the required levels (PCBS, 2000- B). The analytical reports from PCBS showed that no major changes occurred on the rates of antenatal healthcare follow-up between 1996 and 2000 and stayed at approximately 95% of pregnancies (PCBS, 2000- B). The PCBS health survey of 2000 indicates that 95% of mothers who gave birth twice during the three years preceding the survey received antenatal care. The figure is rather high when compared to the figures of the Arab countries. However, it was subjected to variations governed by mother's education especially.

There was an increase in the percentage of antenatal healthcare follow-up during the first trimester to reach a high of 47% in 2000 whereas the same score for 1996 was 38%. Furthermore, the percentage of pregnant mothers who started seeking antenatal medical care during the third trimester dropped to 6% in 2000 whereas it stood at 10% in 1996. It has been noticed that the increase in the percentage of early pregnancy antenatal healthcare follow-up was accompanied by a rise in the average number of visits of such follow-up (PCBS, 2000- B). Figure 1.2 shows that the times of antenatal healthcare follow-up raised from 5.5 to 7.8 times such rise was most prominent in Gaza Strip where it registered 7.5 visits (compared to 4.8 visits in 1996), and for West Bank visits raised from 5.9 in 1996 to 8 visits in 2000. Data shown in figure 1.2 shows the average number of visit for antenatal care by region in which the number of visits raised in 2000.

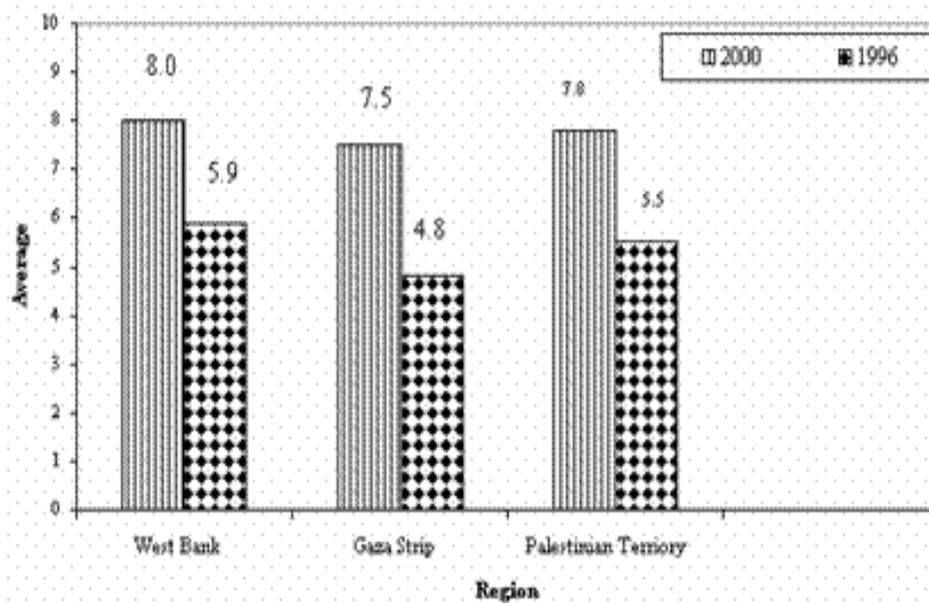


Figure 1.2 Average number of visit for antenatal care in Palestine territory by region.

1.3.5 Postnatal care in Palestine

Postnatal care is defined as the medical care for both newborn and mother during the first six weeks after birth (Baby center L.L.C, 2006). Usually women do not seek postnatal care unless they have a health problem. Two types of postnatal care are carried out, home visits and postnatal awareness. The health education and consultation after delivery carried out by 9 hospitals, 7 of them in West Bank and 2 in Gaza Strip. The total number of mothers benefiting from postnatal care in governmental sector is 14.71, out of which (27.2%) in Gaza Strip and (72.8%) in West Bank. The total rate of mothers receiving postnatal care in governmental sectors is 15.8% of total live births (19.6% in WB and 10% in GS) (MOH-HMIS, 2001). The PCBS 2000 reported that 26.3% from mothers have received post-natal care in Palestine, out of them 29% in the West Bank and 21.4% in Gaza Strip.

According to PCBS analytical report, 26% of deliveries received postnatal healthcare and 7% of them were professionally followed-up at

home through visits of a healthcare provider. One-third of mothers who gave birth at health institutions did not receive any health education after childbirth (PCBS, 2000- B).

The lack of care provided to mothers and newborns during the prenatal period is an important health care problem in the West Bank and Gaza. While a large percentage of women receive some antenatal care, very few returns to health facilities for postpartum check-ups and few begin using family planning during the postpartum period for birth spacing. The percentages are expected to be even lower among low parity women, i.e. those with one or two living children (Center for Development in Primary Health Care, Al-Quds University, 2003). Data in figure 1.3 shows the Percentage of mothers received postnatal care in Palestine territory by region (PCBS, 2000- B).

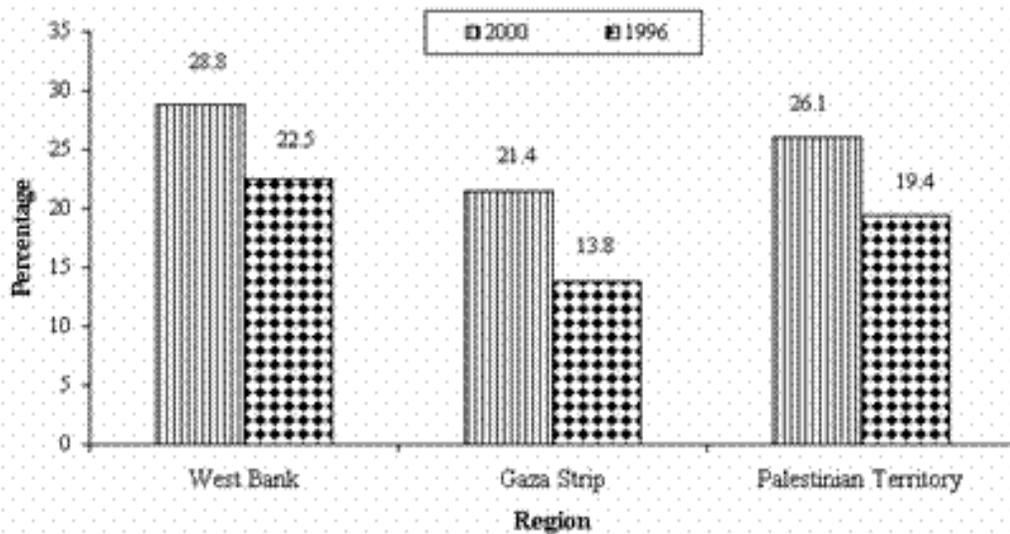


Figure 1.3 Percentage of mothers received postnatal care in Palestine territory by region.

1.4 Approaches to improving maternal health

There are several basic approaches to changing behaviors that can lead to improved maternal health and survival, however, no single best approach

was described. A systematic, theory-based approach to designing, implementing, monitoring and evaluating behavior change interventions could be the best for this purpose. On the other hand, health specialists deciding on and promoting “key behaviors” that women and influential family members need to follow in order to improve maternal health might be useful in this respect. Other opinions preferred that maternal health programs should facilitate a process of community education that stimulates actions determined and planned by the community. These differences in opinion can be reduced to three questions: Who should decide what health or other problems to address? Who should decide what strategy and actions should be implemented? Who should take these actions? (Al-Quds University- Center for Development in Primary Health Care, 2003).

1.4.1 Identification of health problems

For health professionals, epidemiological facts often dictate the prioritization of health problems. If statistics indicate that hemorrhage is the primary cause of maternal mortality, then (assuming feasible interventions exist) that problem should be the program’s first priority. The goal, according to behavioral specialists, is to define the behavior(s) that most affects this outcome. The likelihood of success in influencing the intent to change behavior is greatest when interventions focus on the promotion of a few behaviors (ideally one) and when the behavior is as specific as possible. The use of theoretical models focusing on the determinants of behavior (e.g. attitudes, norms, and self-efficacy) can assist program planners in developing the logic that underpins the prioritization and selection of behaviors relevant within a particular context in order to increase the effectiveness of behavioral interventions. In contrast,

proponents of a “social change” approach to maternal health and gender issues support the idea of communities deciding what health or other problems they wanted to address.

Some who favored a major role for the community in answering this question felt that community choices should not be left completely open, in part because (male-dominated) communities might never consider maternal health as a priority concern. Thus, a “guided” community mobilization approach where the goal is specified is required.

In this approach, the program facilitated a process of community discovery and analysis toward the goal of improving maternal and newborn health, which the communities themselves widened to include reproductive health. Supporting bodies of such programs as well as policy maker may not allow a strong social mobilization approach, since donors often require implementing organizations to propose specific indicators. In addition, the time frames of projects may pose a constraint to the implementation of participatory approaches required to mobilize communities for social change.

1.4.2 Strategies and actions

On this issue also, there was a range of opinions. Some believe that health and behavioral specialists should determine the strategy and actions with substantial input from mothers, families, communities, and health providers obtained via formative research. On the other hand some specialists in the field community mobilization and social change, favored mothers and communities deciding on strategy and actions. Examples of successful projects using both approaches were reported.

1.5 Maternal health behavior change and intervention strategies

1.5.1 Behavior changes

Approximately 500,000 women die each year globally because of pregnancy and child birth-related causes (Zahr, & Wardlaw, 2002). Although improved access to obstetric care is a major precondition for lowering maternal mortality, research in developing countries indicates many barriers to access to care (Tinker, & Koblinsky, 1993; Chapman, 2003). Even when prenatal services are available, women do not always use them. The challenge is to promote appropriate and timely utilization of services especially in the presence of danger signs.

Similar behavior change challenges exist for mobilizing mothers to treat infant and child diarrhea. In developing countries a variety of obstacles, including beliefs, social norms and mainly poverty impede women from treating infants and children in a timely manner or from seeking appropriate help (Goldman, & Gragnolati, 2002). Changing human health behavior is indisputably a difficult task and can be complicated by cultural and logistical barriers (Chapman, 2003; Goldman, & Gragnolati, 2002; Pillai, et al., 2003).

Evaluation of health services tended to ignore analyzing the associations between behavior change and the strategies that comprise a health intervention. Such analysis is important as it can indicate strategies that ought to receive investment and those which should not. Instead, evaluation of health behavior change in developing countries have tended to compare the differences between final stage evaluation values of behavior indicators and their baseline values. Occasionally, control groups are included in the evaluation design to eliminate competing interpretations of results (Campbell, & Stanley, 1963, Valadez, & Bamberger, 1994).

1.5.2 Intervention strategies

Community health interventions use at least four generic strategies to achieve individual and group behavior change:

1. Mass communication, as in radio programs, fairs, movies or videos, and plays.
2. Investment in physical capital, as in the building of community health stations, equipping health workers with scales for use in growth monitoring, or traditional birth attendants with clean birth kits.
3. Investment in human capital, as in training different kinds of paramedical personnel and having them or health professionals involved in health education activities to women in their communities.
4. Investment in social capital, as in the formation of various mothers clubs, women's groups, adolescent groups, men's groups, and/or community health committees/councils.

1.5.3 Approaches and tools for behavioral diagnosis

There are two approaches for conducting formative research; one is to facilitate communities exploring, learning about, and analyzing their problems related to maternal health. These may be general community mobilization methodologies or ones developed with a focus on maternal health. A variation of community mobilization tools are approaches in which communities and/or programs periodically analyze and feed back program and health information to communities, with the hope of stimulating appropriate community reflection and action. In child health, this concept is part of UNICEF's Triple a Approach and has been incorporated into the integrated child health and nutrition program in many countries.

The second approach of formative research is a process planned and carried out by the organization that will later manage the interventions (or by a research group it has contracted). While some of the research methods that may be used are quite participatory and may be designed to avoid findings being too researcher-directed, the researchers, rather than the community, are still in charge and it is they who interpret and decide how to use the information gathered. Many of the projects presented utilized standard tools for formative research – in-depth interviews, focus group discussions, body mapping, Knowledge, Attitudes, and Practices (KAP) surveys.

In general, it is believed that either health systems or communities alone should take all of the actions to improve maternal survival and health. It seems clear that maternal survival in particular requires competent, accessible, and acceptable services that are appropriately utilized by the public. While some aspects of improving maternal health are feasible without the direct participation of health services (e.g., improving maternal nutrition and micronutrient status; some methods of birth spacing), health services normally play an essential role in these and other actions to enhance maternal health. On the other hand, none of these services is of any value without appropriate demand and utilization on the part of pregnant women and influential family members. It was widely agreed that health services should not be defined and organized solely by physicians and public health specialists. A number of program examples exist where community perceptions and preferences regarding the quality of care were, to some degree, incorporated into health services, with promising impacts on services utilization. In Bolivia, for example, knowledge that families wanted the placenta for traditional burial prompted some hospitals to promote returning the placenta to the families (WHO, 2003).

I.6 Aims of the study

The current study aimed at exploring, assessing and evaluating level of knowledge, attitudes and practices among women in the rural Palestinian community towards reproductive health, and enlightening key reproductive health indicators among Palestinian rural women. The study also aimed at evaluating the impact of the various health educational activities implemented by the Palestinian Ministry of Health, Save the Children Federation and the Union of Palestinian Medical Relief Committees aimed at improving knowledge attitude and practices related to reproductive health.

Chapter Two

Methodology

Save the Children Federation, the Palestinian Ministry of Health and the Union of Palestinian Medical Relief Committees have implemented a programmatic intervention in nine marginalized communities in the North West Bank District of Jenin, South West Bank district of Hebron and Gaza Strip to improve women health in these communities. The program consisted of two main components:

- 1- Provision of facility-based services to improve reproductive health services including antenatal care, postnatal care, family planning, breast-feeding, and sexually transmitted disease prevention and care.
- 2- Provision of health education program to women in reproductive age to improved their knowledge, attitudes and practices concerning key reproductive health issues.

The community component of this program has utilized behavior-centered education methodologies and tried to reach women in target communities with structured community interventions in order to achieve desired improvements in the health behaviors of target women. Health messages were carried to target women using different health education and communication tools including lectures, home visits and different community education activities. To measure the impact of the above-mentioned interventions, a baseline study was provided prior to launching the program, and upon finalization of the intervention, a second, post-intervention study was conducted.

The current study is focusing on elaboration of changes in knowledge, attitudes and practices occurring as a result of the community education program in the area of postnatal care, family planning and sexually transmitted diseases.

2.1 Study design

This study is comparative study that compares the outcomes of the baseline survey with the results of the post-intervention survey conducted upon completion of the community intervention. To achieve our aims, a specially designed questionnaire was prepared for this purpose and data was collected in two time points:

Phase 1: Prior to implementing health promotion education program in selected Palestinian rural society. Data for the baseline survey was collected during July 2001.

Phase 2: After implementing health promotion education program and the data for this phase was collected during July 2002. Phase 2 was conducted through distributing the same questionnaire with in the same rural areas, for the purpose of comparing results of the two questionnaires for two phases before and after applying health promotion education program.

Target communities were exposed to structured health promotion education program that aimed to improving women knowledge attitudes and practices in issues related to reproductive health. This program benefited from a pre-intervention KAP survey to inform about level of KAP of target women and set baseline to be reevaluated after applying health education program.

2.2 Study population

The study population consisted of 1347 married women in the age group (15-49) years, living in rural areas in the north, south of the West Bank and Gaza strip. Table 2.1 shows the distribution of the study population according to the place of residence.

Table 2.1 Distribution of study population according to place of residence

Location	Population size	Number of cases	Household selection
Bardala	1148	25	Each 8 th household
Ein Beida	791	15	Each 9 th household
Tomoun	7635	160	Each 8 th household
Aqqaba	4441	93	Each 8 th household
Tayasir	1753	36	Each 8 th household
Sammou'	4000	84	Each 8 th household
Daherieh	4000	84	Each 8 th household
Abu Tea'ma	2500	53	Each 8 th household
Um Al-Naser	3000	63	Each 8 th household

2.3 Sampling method

Women were selected using the simple stratified random sampling method. The size of the selected sample was based upon the population size for each locality.

- In phase one, the study sample was selected using simple stratified random method and all study subjects were women's in the reproductive age.

- In phase two, study subjects were from the same areas as in phase one with the exception that the selected case were women's among those who benefited from health promotion education program.

2.4 Sample size

A total number of the study sample was 1347 (phase one - pre-intervintion 743; phase two - post-intervintion 604). The total number of cases from Gaza Strip was 226 (Pre 107, Post 119). The total number of cases from south WB 546 (Pre 291, Post 255). The total number of cases from north WB 575 (Pre 345, Post 230). Table 2.2 represent the study sample represented in both phases from the various regions of Palestine.

Table 2.2. Samples distribution according to place of residence - pre and post intervention.

No.	Location	No of Case in Pre Samples	No of Cases in Post Samples
1.	Bardala	20	0
2.	Ein Beida	20	0
3.	Tayasir	41	30
4.	Aqqaba	104	100
5.	Tomoun	160	100
6.	Sammou'	130	141
7.	Daherieh	161	114
8.	Abu Tea'ma	48	61
9.	Um Al-Naser	59	58
Total		743	604
Grand Total		1347	

2.5 Instrument of data collection and questionnaire design

Tool of the survey consisted of a questionnaire that included six sections. The study questionnaire was developed through a task-force that consisted of the senior reproductive health experts in the country and namely:

- 1- Dr. Suzan Abdo.
- 2- Dr. Khadijeh Jarrar.
- 3- Dr. Salwa Najjab.
- 4- Dr. Sana'a Shadid.
- 5- Dr. Ali Shaar.
- 6- Dr. Obaida Qamhieh.
- 7- Ms. Shatha Odeh.
- 8- Dr Naim Sabra.
- 9- Ms. Jumana Haj Ahmed.

Sections of the questionnaire

A. Background Information Section

Included demographic information on location and respondents.

B. Antenatal Care Section:

Included a set of questions related to the knowledge. To assess the knowledge of respondents about antenatal care, attitude scale and variables related to it, and the practice of respondent in this aspect.

C. Postnatal Care Section

Include also variables oriented at measuring the knowledge about the importance of postnatal care both for mothers and infants, attitudes towards postnatal care and the practices in this field.

D. Family Planning Section

Included questions related to the knowledge about definition and modern methods for family planning, attitudes about family planning among respondents and partners, and again the level of practicing the use of modern family planning methods and the reasons why not practicing.

E. Breast Feeding Section

Include the knowledge about the concept of exclusive breast feeding, the knowledge about the advantages of breast feeding for mother and infant. This section includes also the measurement of attitudes about breast feeding and cultural norms in this field. This section again includes the measurement of practicing of breast feeding as such and about the good practice of breast feeding in term of timing and length of episode.

F. Sexually Transmitted Disease Section

This section includes the measurement of knowledge, attitude and practices related to sexually transmitted diseases. This section aims at

exploring the gaps in the three elements and the cultural barriers concerning this sensitive issue.

2.6 Data collection

One to one interviews with respondents were utilized for collecting data and answering the questionnaire from door to door in Palestinian rural areas. Trained female volunteers collected the data. Women were interviewed at homes, where it is most comfortable and private atmosphere to tackle such sensitive subject. Data collectors used a translated form of the questionnaire into Arabic language.

2.7 Pilot study (Field pilot testing of the questionnaire)

A pilot study was conducted prior to the start of data collection. Pilot testing enabled recognition of shortages in the structure and design of the study tool. Based on the results of the pilot testing, modifications were made to accommodate the objectives of the study and communities under study.

2.8 Data analysis

Data were entered to the computer using the SPSS software program. Data analysis used percentages, frequencies and T-test using the same statistical package.

Chapter Three
Results and Discussion

Results and discussion in this chapter focuses on three major areas of concern in this study. These areas are postnatal care, family planning and sexually transmitted infections.

3.1 Demographic characteristics of study population

3.1.1 Distribution of study population according to study regions

Table 3.1 shows the distribution of study population according to regions targeted in the data collection and reflects the regions that were targeted by the programmatic interventions. The percentages of 14.4, 39.2, and 46.4% represent the distribution of study population for Gaza, Southern and Northern parts of West Bank in pre-intervention program respectively. Post-intervention program percentages of 19.7, 42.2, and 38.1% represent the distribution of study population for Gaza, Southern and Northern parts of West Bank, respectively. Representation of study sample was based on population size of each locality within the studied regions.

Table 3.1 Distribution of study population according to study region

Region	Pre intervention		Post intervention	
	No.	%	No.	%
Gaza	107	14.4	119	19.7
South WB	291	39.2	255	42.2
North WB	345	46.4	230	38.1
Total	743	100	604	100

3.1.2 Distribution of study population according to age

Both the intervention program and the current study targeted women in reproductive age. Study population ranged between 15-49 years of age, with a mean age of 29.9 years for those included in the pre-intervention measurements and 30.3 years for those in the post-intervention period. Form the mean values detected in the pre and post measurements, small differences in the means suggests for consistency in the populations of the

two periods and advocates for the quality of study design and data collection.

3.1.3 Distribution of study population according to age at marriage

Data presented in Table 3.2 shows age at marriage of study population, in both the pre-intervention and post-interventions periods. Marriage before the age of 18 was represented by 55.2 and 57.3% for pre and post phase, respectively. The mean age at marriage in both phases was 18.8 years. The findings of such mean age of 18.8 years at marriage strongly indicates early age of marriage in the ruler areas of the Palestinian community and supports the finding of 55% of those cases married before the age of 18. The average number of children per family of respondent in pre- intervention is 4.49 and for post-intervention are 4.38.

From methodological point of view, similarity in the mean value of age at marriage is another indication and quality control indicator for the study design and data collection process. According to the recommendations and standards of the World Health Organization as well as many other bodies, concerned with women health, it is clear that more than half of the Palestinian female population is at high risk for pregnancy related complications due to early marriages. This finding also indicates that the area is in need for urgent public health programming and policy interventions.

Table 3.2 Distribution of study population according to age at marriage

Age at Marriage	Pre intervention		Post intervention	
	No.	%	No.	%
less than 18	410	55.2	346	57.3
18-25	292	39.3	228	37.7
26-42	37	5.0	27	4.5
Excluded missing data	4	0.5	3	0.5
Total	743	100	604	100.0

3.1.4 Distribution of study population according to accomplished years of study

Table 3.3 represents the distribution of the study population in according to accomplished schooling years. The majority of study population falls in the third category (7-12 years) with some differences in the pre and post samples. The differences between the pre and post represent two different populations selected in the two occasions and separated by one year. The mean years of education for both groups were similar (7.83 for pre and 8.84 years for post). If we add the first and the second categories, one can see that around 93% of the study group were in their secondary school stage or less, reflecting a very low level of education. Such low level of education will affect the level of knowledge as well as level of awareness among the study group. Differences between pre and post phases in this respect are marginal.

Table 3.3 Distribution of study population according to accomplished school years

Educational level/years accomplished	Pre intervention		Post intervention	
	No.	%	No.	%
0-2	76	10.2	31	5.1
3-6	187	25.2	114	18.9
7-12 years	431	58.0	409	67.7
More than 12	35	4.7	34	5.6
Excluded -Missing Data	14	1.9	16	2.7
Total	743	100.0	604	100.0

3.2 Knowledge, attitudes and practices of study population in pre and post phases

3.2.1 Post natal care knowledge, attitudes, and practices among study population

3.2.1.1 Knowledge

Table 3.4 shows post natal care knowledge, attitudes, and practices, of the study population in pre and post phases. Knowledge about postnatal

care was defined as the knowledge about three danger signs on infant and mother, knowledge about the importance of postnatal follow-up and the knowledge about the appropriate time for bathing the newborn after birth.

With respect to improvement in knowledge about post natal care, the findings of this study clearly shows that no improvements were observed among the study population in the post intervention phase. It was also found that no significant difference between the two groups concerning the set of questions used to measure knowledge (danger signs and postnatal follow up). This is clear from the finding of significant differences in the two phases concerning baby bathing as differences were in favor of the pre intervention group ($P= 0.00$ at $\alpha = 0.05$), who reported bathing in the right time and not immediately after birth. A possible explanation of such differences in knowledge might be due to the fact that women believe in earlier bathing as a healthier condition for the newborn.

All together, it is clear that the health education intervention failed in achieving improvement of mother's knowledge concerning postnatal care and it is not clear whether health education program has addressed this issue at all. Exploration of regional differences in this relation might highlight or explain such observations and conclusions.

3.2.1.2 Attitudes

Positive attitudes with respect to the importance of post natal follow up and seeking postnatal care even if the mother is healthy among post intervention compared to pre intervention phase (see table 3.4). The differences were statistically significant ($P= 0.00$ at $\alpha = 0.05$ for both questions). Similar differences were observed for attitude towards seeking postnatal care if child is healthy among both study groups, however pre intervention seems to a negative attitude towards giving birth at hospitals

and the difference compared to the post intervention group were significant ($P= 0.00$ at $\alpha = 0.05$). The reason behind such finding is not clear and the most likely explanation could be errors related to data entry or collection. In general, attitudes is a very difficult area for research as people tend to be positive in perception and this to large extent does not get reflected into practices as will be shown later in the study.

3.2.1.3 Practices

Differences between pre and post phases with respect to practices were statistically significant and improvement in practices among post intervention phase was clear concerning delivers at hospitals and under medical care (82.6% pre, 83% post; $P= 0.001$ at $\alpha = 0.05$); home postnatal examination by health workers (32.4% pre, 56.6% post; $P= 0.00$ at $\alpha = 0.05$); mothers going for routine postnatal care (30% pre, 67.4% post; $P= 0.00$ at $\alpha = 0.05$); provide a routine check to the baby by health worker (82% pre, 96.7% post; $P= 0.00$ at $\alpha = 0.05$). Post natal care for infants within the first 3 days after delivery did not show any improvement among both study groups. The mean age of infant attending first postnatal examination with in 1-3 days after birth in pre-intervention was 16.39 and in post-intervention were 15.54, indicating a delay in post natal care for infants (see table 3.4).

Table 3.4 Post natal care knowledge, attitudes, and practices among study population in pre and post phases

	Variable	Pre		Post		P-value
		No.	%	No.	%	
Knowledge	With knowledge about three danger signs on infant	11	1.5	3	0.5	0.052
	With knowledge about three danger signs on mother	25	3.4	26	4.3	0.887
	Know about	133	17.9	89	14.7	0.025

	importance of postnatal follow-up					
	Know the appropriate time for baby bathing	351	47.3	187	31.0	0.000
Attitudes	Importance of postnatal follow up	612	82.3	584	96.7	0.000
	Importance of giving birth at hospital	705	94.9	186	30.8	0.000
	Importance of seeking postnatal care even of child is healthy	662	89.1	552	91.4	0.527
	Importance of seeking postnatal care even of mother is healthy	536	72.1	530	87.8	0.000
Practices	Place of last birth - Hospitals and under medical care	614	82.6	501	83.0	0.001
	Carry out home postnatal examination by health worker	241	32.4	342	56.6	0.000
	Practiced routine postnatal care	223	30	407	67.4	0.000
	Practice of infants post natal care within 1-3 days after delivery	37	5	62	10.3	0.468
	A routine check to the baby by health workers	609	82	584	96.7	0.000
Total		743	100.0	604	100.0	

3.2.2 Family planning knowledge, attitudes, and practices among study population

3.2.2.1 Knowledge

In general both study groups showed limited knowledge concerning family planning. Improvement in knowledge for all tested variables was observed with respect to family planning among post intervention study group. Concerning knowledge of definition of the concept of family planning less than 50% of both groups were able to define family planning. The rest believe that family planning is limiting number of children.

However, difference among those who were able to define FP in pre (39%) and post (48%) was statistically significant ($P= 0.00$ at $\alpha = 0.05$). Improvement among post intervention group was also observed with respect to knowledge about the four methods of FP and percentage was represented by 40.7% compared to 32.9% among pre intervention group. The differences was statistically significant between the two groups ($P= 0.002$ at $\alpha = 0.05$). Improvement in knowledge about benefits of FP for mother was also found among post intervention group (23.5%) compared to (15.4%) among the group of pre intervention phase. The differences between the two groups was also statistically significant in this respect ($P= 0.005$ at $\alpha = 0.05$). Improvement in knowledge about benefits of FP for children and breast feeding as a family planning method was also clear among post intervention group, however, differences between the two groups were of no significant value. Findings concerning knowledge about FP seem to suggest that the conducted intervention health program did not significantly improve knowledge, thus, indicating the urgent need for further educational intervention programs concerning reproductive health.

3.2.2.2 Attitude

Positive attitudes concerning the importance of planning the number of children, joint decision about FP and the used method and pregnancy spacing were observed among both studied groups (see table 3.5). However, a negative attitude was observed among the post intervention group (72.2%) compared to the pre intervention group (75.9%) concerning the use FP methods. Differences between the two studied groups were statistically significant in this respect ($P= 0.015$ at $\alpha = 0.05$). The finding of similar attitudes indicates that the implanted program was not effective in this respect. Reasons behind such difference might be due to economical,

political, desire to have children, lack of knowledge, social, cultural and religion.

3.2.2.3 Practices

The finding of 79.3% pregnant women among the pre intervention group and 78.1% pregnant women in post intervention group is a clear indication of limited use of family planning methods and also reflects the high fertility rate among both studied groups (see table 3.5).

With respect to the use of FP methods, similar percentages were reported to use FP methods (69.2% pre, 70.4 post). These findings indicate that around 30% of the studied population never used FP methods. The reason behind the lack of use of these methods might be due to lack of proper education, social believe, economical and for religion believes.

The finding of around 25% of husbands in both studied groups join wife's during visits to family planning services indicates that the role of family planning is restricted to women. Such finding indicates that the whole concept of FP in not clear among the Palestinian community as FP decision must be a shared one.

With respect to the availability of FP services, post intervention group reported more access (93%) compared to pre intervention group (64.1%). Differences between the two studied groups was statistically significant ($P= 0.00$ at $\alpha = 0.05$). A reason behind such difference is most likely to be due to the increased health services in most studied localities within the last few years.

Table 3.5 Family planning care knowledge, attitudes, and practices, for the total population in pre and post periods

	Variable	Pre No.	Pre %	Post No.	Post %	P-value
Knowledge	Know definition of FP	290	39	290	48	0.00
	Have knowledge about four methods of FP	245	32.9	246	40.7	0.002
	With knowledge about benefits of FP for mother	115	15.4	142	23.5	0.005
	With knowledge about benefit of FP for children	486	65.4	437	72.4	0.080
	With knowledge about breast feeding as FP method	396	53.3	354	58.6	0.062
Attitudes	Importance of planning the number of children in family	694	93.4	570	94.4	0.634
	Husband attitude towards importance of family planning	604	81.3	530	87.8	0.127
	Shared decision about use of family planning and the methods used	679	91.4	589	97.5	0.087
	Intention to have a baby in the coming two years	271	36.5	233	38.6	0.465
	Intention to use FP method	564	75.9	436	72.2	0.015
Practices	Pregnant now	589	79.3	472	78.1	0.332
	Ever used FP method	514	69.2	425	70.4	0.613
	Husband joins to FP services	194	26.1	127	21	0.001
	Easy access to FP services	476	64.1	562	93	0.00
Total		743	100	604	100	

3.2.3 Sexually transmitted infections (STIs) knowledge, attitudes, and practices among study population

3.2.3.1 Knowledge

Data presented in table 3.6 strongly indicate that both study population groups were with very limited knowledge concerning STIs. This is clear from the finding of over 90% who do not know the symptoms of STIs, over

85% can not name two STDs, more than 70% do not know about the prevention methods and more than 50% could not name three organs of female reproductive system. However, around 95% of the study population in both groups knew the importance to treat partners. It was also found the post intervention group showed significant improvement in knowledge about STIs. Such variations were of statistical significant values (see table 3.6). The most possible explanation is the fact such diseases are very rare in our community which is considered as a conservative and cultural values and religion believes limits the mode of transmission of such disease.

3.2.3.2 Attitudes

Highly positive attitudes were found among both study groups towards the various tested variables regarding STIs. The tested variables were feeling shame about the infection, feeling shame to discuss the situation with both partner and physician, having a negative attitude towards those who have the disease and the importance to seek treatment for both partners. Improvements in attitudes were found in post intervention compared to the pre intervention group. Differences in attitudes were statistically significant (see table 3.6). It is important to mention that such high positive attitude dose not reflect the observed poor knowledge about STIs.

3.2.3.3 Practices

Acceptable levels of practices were reported by both tested groups with respect to the tested variable. The variable included the periodical check of changes in reproductive system, consultations and discussion of changes with partner, seeking of medical care in case of any observed changes or disease symptoms and the use of preventive methods that limit

disease transmission. The findings also showed that the level of practices were very similar in both studied groups (see table 3.6).

Table 3.6 STIs knowledge, attitudes, and practices, for the total population in pre and post periods.

	Variable	Pre No.	Pre %	Post No.	Post %	P-value
Knowledge	Know about organs of RT	70	9.4	272	45	0.00
	With knowledge about symptoms of STIs	20	2.7	50	8.3	0.00
	With knowledge about two examples of STDs	64	8.6	92	15.2	0.00
	With knowledge about two prevention methods of STIs	45	6.1	170	28.2	0.00
	Importance to treat partner in case of STD	701	94.3	582	96.4	0.114
Attitudes	Don't feel shame if got STDs	556	74.8	512	84.8	0.00
	Don't feel shame to talk to husband about STDs	623	83.9	541	89.5	0.00
	Don't feel shame to talk to doctor about STDs	566	76.1	534	88.4	0.00
	Don't change opinion in someone having STDs	681	91.6	575	95.2	0.00
	Both husband and wife should talk about STDs and seek treatment	685	92.2	582	96.4	0.041
Practices	Practice the habit of watching changes in RT	636	85.6	536	88.8	0.017
	Consult with husbands about changes in RT	631	84.9	514	85.1	0.665
	Seek medical care in case of any changes appear	547	73.7	461	76.3	0.690
	Try to prevent STDs	626	84.2	544	90	0.00
Total		743	100	604	100	

3.3 Knowledge, attitudes and practices of study population in pre and post phases by region

3.3.1 Post natal care knowledge, attitudes, and practices by region

3.3.1.1 Knowledge

Data presented in Table 3.7 shows levels of knowledge among study population in pre and post phases concerning postnatal care for both mother and child. In general knowledge was very limited and reached zero percent levels for some of the tested variables in all studied regions. In Gaza region Knowledge concerning the three danger signs on infant and mother and on the importance of postnatal follow up was very limited and around 84% of the study population in both phases was unable to identify the danger signs and the importance of follow up. The only acceptable level in this region was found concerning the proper time of baby bathing after birth and level of knowledge was significantly higher among the pre intervention phase compared to the post intervention phase ($P= 0.005$ at $\alpha = 0.05$).

Study sample in the south region of the West Bank was also with limited knowledge concerning the tested variables and knowledge reached 31% in its best situation. No statistically significant differences were found between study populations in the two tested phases with the exception concerning baby bathing where the pre intervention group showed a statistically significant higher level of knowledge ($P= 0.00$ at $\alpha = 0.05$). The findings among the inhabitants of the northern region were similar to that observed in the southern region.

Findings about knowledge highlight the programmatic deficiency in this area, as it seems that no concentration on messages related to postnatal care being delivered to program beneficiaries. This is in clear contradiction

with what would have been expected form such intervention as postnatal care in Palestine is a priority area for health education. It is important to mention that this program was of low coverage rates that reached 19% at the national level.

Table 3.7 Post natal care knowledge by region

Region	Knowledge variables	Pre No	Pre %	Post No	Post %	P-value
Gaza	With knowledge about three danger signs on infant	1	0.9	1	0.8	0.945
	With knowledge about three danger signs on mother	0	0	1	0.8	0.342
	Know about importance of postnatal follow-up	12	11.2	19	16.0	0.30
	Know the appropriate time for baby bathing	69	70.4	61	51.3	0.005
South WB	With knowledge about three danger signs on infant	2	0.7	2	0.8	0.894
	With knowledge about three danger signs on mother	16	5.5	24	9.4	0.080
	Know about importance of postnatal follow-up	50	17.7	48	19.1	0.665
	Know the appropriate time for baby bathing	86	31.2	35	14.0	0.00
North WB	With knowledge about three danger signs on infant	8	2.3	0	0.00	0.020
	With knowledge about three danger signs on mother	9	2.6	1	0.4	0.052
	Know about importance of postnatal follow-up	71	20.8	22	9.6	0.00
	Know the appropriate time for baby bathing	196	58.3	91	39.6	0.00

3.3.1.2 Attitudes

Data presented in table 3.8 shows the attitudes of the study population in both phases with regard to the tested variable which include; importance of postnatal follow up, birth at hospital, seeking postnatal care even of child is healthy and seeking postnatal care even of mother is healthy. In Gaza region, positive attitudes with respect to all tested variables were

observed in both groups. Significantly different level of attitude was found with respect of the importance of post natal follow up ($P= 0.003$ at $\alpha = 0.05$) and seeking postnatal care even if mother is healthy ($P= 0.001$ at $\alpha = 0.05$). These differences were in favor of the post intervention phase. Similar findings were observed among the two groups with respect to the other tested variables.

The findings of the study also showed that both of the study groups in the southern and northern regions have high level of positive attitudes with respect to all tested variables, however, a statistically significant differences between the two study groups was found in relation to giving birth at hospital and this difference was in favor of the pre intervention phase (see table 3.8). Although, post intervention group showed a higher level of attitudes, the finding regarding giving birth in hospital, again raises the question of efficiency of the conducted health educational program.

Table 3.8 Post natal care attitudes by region

Region	Attitudes Variables	Pre No.	Pre %	Post No.	Post %	P-value
Gaza	Importance of postnatal follow up	94	88.7	114	95.8	0.003
	Importance of giving birth at hospital	96	90.6	105	88.3	0.176
	Importance of seeking postnatal care even of child is healthy	83	78.3	92	77.3	.053
	Importance of seeking postnatal care even of mother is healthy	64	60.4	85	71.4	.001
South WB	Importance of postnatal follow up	251	86.3	242	95.3	0.00
	Importance of giving birth at hospital	277	95.2	37	14.7	0.00
	Importance of seeking postnatal care even of child is healthy	264	90.7	235	93.3	0.191

	Importance of seeking postnatal care even of mother is healthy	232	79.8	230	90.9	0.001
North WB	Importance of postnatal follow up	266	77.3	225	97.9	0.00
	Importance of giving birth at hospital	332	96.2	44	19.1	0.00
	Importance of seeking postnatal care even of child is healthy	315	91.3	225	97.8	.001
	Importance of seeking postnatal care even of mother is healthy	240	69.6	215	93.9	0.00

3.3.1.3 Practices

Study population in post intervention showed improvement in practices related to postnatal care in all regions (see table 3.9). Variations between pre and post phases were statistically significant in almost all studied variable (place of birth, home postnatal examination, routine postnatal care for mother and infant and age of infant at first postnatal examination). Such variations among the two studied groups in the different regions might be also due to the increasingly improved health services with the whole region in general. On the other hand, improvements are linked to the postnatal services made available as part of the intervention program (designated facilities and staff for follow up of pregnant women and their infants after birth).

Place of delivery changed dramatically from the pre to the post intervention periods. In Gaza, hospital delivery increased from 61.6% to 86.1%. In the north and south, however hospital delivery decreased from 90% to 84.8% and from 89% to 83.1%, respectively. This finding is strongly linked to deteriorated political situation during the period of post-intervention study and extremely difficult access to delivery facilities

during this period. At the national level, decreased access to delivery facilities was a general observation with home deliveries reaching 30 to 40 percent of deliveries in remote rural areas.

Table 3.9 Post natal care practices by region

Region	practices Variables	Pre No.	Pre %	Post No.	Post %	P-value
Gaza	Place of last birth - Hospitals and under medical care	66	61.6	99	86.1	0.00
	Carry out home postnatal examination by health worker	36	33.6	51	42.9	0.155
	Practiced routine postnatal care	39	36.4	76	63.9	0.000
	Practice of infants post natal care within 1-3 days after delivery	6	5.9	5	4.4	0.149
	A routine check to the baby by health workers	101	94.4	118	99.2	0.039
South WB	Place of last birth - Hospitals and under medical care	251	89.0	207	83.1	0.155
	Carry out home postnatal examination by health worker	132	46.2	137	55.0	0.041
	Practiced routine postnatal care	81	28.6	162	64.8	0.000
	Practice of infants post natal care within 1-3 days after delivery	18	10.1	36	16.5	0.002
	A routine check to the baby by health workers	209	73.3	244	98.0	0.000
North WB	Place of last birth - Hospitals and under medical care	297	90.0	195	84.8	0.172
	Carry out home postnatal examination by health worker	73	22.1	154	67.5	0.000
	Practiced routine postnatal care	103	31.2	169	73.5	0.000
	Practice of infants post natal care within 1-3 days after delivery	13	6.7	21	10.2	0.437
	A routine check to the baby by health workers	299	90.6	222	96.5	0.007

3.3.2 Family planning knowledge attitudes and practices by region

3.3.2.1 Knowledge

Table 3.10 clearly shows that the level of knowledge in Gaza region among both study phases was below 52% for all tested variables (definition, methods, benefits and breast feeding as family planning

method). It was also clear that there was a clear decline in knowledge in the post intervention group compared to the pre intervention phase. Differences between the two groups were of statistical significance with respect to knowledge about the definition ($P= 0.04$ at $\alpha = 0.05$) of the concept of family planning as well as the used methods ($P= 0.031$ at $\alpha = 0.05$).

Study group in both phases in the northern and southern regions of the West Bank were with higher levels of knowledge concerning family planning compared to Gaza region and levels reached up 83% for some of the tested variables. The finding of the current study also showed that study subjects in the post intervention phase were with higher levels of knowledge in all studied variables and differences between the two groups were statistically significant for certain variables (see table 3.10).

It is important to mention that the gap in knowledge between Gaza region and the West Bank regions might be due to differences on available educational services between the two areas. In general one could also attribute differences to programmatic and gender related reasons as it was observed that the benefit of the intervention program was centered on the child with a remarkable neglect to the mother as an objective and center of concern in the provision and promotion of such services and practices. The absence of the mother-centered programming is an important area for social and value change efforts in the Palestinian community.

Region	Knowledge Variables	Pre No.	Pre %	Post No.	Post %	P-value
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Gaza	Definition of FP	55	51.4	45	37.8	0.04
	Have knowledge about four methods of FP	42	39.3	31	25.8	0.031
	With knowledge about benefits of FP for mother	11	10.4	23	19.5	0.058
	With knowledge about benefit of FP for children	51	47.7	43	35.8	0.071
	With knowledge about breast feeding as FP method	55	51.9	57	47.5	0.510
South WB	Definition of FP	146	50.5	163	64.2	0.004
	Have knowledge about four methods of FP	106	37.1	135	53.4	0.00
	With knowledge about benefits of FP for mother	42	14.6	73	29.1	0.00
	With knowledge about benefit of FP for children	233	80.3	210	82.7	0.485
	With knowledge about breast feeding as FP method	155	53.3	130	51.8	0.732
North WB	Definition of FP	89	25.9%	82	35.7	0.013
	Have knowledge about four methods of FP	97	28.2%	80	34.8	0.094
	With knowledge about benefits of FP for mother	61	17.7%	46	20.3	0.539
	With knowledge about benefit of FP for children	202	58.7	184	80.3	0.00
	With knowledge about breast feeding as FP method	186	53.9	167	72.6	0.00

Table 3.10 Family planning knowledge by region

3.3.2.2 Attitudes

Table 3.11 shows a noticeable positive attitude towards the tested variable used to measure attitudes among study population in both phases of the study in all studied regions. Improved attitudes among study population of the post intervention phase was found and difference in attitudes were with significant statistical value for certain tested variables (see table 3.11). Study population in all regions showed a negative attitude with respect to the variable concerning the wish to have children within the next two years, this might be due to miss understanding of the tested variable as a tool to measure attitude.

The mean value for the ideal number of children in families was around 3 in all studied regions and was similar for both phases, this, indicating a high positive attitude towards family planning.

Table 3.11 Family planning attitudes by region

Region	Attitudes Variables	Pre No.	Pre %	Post No.	Post %	P-value
Gaza	Importance of planning the number of children in family	94	91.2	114	96.6	0.130
	Husband attitude towards importance of family planning	81	76.4	97	80.9	0.404
	Shared decision about use of family planning and the methods used	90	84.2	114	96.7	.021
	Intention to have a baby in the coming two years	40	37.4	52	43.7	0.015
	Intention to use FP method	69	64.5	78	65.0	0.976
South WB	Importance of planning the number of children in family	276	97.2	228	97.4	0.267
	Husband attitude towards importance of family planning	230	79.3	213	84.2	0.093
	Shared decision about use of family planning and the methods used	262	91.6	246	98.4	0.00
	Intention to have a baby in the coming two years	115	40.1	96	37.8	0.00

	Intention to use FP method	209	73.3	169	66.5	0.00
North WB	Importance of planning the number of children in family	324	94.7	228	99.1	.055
	Husband attitude towards importance of family planning	293	86.4	220	96.0	0.001
	Shared decision about use of family planning and the methods used	327	96.1	229	100.0	0.017
	Intention to have a baby in the coming two years	116	33.8	85	37.1	0.098
	Intention to use FP method	286	83.1	189	82.2	0.801

3.3.2.3 Practices

Table 3.12 represent family planning practices among study population in all studied regions for both pre and post intervention. The findings indicate a remarkable improvement on access to services among the study group in the post intervention phase in all studied areas. This improvement is most likely a result of the programmatic intervention as access was one of the major objectives of this program. Another factor that might contribute to this improvement might be due to the availability of health care centers in almost every village and town, as a result of limited access to cities generated during the Intifada.

Improvement in the use of family planning methods was noticed especially in the northern region of the West Bank among post intervention group and the differences were of significant value compared to pre intervention phase ($P= 0.004$ at $\alpha = 0.05$). Use of these methods was found least in Gaza region and was reported by 54.7% in the pre, and 55% in the post intervention phases. This is reflected in the increased number of now pregnant women and lower percentage of women using family planning methods. Practices concerning the interest of husbands to join wife during here visits to family planning centers was the lowest among the different tested variable in all regions. It is most likely that men believe that this role is women role related to fertility and pregnancy.

Even with seemingly a lower mean number of children fewer than five detected in the post-intervention study (see table 3.13), this probably can not reflect a changing pattern of fertility or indicate an impact of the program on this pattern as this indicator in another long-term indicator that could not be judged based on short-term interventions.

Table 3.12 Family planning practices by region

Region	Practices Variables	Pre No.	Pre %	Post No.	Post %	P-value
Gaza	Pregnant now	22	20.6	32	26.7	0.281
	Ever used FP method	58	54.7	66	55.0	0.966
	Husband joins to FP services	14	15.7	10	8.6	0.117
	Easy access to FP services	70	70.0	119	99.2	0.00
South WB	Pregnant now	48	17.0	65	25.6	0.014
	Ever used FP method	210	72.9	169	66.5	0.106
	Husband joins to FP services	65	24.2	55	23.4	0.842
	Easy access to FP services	171	60.6	215	85.0	0.00
North WB	Pregnant now	73	21.3	34	14.8	0.051
	Ever used FP method	246	72.1	190	82.6	0.004
	Husband joins to FP services	115	35.4	62	27.4	0.049
	Easy access to FP services	235	68.7	228	99.1	0.00

Table 3.13 Mean number of children under five

Region	Pre	Post
Gaza	1.76	1.67
South WB	1.65	1.58
North WB	1.44	1.19

3.3.3 Sexually transmitted infections knowledge, attitudes and practices by region

3.3.3.1 Knowledge

Data presented in table 3.14 strongly indicate that both study population groups were with very limited knowledge concerning STIs in Gaza region. This is clear from the findings on the different tested

variables. For example, only 3.7% (pre phase) knew the symptoms of STIs and the best knowledge was concerning importance to treat partner 53.2% (post phase).

In the West Bank region, limited knowledge was observed with respect to three of the tested variables (symptoms, examples, and prevention methods of STI infections). However, good knowledge was found with respect to reproductive tract and partner treatment in case of STIs. Improvement in knowledge among the post intervention phase was also found in almost all tested variable compared to the pre intervention phase.

Low level of knowledge was found among the study population in both phases in the northern region in almost all studied variable. However an improvement in knowledge was clear among the post intervention phase.

Table 3.14 Sexually transmitted infections knowledge by region

Region	Knowledge Variables	Pre No.	Pre %	Post No.	Post %	P-value
Gaza	Know about organs of RT	16	15.0	31	26.1	0.040
	With knowledge about symptoms of STIs	4	3.7	7	5.9	0.455
	With knowledge about two examples of STDs	16	15.0	11	9.2	0.179
	With knowledge about two prevention methods of STIs	5	4.7	17	14.3	0.150
	Importance to treat partner in case of STD	36	12.5	134	53.2	0.597
South WB	Know about organs of RT	95	89.6	110	91.7	0.000
	With knowledge about symptoms of STIs	9	3.1	5	2.0	0.390
	With knowledge about two examples of STDs	33	11.5	51	20.2	0.006
	With knowledge about two prevention methods of STIs	26	9.0	104	41.4	0.000
	Importance to treat partner in case of STD	277	95.8	248	99.6	0.005
North	Know about organs of RT	18	5.2	107	47.1	0.000

WB	With knowledge about symptoms of STIs	7	2.0	38	16.6	0.000
	With knowledge about two examples of STDs	15	4.4	30	13.8	0.000
	With knowledge about two prevention methods of STIs	14	4.1	49	21.7	0.000
	Importance to treat partner in case of STD	329	95.9	224	97.8	0.215

3.3.3.2 Attitudes

Highly positive attitudes were found among both study groups towards the various tested variables regarding STIs in all regions. The tested variables were feeling shame about the infection, feeling shame to discuss the situation with both partner and physician, having a negative attitude towards those who have the disease and the importance to seek treatment for both partners. Such high positive attitude levels dose not reflect the poor knowledge observed among study population in all regions (see table 3.14).

Table 3.15 Sexually transmitted infections attitudes by region

Region	Attitudes Variables	Pre No.	Pre %	Post No.	Post %	P-value
Gaza	Most people could have STD	90	84.1	75	62.5	0.000
	I can have STD	97	90.6	89	74.2	0.010
	Don't feel shame if got STDs	78	74.3	78	65.5	0.001
	Don't feel shame to talk to husband about STDs	94	87.8	96	80.6	0.106
	Don't feel shame to talk to doctor about STDs	87	82.0	94	79.0	0.007
	Don't change opinion in someone having STDs	101	94.4	106	88.3	0.077
	Both husband and wife should talk about STDs and seek treatment	94	87.9	111	92.5	0.177
South WB	Most people could have STD	198	68.5	188	74.0	0.240
	I can have STD	246	85.1	168	66.1	0.000
	Don't feel shame if got STDs	221	76.5	224	88.2	0.001
	Don't feel shame to talk to husband about STDs	253	88.8	233	91.7	0.483

	Don't feel shame to talk to doctor about STDs	225	78.9	223	88.1	0.002
	Don't change opinion in someone having STDs	207	91.1	272	94.5	0.246
	Both husband and wife should talk about STDs and seek treatment	262	90.6	244	96.8	0.000
North WB	Most people could have STD	295	86.0	219	95.3	0.000
	I can have STD	306	89.5	225	98.3	0.000
	Don't feel shame if got STDs	257	75.0	210	91.3	0.000
	Don't feel shame to talk to husband about STDs	276	81.2	212	92.6	0.000
	Don't feel shame to talk to doctor about STDs	254	75.4	217	94.4	0.000
	Don't change opinion in someone having STDs	308	89.8	227	99.1	0.000
	Both husband and wife should talk about STDs and seek treatment	329	96.8	227	99.6	0.000

3.3.3.3 Practices

Acceptable levels of practices were reported by both tested groups with respect to all tested variable in the different regions. The variables included the periodical check of changes in reproductive system, consultations and discussion of changes with partner, seeking of medical care in case of any observed changes or disease symptoms and the use of preventive methods that limit disease transmission. The findings also showed that the level of practices were very similar in both studied groups, however, improvements in practices was more pronounced in the northern region of the West Bank among post intervention phase (see table 3.16).

Table 3.16 STIs practices by region

Region	Practices Variables	Pre No.	Pre %	Post No.	Post %	P-value
Gaza	Practice the habit of watching changes in RT	102	95.3	107	89.2	0.052
	Consult with husbands about changes in RT	101	95.3	103	85.8	0.056
	Seek medical care in case of	98	96	104	88.1	0.024

	any changes appear					
	Try to prevent STDs	92	87.6	108	90.8	0.238
South WB	Practice the habit of watching changes in RT	235	81.3	202	79.8	0.001
	Consult with husbands about changes in RT	229	79.5	186	73.8	0.00
	Seek medical care in case of any changes appear	183	65.9	145	57.7	0.00
	Try to prevent STDs	236	82.8	214	84.9	0.001
North WB	Practice the habit of watching changes in RT	299	87.1	227	99.1	0.00
	Consult with husbands about changes in RT	301	87.7	225	97.8	0.00
	Seek medical care in case of any changes appear	266	79.2	212	96.8	0.00
	Try to prevent STDs	298	88.7	222	98.2	0.00

3.4. Conclusion and Recommendations

3.4.1 Conclusions

The current study describes an appropriate public health approach to behavior changes, supporting the programmatic KAP surveys conducted in the region, with the hope to draw valid conclusions about the impact and quality of such intervention. Although, behavior change needs long time of interventions, the current study showed a noticeable change and improvement in knowledge and practices in certain aspects of the targeted behavior of the intervention programs.

The improved behavioral pattern was heavily dependant on the availability of services within target communities. While this might lead to the belief that services alone could bring the behavior change, the behavior change that was documented in the study is quite remarkable and would not be achieved solely through clinical practice and facility-based services.

The overall figures describing the total study population masked a regional variation that was clear across the board. Regional variations

observed in this study support the assumption that impact of health education program was deeper in the northern West Bank locations. This observation was supported by the qualitative data and propping with the northern part of the program being closely monitored and technically supported more than other regions for access problems arising during the time of the project.

Access to healthcare was a critical issue noticed throughout the study with place of delivery being a major indication of difficult access to hospitals. Actually lower number of those delivered in the hospitals most probably due to difficult access to delivery facilities.

Knowledge about family planning has improved significantly, but this was not associated with proportional improvement of practices in this area. This is a culturally sensitive issue in Palestine and it is not expected that a short-term educational intervention would dramatically change neither knowledge nor attitudes and practices in this field.

Fertility indicators have shown some changes between the pre and post-intervention phases. This change was not however statistically significant and does not indicate a real change in the fertility patterns in the studied population, again as such an indicator does not change as a result of short-term interventions and rather needs a more holistic approach dealing with policies, culture and socio-economic conditions.

The knowledge and practices of post-natal services and practices was improved during the study period. This however was significantly associated with the understanding that postnatal care is a function to support the survival and well-being of the newborn. Knowledge about the benefit of post-natal care for mother did not improve and the absence of mothers in the picture of postnatal care is a serious health and ethical issue that needs further elaboration and studies.

3.4.2 Recommendations

The current study recommends the followings:

- It is worth to suggest similar approaches for behavior-change communication programs (BCC) and the connecting BCC programs to available services is expected to enhance impact and supports achieving deeper change on people's behaviors.
- The quality of impact was significantly associated with the intensity of management follow up and supervision as in the case of the northern of the West Bank. Supporting behavior change communication programs with appropriate technical and management support is highly recommended to enhance this impact.
- Success of family planning programs is highly dependent on the social and cultural context. This has to be taken into consideration in future planning and in designing FP services in the area.
- More focus on the mother should be practices in designing antenatal, postnatal and family planning programs. The current study and maybe other studies have linked these services with the benefit of the child rather than bringing a maternal benefit. A gender issue for further exploration.
- Attitudes were moving in a quite unique direction, and some time different from that of knowledge and practices. It is worth reconsideration of attitudes a relevant mediator between knowledge and practices in the concept of behavior change.

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Appendices

Questionnaire Form

Save the Children Federation
 Union of Palestinian Medical Relief Committees
 KAP Survey on Reproductive Health
 September 2000

مشروع تطوير الخدمات المجتمعية بحث المعرفة, السلوك والمواقف حول الصحة الإيجابية وصحة الطفل

المقدمة:

الأخت المواطنة:

يهدف هذا البحث إلى الإطلاع على مجالات التطوير والتحسين المتعلقة بالصحة والتي سوف تنعكس ايجابياً على صحتك وصحة عائلتك. بناء على المعلومات المستخلصة من هذه الدراسة، سوف تقوم مؤسسة إنقاذ الطفل بالتعاون مع اتحاد لجان الإغاثة الطبية الفلسطينية ووزارة الصحة الفلسطينية بإدخال تطويرات وتحسينات على نوع، توزيع وجودة الخدمات المقدمة في منطقتكم وخاصة تلك المتعلقة بصحة الأم والطفل.

الإجابات التي سوف تحصل منك سوف تساعد في تحسس الاحتياجات، وهذه الإجابات سوف تعامل بشكل يضمن سرية وخصوصية هذه الإجابات وسوف تستخدم من اجل عملية التطوير المذكورة فقط.

A
Background Information
 معلومات مرجعية عامة

AL معلومات عامة عن الموقع			
(ALL) الموقع - اسم القرية:	ALR المنطقة		
(ALH) رقم المنزل (حسب الاختيار العشوائي) (ALQ) رقم الاستمارة (حسب التسلسل)	(3) شمال الضفة الغربية	(2) جنوب الضفة الغربية	(1) غزة

AR
معلومات عن مجيب الاستمارة

أود الآن معرفة بعض المعلومات العامة عنك

كيفية التسجيل	المعلومة
عدد السنوات.....	(AR1) السن
عدد السنوات.....	(AR2) السن عند الزواج
عدد الأطفال الأحياء: ذكر..... أنثى.....	(AR3) عدد الأطفال
عدد سنوات الدراسة.....	(AR4) التعليم
لا نعم	(AR5) العمل خارج البيت (العمل وتقاضي راتب)
.....	(AR6) نوع العمل خارج البيت إن وجد
سجل من يقوم بذلك	(AR7) من يعتني ببيتك وأطفالك أثناء وجودك خارج البيت للعمل؟
.....	(AR8) اسم الابن/ة الأخير
الاسم والسن بالسنوات والأشهر	(AR9) وسنه/1

B Prenatal care الرعاية أثناء الحمل

(BK) المعرفة: أسئلة عامة عن الرعاية أثناء الحمل, يرجى الإجابة عليها بقدر معرفتك

BK1	ما هي علامات الخطر أثناء الحمل؟	- تسجل الإجابة كما هي وتقارن بالإجابة النموذجية
BK2	ما هي فائدة صور جهاز الصونار (التلفزيون) حسب رأيك؟	- تسجل الإجابة كما هي وتقارن بالإجابة النموذجية
BK3	ما هي الطعومات التي تعطى للمرأة الحامل؟	- تسجل الإجابة كما هي وتقارن بالإجابة النموذجية
BK4	ما هي الأعراض الجانبية لحبوب الحديد؟	- تسجل الإجابة كما هي وتقارن بالإجابة النموذجية
	مجموع علامات المعرفة	

(BA) المواقف: اختر من 1-5 حسب اعتقادك, بحيث

1- غير مهم على الإطلاق	2- غير مهم	3- لا اعرف
4- مهم	5- مهم جدا	
هل تعتقد انه من المهم		
BA1	مراجعة الرعاية الصحية أثناء الحمل الطبيعي	1 2 3 4 5
BA2	مراجعة الرعاية الصحية أثناء الأشهر الثلاثة الأولى	1 2 3 4 5
BA3	تناول الحبوب المزودة بالحديد	1 2 3 4 5
BA4	تلقي طعومات ولقاحات وقائية	1 2 3 4 5
BA5	تفحص ومتابعة علامات الخطر	1 2 3 4 5

(BP) الممارسات: بالنسبة للحمل الأخير أو الحالي

BP1	هل قمت بمراجعة مقدم للرعاية الصحية لمتابعة الحمل؟	تسجل إجابة: نعم أو لا
BP2	عمر الجنين عند أول زيارة للرعاية من اجل الحمل	تسجل الفترة الزمنية المذكورة:
BP3	كم مرة قمت بزيارة الرعاية الصحية أثناء الحمل الحالي, أو الأخير؟	تسجل عدد المرات: -----
BP4	هل تلقيت خلال الحمل لقاح ضد الكزاز؟	تسجل نعم أو لا
BP5	هل تناولت حبوب مزودة بالحديد أثناء الحمل؟	تسجل نعم أو لا
BP6	عدد فحوصات التلفزيون التي قمت بها أثناء الحمل؟	تسجل عدد المرات المذكورة: ---- --

C

Postnatal care

الرعاية بعد الولادة

(CK) المعرفة: أسئلة عامة عن الرعاية بعد الولادة, يرجى الإجابة عليها بقدر معرفتك

CK1	ما هي الأعراض التي تدل على وجود مرض لدى الطفل الرضيع خلال فترة النفاس؟	- تسجل الإجابة كما هي وتقارن بالإجابة النموذجية
CK2	ما هي الأعراض التي يمكن أن تدل على وجود مرض لدى الأم بعد الولادة خلال فترة النفاس؟	- تسجل الإجابة كما هي وتقارن بالإجابة النموذجية
CK3	لماذا من المهم المتابعة الصحية أثناء فترة النفاس؟	- تسجل الإجابة كما هي
CK4	متى يجب أن تقوم الأم بحمام رضيعها بعد الولادة؟	- تسجل الإجابة كما هي

مجموع علامات المعرفة		

(CA) المواقف: اختر من 1-5 حسب اعتقادك, بحيث

1- غير مهم على الإطلاق	2- غير مهم	3- لا اعرف
4- مهم	5- مهم جدا	
هل تعتقد ان انه من المهم		
CA1	يقوم العاملین الصحيين بفحصك بعد الولادة	1 2 3 4 5
CA2	الولادة في المستشفى	1 2 3 4 5
CA3	الذهاب للرعاية الصحية بعد الولادة حتى إذا كان الطفل سليم	1 2 3 4 5
CA4	الذهاب للرعاية الصحية حتى إذا كانت صحة الأم جيدة	1 2 3 4 5

(CP) الممارسات: بالنسبة للحمل الأخير أو الحالي

CP1	أين كان مكان ولادتك الأخيرة؟	1- المستشفى 2- بيت الولادة 3- البيت 4- مكان آخر (حدد)-----
CP2	هل قام/ت عامل/ة صحية, القابلة, أو الممرضة بفحصك بعد رجوعك إلى البيت/ لاحظ الهدف من الزيارة هو الفحص الروتيني؟	تسجل نعم أو لا
CP3	هل ذهبت بنفسك إلى الفحص الروتيني بعد الولادة/ لاحظ الهدف من الزيارة هو الفحص الروتيني؟	تسجل نعم أو لا
CP4	بعد كم يوم من الولادة ذهبت إلى المركز الصحي أو المستشفى للفحص والمراجعة الروتينية؟	تسجل عدد الأيام, الأسابيع بعد الولادة-----
CP5	هل قام/ت العاملة الصحية بفحص الطفل روتينيا	تسجل نعم أو لا

D Family Planning تنظيم الأسرة

(DK) المعرفة: أسئلة عامة عن تنظيم الأسرة, يرجى الإجابة عليها بقدر معرفتك

DK1	ماذا يعني لك تنظيم الأسرة؟	- تسجل الإجابة كما هي وتقرن بالإجابة النموذجية
DK2	ما هي الوسائل التي تعرفين أنها تستعمل لتنظيم الأسرة؟	- تسجل الإجابة كما هي وتقرن بالإجابة النموذجية
DK3	ما هي الفوائد التي تجنيها الأم من تنظيم الأسرة؟	- تسجل الإجابة كما هي وتقرن بالإجابة النموذجية
DK4	ما هي الفوائد التي يجنيها الطفل من تنظيم الأسرة؟	- تسجل الإجابة كما هي وتقرن بالإجابة النموذجية
DK5	هل تعتبر الرضاعة الطبيعية وسيلة لتنظيم الأسرة؟	- تسجل الإجابة كما هي وتقرن بالإجابة النموذجية

(DA) المواقف: اختر من 1-5 حسب اعتقاداتك, بحيث

	1- غير مهم على الإطلاق	2- غير مهم	3- لا اعرف
	4- مهم	5- مهم جدا	
هل تعتقد انه من المهم			
DA1	تنظيم عدد الأطفال في العائلة	1 2 3 4 5	
DA2	العدد المثالي للأطفال في العائلة	1- أكثر من ستة 2- ستة 3- خمسة 4- أربعة 5- اقل من أربعة	
DA3	زوجي يعتقد أن استخدام وسائل تنظيم الأسرة	1 2 3 4 5	
DA4	القرار حول استخدام تنظيم الأسرة والوسيلة المستخدمة يجب أن يكون مشتركاً بين الزوج والزوجة	1 2 3 4 5	
DA5	هل تتوین إنجاب طفل آخر خلال السنتين القادمتين؟	1- نعم بكل تأكيد 2- نعم على الأغلب 3- لا اعرف 4- لا على الأغلب 5- لا بالتأكيد	
DA6	هل تتوین عمل شيء أو استخدام وسيلة لتأجيل الحمل أو تجنب الحمل؟	1- لا بالتأكيد 2- لا على الأغلب 3- لا اعرف 4- نعم على الأغلب 5- نعم بالتأكيد	
DA7	إذا كان الجواب بالنفي, لماذا؟	- تسجل الإجابة كما هي	

(DP) الممارسات

DP1	كم من أطفالك تحت سن الخامسة؟	تسجل عدد الأطفال-----
DP2	هل أنت حامل الآن؟	تسجل إجابة نعم أو لا
DP3	هل استخدمت أبدا وسيلة لتنظيم الأسرة؟	تسجل إجابة نعم أو لا
DP4	إذا كانت الإجابة نعم, ماذا استخدمت؟	- تسجل الإجابة كما هي
DP5	إذا كانت الإجابة نعم, كم كان عدد أطفالك عندما استخدمت وسيلة منع الحمل للمرة الأولى؟	تسجل عدد الأطفال
DP6	هل يصحبك زوجك إلى خدمات تنظيم الأسرة؟	تسجل إجابة نعم أو لا
DP7	هل يوجد في محيطك خدمات تنظيم أسرة سهلة الوصول؟	تسجل إجابة نعم أو لا
DP8	إذا كانت الإجابة نعم, أين وما هي المؤسسة؟	- تسجل الإجابة كما هي

E Breast Feeding الرضاعة الطبيعية

(EK) المعرفة:

ما هي الرضاعة الطبيعية الخالصة؟	EK1	- تسجل الإجابة كما هي وتقارن بالإجابة النموذجية
ما هي الفوائد التي تجنيها الأم من الرضاعة الطبيعية؟	EK2	- تسجل الإجابة كما هي وتقارن بالإجابة النموذجية
ما هي الفوائد التي يجنيها الطفل من الرضاعة الطبيعية؟	EK3	- تسجل الإجابة كما هي وتقارن بالإجابة النموذجية
ما هي المشاكل التي يمكن أن نواجهها خلال الرضاعة الصناعية من الزجاجة؟	EK4	- تسجل الإجابة كما هي
على أي عمر يمكن حسب رأيك إضافة مشروبات مساندة للطفل؟	EK5	- تسجل الإجابة كما هي
على أي عمر يمكن إضافة أطعمة مساندة للطفل؟	EK6	- تسجل الإجابة كما هي
مجموع علامات المعرفة		

(EA) المواقف:

اختر الإجابة من 1-5 حسب ما تراه الأقرب		
الرضاعة الطبيعية ممكنة في جميع الحالات تقريبا	EA1	1. لا أوافق قطعا 2. لا أوافق على الأغلب 3. لا اعرف 4. أوافق 5. أوافق كليا
الرضاعة الطبيعية الخالصة بدون أي إضافات كافية للطفل في الأشهر الستة الأولى	EA2	1. لا أوافق قطعا 2. لا أوافق على الأغلب 3. لا اعرف 4. أوافق 5. أوافق كليا
الأطعمة الإضافية غير ضرورية خلال الستة اشهر الأولى	EA3	1. لا أوافق قطعا 2. لا أوافق على الأغلب 3. لا اعرف 4. أوافق 5. أوافق كليا
الرضاعة الطبيعية يجب أن تبدأ مباشرة بعد الولادة	EA4	1. لا أوافق قطعا 2. لا أوافق على الأغلب 3. لا اعرف 4. أوافق 5. أوافق كليا
من الضروري إضافة أغذية وسوائل إلى الطفل باكرا بعد الولادة	EA5	1. أوافق كليا 2. أوافق على الأغلب 3. لا اعرف 4. لا أوافق على الأغلب 5. لا أوافق على الإطلاق

(EP) الممارسات:

لا	هل قمت بإرضاع طفلك أو أطفالك؟	EP1
تسجل إجابة نعم أو لا	ما هي المدة التي ترضعين طفلك عادة؟	EP2
- تسجل الفترة المذكورة بالسنين والأشهر	كم من الوقت تستمر عملية الإرضاع الواحدة؟	EP3
- تسجل الإجابة كما هي	لماذا توقفت عن إرضاع طفلك الأخير؟	EP4
- تسجل الإجابة كما هي	متى وضعت الطفل على صدرك للإرضاع بعد الولادة؟	EP5
- تسجل الفترة مع التحديد	كم كان عمر ابنك عندما بدأت باعطاءه طعام؟	EP6
- تسجل عمر الطفل بالأشهر		

F

Sexually- Transmitted Infections

الأمراض المنقولة عن طريق الاتصال الجنسي

(FK) المعرفة:

FK1	ما هي الأعضاء التي يتكون منها الجهاز التناسلي عند المرأة؟	- تسجل الإجابة كما هي وتقرن بالإجابة النموذجية
FK2	ما هي الأعراض التي تكون مصاحبة لالتهابات القنوات الإنجابية؟	- تسجل الإجابة كما هي وتقرن بالإجابة النموذجية
FK3	أعط أمثلة على أمراض تكون منقولة عن طريق الاتصال الجنسي؟	- تسجل الإجابة كما هي وتقرن بالإجابة النموذجية
FK4	كيف يمكن الوقاية من هذه الالتهابات؟	- تسجل الإجابة كما هي وتقرن بالإجابة النموذجية
FK5	هل من الضروري معالجة الزوج/ الزوجة عند اكتشاف التهاب في المجرى الإنجابي لدى أحدهما؟	نعم لا

(FA) المواقف:

FA1	معظم الناس ممكن أن يصابوا بالتهابات الجهاز الإنجابي	1. لا أوافق نهائيا 2. لا أوافق على الأغلب 3. لا اعرف 4. أوافق 5. أوافق كليا
FA2	أنا اعتقد انه يمكن أن أصاب بالتهاب الجهاز الإنجابي	1. لا أوافق نهائيا 2. لا أوافق على الأغلب 3. لا اعرف 4. أوافق 5. أوافق كليا
FA3	إذا أصبت بهذه الالتهابات, سوف اشعر بالخجل الشديد	1. أوافق كليا 2. أوافق على الأغلب 3. لا اعرف 4. لا أوافق على الأغلب 5. لا أوافق مطلقا
FA4	اشعر بالخجل التحدث إلى زوجي عن هذا النوع من الالتهابات	1. أوافق كليا 2. أوافق على الأغلب 3. لا اعرف 4. لا أوافق على الأغلب 5. لا أوافق مطلقا

1. أوافق كلياً 2. أوافق على الأغلب 3. لا اعرف 4. لا أوافق على الأغلب 5. لا أوافق مطلقاً	اشعر بالخجل التحدث إلى الطبيب حول هذه الالتهابات	FA5
1. أوافق كلياً 2. أوافق على الأغلب 3. لا اعرف 4. لا أوافق على الأغلب 5. لا أوافق مطلقاً	إذا عرفت أن شخصاً لديه هذه الالتهابات, سوف أغير نظرتي له	FA6
1. لا أوافق نهائياً 2. لا أوافق على الأغلب 3. لا اعرف 4. أوافق 5. أوافق كلياً	اعتقد أن كلا الزوجين يجب أن يتحدثا حول التهابات الجهاز الإنجابي ويقصدون المعالجة	FA7

FP) الممارسات

1. لا نهائياً 2. نادراً 3. بعض الأحيان 4. غالباً ما أقوم بذلك 5. دائماً	أراقب نفسي واتابع أي تغييرات	FP1
1. لا نهائياً 2. نادراً 3. بعض الأحيان 4. غالباً ما أقوم بذلك 5. دائماً	أقوم باستشارة زوجي حول التغييرات التي ألاحظها	FP2
1. لا نهائياً 2. نادراً 3. بعض الأحيان 4. غالباً ما أقوم بذلك 5. دائماً	أقصى الرعاية الصحية عند ملاحظتي التغييرات حالاً	FP3

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1. لا نهائيا 2. نادرا 3. بعض الأحيان 4. غالبا ما أقوم بذلك 5. دائما	أحاول الوقاية من الإصابة بالتهاب الجهاز الإنجابي	FP4
تسجل الإجابة كما هي	إذا كانت الإجابة نعم, كيف	FP5
1. لا نهائيا 2. نادرا 3. بعض الأحيان 4. غالبا 5. دائما	عند حدوث المعاشرة الزوجية, يستعمل زوجي الواقي	FP6
1. لا نهائيا 2. نادرا 3. بعض الأحيان 4. غالبا 5. دائما	إذا أصبت بالتهاب الجهاز الإنجابي, سأطلب من زوجي العلاج أيضا	FP7

References of the Questionnaire

- 1- KPC 2000, Knowledge, Practices and Coverage Survey.
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جامعة النجاح الوطنية
كلية الدراسات العليا

مدى تأثير برنامج التثقيف والتعزيز الصحي على المعرفة والاتجاهات
والممارسات المتعلقة بالصحة الإيجابية لدى النساء
في سن الإيجاب في الريف الفلسطيني

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قدمت هذه الأطروحة استكمالاً لمتطلبات درجة الماجستير في الصحة العامة بكلية الدراسات
العليا في جامعة النجاح الوطنية في نابلس، فلسطين.

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ب

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الملخص

هدفت الدراسة الحالية إلى قياس مدى تأثير التدخل بواسطة برامج التثقيف وتعزيز الصحي على مستوى المعرفة والاتجاهات والممارسات عند النساء المتزوجات في سن الإجاب حول مواضيع الصحة الإيجابية في قرى شمال وجنوب الضفة الغربية وقطاع غزة. لتحقيق هذا الهدف تم إعداد استبانة صممت لهذا الغرض وأجريت الدراسة في الفترة الزمنية 2001 - 2002 على مرحلتين الأولى كانت قبل التعرض إلى البرنامج التثقيفي والمتعلق بالصحة الإيجابية، والثانية بعد التدخل من خلال برامج تثقيفية خاصة حول الموضوع. تم جمع المعلومات من خلال المقابلة الشخصية للنساء في المجموعة قيد الدراسة. شملت الدراسة 1347 امرأة في المرحلتين الأولى والثانية، حيث بلغ عدد النساء في المرحلة الأولى 743، وفي المرحلة الثانية 604، في المرحلة الأولى بلغ عدد النساء 107 (14.4%) من قطاع غزة، أما من منطقة جنوب وشمال الضفة الغربية بلغت 291 (39.2%) و 345 (46.4%) على التوالي. تم اختيار العينات بطريقة عشوائية منتظمة ومن ثم تم تحليل النتائج إحصائياً بواسطة البرنامج الإحصائي SPSS.

تشير نتائج الدراسة إلى تقارب نتائج متوسط عمر السيدات في المرحلتين حيث بلغ في المرحلة الأولى 29.9 وفي المرحلة الثانية 30.3، كما تبين أن ما نسبته 55.2% من النساء المتزوجات كن دون سن 18 عاماً في المرحلة الأولى وما نسبته 57.3% في المرحلة الثانية وهذا يشير إلى ارتفاع نسبة الزواج المبكر في المناطق الريفية الفلسطينية، حيث أن متوسط أعمار السيدات عند الزواج للمرحلتين بلغت 18.8% وهو مستوى متدني يعزز النسب المرتفعة للزواج المبكر دون سن 18. كما وتشير النتائج إلى تدني مستوى التعليم عند النساء في المناطق الريفية الفلسطينية فقد بلغ متوسط عدد سنين الدراسة في المرحلة الأولى 7.83 وفي

المرحلة الثانية 8.84، وان 93% من السيدات في المرحلتين لم يتجاوزن المرحلة الثانوية من التعليم.

تشير النتائج إلى تدني مستوى المعرفة عند النساء بالنسبة للرعاية الصحية بعد الولادة حيث ان التدخل ببرنامج التثقيف الصحي لم يحقق تغييرات ملموسة في مستوى المعرفة في هذا المجال، وان النتائج المتعلقة بالاتجاهات كانت ايجابية ومرتفعة في معظم الأحيان، وكما أن الممارسات قد شهدت بعض التحسن في المرحلة الثانية كما لوحظ تدني في الممارسات المتعلقة بموعد إجراء الفحص الروتيني للطفل بعد الولادة.

بالنسبة لنتائج المعرفة المتعلقة بتنظيم الأسرة هناك تحسن في مستوى المعرفة في المرحلة الثانية مع ملاحظة تدني نسبة المعرفة بمفهوم تنظيم الأسرة الى ما دون 50% في المرحلتين.

أما بالنسبة للاتجاهات المتعلقة باستخدام وسائل تنظيم الأسرة فقد تدنت من 75.9% في المرحلة الأولى إلى 72.2% في المرحلة الثانية. كما تبين نتائج الممارسات المتعلقة بتنظيم الأسرة ان نسبة السيدات الحوامل في المرحلة الأولى 79.3% وللمرحلة الثانية 78.1% وهي نسبة مرتفعة تشير الى محدودية استخدام وسائل تنظيم الأسرة والى ارتفاع معدل الخصوبة. كما تشير النتائج توفر خدمات تنظيم الأسرة حيث لوحظ ارتفاع كبير في سهولة الوصول للخدمات (64.1% في المرحلة الأولى و 93% في المرحلة الثانية).

على الرغم من وجود تحسن في مستويات المعرفة لعينات المرحلة الثانية بخصوص الامراض المنقولة جنسيا الا انها لا تزال متدنية نسبيا، حيث ان حوالي 90% من السيدات لم يتمكن من معرفه الأعراض المتعلقة بها، وان ما نسبته 85% لم يستطيعن ذكر مثالين عليها، وان حوالي 70% لم يتمكن من معرفة طرق الوقاية، كما ان 50% لم يستطيعن معرفة ثلاث أعضاء للجهاز التناسلي عند المرأة. أما بالنسبة للممارسات فقد أشارت النتائج الى وجود مستوى ممارسات صحية مقبولة في المرحلتين.

أشارت النتائج إلى محدودية المعرفة حول موضوع الرعاية الصحية بعد الولادة في كافة مناطق الدراسة مع عدم وجود فروقات تتعلق بتغيير الموقع الجغرافي، أما بالنسبة للاتجاهات فقد أشارت النتائج إلى وجود نسبة عالية من الاتجاهات الايجابية لمختلف متغيرات الدراسة وفي مختلف المناطق قيد الدراسة، حيث كانت جميعها ايجابية بالنسبة لمنطقة قطاع غزة اما بالنسبة الى شمال وجنوب الضفة الغربية فقد لوحظ ان الاتجاهات المتعلقة بالولادة في المستشفى وتحت

إشراف طبي قد تدنت, اما بالنسبة للممارسات فقد أشارت النتائج إلى وجود تحسن في الممارسات في جميع مناطق الدراسة ولجميع المتغيرات ما عدا الولادة في المستشفى و تحت إشراف طبي فقد كانت النتائج المتعلقة بمنطقة قطاع غزة ايجابية بلغت 61.6% في المرحلة الأولى و 86.1% في المرحلة الثانية, وان الممارسات لكل من منطقة جنوب وشمال الضفة الغربية قد شهدت تراجع في الولادة تحت إشراف طبي فقد بلغت في جنوب الضفة الغربية 89% في المرحلة الأولى وتراجعت الى 83.1% في المرحلة الثانية, اما في شمال الضفة الغربية فقد بلغت 90% في المرحلة الأولى وتراجعت الى 84.8% في المرحلة الثانية.

أما فيما يتعلق بمستوى المعرفة بخصوص موضوع تنظيم الأسرة لوحظ تدني مستوى المعرفة في منطقة قطاع غزة بالمقارنة مع مناطق شمال وجنوب الضفة الغربية, حيث ان مستوى المعرفة لجميع المتغيرات في منطقة قطاع غزة لم يتجاوز 52%, كما أشارت النتائج الخاصة بمنطقة غزة إلى التراجع في مستوى المعرفة المتعلقة بتنظيم الأسرة في المرحلة الثانية بالمقارنة مع المرحلة الأولى. اما بالنسبة للاتجاهات المتعلقة بتنظيم الأسرة فقد كانت ايجابية في جميع المناطق, تشير نتائج الدراسة أيضا إلى وجود تحسن في الممارسات المتعلقة بتنظيم الأسرة, حيث وجد أن نسبة استخدام وسائل تنظيم الأسرة كانت الأعلى في منطقه شمال الضفة الغربية واقلها في قطاع غزة, وهذا ما يؤكد متوسط عدد الأطفال في العائلة دون سن خمس سنوات حيث كان لمنطقة الشمال اقل متوسط بالمقارنة مع المناطق الأخرى, أما بالنسبة لمشاركة الأزواج لزوجاتهم عند زيارة مراكز الرعاية الصحية وتنظيم الأسرة فقد شهدت مستوى متدني في كافة المناطق.

أشارت نتائج مستوى المعرفة في موضوع الأمراض المنقولة جنسيا إلى تدني مستوى المعرفة بالنسبة لمنطقة قطاع غزة حيث ان أدنى نسبة في مستوى المعرفة كانت 3.7% في المرحلة الأولى والتي تتعلق بالأعراض المصاحبة للأمراض المنقولة جنسيا وان أعلى نسبة بلغت 53.2% في المرحلة الثانية والتي تتعلق بأهمية معالجة الشريك في حالة الإصابة بهذه الأمراض. أما في منطقة جنوب الضفة الغربية فقد تشير نتائج المعرفة الى وجود تحسن في مستويات المعرفة للمرحلة الثانية وبالأخص فيما يتعلق بمعالجة الشريك المصاب, ومكونات الجهاز التناسلي عند المرأة, مع وجود تدني في مستويات المعرفة للمتغيرات الأخرى. أما بالنسبة للاتجاهات المتعلقة بالأمراض المنقولة جنسيا فقد اشارت النتائج الى وجود اتجاهات ايجابية في كافة مناطق الدراسة, والى وجود مستوى جيد من الممارسات الايجابية المتعلقة بهذا

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الموضوع حيث شهدت منطقة شمال الضفة الغربية اعلى مستوى بالمقارنة مع المناطق الاخرى مع وجود تحسن ملحوظ لدى عينة المرحلة الثانية من الدراسة. إن الاتجاهات الايجابية والمتعلقة بكافة متغيرات الدراسة لم تنعكس بصورة ايجابية على كل من السلوكيات والمعرفة المتعلقة بالصحة الإنجابية بشكل عام.

على الرغم من وجود مؤشرات ايجابية كنتيجة لبرنامج التثقيف الصحي في المناطق الريفية إلا أن النتائج تشير وبشكل عام إلى ضرورة القيام بالدراسات الأولية حول احتياجات المجتمع وذلك بهدف تحديد الاولويات الخاصة بكافة البرامج التطويرية والتثقيفية لرسم سياسات واضحة تتعلق بالصحة الإنجابية في المجتمع الفلسطيني.