الجهاز المركزي للإحصاء الفلسطيني

صحة الأم والطفل في فلسطين
دراسة وطنية نوعية

تموز/ يوليو، 2000

تنويه

الأفكار الواردة في هذا التقرير تعبر عن آراء المؤلفين، ولا تعبر بالضرورة عن موقف الجهاز المركـــزي للإحصـــاء الفلسطيني، أو آراء السلطة الوطنية الفلسطينية بشكل عام.

جميع المراسلات توجه إلى قسم خدمات الجمهور على العنوان التالي:
الجهاز المركزي للإحصاء الفلسطيني
ص.ب. 1647
رام الله – فلسطين

هاتف: 2406340 (2-972) فاكس: 2406343 (2-972)
بريد إلكتروني: diwan@pcbs.pna.org صفحة إلكترونية:http://www.pcbs.org

أنجز هذا التقرير لصالح الوكالة الأمريكية للتنمية العالمية (USAID) وعبر تعاون فني مع مؤسسة ماكرو انترناشيونال

التقرير الملخص
صحة الأم والطفل في فلسطين
دراسة وطنية نوعية

د. إدوارد ك. جرين
ماكرو انترنشينال
كالفيرتون، مريلاند، الولايات المتحدة الأمريكية

خالد أبو خالد
و
محمد العمري
الجهاز المركزي للإحصاء الفلسطيني
رام الله، فلسطين

تقديم

تعتبر هذه الدراسة جهدا أوليا يمكن لها أن تمهد الطريق لمزيد من البحث، وقد اعتمدت على فئات أساسية مستهدفة ومجموعات نقاش وبحث مركزة. وقد جاءت نتائج الدراسة مطابقة إلى حد ما لنتائج المسح الصحي الذي نفذه الجهاز في العام 1996 في الأراضي الفلسطينية.

يأمل الجهاز المركزي للإحصاء الفلسطيني أن تكون هذه الدراسة محط استثمار من الباحثين والدارسين والمهتمين لإجراء تحليل معمق في المواضيع ذات العلاقة بصحة الأم والطفل، كما يأمل الجهاز في أن تسهم نتائج هذه الدراسة في تطوير القطاع الصحي في الأراضي الفلسطينية من خلال تطوير البرامج الصحية وتطوير جودة الخدمات الصحية.

والله نسأل أن يتكلل عملنا بالنجاح

تموز، 2000

د. حسن أبو لبده

رئيس الجهاز

قائمـــة المحتويـــات

المقدمة

طلبت وكالة الولايات المتحدة للتنمية الدولية إجراء دراسة وطنية، عملية ونوعية لصحة المرأة والطفل في الأراضي الفلسطينية، وذلك كجزء من مبادرتها التجريبية في مجال صحة المرأة والطفل. وكاستجابة لهذا الطلب، تم إجراء دراسة تتألف من العديد من طرق البحث الكمية، ومقابلات أولية عميقة مع فئات أساسية مستهدفة، ومجموعات نقاش وبحث مركزة، حيث تم إجراء الدراسة بشكل متقطع خلال الفترة الممتدة من شباط إلى كانون الأول 1999. وقد تم إجراء مقابلات مع 358 مواطنا فلسطينيا، وشارك قسم منهم في مجموعات نقاش وبحث مركزة وغير رسمية (غالبيتهم من النساء) موزعين على مختلف مناطق الضفة الغربية وقطاع غزة.

نفذ الجهاز المركزي للإحصاء الفلسطيني هذه الدراسة بموجب اتفاقيتين مع كل من منظمة كير الدولية (المرحلة الأولى)، ومؤسسة ماكرو انترناشينال (المرحلة الثانية).

محددات الدراسة

تتعلق إحدى محددات هذه الدراسة بكمية ومجال المعلومات المطلوبة، حيث تم جمع معلومات حول: المواقف، والمعرفة، والقيم، والسلوك المتعلق بالزواج والإنجاب، والمباعدة بين المواليد وتنظيم الأسرة، والحمل، والولادة وتغذية الرضع، والرعاية الصحية في البيت والمرافق الصحية، وبعض المجالات الأخرى كدور مقدمي خدمات الولادة التقليدية والمعالجين التقليديين.

وبسبب اعتبارات عملية (ليس بوسع المرء أن يجري مقابلة مع الأفراد لفترة تزيد عن ساعة ونصف الساعة، إضافة إلى أن مجموعات النقاش والبحث المركزة لا يمكنها أن تعالج سوى عدد محدود من المواضيع)، لم نتمكن من استكشاف أي من هذه المواضيع المحددة بالدرجة التي كنا نرغب بها.

يتوجب النظر إلى هذه الدراسة باعتبارها جهداً أولياً – وهذا هو بالطبع ما تم التفكير به– يمكن لها أن تمهد الطريق لمزيد من البحث، الذي لا يزال يعتبر ضرورياً بلا شك.

النتائج الرئيسة

لقد تم تحقيق عدد كبير من المكاسب والإنجازات الصحية في مجال صحة الأم والطفل خلال السنوات الأخيرة. وتجدر الإشارة إلى أن بعض المجالات الصحية (على سبيل المثال: نسبة النساء اللاتي يواظبن على تلقي رعاية صحية في مرحلة ما قبل الولادة، مستوى خدمات صحة الأم والطفل، والوضع الصحي الكلي في المناطق الريفية، ونسبة حالات الولادة التي تتم في مرافق صحية و/أو تلك التي يشرف عيها طاقم مدرب)، لم تكن بالمستوى السيئ الذي تم افتراضه قبل إجراء هذه الدراسة كما كان عليه الحال قبل 4 – 5 سنوات، أي قبل حدوث هذه التحسينات. هذه النتائج، مدعمة بنتائج مسوحات بالعينة أجريت مؤخراً على الصحة الفلسطينية، تعني أنه يمكن للجهات العاملة في القطاع الصحي أن تركز مصادرها بشكل أكثر نجاعة على المجالات والمجموعات السكانية التي تعاني من أية مشاكل. وتتضمن هذه المجالات:

* الزواج المبكر نسبياً.

* معدلات الخصوبة المرتفعة.

* الأحمال المتعاقبة.

* فترات متباعدة قصيرة نسبياً بين المواليد.

* اعتماد كبير على واحدة أو اثنتين من وسائل منع الحمل.

* الاستخدام الأول لوسائل منع الحمل لا يتم بوقت مبكر بشكل متساو بين النساء.

* الأمهات لا يرضعن رضاعة طبيعية مطلقة لفترة كافية.

* نسبة ضئيلة من الأمهات اللاتي يؤخرن الرضاعة لمدة 3 – 5 أيام أو لا يرضعن.

* العديد من الأمهات لا يتلقين رعاية صحية في مرحلة ما بعد الولادة، ولا حتى يدركن الحاجة إليها.

* تزاول الأمهات الأعمال والواجبات البيتية خلال فترة قصيرة بعد الولادة.

* الزواج بين الأقارب آخذ في التناقص، ولكن لا تزال هناك نسبة ليست بالقليلة، الأمر الذي يؤدي إلى مشاكل صحية وخلقية.

* تتسبب بعض الأمهات في حدوث الأمراض التي تنقل بالماء، جراء قيامهن بإعطاء الرضع محلول سكر وماء غير مغلي.
* فقدان الجنين (إسقاط الحمل، ولادة الطفل ميتا).

وإحدى المجالات الشائكة التي لم يتم بحثها بشكل خاص (ولكنها تعتبر هامة للتخطيط والتنفيذ) المشاكل التي تواجه عملية تنسيق جهود العديد من مقدمي الخدمة الصحية في القطاع الصحي، وهي: السلطة الوطنية الفلسطينية (وزارة الصحة بشكل خاص)، ووكالة الأمم المتحدة لإغاثة وتشغيل اللاجئين الفلسطينيين في الشرق الأدنى (UNRWA)، والمنظمات غير الحكومية النشطة التي تتكون من المنظمات غير الحكومية المحلية والدولية (راجع جقمان وآخرون 1995).

قبل الخوض في المجالات الشائكة بمزيد من التفصيل، يبدو أنه من المهم أن نتناول هذه المجالات من منظور أوسع، وذلك من خلال ذكر العوامل التي يبدو أنها قد ساهمت في وجود وضع صحي محسن في مجال صحة الأم والطفل. ومن الجدير بالذكر أن النقاط التالية مستمدة من دراستنا جنباً إلى جنب مع المراجعة الشاملة للدراسات التي أجريت في الفترة الأخيرة في فلسطين.

العوامل التي تساهم في تحسين الوضع الصحي

1. هنالك مشكلة ضئيلة فيما يتعلق بالوصول إلى الرعاية الصحية، حيث يعيش السكان الفلسطينيون على مقربة (أقل من 5 كم) من المركز الصحي، ويبدو أن لديهم اعتمادا واحتراما كبيرين للأطباء ولنظام الرعاية الصحية.

2. الرعاية الصحية متوفرة، مجانية أو بتكلفة ضئيلة، ويتم الحصول عليها من وزارة الصحة، والمنظمات الدولية مثل وكالة الأمم المتحدة لإغاثة وتشغيل اللاجئين الفلسطينيين في الشرق الأدنى، ومنظمة الأمم المتحدة للأطفال، ومختلف المنظمات غير الحكومية المدعومة من الوكالات المانحة الخارجية، والمنظمات غير الحكومية المحلية، وعلى رأسها اتحاد لجان الإغاثة الطبية الفلسطينية.

3. لا يوجد فعلياً قابلات (دايات) غير مدربات، بينما هناك دور ضئيل للمعالجين التقليديين في نظام الرعاية الصحية الروتيني أو في نظام الرعاية الصحية ككل.

4. غالبية النساء تقريباً يضعن مواليدهن في مرافق صحية، ويتم تسجيل معظم المواليد، كما أن غالبية الأطفال يتلقون المتابعة اللازمة للتحصين، حيث يتم ذلك على مستوى التجمع إذا كان ذلك ضرورياً.

5. يحصل ما لا يقل عن 93% من النساء على رعاية صحية في مرحلة ما قبل الولادة. وتخضع غالبية النساء لفحص فقر الدم في هذا الوقت، ويتم إعطاؤهن مقويات الحديد للتغلب على فقر الدم، إذا ثبت وجوده لديهن. وهكذا نجد أن قسما ضئيلا من النساء المصابات بفقر الدم الناتج عن الحمل لا يتلقين علاجاً. (لكن معدلات الأنيميا لا تزال مرتفعة لدى النساء، على نحو يفوق الحد المتوقع في ظل ما نعرفه عن العلاج والتغذية. وقد ذكر تناول الشاي بكثرة على أنه عامل مساهم في هذا الوضع).

6. يوجد في معظم القرى عامل صحي واحد، ومن الجدير بالذكر أن كلاً من الصحة الإنجابية وصحة الولادة تعتبر من المجالات التي تلقى تركيزاً من العاملين الصحيين في القرى.

لقد فشل برنامج "العاملين الصحيين في القرى" في بلدان عديدة بسبب نقص الرواتب أو التعويضات الأخرى، وعدم ملاءمة التدريب والإشراف، والفوضى والارتباك بشأن المهام العلاجية والوقائية، ونقص وسائل المواصلات، وضعف عمليات الاختيار، وغير ذلك من المشاكل الشائعة. أما على المستوى الفلسطيني فيتم اختيار "العاملين الصحيين الفلسطينيين في القرى" على المستوى المحلي؛ ويتم تدريبهم لسنتين كاملتين، يليها تطبيق لما تعلموه تحت إشراف جهات مناسبة، كما يبدو أنهم مجهزون بشكل مناسب ويخضعون لإشراف جيد، ويقسمون وقتهم بين الخدمات العلاجية والوقائية. وفي الحقيقة، تعطي فلسطين مثالاً غير اعتيادي على البرنامج الوطني لـ"العاملين الصحيين في القرى"؛ الذي يبدو أنه يعمل بشكل جيد، حتى وإن كان ممولاً بشكل كبير من منظمات دولية ورغم أنه يعتبر بالتالي غير مستديم، ويبدو أن الأثر الذي تركه هذا البرنامج تمثل في تعزيز الوضع الصحي في القرى لدرجة أنه أصبح يفوق الوضع الصحي في المناطق الحضرية، على الأقل من ناحية بعض المتغيرات التي تتعلق بصحة الأم والطفل.

7. يبدو أن هناك تغطية كاملة تقريباً للتحصين هذه الأيام؛ وذلك من خلال المتابعة المنتظمة للنساء اللاتي أنجبن، حيث تشير إحصاءات شمول التحصين لوزارة الصحة للعام 1997 (وزارة الصحة 70:1998) إلى مستوى تغطية بنسبة تتراوح بين 95 % - 96%.

8. توصلت دراسة فلسطينية حديثة (بريسولي وآخرون 1998 "Bresoli et al 1998") إلى دلائل قليلة جداً لإثبات وجود سوء تغذية لدى الأمهات والرضع، وأشارت إلى وفرة كبيرة في الخدمات الصحية. ومن الجدير بالذكر أن النتائج التي توصلت إليها الدراسة تدعم هذه النتائج.

9. لا يبدو أن هناك شيئاً يمكن تسميته حقاً بالنظام الصحي المحلي، من حيث نظام المعتقدات والمعارف الصحية المختلف بشكل أساسي عن النظام الغربي/الحديث للطب العضوي والمنافس له. ونسبياً، يعتبر الفلسطينيون الآن مثقفين جيداً، وبشكل خاص في المجال الصحي.

10. تسعى إحدى المنظمات غير الحكومية الفلسطينية العاملة في المجال الصحي (اتحاد لجان الإغاثة الطبية الفلسطينية) والمسئولة عن تدريب العاملين الصحيين في القرى إلى "تمكين وتفويض النساء الفلسطينيات"، وهو الهدف الذي تؤيده أو تتعاطف معه وزارة الصحة الفلسطينية.

تشير بعض التقارير إلى وجود وضع صحي مختلف، ويعود ذلك إلى أن المعلومات المستخدمة قديمة وغير محدثة، وعلى سبيل المثال يشير تقرير منظمة الأمم المتحدة للأطفال (اليونيسف) للعام 1996، والذي يستند إلى معلومات من مجموعات نساء غير مسماة، إلى أن الخدمات الصحية المقدمة للنساء قد تبدو جيدة، إلا أنها باهظة الكلفة أو لا يمكن الوصول إليها أو أنها غير موجودة. وهذا الاستنتاج يتعارض مع الدراسة الحالية جنباً إلى جنب مع المسح الصحي الذي أجراه الجهاز المركزي للإحصاء الفلسطيني عام 1996.

المجالات الشائكة بالتفصيل

من الجدير بالذكر أن هناك تعاوناً وتوافقاً بين الدراسة النوعية ومسوحات العينة الأخيرة، وبشكل خاص المسح الصحي الذي نفذه الجهاز المركزي للإحصاء الفلسطيني في العام 1996.

أما المجالات الشائكة فتتمثل فيما يلي:

1. زواج مبكر نسبياً

بلغ العمر الوسيط عند الزواج الأول لدى الإناث 18 سنة في عام 1996، وفقاً لبيانات الجهاز المركزي للإحصاء الفلسطيني. وقد أشار عدد من المسوحات بعد ذلك إلى أنه من الممكن أن يكون العمر الوسيط قد ارتفع إلى 19 سنة، وسواء كان العمر الوسيط يبلغ 18 سنة أو أكثر من ذلك بقليل، إلا أن هناك حقيقة لا تزال قائمة ومفادها أن 50% من حالات الزواج لا تزال تتم دون العمر الوسيط المذكور، بحيث ينخفض بعضها حتى سن 12 أو 13 سنة (وهذه حالات نادرة جداً).

تشير النتائج التي خلصت إليها الدراسة إلى أن الزواج المبكر مرتبط بالفقر بشكل أساسي، وبعدم التعليم بدرجة ثانية. وقد أوضحت غالبية المبحوثات المشاركات في المجموعات المركزة التي شملتها الدراسة أن تفكير الناس بالزواج تحت سن أقل من 17 أو 18 قد أصبح ضرباً من الماضي، على النحو الذي يقوم به الفقراء، أو الناس الأقل تعليماً أو الناس عديمي الخبرة أو سكان الريف.

غالباً ما نجد أن الأبوين الفقيرين يرغبان بتزويج بناتهم (وبشكل خاص إلى رجال أغنياء) لأسباب عديدة، أول هذه الأسباب وأكثرها أهمية أن الدعم والمسئولية الاقتصادية تلقى على عاتق الزوج، وأن بعض الأعباء الاقتصادية تخفف عن الأب أو من يكسب لقمة العيش في عائلة الفتاة.

تدرك الفتيات صغيرات السن والنساء الفلسطينيات مساوئ الزواج المبكر، كأن تفقد الفتاة فرصة إكمال تعليمها أو أن تضطر لإنجاب الأطفال قبل أن تكون قد نضجت من ناحية عاطفية ونفسية. وفيما يتعلق بالنوع الأول من المساوئ، علقت إحدى النساء المشاركات في المجموعات المركزة، بينما أعربت بقية المشاركات عن موافقتهن على ما تقول، بقولها:

"إذا كانت النقود متوفرة، يفضل تأخير زواج الفتاة حتى تنهي تعليمها؛ لأن التعليم كالسلاح الذي يعطي المرأة القوة."

وقد تراوحت الإجابات بين 15 و 25 سنة، على النحو المبين بالمثال التالي:

"أفضل سن للزواج هو 25 سنة. ففي هذا السن، تكون الفتاة ناضجة ومدركة لجميع الأمور من حولها ... وفي هذا السن، تكون الفتاة قد أكملت تعليمها وحصلت على فرصة لتعيش حياة ما قبل الزواج. كما أن الجهاز التناسلي لديها يكون قد تطور بما فيه الكفاية للحمل والإنجاب. وفي هذا السن، يمكن لها أن تتعامل مع زوجها وعائلته وجميع من حولها بطريقة أفضل " (ربة بيت، 30 سنة، مخيم الأمعري للاجئين).

"أفضل سن للزواج هو 15 سنة. ففي هذا السن، تكون الفتاة ناضجة ومدركة لجميع الأمور من حولها ... الفتاة التي تتجاوز سن 20 سنة لن تتزوج" (فتاة من اليامون، 16 سنة، حاصلة على شهادة التعليم الابتدائي).

علقت بعض النساء بقولهن: إن مواقف الرجال من سن الزواج هي التي يجب أن تتغير، وليس مواقف النساء.

2. معدلات خصوبة مرتفعة

3. حالات حمل متكررة

4. فترات قصيرة نسبياً للمباعدة بين المواليد

انخفضت معدلات الخصوبة في الضفة الغربية خلال السنوات الأخيرة (انخفض معدل الخصوبة الكلية إلى حوالي 5.6)، بينما تغيرت هذه المعدلات بشكل طفيف في قطاع غزة (معدل الخصوبة الكلية يصل إلى حوالي 7). هنالك العديد من العوامل التي تدعم إنجاب المزيد من الأطفال، وحتى أن هناك بعداً سياسياً لاستمرار ارتفاع معدلات الخصوبة في بعض المناطق. وقد أبدى عدد من الذين أجريت معهم مقابلات في هذه المناطق ملاحظات مثل:

"نحن بحاجة إلى العديد من الأطفال لكي نعوض الشهداء"

"نحن بحاجة إلى تعويض أبنائنا الذين جرحوا وقتلوا على يد الإسرائيليين أثناء الانتفاضة"

"نحن بحاجة إلى العديد من الأطفال لاستعادة القدس"

لا يختلف العدد المثالي المرغوب فيه من الأطفال كثيراً (والذي يتراوح بين 4 إلى 6 أطفال وفقاً للدراسة الحالية وبين 5 إلى 6 أطفال وفقاً للدراسة التي أجراها الجهاز المركزي للإحصاء الفلسطيني عام 1996) عن معدل الخصوبة الحقيقي. وقد أعطى عدد كبير من المبحوثين إجابات مثل أنهم يرغبون في إنجاب "8 أطفال على الأقل" و "بين 10 إلى 12 طفلاً" (وقد أشار عدد ضئيل من المبحوثين إلى أنهم قد أنجبوا فعلاً هذا العدد أو عددا اكبر من الأطفال). لذلك، فإن التغير في القيم والمواقف يبدو شرطاً ضرورياً لإحداث انخفاض كبير في معدلات الخصوبة. كما ويمكن القول أن هنالك ضرورة لحل سياسي مرض للفلسطينيين جنباً إلى جنب مع تنمية اقتصادية كبيرة قبل انخفاض معدلات الخصوبة بشكل كبير في غزة وغيرها من المناطق ذات الخصوبة العالية.

وبشكل محدود، علق العديد من المبحوثين بقولهم إن الإسلام يشجع تعليم المرأة، وبالتالي أوضح جميع الناس الذين تمت مقابلتهم أن التعليم الإضافي يعتبر سبباً وجيهاً لزواج النساء في سن غير مبكر، إن لم يكن للتأخير أو المباعدة بين المواليد.

فيما يتعلق بالمباعدة بين المواليد، يبدو أن هناك اعترافاً أوسع للفوائد الصحية وغير الصحية للمباعدة بين المواليد مدة 2 أو 3 سنوات أو أكثر. ويدعم القرآن فترة مباعدة مدتها سنتين، حتى أن إمام يبلغ 90 سنة من العمر علق بقوله "الله يقول سنتين" للمباعدة بين المواليد. كما أن نسبة مرتفعة من النساء وبعض الرجال قالوا بأنه يتعين على الأم أن تستريح لفترة أطول، 2 – 3 سنوات، بين حالات الحمل. ومن المفهوم أن مثل هذه المباعدة تسمح للمرأة أن تعنى بشكل أفضل

بمولودها الأخير، بما في ذلك فترة كافية للرضاعة. ومن الأسباب الأخرى المذكورة للمباعدة بين المواليد مدة 2 إلى 3 سنوات، أن من شأن ذلك تمكين الأب من جمع المال الذي يمكنه من تلبية التكاليف المترتبة على إنجاب طفل آخر؛ وأن هذه الفترة توفر راحة نفسية للمرأة؛ وتحافظ على جمال المرأة؛ وتجدد "حيوية العائلة"؛ وتوفر الوقت اللازم للمرأة للعناية بزوجها ("الزوج بحاجة إلى رعاية أيضاً").

إلا أن النساء غالباً ما يتعرضن للضغوطات من الزوج، والحماة، والمجتمع لإنجاب مواليد متتالين بسرعة، بحيث تصل الفترة بين المولود والمولود إلى أقل من سنتين. وهذا ينطبق في حالة إنجاب الإناث فقط حيث يفضل الأهل إنجاب الذكور بشكل كبير.

5. أول استخدام لوسائل منع الحمل لم يكن في سن مبكر بما فيه الكفاية

6. اعتماد كبير على واحدة أو اثنتين من وسائل منع الحمل

النمط العام هو أن تنجب النساء 4 إلى 5 أطفال ومن ثم يبدأن في استخدام اللولب (IUD). وتعبر العديد من النساء على مر الأيام عن تفضيلهن للبدء في استخدام وسائل منع الحمل في سن مبكرة، حتى أن بعض النساء يفضلن بأن يبدأن في استخدام وسائل منع الحمل عندما يتزوجن من أجل تأخير قدوم المولود الأول. وقد توصلت الدراسة إلى استنتاج مفاده أن ضغوطاً مكثفة تفرض على النساء لإنجاب أطفال عندما يتزوجن مباشرة، ودون تأخير. وإذا حدث هنالك تأخير، يتم أخذ النساء إلى عيادات معالجة العقم وحتى إلى المعالجين الشعبيين لمعرفة سبب عدم الحمل.

هنالك ضغوطات سلبية أخرى على النساء اللاتي لا ينجبن أطفالاً بسرعة. وحتى أن عائلة البنت تضيف إلى مثل هذه الضغوطات. وهم يرون في الطفل الذي تنجبه ابنتهم كضمان على استقرار الزواج. ويقوي الأطفال العلاقة والروابط بين عائلة الزوج والزوجة، وكلما حدث ذلك مبكراً، كلما كان ذلك أفضل. ويشعر كل من الزوج والزوجة بالضغوط العائلية والاجتماعية لإثبات قدرتهم على الإنجاب. ويشكل عدم القدرة على الإنجاب أو العقم أرضية للطلاق، الأمر الذي ترغب كلا العائلتين ذات العلاقة بتجنبه. وينبغي أن لا نفاجأ لوجود اهتمام كبير وحتى خوف من العقم. ويتخصص العديد من المداوين الشعبيين في معالجة العقم.

وتؤكد النتائج التي توصلت اليها الدراسة على ما جاء في نتائج المسح الصحي بشأن معظم الطرق الشائعة لمنع الحمل، حيث أشارت النتائج إلى أن طريقة اللولب IUD تعتبر أكثر الطرق شيوعاً، يليها حبوب منع الحمل (التي يتم تناولها عبر الفم). (تشير المسوحات إلى أنه يتم تفضيل استخدام IUD بنسبة 3 إلى 6 مرات على استخدام حبوب منع الحمل). ويقل عدد النساء اللاتي يستخدمن الحقن أو الحبوب الرغوية، أو اللاتي يستخدم أزواجهن العازل/الكندوم (نادراً ما كان يتم ذكر النوع الأخير).

لا تعتبر IUD طريقة مثالية لمنع الحمل لدى النساء اللاتي يرغبن في استخدام وسائل منع الحمل في سن مبكرة، أو لتخطيط فترات متباعدة بين المواليد تصل إلى 2 – 3 سنوات. إلا أن IUD لا تزال الأكثر انتشاراً وتفضيلاً، بينما يقل استخدام الطرق الأخرى. أما ثاني طريقة أكثر شيوعاً فتتمثل في حبوب منع الحمل، والتي يستخدمها عدد ضئيل نسبياً من النساء. وهنالك الكثير من الأساطير والسلبيات التي تربط هذه الوسائل وطرق منع الحمل الأخرى.

*** أمثلة على السلبيات المرتبطة بوسائل منع الحمل**

تعتقد بعض النساء بأن الحقن تسبب عقماً دائماً. وقد علق عدد من العاملين الصحيين والمستجيبين بشكل عام بقولهم أن هذه الطريقة تعتبر أقل الطرق شيوعاً. ويعتقد البعض بأن حبوب منع الحمل تسبب البدانة، والعصبية، والصداع، والأورام، ونقص حليب الثدي ("أو جفاف غدد الحليب من صدر المرأة")، وعدم انتظام الحيض، والتشوهات الخلقية، والسرطان، وتلحق أضراراً بعيون وظهر المرأة، أو أنها تسبب العقم الدائم. (وهذا يمثل قائمة مركبة بالمخاوف التي تم أخذها من ردود عديدة، حيث أن أياً من المبحوثين لم يذكرها جميعاً).

وبمعزل عن الآثار الجانبية التي يعتقد بوجودها، تشمل أسباب عدم استخدام وسائل منع الحمل معارضة الزوج (غالباً ما تتم الإشارة إليه)؛ أو معارضة آخرين من عائلة الزوج (غالباً ما تتم الإشارة إلى معارضة الحماة بشكل خاص)؛ أو أن لا ترغب المرأة نفسها في استخدام وسائل منع الحمل – الرغبة في إنجاب المزيد من الأطفال. وتتمثل الأسباب الأخرى في الاقتناع بوجود تعارض مع الدين، "عدم الملاءمة"، والاعتقاد بأن "الله سيساعد من ناحية اقتصادية إذا كان هنالك مولود آخر"، أو أن "الله سيوفر"؛ ولذلك فإنه من غير الضروري أن يتم استخدام وسائل منع الحمل. أما ألاسباب وراء معارضة زوج المرأة أو عائلته استخدام وسائل منع الحمل فتتمثل في رغبتهم بإنجاب المزيد من الأطفال أو لاعتقادهم أن وسائل منع الحمل قد تؤذي المرأة.

هنالك حاجة واضحة لترويج عدد من الطرق المؤقتة والحصول على معلومات دقيقة جنباً إلى جنب مع وسائل منع حمل للسكان بشكل واسع.

7. نسبة ضئيلة من الأمهات اللاتي يؤخرن الرضاعة الطبيعية مدة 1 – 3 أيام لا يرضعن بتاتاً

أشارت نتائج الدراسة إلى أن نسبة ضئيلة من النساء، على الأرجح أقل من 9%، يؤخرن الرضاعة الطبيعية لمدة 1-3 أيام بعد الولادة. وقد اتضح أن الأمهات اللاتي أشرن إلى هذا في إجاباتهن يتمتعن بمستويات متدنية من التعليم الرسمي. ويبدو أن ممارسة تأخير الرضاعة هذه ترتبط بمعتقدات مفادها أن الكميات الأولى من حليب الأم تكون غير نقية، أو ضئيلة أو تعاني من عيوب أخرى. (هذا الموضوع بحاجة إلى المزيد من البحث)، إلا أن غالبية الذين تناولتهم الدراسة والذين شاركوا في مداولات مجموعات التركيز يدركون القيمة الإيجابية والوقائية التي يكتسبها الطفل من حليب اللبأ. وقد أوضح أحد العاملين الصحيين أن الولادة القيصرية تشكل إحدى العوامل المرتبطة بتأخير الرضاعة الطبيعية، ونحن بالفعل واجهنا عدداً من الإشارات إلى الولادة القيصرية في الدراسة. وتشير دراسات أخرى (على سبيل المثال: إسماعيل وشاهين 1996) إلى أن عدد حالات الولادة القيصرية قد يكون أكبر مما يمكن تبريره.

8. الأمهات لا يرضعن رضاعة طبيعية مطلقة لفترة كافية

9. ظهور بعض الأمراض التي تنتقل بالماء لدى بعض النساء اللاتي يقدمن سكراً وماء غير مغلي لأطفالهن

تميل الأمهات إلى إعطاء أطفالهن شاي (أعشاب) جنباً إلى جنب مع سكر وماء (أو عسل وماء) في الأسابيع القليلة الأولى من حياتهم. ففي حالة إعطاء الرضيع مشروب الشاي العشبي، فانه يتم غلي الماء في معظم الأحيان، وكذلك فان الأعشاب مثل النعناع والبابونج أيضاً جيدة وغير ضارة. وبذلك، فإن الشاي العشبي لا يبدو أنه يسبب مشاكل صحية. لكن، في المناطق ذات مياه الشرب غير الجيدة، فإن إعطاء السكر أو العسل في الماء قد يؤدي إلى إصابة الرضيع

بالأميبا وغيرها من الأمراض التي تنتقل عبر المياه. ويرى العاملون الصحيون في بعض قرى الضفة الغربية أن مثل هذه الأمراض التي تنتقل بالماء غالباً ما تكون لدى الأطفال خلال الأسابيع القليلة الأولى من حياتهم.

10. العديد من الأمهات لا يتلقين رعاية صحية في مرحلة ما بعد الولادة، ولا يدركن الحاجة للقيام بذلك

أشارت نتائج المسح الصحي الذي نفذ في العام 1996 إلى أن 20% من الأمهات يواظبن على تلقي رعاية صحية في مرحلة ما بعد الولادة. فيما تشير النتائج التي خلصت إليها الدراسة الحالية إلى أن تحسناً قد طرأ على هذا المجال، وأن هناك بعض القضايا الخاصة بقياس كيفية تعريف الرعاية في مرحلة ما بعد الولادة، وتجدر الإشارة إلى أن هذه الدراسة تتوافق مع عدد من مسوحات العينة العشوائية خلال السنوات الأخيرة من حيث أن 93% فأكثر من النساء يتلقين رعاية صحية في مرحلة ما قبل الولادة.

بصرف النظر عن النسبة الدقيقة للنساء اللاتي يواظبن على تلقي الرعاية الصحية في مرحلة ما بعد الولادة في هذه الفترة، إلا أننا نتفق على أن هذه النسبة لا تزال متدنية جداً. ولعل نصف النساء اللاتي ولدن لا يذهبن إلى مرافق صحية لتلقي رعاية صحية في مرحلة ما بعد الولادة، ولم يتلقين أي زيارة من العاملين الصحيين في القرى أو غيرهم من مقدمي الرعاية الصحية في البيوت. وتجدر الإشارة إلى أن بعض النساء اللاتي شملتهن الدراسة قد أشرن إلى أنهن تلقين رعاية صحية في مرحلة ما بعد الولادة وزيارات بيتية أخرى قام بها عدد من العاملين الصحيين في القرى. وقد تلقين أثناء هذه الزيارات نصائح حول الرضاعة الطبيعية، والعناية بتغذية الرضيع، وتنظيم الأسرة ... وغير ذلك، وغالباً ما كن يتلقين مقويات من الحديد والكلس.

وتتمثل العقبة الرئيسة أمام ارتفاع معدلات الرعاية الصحية في مرحلة ما بعد الولادة في أن العديد من النساء لا يرين أن هناك ضرورة لمثل هذه الزيارة، طالما أنهن يشعرن بأنهن بخير، ولا يلاحظن وجود أية مشاكل صحية. لكن، يجب أن نتذكر دوماً أن مستوى معدلات تحصين الأطفال تبلغ حوالي 96%. وهذا يعني أن الأمهات يقمن بزيارة مقدمي الخدمات فوراً بعد الولادة (بهدف التحصين). ويبدو أن هذا يشكل فرصة لكل من زيادة وعي الأمهات بقيمة الرعاية الصحية في المرحلة التي تلي الولادة وفرصة لتقديم هذه الرعاية.

11. زواج الأقارب

"الزواج بين أبناء العم" في تناقص، لكنه لا يزال يشكل ظاهرة كبيرة بين السكان، الأمر الذي يؤدي إلى مشاكل خلقية وصحية.

هنالك تفضيل تقليدي للزواج بين أبناء العم، أي الزواج بين أبناء العم من الدرجة الأولى من جانب الأب. وتعتبر العيوب الخلقية أو التشوهات المرتبطة بالاختلاط الجيني بين الأقارب من الأسباب الرئيسة لوفيات الرضع في فلسطين.

لقد أشارت إحدى الدراسات التي أجريت مؤخراً في غزة (WAC 1999) إلى أن "57.2% من النساء قد تزوجن من أقارب لهن". ويبدو أن هذا أقل انتشاراً منه في الضفة الغربية. وتشير الدراسة التي أجراها فريقنا إلى أن نصف الفلسطينيين تقريباً يفضلون مثل هذا النوع من الزواج، بينما النصف الآخر لا يفضل ذلك، وذلك مع تنوع الأسباب التي يعطيها كل من المؤيدين والمعارضين لهذا الزواج. ومن بين المزايا الشائعة للزواج بين أبناء العم أن هذه العادة تساهم

في الحفاظ على الميراث (الأرض، والبضائع، والثروة) داخل العائلة الممتدة. ومن جملة الأسباب المنطقية التي يطرحها مؤيدو هذه الظاهرة أن هذا الزواج "يحافظ على الثروة داخل العائلة"؛ و" أن الزوج والزوجة غالباً ما يكونان يعرفان بعضهما جيداً قبل الزواج"؛ وببساطة "هذه هي عاداتنا". وهنا بعض الملاحظات الممثلة للذين أجريت معهم مقابلات:

"أنا لا أفضل زواج الأقارب، خاصةً بين الأقارب من الدرجة الأولى. وهو غير جيد بسبب المشاكل الوراثية التي قد تنجم عنه؛ وذلك من أجل تجنب المشاكل الاجتماعية التي قد يتسبب بها الزواج بين الأقارب." (امرأة، 35 سنة، مخيم الدهيشة للاجئين).

"الزواج من قريب أو قريبة له جوانب إيجابية، فهما يعرفان مسبقاً بعضهما البعض والعائلة الأخرى. ولا يتعين عليهما أن يعتادا/يتعرفا على بعضهما البعض" (امرأة، معلمة متقاعدة، 51 سنة، قرية قرب القدس).

"من الجيد أن تبقى العائلة متحدة، وهي تحفظ ثروة العائلة للأولاد، رجل يبلغ 75 من العمر، وغير متعلم، احدى مخيمات اللاجئين- غزة"

وبشكل عام، فأنه يبدو أن تفضيل زواج الأقارب (أبناء العم) أو الموافقة عليه في تدن مستمر.

*** المشاكل الشائكة التي لا تزال بحاجة إلى استكشاف**

- فقدان الجنين (إسقاط الحمل أو الأجنة الأموات)

لم تتطرق مسوحات العينة الأخيرة ولا الدراسة النوعية الحالية إلى موضوع إسقاط الحمل، أو الإجهاض (سواء بشكل تلقائي أم متعمد)، أو الأجنة التي تولد ميتة. وقد تحدثت بعض النساء المشاركات في المجموعات المركزة عن حالات إسقاط الحمل التي تعرضن لها. وتشير الإحصاءات الخاصة بمعدلات انتشار مثل هذه الحالات الصادرة عن مستشفيات مثل مستشفى الشفاء (غزة) ومستشفى النصر في عام 1997 (وزارة الصحة الفلسطينية 1998: 90 - 93) إلى وجود معدلات مرتفعة نسبياً من حالات "الإجهاض" (241 حالة في مستشفى الشفاء و79 حالة في مستشفى النصر)؛ و"غير ذلك من حالات الإجهاض غير المحددة" (1,043 حالة في مستشفى الشفاء و568 حالة في مستشفى النصر)؛ و"حالات حمل أخرى مع نتائج إجهاضية" (107 حالات في مستشفى الشفاء و58 حالة في مستشفى النصر)؛ و"تعقيدات أخرى في الحمل والولادة" (2,263 حالة في مستشفى الشفاء و566 حالة في مستشفى النصر)؛ و"حالات ولادة فردية ومتعددة عبر عملية قيصرية" (1,708 حالات في مستشفى الشفاء و457 حالة في مستشفى النصر).

إذا كانت هذه الإحصاءات، خاصةً من مستشفى الشفاء، ممثلة على المستوى الوطني، فإن هنالك بعض المشاكل مثل فقدان أجنة أو استخدام كبير للعمليات القيصرية (كما أشار إسماعيل وشاهين 22:1996) تستدعي المزيد من الدراسة والاستكشاف. وقد تتعلق مشاكل الحمل هذه بصغر عمر العديد من الأمهات، أو بقصر فترات المباعدة بين المواليد، أو باستخدام الخدمات الصحية أو جودة مرافق الرعاية، أو غيرها من العوامل.

استنتاجات وتوصيات

1. التركيز على الاستدامة:

من أكثر الأمور أهمية والتي يمكن لوكالة الولايات المتحدة للتنمية الدولية أن تقوم بها، هو تحسين والمحافظة على استدامة الخدمات الصحية المطورة حديثاً والممولة من جهات أجنبية مانحة؛ وكذلك استدامة الوضع الصحي المحسن للنساء والأطفال (جنباً إلى جنب مع التحسنات التي طرأت على المعتقدات والممارسات). ويتطلب ذلك انفصالاً تدريجياً للمستهلك الصحي الفلسطيني عن الخدمات الصحية المجانية أو المدعومة. ويمكن القيام بذلك من خلال تقديم أو تكثيف الرسوم مقابل الخدمة، والتوزيع المستند إلى التجمع، والتسويق الاجتماعي، وبرامج مشابهة. وقد توصلت الدراسة الحالية إلى دليل على رغبة في الدفع مقابل خدمات صحية جيدة أو محسنة.

2. تركيز أكثر على المناطق الحضرية الفقيرة:

حالياً، وعند الأخذ بالحسبان المناطق السكنية الرئيسة الثلاثة في فلسطين (المدينة، والمخيم، والقرية)، يمكن القول بأن الحاجة إلى إحداث تحسينات في صحة الأم والطفل قد تكون أكبر في المناطق الحضرية الفقيرة. وفي الحقيقة، فإن معدلات تطعيم النساء ضد الكزاز في القرى أعلى مما هي عليه في مناطق أخرى، كما أنها تتمتع بمعدلات في مجال استخدام وسائل منع الحمل، كما أن أبناء هذه التجمعات يتمتعون بمعدلات تحصيل أفضل مما هي في المدن (الجهاز المركزي للإحصاء الفلسطيني 1997: 144، 94، 170). كذلك الأمر، تتمتع النساء في المخيمات بمعدلات أعلى من النساء القاطنات في المدن في مجال المواظبة على تلقي خدمات الرعاية الصحية في مرحلة ما قبل الولادة. وتشير الدراسة الراهنة إلى أن الجهود التي تبذلها المنظمات غير الحكومية في تدريب العاملين الصحيين في القرى والطواقم ذات العلاقة على مستوى التجمع السكني تشكل على الأقل جزءاً من التحسينات في الوضع الصحي في القرية، وذلك من خلال الخدمات الوقائية بما فيها الزيارات المنزلية.

3. الحاجة إلى تقييم أثر العاملين الصحيين في القرى والمدن:

كما ويعرف المانحون الدوليون بأن هنالك جدلاً كبيراً حول قضايا التكلفة المترتبة على برامج العاملين الصحيين في القرى والعاملين الصحيين في المدن. وينبغي على وكالة الولايات المتحدة للتنمية الدولية أو غيرها من الوكالات المانحة أن تدعم دراسة حول كل من الأثر ومدى نجاعة التكلفة للعاملين الصحيين في القرى في فلسطين؛ وذلك من أجل تحديد مقدار الدعم الذي تستحقه مثل هذه البرامج في المستقبل. لقد تم تدريب عدد من العاملين الصحيين في المدن وتم إرسالهم للعمل في المناطق الحضرية. من الناحية الخارجية، فان هذا يبدو كفكرة جيدة، لكن الوقت قد حان لتقييم جهود العاملين الصحيين في القرى والمدن باستخدام الطرق النوعية والكمية.

4. مناهج التعليم/التثقيف الصحي:

تشير النتائج إلى أن التثقيف الصحي الذي يتم وجهاً لوجه والتثقيف الصحي العام عبر وسائل الإعلام يشكلان منهجين ناجعين ويتركان آثاراً إيجابية. غالبية الفلسطينيين يشاهدون التلفزيون، ويبدو أن الفترة من 7:00 – 8:00 مساء أفضل وقت للوصول إلى النساء عبر شاشة التلفزيون. كما تعتبر المجلات، والصحف، والإذاعة من المصادر الأخرى

للمعلومات الصحية، كما هو عليه الحال بالنسبة لوكالة الأمم المتحدة لإغاثة وتشغيل اللاجئين الفلسطينيين في الشرق الأدنى، والمنظمات غير الحكومية، والطاقم الصحي الحكومي. أما العاملون الصحيون في القرى وغيرهم من العاملين في مجال التثقيف الصحي المجتمعي فانهم يبثون رسائل تثقيفية. ومن الأمثلة الأخرى على التثقيف الصحي بين الأشخاص، التي ذكرت في الدراسة: أن أطباء يأتون إلى المدارس ويتحدثون عن مواضيع صحية وأن أئمة المساجد يتحدثون عن مواضيع صحية خلال خطبة صلاة الجمعة.

5. تنظيم الأسرة:

بما أن النساء وأزواجهن يؤخرون الحصول على نصيحة طبية حول اختيار وسائل منع الحمل، وبما أن هناك القليل من الطرق المستخدمة، يبدو من الواضح أن هناك حاجة لتثقيف المقدمين للخدمات الصحية حول مدى الطرق المؤقتة المتوفرة حالياً. ويحتاج المقدمون للخدمات الصحية إلى ترويج طرق أخرى عدا IUD بدرجة كبيرة، وترويجها مبكراً بشكل متساو. كما أن هنالك حاجة إلى المزيد من التعليم الموجه إلى عامة الناس ومقدمي الخدمات الصحية حول مخاطر المباعدة بين المواليد بأقل من سنتين. كذلك فانه من الممكن تثقيف المجموعتين، أو على الأقل العاملين الصحيين، حول العلاقة بين المباعدة القليلة بين المواليد وبين فقدان الجنين.

6. التركيز على الرجال:

تشير النتائج إلى أن الزوجة تعتبر الأسهل من حيث تغير موقفها من تنظيم الأسرة، والمباعدة بين المواليد، وسن الزواج. وتعتبر إمكانية التأثير على الأزواج، والرجال بشكل عام، أكثر صعوبة، إلا أنهم يعتبرون أكثر المجموعات حاجة إلى التثقيف الصحي. كما أن هناك حاجة إلى استهداف النساء المتقدمات في السن، ممن يلعبن دور الحموات، بشكل خاص. وقد شددت النساء اللاتي أجريت معهن مقابلات والعاملات الصحيات على الحاجة إلى استهداف الرجال فيما يتعلق بالتثقيف الصحي الإنجابي. إلا أنه ليس من السهل القيام بذلك، باستخدام المقابلات وجهاً لوجه، لسببين عمليين هما: الأول، عادة ما يكون الرجال غير متواجدين أثناء ساعات النهار لكونهم متواجدين في أعمالهم؛ أما الثاني، فغالباً ما يكون العاملون الصحيون في القرى من النساء، الأمر الذي لا يعتبر مناسباً من ناحية ثقافية أن تتحدث النساء إلى الرجال حول الجنس، ووسائل منع الحمل والسلوك الإنجابي، في الوقت نفسه (لا يبدو أن بحث الزواج المبكر والمباعدة بين المواليد بشكل عام يشكل مشكلة). كما أنه لا يعتبر مناسباً من الناحية الثقافية أن يزور عاملون صحيون النساء في منازلهن.

لكن، كيف يمكن الوصول إلى الرجال على المستوى المحلي؟ فيما يتعلق بالتثقيف وجهاً لوجه، يمكن للعاملين الصحيين (الذكور) أن يزوروا الرجال في ساعات ما بعد الظهر أو ساعات المساء. ويمكن الوصول إليهم في أماكن عملهم. ويمكن للعاملات الصحيات أن يجربن مناهج وطرقاً مختلفة للوصول إلى الرجال وتثقيفهم والتأثير عليهم. ويقترح بعض العاملين الصحيين أن يشارك أئمة المساجد في هذا الشأن خلال الساعة التي تسبق صلاة الجمعة (خطبة الجمعة)، حيث يمكن لأي شخص أن يطلب من الإمام التحدث عن موضوع يصب في الصالح العام. على سبيل المثال، تحدث أحد الأئمة المحليين مؤخراً حول مخاطر النظر إلى الشمس أثناء كسوف الشمس في صيف عام 1999. وعادة ما يميل الأئمة إلى التعاون عندما يطلب منهم التحدث حول الزواج المبكر، وتنظيم الأسرة، وغير ذلك من المواضيع الصحية التي تصب في المصلحة العامة. وينبغي أن يدعم مثل هذا التثقيف الصحي الذي يتم وجهاً لوجه بمواد مطبوعة أو مواد إعلامية إلكترونية، توجه إلى الرجال بشكل خاص.

7. جودة قضايا الرعاية:

فيما عدا بعض الشكاوى حول جودة الخدمات في المؤسسات الصحية الحكومية المزدحمة، لم تظهر العديد من المشاكل في هذه الدراسة الراهنة، أو في المسح الصحي لعام 1996. إلا أن الملاحظات المقدمة من المستهلك أو من جانب المرضى قد لا تعكس المشاكل التي قد تنتشر حقاً في جانب مقدم الخدمة، وذلك وفقاً للأدلة المستمدة من الدراسات السابقة والتقييم الأخير الذي أجراه مجلس السكان الدولي على جودة الرعاية.

بما أن غالبية حالات الولادة تحدث في مرافق صحية، إلا أنه لا يزال هنالك معدلات مرتفعة نوعاً ما من النتائج السلبية للولادة (يبدو أن ولادة أجنة أموات لا تشكل جزءاً من إحصاءات وفيات الرضع)، وبالطبع فإنه من الممكن تحسين هذه المخرجات من خلال التحسينات التي يمكن إجراؤها في جودة خدمات الولادة. كما يمكن تحسين جودة هذه الخدمات أيضاً بتقليل عدد النساء اللاتي يلدن في سن مبكر أو أواسط العشرينيات من أعمارهن، ومن خلال زيادة المباعدة بين المواليد، والحد من حالات الزواج بين الأقارب.

لقد قامت منظمة كير الدولية بتدريب كادر من العاملين الصحيين المجتمعيين (الذكور)؛ كما أنه من الممكن أن يكون بعض المنظمات غير الحكومية الأخرى قد بدأت في القيام بأمور مشابهة.

Palestinian Central Bureau of Statistics

Palestinian Maternal and Child Health
a Qualitative National Study

July, 2000

Note for Users of this Report

Opinions expressed in this report are those of the authors, and do not necessarily reflect those of PCBS or PNA.

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All correspondence should be directed to:
Department of user services
Palestinian Central Bureau of Statistics
P.O.Box 1647
Ramallah, Palestine.

Tel: 972-2-2406340
Fax: 972-2-2406343
E-Mail: diwan@pcbs.pna.org
web-site: http://www.pcbs.org

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Palestinian Maternal and Child Health: a Qualitative National Study

(Full Study Report)

Edward C. Green, Ph.D
Macro International
Calverton, Maryland, USA

Khalid Abu-Khalid
and
Mohammed Omari
Palestinian Central Bureau of Statistics.

Ramallah, Palestine

ACRONYMS

CBD:	Community Based Distribution
CBR:	Crude Birth Rate
CPR:	Contraceptive Prevalence Rate
FP:	Family Planning
IEC:	Information Education and Communication
MCH:	Maternal and Child Health
IUD:	Intrauterine Device
MOH:	Ministry of Health
MWRA:	Married women of reproductive age
NGOs:	Non Governmental Organizations
OC:	Oral contraceptive
PCBS	Palestinian Central Bureau of Statistics
TBA:	Traditional Birth Attendant
TFRs:	Total Fertility Rates
UPMRC:	Union of Palestinian Medical Relief Committees
USAID:	United States Agency for International Development
VHW:	Village Health Worker
WAC:	Women's Affairs Center
WBG:	West Bank/Gaza Strip

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Preface

The implementation of this survey came as completions of the efforts done by the Palestinian Central Bureau of Statistics (PCBS) in order to upswing the health status of the Palestinian people. The survey was implemented in co-operation with the United States Agency for International Development (USAID).

This survey constitutes the initial stage for deeper research. It relies on main sectors of the population, and includes a number of discussion and research groups. The results of this survey were correspondent to the results of the previous health survey implemented by PCBS in the year 1996.

The PCBS hopes that this survey contains a valuable source for researchers interested in deep analysis of issues related to mother and child health. In addition, the PCBS is also hoping that this study aid in developing the health sector in the Palestinian Territory through the developmental health programs and enhance the quality of the health services.

July, 2000

Hasan Abu-Libdeh Ph.D.
President

Executive Summary

Background and Objective

The US Agency for International Development (USAID) requested a national, in-depth, qualitative study of the health of women and infants in the Palestinian Territory, as part of its Maternal and Child Health Pilot Initiative. In response to this request, a study combining several qualitative research methods, namely in-depth and key informant interviewing, focus group discussion, and limited rapid ethnographic methods, was carried out between February and December 1999. A total of 358 Palestinians were interviewed or participated in informal focus group discussions, conducted in all significant geographic areas of the Palestinian Territory.

Limitations to the Study

There are two major limitations to the study. One relates to the quantity and scope of information requested. We could well have focused on only one of the topics requested, for example family planning or infant care and nutrition, even in a study employing in-depth interviews lasting 1.5 hours as well as focus group discussions. Yet the research team's scope of work was to find out as much as possible about attitudes, knowledge, values, and behavior related to: marriage and procreation; birth spacing and family planning; pregnancy, childbirth and infant nutrition; health care at home and at health

facilities, and some related areas such as the role of traditional birth attendants and traditional healers, and home-based health care. Given practical considerations such as how long an interviewee is willing to answer questions and how many topics can be introduced to a focus group discussion, there was not a great deal of time to discuss any one of the specific topics in as much depth as desirable. This study should be regarded as a first effort-indeed, that is how it was conceived. It can point the way to further research that is no doubt still needed.

The other weakness is that due to circumstances beyond anyone's control, the expatriate co-investigator was not in the Palestinian Territory during Phase 2 interviews. Had he been present, there would have been more modifications of the interview schedule during that phase, which would have made it possible to go into more detail in some areas of investigation.

Nevertheless, there is great corroboration and concordance between the qualitative study and recent sample surveys.

Implications of Major Findings

There have been considerable health gains in maternal and infant health in recent years. Some areas of health concern prior to the study (e.g. the proportion of women attending

prenatal care, the level of MCH health services and overall health status in rural villages; the percentage of births occurring in health facilities and/or attended by trained personnel), appeared to be not as problematic as assumed and not as problematic as was the case only 4-5 years ago, before recent improvements. These findings, fully supported by recent sample surveys of Palestinian health, mean that parties working in the health sector can focus resources more efficiently on remaining problem areas and populations. These include:

- High fertility rates
- Frequent pregnancies
- Relatively short birth intervals
- Over-reliance on one or two contraceptive methods
- First contraceptive use not occurring early enough in parity
- Relatively early marriage
- Mothers not breastfeeding exclusively long enough
- A small percentage of mothers who delay breastfeeding 1-3 days, or do not breastfeed
- Many women not attending postnatal care, nor understanding the need for this
- Women returning to household work duties too soon after delivery
- "Cousin marriages" among a decreasing but still significant proportion of the population, leading to congenital health problems
- Introduction of water-borne pathogens by some mothers giving sugar and unboiled water to babies
- Fetal loss (miscarriage, stillbirths)

Regarding the last, neither recent sample surveys nor the present qualitative study explored miscarriage, abortion, or stillborn deaths. Some women in focus groups mentioned their own miscarriages. And statistics from hospitals such as Shifa (Gaza) and Naser, reported to the MOH in 1997 (MOH 1998:90-93) show fairly high numbers of cases of "missed abortion," "other abortion unspecified," "other pregnancies with abortive outcome," "other complications of pregnancy and delivery," and "single and multiple delivery by caesarean."

If these statistics, especially from Shifa Hospital, are representative in any way, then there are problems of fetal wastage and perhaps overuse of caesarean operations (as suggested by Ismail and Shahin 1996:22) that ought to be explored further. These pregnancy outcomes might be related to young age of many women who give birth, to narrow birth spacing intervals, to health service utilization or quality of care in facilities, or to other factors.

Another problem area not specifically investigated but nevertheless important for program planning and implementation relates to problems coordinating several major service delivery players in the health sector: the Palestinian Authority/Ministry of Health; the UN Relief and Works Agency, and the robust non-governmental organization sector, consisting of both national and international NGOs (cf. Giacaman et al 1995).

Broader Conclusions and Recommendations

Sustainability Focus

One of the most important things USAID can do is to improve the sustainability of the recently improved health services that are currently funded by foreign donors, and that help account for the improved health status of women and infants (along with improvements in health-related beliefs and practices). This will require a gradual weaning of Palestinian health consumers from dependency on free or highly subsidized health services. This can be done through introduction or intensification of fee-for-service, CBD (community-based distribution), social marketing, and similar programs. The present study found evidence of willingness to pay for good or improved health services.

More Focus on Poor Urban Areas

At present, considering the three major Palestinian residential settings (city, camp and village), need for improvements in MCH may be greatest in poor, urban areas. Women in villages in fact higher have tetanus toxoid injection coverage and higher contraceptive user rates, and their children have better immunization coverage, than women in cities (PCBS 1997:144,94,170). Likewise, refugee women have higher rates of prenatal care attendance than urban women. The present study suggests that NGO efforts of training village health workers and related community-level personnel account for at least some of the improvements in village health status, through preventive services including home visits.

Assess Impact of Village/Community Health Workers

As international donors well know, there is considerable controversy over cost effectiveness issues of VHW and CHW (community health worker) programs. USAID or other donors should support a study of both the impact to date and the cost-effectiveness

of VHWs in Palestine, in order to decide how much support such programs deserve in the future. CHWs have recently been trained and sent to work in urban areas. On the face of it, this seems like a good idea, but it is time to evaluate the VHW/CHW effort using both qualitative and quantitative methods.

Health Education Approaches

Study findings suggest that both face-to-face health education and mass media education are effective approaches and are having positive impact. Most Palestinians have access to television. Between 7:00-8:00 pm seems to be the best time for reaching women via TV. Magazines, newspapers, and radio are other identified sources of health information, as are UNRWA, NGOs, and government health personnel. VHWs and other community-based health educators are transmitting messages and seem to be changing behavior. Other examples of interpersonal health education mentioned in the study were: doctors coming to schools and talking on health topics, and Imams speaking on health topics during the hour before Friday prayers.

Family Planning

Since women and their husbands defer to medical advice on choice of contraceptives, and since so few methods are currently used, it seems clear that there is a need to better educate health providers about the range of temporary methods currently available. Health providers need to promote methods other than the IUD to a far greater extent, and promote them earlier in parity. There also needs to be more education, directed both at the general public and at health care providers, about the dangers of spacing births by less than two years. It may be possible to educate both groups, but at least health workers, about the relationship between short birth intervals and fetal loss.

More Focus on Men

Study findings suggest that the wife is the easiest person in whom to change attitudes about family planning, child spacing, age of marriage, etc. Husbands, and men in general, are harder to influence, yet they are the group most in need of reproductive health education. Older woman in the role of mother-in-law also need to be targeted specially. Still, women interviewees and health workers have mostly emphasized the need to target men for reproductive health education. Yet this is not so easy, at least using face-to-face approaches, for at least two practical reasons: 1) men are not usually around in the daytime because they are working; and 2) VHWs are always women,[1] and it is not culturally appropriate for women to talk to men about sex, contraception and reproductive behavior (discussing early marriage and birth spacing in general terms seem not to be a problem). It would also not be culturally feasible for a male VHW to visit women in their homes.

[1] CARE International has trained a cadre of male community health workers; it may be that some other NGOs have begun to do the same. CARE's program should be evaluated with a special view toward assessing the impact of male health educators on the KAP of men whom they educate.

How to reach men at the local level? For face-to-face education, male VHWs might visit men in the late afternoon or evening. They could be reached in the workplace. Women health educators might try different approaches to reach and educate and influence men. And some health workers interviewed suggested involving local Imams. During the hour before Friday prayers, anyone can ask the Imam to talk about a topic in the public interest. For example, a local Imam recently spoke for an hour about the dangers of looking at the sun during the solar eclipse of summer, 1999. Imams tend to be cooperative when asked to talk about early marriage, family planning, and any other health topics that are in the public interest. Any such face-to-face health education needs to be supported and reinforced by print and electronic media, aimed specifically at men.

Quality of Care Issues

Other than some complaints about quality of service in crowded government health facilities, not many problems arose in the present study, nor in the 1996 PCBS health survey. However, perceptions on the consumer or patient side may not reflect problems that may actually prevail on the provider side, as anecdotal evidence and the recent quality of care assessment by the Population Council suggest.

Since the great majority of births take place in health facilities, yet there is still a fairly high rate of negative birth outcomes (stillbirths seem to not be part of infant mortality statistics), perhaps these outcomes could be ameliorated by improvements in quality of obstetric services. These outcomes could also be improved by reducing the number of women who give birth during their early or middle teenage years, by increasing birth spacing intervals, and by reducing the frequency of cousin marriages.

Full Study Report

1. Background and Introduction

The US Agency for International Development (USAID) requested a national, in-depth, qualitative study of the health of women and infants in the Palestinian Territory, as part of its Maternal and Child Health Pilot Initiative. In response to this request, a study combining several qualitative research methods, namely in-depth and key informant interviewing, focus group discussion, and limited rapid ethnographic methods, was carried out between February and December 1999. A total of 358 Palestinians were interviewed or participated in informal focus group discussions, conducted in all significant geographic areas of the West Bank and Gaza Strip.

Interview Schedule

Qualitative research is open-ended. It does not rely on a questionnaire, in the sense of a structured, unmodifyable interview instrument with relatively fixed response categories. The present study used a flexible, open-ended, semi-structured interview schedule for in-depth interviewing. The instrument was modifiable, which is to say we were able to add questions--indeed whole lines of inquiry--as we accumulated information and patterns begin to emerge. We were also able to drop questions after we felt that a pattern had become sufficiently well-established. The qualitative research process is inductive and creative in that it tests, discards and confirms hypotheses in a very preliminary way, as the interviewing proceeds. Survey research, by contrast, tends to confirm and measure the details of what may already be fairly well-known, allowing for anticipation and categorization of responses.

The interview schedule for the present study consisted of some 50 questions, many of which contained more specific sub-questions or topics to explore. It was developed in accordance with a Scope of Work prepared by USAID/WBG, which contained numerous maternal and child health topics of interest to USAID's Maternal and Child Health Pilot Initiative. The draft interview schedule was submitted to USAID/WBG, USAID/Washington, CARE International and (informally) to Macro International for comments and suggestions. Any suggestions provided were incorporated in some way into the interview schedule.

During phase one, the instrument was modified as patterns began to be established. It was not modified during phase 2, due to the exigencies of fieldwork rather than according to plan.

Fieldwork

Stage 1. The first author trained 2 key staff in the Health Statistics division of PCBS in qualitative research methods. He then supervised and participated in interviews and focus group discussions. In this phase, 61 Palestinians were interviewed or participated in small focus group discussions. Dr. Green wrote an Interim report based on these preliminary findings.

The first phase was conducted under CARE International, and several CARE/Palestine staff were involved as interpreters, translators and local contacts for interviewees. Phase 1 Fieldwork took place primarily during July and August 1999, although earliest interviews began in Feb. 1999.

Stage 2.

Phase 2 was conducted under the sponsorship of Macro International. In this phase, 297 Palestinians were interviewed, bringing the total interviewed to 358. Phase 2 Fieldwork took place during December 1999. Analysis and report writing occurred during January and part of February 2000.

A one-day training course in qualitative methods was conducted for interviewers (with previous experience in PCBS survey research) in the West Bank on Nov. 28th, 1999. A similar one-day training course was provided to interviewers in Gaza on Dec. 20th, 1999.

A combined team of 12 interviewers completed 297 interviews (the aim was 300) during a 12 day period in the West Bank, and 11 days in Gaza. Since Palestinian travel between the West Bank and Gaza is severely restricted by Israeli authorities, different interviewers worked in the two areas (7 in West Bank, 4 in Gaza), and two separate trainings were necessary.

Selection of Those Interviewed.

Interviews were conducted with a range of informants and in a variety of settings in order to capture variation that might be expected to occur along lines of geography, gender, SES (socioeconomic status), West Bank or Gaza residence, refugee camp or non-refugee camp residence, degree of religious conservatism, and rural/urban residence. In short, every effort was made to interview Palestinians that represent the variety of opinion and behavior found nationally.

Most (about 85%) interviewees were chosen because they represent the general public. The term here refers to those who represent the target audience in the anticipated USAID-supported maternal and child health project, namely women of reproductive age, men (husbands), and older women (as in mothers-in-law). Other Palestinians who represent relevant viewpoints were also interviewed. Such "key informants" might be regarded as special target audiences for a future project, and they include religious or political leaders,

TBAs (dayas), traditional healers, and health workers of all levels (but particularly midwives, nurse midwives and village health workers.)

Geographically, interviews were spread between West Bank and Gaza in proportions that reflect relative population size. Jerusalem is part of Middle West Bank in the following table showing the number and location of Phase 2 interviews.

It should be noted that in phase 2 fieldwork, in which most interviews were conducted, there was a degree of random sampling: the PCBS sampling expert chose localities for interviews on the basis of random sampling of census tract enumeration areas. Once a locality was selected, interviewers then used purposive "sampling" or selection to ensure that informants of special interest (e.g. TBAs, local health workers) were among those included.

Number and Location of Interviews*

Locality Type	West Bank	Gaza	Total
City	62	63	125
Village	59	0	59
Camp	55	58	113
Total	176	121	297

(* Phase 1 interviews with 61 Palestinians are not included here, but they were in the same areas in similar proportions, except that southern West Bank was less represented. **Total interviewed = 358**).

Note about Inclusion of Health Worker as Key Informants.

The expatriate investigator has discovered from research in many parts of the world that there is very little, if anything, that VHWs (village health workers) and other community-level health workers do not know about the health-related beliefs, attitudes and behavior of the people they work with, especially if they come from the same community. This is true in any society. Therefore, an effective, quick, inexpensive and easy way to discover health related beliefs and behavior is to systematically interview local level health workers as key informants. There is even the advantage that health workers are more likely than the general public to speak frankly about beliefs and behaviors that are not approved or are in conflict with formal health education, or that are considered superstitious or backward. Thus, interviews with health workers can serve as validity checks on what mothers and others in the general public say about their own behavior--an important check not available in sample survey research. Moreover, it is often useful to know what health promoters promote, and what type of health services are provided, and by whom, when interpreting answers about health beliefs and practices.

Finally, health workers know what is important epidemiologically and etiologically, therefore they can help interpret meaning and significance for the researcher. They might even volunteer important health information not specifically asked for by interviewers.

As public health researchers everywhere know, actual behavior may differ from self-described behavior. The latter may be idealized or sanitized to meet interviewer expectation and conform with prevailing norms. For example, studies have shown that surveyed Americans say they wash their hands before eating, but when the same people are observed, most do not. Therefore in the present study, it may be prudent to assume that some behaviors are not quite as positive (which we might define here as conforming to recent health education messages) as depicted. Patterns described by community-level health workers might be closer to the truth. Still, there was not great divergence between self-described and other-described behavior; it was more a matter of degree.

One exception can be found in the section **Health Facilities**, where a health worker describes in rather strong language-and using credible-seeming examples-the reservations people may have about the quality of crowded government health facilities. Yet very few interviewees in the PCBS survey (PCBS 1997:113), and few in the present study, voiced complaints about such services.

Note about Focus Group research

The research team conducted several informal group discussions in order to benefit from some of the advantages of focus group dynamics, such as expressions of competing viewpoints and illustrations of values and norms in action and in appropriate sociocultural context. Decision-making and relationship dynamics between daughters-in-law and mothers-in-law, and between husbands and wives were among the topics explored this way.

One of the problems inherent in this method, particularly in more conservative, tradition-bound societies, is getting participants to speak frankly and freely. Focus group moderators are faced with the challenge of "breaking the ice" among participants who do not know one another and who may well fell awkward speaking in front of strangers about intimate topics. In the present study, this problem was overcome when pre-existing groups were used as focus groups, which was the case with most groups.

Specifically, CARE International was working with women's income-generating groups. When one of these groups was experimentally used as a focus group, it was found that the women already felt very comfortable with each other and they were willing to speak frankly about their reproductive histories (including miscarriages and other fetal loss) because it seemed everyone already knew about such details of one another's lives. Added to this, the CARE project director who normally had weekly contacts with all income-generating groups, was already liked and respected by the women of the group. The expatriate investigator was able to team up with her and together serve as focus group moderators. The result was that there was virtually no problem getting participants to

speak frankly and candidly. The quality of the findings was excellent and no time had to be devoted to breaking the ice and overcoming shyness. All this was in spite of the time lost providing translations for the expatriate investigator.

Analysis of Findings

Unlike survey findings, which can be quickly analyzed (but not interpreted) by computer, qualitative findings must be slowly read through, and findings are expressed as extended comments and observations, not short yes/no or multiple choice responses.

The expatriate investigator (Green) and the Phase two Palestinian co-investigator (Abu-Khalid) independently read through the findings and identified patterns and sub-patterns, and linked these when possible to factors such as age and education level. This was done independently of one another in order to minimize cultural bias or blinders. When comparisons were made, there were no divergent findings or interpretations between the two investigators.

The Issue of Quantifying Health Patterns derived from Qualitative Research

The purpose of the qualitative study was not to quantify patterns, since this is the purpose and strength of sample surveys. Yet at least crude quantification is possible to achieve. For example, we can go through all the answers to a question about prenatal and postnatal care, and without counting responses, we can conclude from calculations that almost all respondents attend prenatal care, while perhaps just over half seem to attend postnatal care.

In fact, we tested the degree of quantitative concordance between our study and the 1996 PCBS national health survey (and for one question, a 1999 study done in Gaza) by comparing findings on five questions that provided quantifyable answers: age of marriage, number of desired children, percentage of women who attend prenatal care, percentage of women who attend postnatal care, and preference or behavior regarding cousin marriage. We did this by calculating the mean averages of the answers given. Note that we asked questions about general patterns rather than what a particular respondent said about his/her behavior. That is, we asked a question like, "At what age do Palestinian women usually get married in this community?" rather than, "At what age were you (first) married?" This difference alone ought to produce differences in quantifyable responses.

Yet as can be seen, findings are highly comparable between the qualitative study and the random sample national survey of PCBS (and the WAC 1999 survey in Gaza, for the last comparison). And when there are differences, these are expected and possible to explain.

Comparison between PCBS Survey and Qualitative Study Findings

	Qualitative Study (1999)	PCBS Health Survey (1996)
Age of marriage	17.1	18
Number of children desired	5.08	5.5
prenatal care attendance	98%	92.9%
postnatal care attendance	58.5%	20%
Prefer "cousin marriage" (Gaza only)	48% (refers to self-reported preference, not actual behavior)	43%-57% From WAC 1999, not PCBS)

*Hundt et al (1997) found 95% of sampled women in Gaza reported attending prenatal care

We see that in age of marriage and number of children desired, qualitative findings are virtually identical with, and within the statistical margin of error of the PCBS random sample survey. Furthermore our figure for cousin marriage preference in Gaza is fully compatible with the WAC (1999) study in Gaza, which provides figures for self-reported behavior rather than preference. The 43% in the latter study was derived from examining court records showing marriage between cousins; the 57% was derived from self-reported behavior. Our figure is only slightly below the mean between the two WAC study figures. If anything, this lower figure is to be expected since there has been health education directed against cousin marriage, and our study was conducted somewhat later than the WAC study.

In other comparison areas there are some differences, yet these are in fact differences that might be expected due to the impact of health education and improved health services. Reported prenatal care levels are somewhat higher (5 percentage points) between 1996-1999, and postnatal care attendance is significantly higher after three years, rising from 20% to 58.5%. In the past 3 years there has been emphasis on persuading women to attend postnatal care, given the disappointing findings in the 1996 PCBS health survey. Moreover, we counted home visits for postnatal care in our study, and PCBS did not, and that alone could account for most of the difference between the two findings.

We predict that the PCBS 2000 national health survey will find a postnatal care attendance level close to 60% (depending, of course, on how the question is asked, and whether or not home visits are counted).

Considering that the qualitative study relied on a representative convenience (or purposive) sample (yet covering all major geographic areas) of key informants, rather than a scientifically derived random sample, it is of considerable methodological interest that the quantification of patterns is similar between the qualitative study and recent surveys. It shows once again that health KAPB (knowledge, attitudes, practices and beliefs) are quite highly patterned and that strict random sampling is not necessary in order to discover health patterns in a broad, general way. As health planners and program directors know, it does not matter whether 48% or 50% prefer or practice cousin marriage, or whether 93% or 98% attend prenatal care. The first becomes "about half", and the second becomes "almost all" for policy or program purposes.
In spite of this interesting methodological point, we do not quantify patterns in this report except to note similarities with quantitative findings from PCBS and other sample surveys, or note that "most" interviewees, or "a minority" gave certain types of answers. It is important to note that none of the answer patterns in the qualitative study differed in general frequency from those found in recent sample surveys among Palestinians. This is a very positive finding that tends to validate the reliability and validity of both types of health KAPB research.

Inclusion of Literature Review

There are quite a few recent studies pertaining to Palestinian reproductive and perinatal health, defined broadly. Yet most are unpublished and many have not circulated far beyond the sponsoring organization or agency. Because most of this literature is unknown or at least not well-known, and there seemed to be no publications or reports that summarized and synthesized existing findings (except Stephenson 1996),[2] it seemed useful to provide such summaries in the present report. These summaries are usually provided just before presenting our findings derived from qualitative research, a comparative method little used in studies of Palestinian health.

Since a strength of qualitative research is to put flesh on the bare bones of survey findings, so to speak, it is useful to first know what the bare bones are. Quantitative and qualitative research findings also complement one another. Having both in a single report provides the most complete picture, both for the general reader and specifically for those needing reliable and valid empirical information for program and policy development.

[2] This UNICEF literature review report, while informative in some areas, reaches conclusions that do not reflect the current or even the earlier perinatal health situation (e.g., the comment that the "vast majority" of women "rarely use contraceptives" (Stephenson 1996:7). In fact, at that year of writing, 53% of ever-married women had used a modern contraceptive method.

Quantitative and qualitative research findings also serve as methodological (especially validity) checks on one another. As will be seen, recent survey findings provide highly consistent and comparable statistics, and findings from the qualitative study are also fully in accord with survey findings. There are no major conflicting findings among the major surveys cited (or found in the literature review, for that matter) and between these and the qualitative study. This speaks well for the methods used in both surveys and the present study.

For the reader not interested in summaries of survey findings, these sections are clearly marked and can be skipped.

Literature Review: National and Household Demographics, and Public Services

According to the census conducted by the Palestinian Central Bureau of Statistics in 1997 (PCBS 1998), the population of the so-called Palestinian Territory including East Jerusalem is 2,895,683 (1,470,506 males and 1,425,177 females). The West Bank population is 1,873,476 (951,693 males and 921,783 females), and the Gaza population is 1,022,207 (518,813 males and 503,394 females). Those classified as refugees amounted to 1,074,718 (413,147 in the West Bank, 651,571 in Gaza Strip).

Adult literacy rates in 1996 were male (91.5%) and female (77%) (MOH 1998:16).

47.3% of the Palestinian population is below the age 15 and the percentage of females in reproductive age (15-49) to the total population in the Palestinian Territory is 21.3%. Total fertility rate (TFR) in the Palestinian Territory is 6.1; 5.6 in the West Bank and 6.9 in Gaza.

The average Palestinian household size is 6.4 (6.1 in the West Bank, 6.9 in Gaza). An earlier, 1992 national survey found an average of 7.5 persons per household (compared to 3.4 among Israeli Jews and 5.6 among Israeli non-Jews) (Heiberg and Ovensen 1993:46). In West Bank and Gaza, Christian households were smaller than Muslim households, reflecting lower fertility among Christians (Heiberg and Ovensen 1993:47).

According to the FAFO (Norwegian) national sample survey of Palestinians, people in Gaza have the least wealth while those in East Jerusalem have the most, with those in the West Bank in between but closer to Jerusalem levels (Heiberg and Ovensen 1993:159). Rural-urban wealth differences are not as great as those found in developing countries. UNRWA refugees in camps are poorer than other Palestinians, but non-camp refugees, especially in West Bank, are much the same as non-refugees in wealth levels (Heiberg and Ovensen 1993:160-62).

The PCBS census (PCBS 1997) provides findings related to public services (piped water, electricity and sewage system) that are relevant to health status. Statistics on private households by availability of piped water and type of piped water show that 83.3% are connected to public networks, 12.1% to a private system, 4.1% have no piped water and

0.1% did not answer. Regarding electricity, 94.6% were connected to public networks, 2.4% had a private generator, and 2.9 had no electricity (0.1% not stated). Regarding sewage systems, 33.7% were connected to public sewage systems, 63.7% had a cesspool, and 2.4% had no sewage system (0.2% not stated).

According to the same census (PCBS 1998), the distribution of households by availability of durable goods to the household were: private car ownership (20.4%), refrigerator ownership (80.4), solar boiler ownership (61.2), central heating (1.5), home library (13.9), cooking stove (96.9), washing machine (73.2), T.V. (84.6), video (13.3), computer (4.0) and phone line (19.5). These may serve as wealth or SES indicators as well. Comparable durable good or SES indicators were found in another study by CARE International (CARE 1996). Although this study was conducted only in one district in north West Bank (generally said to be wealthier than the southern West Bank), the inventory found: having own electricity (c.90%), radio ownership (85%), TV ownership (c.90%), owning video recorder (12%), having telephone in house (6%), having refrigerator in house (78%), owning a vehicle in household (28%), and having municipal water supply in household (21%).

West Bank statistics on radio and television ownership from 1992 show that most people owned both even then (82% radio, 54% TV).[3]

Literature Review: Marriage and Procreation

According to the last national demographic survey (PCBS 1997), the median age of marriage for women is 18. A sample survey in West Bank found a median age of 19 (Ismail and Shahin 1996: 7-8).

Returning to the PCBS (1997) survey, 47% of women have a birth interval of less than 2 years. Contraceptive prevalence is about 32% for modern methods. The IUD accounts for 58% of all contraceptive use. Most contraception is among women who had 4 or more living children. (Other studies have yielded similar findings). Since contraception is not normally used until later parity, there is a need to educate youth about contraception before they marry, and/or to focus on young couples. Various reports suggest that family planning education emphasize spacing rather than limiting overall family size, since this is far more culturally acceptable.

A random sample survey in Gaza (WAC 1999) shows that for Gaza as a whole, 42% of marriages were age 17 or under, i.e., below age 18. About half (50.4%) of a sample of marriages were arranged and not a women's personal choice. Age of marriage rises steadily with level of education of both males and females, but this is not related to whether or not marriage is arranged (WAC 1999:21). One anomalous finding from this survey is that 90.1% of women "indicated that they felt no external pressure to have

[3] Source: http:://www.odci.gov/cia/publications/factboook/we.html, from USAID/WBG document dated 11/24/98.

children" (WAC 1999:21), at odds with present qualitative findings that describe pressure from many sources. It seems that "external pressure" in the survey instrument was not understood; this serves as a good example of how survey findings can be misleading.

Qualitative Study Findings: Marriage and Procreation

Age of Marriage

All Palestinian women are expected to marry and reproduce. Marriage is said to be "inevitable". Some girls still marry when they are in their early teens-at 12 or 13 in extreme cases-but most nowadays marry at 18. According to the latest PCBS survey, the median age of female marriage is 18 for both West Bank and Gaza (it has risen to 25 in Israel, "compared to 22 a generation ago," according to ICBS). Other recent surveys found slightly higher median ages. For example, WAC (1999:18) shows that mean age of first marriage in Khan Younis (Gaza) is 19.32 for females and 25.09 for males. It is a bit lower for refugee camp women (17.4) in the same area. Gaza-wide, 42% of marriages were age 17 or under, i.e., below 18 (WAC 1999). Ismail and Shahin (1996) also found a median female marriage age of 19. In any case, the recent trend has been toward later marriage. Four years ago, UNICEF (Stephenson 1996:13) noted a "slight trend toward later marriage because of aspirations for higher educational attainment."

Early marriage is regarded by most respondents as a thing of the past, or a practice of poor, uneducated, unsophisticated and/or rural people. With modernization ("civilization" in the words of some, or even "the spread of science"), greater education (including reproductive health education on the value of deferred marriage), and "awareness" from television, radio and other outside contacts, young women have come to expect more opportunities for education and more choice in age of marriage and choice of partner. Adolescent women would prefer to defer marriage until they have had more education. Norms and expectations are changing, as the following quotations show:

> "In these days, awareness has increased. T.V. sets spread girls' awareness and consequently they refuse early marriage". (refugee woman, age 57, Gaza)

> "He who does not have enough money to educate his daughters will consider their early marriage to avoid his responsibility toward them." (housewife, age 23, Gaza)

> "People will laugh at those families whose daughters marry at 16." (educated woman from Taybeh village, West Bank)

The religion of the majority, Islam, might be seen as a counterbalance, to some extent, to the combined forces of modernization, education, mass media, etc.

Islam is said to encourage marriage, and the Prophet enjoined believers to go forth and propagate.[4]

Poorer parents want to get their daughters married (especially to wealthier men) for several reasons, the main one being that economic support becomes the responsibility of the new husband, and the father or breadwinner in the bride's family becomes relieved of some economic burden.

The practice of ***mahr*** (bridewealth) was set forth in the Quran; it provides the bride with a measure of independence and power. Its value is set by the father of the groom, or one of his close male relatives (brother, father). Mahr has been called "a proxy indicator for socioeconomic status" (WAC 1999:31), meaning its value varies according to ability to pay. Mahr used to cost about 4000-5000 NIS, according to our findings, as well as some gifts of gold to the new bride. It was said to take 3 or 4 years to earn the money necessary for bridewealth. With poverty, unemployment and modernization, bridewealth has become cheaper and therefore easier to pay during the Intifada. This was cited as another reason working in favor of early marriage.

In West Bank villages, marriage tends to occur at an earlier age than the median of 18. There is a saying that "Man is the umbrella for a woman," meaning that a woman needs a man for protection. Some people believe that a chance to get married occurs only once in a lifetime, and so a girl is pressured to seize it.

Another reason given for parents to marry off their daughters at an early age is their wish to "see their grandsons" (sometimes "grandchildren") in their lifetime, and the sooner the better.

Younger Palestinian girls and women recognize disadvantages of early marriage, such as a girl missing educational opportunity, and having to bear children before she is emotionally and physiologically mature. Regarding the former, a woman in a focus group in Gaza commented, with others agreeing:

> "If money is available it's better for a girl to delay marriage and finish her education, because education is like a weapon that gives a woman power."

Some women commented that it is male attitudes on age of marriage that need changing, not those of women. The present study provides evidence that this is already happening.

One of the problems associated with early marriage is that very young mothers tend to be very dependent on their mothers-in-law, including for helping with one or more babies (which arrive very soon after marriage. See below).

[4] Yet see below, **Is there a Religious Dimension to High Fertility?** for an overall assessment.

A few informants suggested that the pattern of men commuting to Israel for jobs tends to make them favor early marriage for their daughters. The general political situation was said to be a factor by some informants. Nowadays people have fear and anxiety over the general chaos and violence, especially in Gaza and the Hebron area. People are suspicious of each other and parents are afraid that their sons will become activists and thus targets for the Israeli military. Therefore they feel that early marriage for boys as well as girls will calm them down because they will have to become more responsible and cautious once they are married and have babies to care for.

One high-school educated Gaza housewife commented that "Early marriage prevents girls from becoming juvenile delinquents."

Some in Gaza mentioned the fear, anxiety, and mutual suspicion related to the general chaos and violence due to the occupation of Gaza, and cited marriage, family and procreation as shelter from the storm, so to speak (see discussion below, **Is there a Political Dimension to High Fertility?**).

The Ideal Age for Marriage

The best age for marriage identified by most respondents clustered around 19-22, sometimes older. At this age a woman is said to be mature and best able to bear and properly raise children. She has also had a chance for further education. In a comment that emerged from a Gaza focus group, by age 20 "she has a wise mind and good conscience," meaning that a woman by that age understands the responsibilities of marriage and childbearing. Yet the range of responses was between 15-25, as the following quotes exemplify.

> "The best marriage age is 25 years. At this age, the girl is mature and aware of all matters. At this age, she has continued her education and had an opportunity to live her pre-marriage life. Also, her reproductive system is developed enough for pregnancy and delivery. At this age, she can deal with her husband and his family as well as those around her in a better way." (Midwife, age 30, Amari Refugee Camp)

> "The best marriage age is 15 years. At this age, the girl is mature and aware of all matters...the woman who exceeds 20 years of age will not get married." (female from Alyamun, age 16, elementary school education)

> "The best age is 16 years, so she doesn't get old and stay with her family, and also (so she can) get a future and be protected and respected." (75 year old non-literate male, Gaza refugee camp).

The elderly, uneducated informant just quoted represents the old values and viewpoint. He also thought women ought to have 10 children "to help the parents and to enlarge the

family for protection and status in society," again a more old-fashioned viewpoint. Yet even he observed that marriage age has risen in recent years.

In sum, there remain some strong pressures for a woman to marry at an earlier age, especially if the family is poor, rural, less educated and there is no opportunity for secondary or post-secondary education for the girl. Yet attitudes and behavior are changing due to multiple factors, and the trend is toward marriage at a higher age for women. At present, there is a knowledge/behavior gap between the age when women marry and when they would like to marry. Many women, and some men interviewed, agree that the best age for marriage is 20 or slightly higher. Yet the median age, when last surveyed nationally, was 18.

The present study provides evidence from both male and female respondents that nowadays, decisions about whom to marry are rarely imposed on women. A woman's ability to make such decisions for herself are increasingly respected.

Pressure to Produce Children Quickly.

Once a couple is married, there is usually high pressure from the husband and his family (especially the bride's mother-in-law) for the new bride to produce a baby quickly, within 10 to 12 months. Other relatives, friends, and the broader community also expect to see the first baby without delay. Neighbors might compare the new wife to other wives who quickly conceived: "Why not you?", they ask. In fact, a woman is often taken to a doctor if she doesn't produce right away, to see what is wrong with her. Her husband thinks of taking a second wife if he doesn't see a baby quickly, and he may do so. Infertility seems to be a reason for continued polygamy among Palestinians. Women occasionally cited fear of finding themselves in a polygamous marriage as a reason to produce their first child without delay.

If a wife proves to be infertile, interviewees said that her husband would quickly take another wife (although he would not leave the first wife). The norm seems to be to have children at any price. Families want boys in order to carry on the family name, so the wife who produces daughters is under particular pressure to keep trying for sons. But pronatalism in some areas or among some families is so strong that even if a woman has three sons in a row, there is still pressure to produce more babies.

There are other negative sanctions for a woman who does not quickly bear children. In fact, Even the girl's own family adds to this pressure. They see the baby of their daughter as insurance for stability in the marriage. Children strengthen the ties between the families of the husband and wife, and the sooner this begins, the better. Both the husband and wife feel family and social pressures to prove their productivity. Infertility or sterility are grounds for divorce, something both families involved want to avoid. It should come as no surprise that there is considerable concern over, and fear of, infertility (see below,

The Role and Status of Traditional Healers.

"Tradition" and "culture" were sometimes cited as reasons explaining why a woman is expected to bear the first baby quickly, but interviewees were often able to articulate more specific reasons. One Nablus man said women themselves want to "have children in the house for entertainment," and so do not delay childbirth.

Many women said they would prefer to have "a grace period" before bearing the first child, in the words of several respondents. Some younger, more modern, educated women prefer to use contraception nowadays and wait before bearing a first child, but there remain strong pressures against this. Still, some more educated husbands agree with their wives on this matter, allowing them to use contraceptives. Better educated, working women may nowadays delay childbirth for the first year or the second of marriage. Reasons for this delay, provided by male as well as female informants, were that the newlyweds need to have some time to get to know one another, to become closer, before including a child in the family.

The Ideal Number of Children

The majority of respondents, most of whom were women, said between 4 and 6 is the best number of children to have, about the same as the 1996 PCBS health survey finding that most "couples want to have an average of 5-6 children" (PCBS 1997:21). Younger and better-educated women tended to say 4 or slightly fewer was the best number. Some from this group mentioned that they had more children because of pressure from husband, husband's family, or the broader community. Some representative responses:

> "Four children, in order to be able to raise and educate them in a proper way." (refugee housewife, age 24, Gaza)
>
> "Four children, because of economic factors and hardships in life. And in order to provide quality children--and a quality society." (Woman with 12 children, age 62, refugee camp in central West Bank)
>
> "Six children, in order to support them financially and to educate them and take care of them." (woman, retired teacher, 51 years old, 5 children, in village near Jerusalem)

Some who gave lower numbers mentioned the need for financial resources to cover the costs of raising and educating children properly. Those who gave answers in the 2-4 range sometimes specified that at least 2 boys need to be produced. If a woman only produces girls, no matter how many, she is still under pressure to produce boys, in conformity with to patrilineal and patriarchal values and practices of Palestinians.

However, a substantial number gave answers such as "at least 8 children" and "between 10 and 12" (and more than a few had had that many or more children themselves). Some men interviewed, but by no means all, gave a desired number of children higher than 4:

> "Eight children in order to have reproduction in accordance with the sayings of the Prophet, and to have male rather than female children." (male, medical laboratories technician, age 32)

> "...God the Omniscient alone determines this. The Prophet said, 'propagate to boast of you before the nations at Doomsday'. Also (He said) to propagate as many children as possible." (Imam, age 90, Ayda Refugee Camp)

Those who gave more pronatalist answers sometimes mentioned that having many children meant having or gaining "power," social status, security and family support. Support meant not only for parents in their old age. One informant explained to the foreign researcher that Palestinians don't turn to the government for assistance, not necessarily because they don't trust the government. They didn't really have a government until recently, and they didn't want to go to Israeli authorities to solve problems before that. Families took care of themselves. In the informant's words, "It's like, me and my family against the world."

A number of older respondents used the Arabic word izweh, which implies status, protection, and help, when discussing the value of children.

Some informants mentioned that "the Prophet encourages" large families. Some interviewed in villages, e.g., near Jenin, commented that they want large families in order to have children to help with the farm work, a common view expressed among agricultural people in most parts of the world.

> "(Pressure comes from) the mother–in–law for purposes related to enhancing family power and support. Also, the husband would like to have as many children as possible in order to boast among people." (woman nurse, age 25, Ali Al–Muhtaseb Hospital)

In sum, there seems to be some unmet need for family planning information and services since for the most part, the desired or ideal number of children is slightly lower than the number of children women actually have (6.9 in Gaza, 5.6 in West Bank, as of 1997). Yet the ideal and actual (TFR) numbers are not far apart. The number of children expressed by most respondents is still high, therefore a change in values and attitudes seems a necessary condition for significant fall in fertility rates, apart from any impact of economic factors and possible government policies, interventions or incentives.

The ideal number of children expressed by Palestinian interviewees has not changed much in the last decade. For example, An UNRWA family planning KAP survey in the West Bank (UNRWA 1993, quoted in Barghouthi, Fragiacomo and Qutteina 1999:124) showed that "an average of 9.6 children would be born to a married woman during her lifetime. This is in sharp contrast to the respondents' desired family size of 5.5 children." Since then, West Bank fertility has fallen considerably, but ideal family size has not.

Is there a Political Dimension to High Fertility?

As Courbage (1997:223) has observed, "Palestinian fertility has remained high despite relatively high female literacy rates and other factors usually associated with onset of the demographic transition." In fact, until recently, Palestinian fertility had fallen everywhere except the Palestinian Territory themselves. That is, fertility rates declined from previously very high levels among Palestinians living in Israel, Jordan, Egypt, and elsewhere, but not in West Bank or Gaza. Then fertility rates began to fall in the West Bank.

A 1995 UNICEF study, citing Giacaman (1994), comments that Palestinian "political ideology and cultural norms encourage women to bear many children..." (Stephenson 1996:20). An article by an anonymous author in "Planned Parenthood Challenges" (1994:(1):28-30) claims that "the political situation and the 1987 start of the Intifada...made delivery of even existing (family planning) services more difficult and helped create a pronatalist atmosphere which was fuelled by religious opposition to family planning." This article mentions that "...the FPA is also actively seeking the involvement of religious leaders in discussions about the incorporation of FP in refugee health programs."

Heiberg and Ovensen (1993:62) show that the pattern of annual births reported by the Israeli Central Bureau of Statistics (ICBS) between 1968-1991 show little if any decline in the Palestinian birth rate during the 1970s or early 1980s. In fact, ICBS figures show a rising birth rate since the outbreak of Intifada. Meanwhile, Palestinian birth rates elsewhere have fallen.

Batya Elul (1996), in a paper entitled "High and unabating fertility in the Israeli occupied territories: unraveling the puzzle," believes that Israeli policies have had an impact on Palestinian fertility by provoking heightened nationalism. She cites Fargues (1994), who shows that during two other times in Palestine history of the past 50 years, Palestinian fertility rose at the same time as heightened political conflict and nationalism (the Great Revolt of the 1930s, and the time of the emergence of the PLO). However, she says it is difficult or impossible to measure this in surveys, or indeed any approach that relies on the individual as the unit of analysis (Elul 1996:30). She suggests that focus groups and anthropological approaches would be more fruitful methods for teasing out political (or religious) factors.

Courbage (1997) also suggests that Palestinian fertility tends to rise in response to "political tension."

Some informants and respondents in the present qualitative study mentioned political factors affecting fertility, in both individual interviews and in focus group discussions, although such factors were sometimes mentioned only after prompting. For example, after hearing various reasons to have many children, interviewers would ask, "are there any reasons related to politics or the political situation?"). A number of comments had to

do with losing children during the Intifada, and the need to replace them, "in order to compensate for the martyrs." This refers especially to sons.

> "In a war, it's better to have more children in order to compensate for the ones that have been lost." (housewife, age 41, illiterate, Gaza)

Others said it is necessary to be strong in the face of Israeli aggression and occupation. One housewife in Gaza was blunt and apparently needed no prompting: people in Gaza have many children in order "to liberate Jerusalem." (This same woman said that women should rest 4 years between pregnancies "so the wife can look after herself, her baby and her house. After 4 years the last child is ready for kindergarten.")

Still others spoke of war-like conditions and mentioned the need to build a strong state capable of defending itself against its enemies. In fact, the PLO and the PA have promoted the practice of having many children in the past, in order to be numerically strong and not let Israel sweep Palestinian people away from their ancestral lands. Now the official policy in Palestinian MOH is to reduce fertility, but outside the MOH and Ministry of Education and certain agencies that may feel directly the pressure of rising population, others in the Palestinian Authority may still express the earlier pronatalist view.

Still other interviewees mentioned closure of borders and loss of jobs, as well as losing members of the family to injury and prison during the Intifada--all as serving to make people want to have more children.

It should be mentioned that such comments tend to come from Gaza or the Hebron area, occasionally from the Nablus area. These three areas, perhaps not by coincidence, have the highest percentages of live births among areas of Palestine (MOH 1998:14).

"The Crude Birth Rate in Palestine was 34.4 per thousand in 1997. This shows a sharp reduction in crude birth rate during the years 1995-1997. The sharp increase in birth rate during the years 1987-1994 is due to the political instability in the area and the previous absence of relevant intervention policies...Gaza City province had the highest crude birth rate (40.4 per thousand and Ramallah province had the lowest...26.8 per thousand. (MOH, 1998:14)

In sum, there is a political dimension to continuing high fertility in Gaza and some areas of the West Bank. As long as Palestinians feel oppressed by Israeli occupation, part of the patriotic response is to have many children. It is impossible to quantify this factor underlying high fertility (exactly how much of the 6.9 TFR in Gaza is due to political factors?), but it certainly would seem that even if there is a trend toward lower fertility, there will need to be a political settlement satisfactory to Palestinians to achieve a TFR anything like 3.0.

Is there a Religious Dimension to High Fertility?

Is religion also a factor in high fertility? Fertility among Christian Palestinians is much lower than that of Muslims (TFR of 2.59 versus 6.16 in 1996, according to PCBS). Yet Christians tend to be better educated and wealthier, factors that tend to be associated with reduced fertility.

It has already been observed by respondents that Islam and the Prophet enjoin believers to go forth and propagate, as Christians also believe they should do, and that some Muslims, such as the Imam quoted above, believe that number of children a woman has is determined by God alone. This raises the question of the position of Islamic clerics, and Muslims in general, on contraceptives.

A UNRWA nurse informant from Arab Jerusalem explained that when she started with family planning some five years earlier, she and her colleagues had a difficult time. Muslim and Catholic leaders opposed contraception. UNRWA held workshops and for these religious leaders during which UNRWA staff tried every argument to change the leaders' attitudes. "Somehow abortion always got into these discussions." The informant would argue that if a fetus is shown to be abnormal, the mother shouldn't continue the pregnancy. This made the religious leaders "go crazy". They would argue that God created this baby, therefore He must want it to live.

But times have changed in the past five years, the nurse explained. Recently husbands have come to ask about contraception. Most of them are educated husbands who already have some children. However, parents in their first pregnancy are still very hard to convince of the value of contraception. They say "It's our first. We want more. If we use family planning, we won't have another baby." Many still think of contraception as a final resort to end fertility permanently, this informant said.

Overall, interviewers in the qualitative study found little evidence of current opposition to contraceptives by Islamic clerics. Health workers interviewed reported that Imams tend to be cooperative when asked to talk about problems associated with early marriage, family planning, and whatever health topics are in the public interest during the hour before Friday prayers. An interview with a cleric (a mufti) appeared in a local paper during fieldwork. The mufti agreed that Islam favors having many children, but he said child spacing is important, contraceptives are valuable, and matters about child spacing and the ultimate number of children should be a couples' joint decision and no one else's.
As discussed below, 88% of repondents in a 1996 national survey thought that religion has no objection to family planning (meaning use of contraceptives), while only 12% thought it does (PCBS 1997:20).

Several female respondents commented that Islam encourages women's education and virtually all people interviewed made the point that further education is a good reason for women to marry later, if not to delay or space their births.

Cousin Marriage

A traditional preference for cousin marriage (marriage between first cousins on the father's side) is declining in preference and practice. Traditionally, a man is said to have "rights" over a female cousin in his extended family (A'aila mumtada), should he want her as a wife. A perceived advantage of cousin marriage is that the custom keeps inheritance (land, goods, wealth) within the extended family.[5] Commonly expressed rationales were to "keep the wealth within the family," the husband and wife tend to know each other well before marriage, and simply, "this is our custom."

A recent survey in Gaza (WAC 1999) showed that "57.2% of women were found to have married relatives." This study also examined court marriage records (a flawed process, authors admitted) and found a somewhat lower figure of Gaza marriages between relatives, 43%. While there was no aim to quantify findings in the present qualitative study, 43%-57% seems a bit higher than responses from people in the West Bank suggest. Most respondents said the custom is declining because people have been told that congenital health problems result from inbreeding.[6] (see Mahjneh et al 1992 for evidence of genetic problems from inbreeding among Palestinians). Interviews have shown that divorce or a bad marriage between cousins can cause friction and strife within extended families, a perceived disadvantage.

Some representative comments of respondents:

> "I do not prefer marriage among relatives, especially among immediate relatives. It is not good due to the hereditary problems it may cause and in order to avoid the social problems that might be caused by marriage among relatives." (woman, age 35, Al–Diheisheh Refugee Camp)
>
> "(I do not like cousin marriage)...for fear of potential social problems, hereditary diseases, malformations, handicaps, …etc. Dealing with outsiders might be easier than with relatives." (midwife, age 25)
>
> "Getting married to relative has good aspects. They already know each other and the other family. They don't have to get acquainted." Woman, retired teacher, age 51, village near Jerusalem.
>
> "It is good to keep the family united and it keeps the wealth in the family for the children." Man, age 75, non-literate, Gaza refugee camp.

[5] Earlier literature mentioned the importance of the extended patrilineage (Hamula) among Palestinians, contributing to continued high fertility (Friedlander et al 1979, quoted in Elul 1996).

[6] A campaign against cousin marriage is currently underway in Saudi Arabia, according to the International Herald Tribune (1/17/00).

Cousin marriages may still be preferred in Gaza.

Regarding the congenital effects of endogamy, the leading cause of death during the first year of life, as noted elsewhere, is "congenital anomalies" (18.6%) (MOH 1998:82). One informant in the present study is a director of a CBR (community-based rehabilitation) program in the West Bank. She had recently done door-to-door surveys of West Bank villages, looking for physical and mental disabilities, hoping to shed light on their origin and prevention as well as prevalence. She and her colleagues were surprised to learn that the majority of disabilities in villages were not related to genetic inbreeding, but rather to poor health practices such as letting ear infections go too long before treatment, or allowing fever temperatures remain high too long before seeking medical care. Many disabilities were therefore not due (as much as thought) to genetic inbreeding, but were preventable through improved health education for villagers.

B. Birth Spacing and Family Planning

Quite a lot of data related to family planning are available from the published and unpublished literature. It is useful to summarize relevant findings here, before presentation of our qualitative findings.

Literature Review: Family Planning

Knowledge of any modern contraceptives method is extremely high, 99.6%, among Palestinian women. Most Palestinian women (in 95% range), approve of family planning, and this has been true at least as far back as 1993. Ever-use of any method is 57% in West Bank and 43% in Gaza. Current use levels among currently married women is lower (33.6% and 24.5% respectively):

Percent Distribution of Ever-Married Women who have ever used a Contraceptive Method, by method, Age and Residence

Residence & Age	IUD	PILL	Other modern method	Any Method
West Bank				
Current Age				
<30	30.7	17.2	42.9	62.3
30-49	50.9	39.3	68.6	79.3
Total	41.9	29.5	57.2	71.7
Gaza Strip				
Current Age				
<30	23.0	10.8	32.2	43.0
30-49	37.0	19.4	52.9	61.9
Total	30.3	15.3	43.0	53.0
Palestinian Territory				
Current Age				
<30	28.1	15.0	39.3	55.8
30-49	46.6	33.1	63.8	73.9
Total	**38.2**	**24.9**	**52.6**	**65.7**

(source: PCBS 1997:141)

Perhaps contrary to expectation, contraceptive use is highest (59.3%) in villages, and lowest (50.8%) in camps. As expected, contraceptive use rises steadily with level of education, but only slightly (PCBS 1997:144).

Findings about knowledge of contraceptives showed that IUD and pills are recognized by 99% of respondants, breastfeeding by 93%, condoms by 68%, injections by 65%, vaginal methods by 54%, and "safe period" by 74%. The percentage of currently used methods by those currently married were IUD (47.6%), withdrawal (12.8%), pills (8.4%), "safe period" (11.3%), breastfeeding (7.3%), legation (6.2%), condoms (3.3%), injections (1.3%,), vaginal methods (1.1%) and other methods (0.7%) (PCBS 1997).
The IUD is significantly more popular than the pill, and these two account for most methods ever-used (PCBS 1997:141).

The intention for first-time use for the purpose of child spacing was 76%. Currently married women currently using any method was 45.3% (West Bank 50.7%; 33.9% for Gaza). The preference among non-users who intended to use contraceptives was IUD (61.2%), oral contraceptive (13.2%), other modern method (7.3%) traditional methods (18.3%).

Current Contraceptive Use Levels among Currently Married Women

Region	Any method	Any modern method	Pill	IUD
West Bank	50.7	33.6	4.3	24.1
Gaza	33.9	24.5	2.7	16.2
Overall	**45.2**	**30.7**	**3.8**	**21.5**

Source: PCBS 1998 (from 1996 Survey)

Among age group 30-49, first contraceptive use (ever-use) tends to have begun only after the 4th child (38.1%) in this group first used a contraceptive only after 5 or more children. However, among the under-30 group, first contraceptive use may begin after 1 or 2 children (67.2% report first use after first 2 children). Thus, the trend is toward lower-parity contraceptive adoption (PCBS 1997:147).

The main reason for contraceptive use for age group 30-49 was "child spacing", but a third of respondents (32.5%) mentioned "to stop child bearing" as the reason. This latter reason was cited by only 9.5% in the younger age group, as expected (PCBS 1997:150) As might be expected, stated contraceptive use for "child spacing" rises steadily with level of education (PCBS 1997:150). Less educated women are less understanding of the child spacing purpose of contraception.

The main stated problem with any modern contraceptive overall is the category "health problems", cited by 94.1%. Among the main reasons for non-use are menopause (44%), "husband" 18%, oppose FP 13%, side effects 11%, and religious reasons 7%. The last reason is almost twice as likely to be given in villages as in cities (9.8% v. 5.0%). "Husband" (his opposition, presumably) is given as reason by 21.8% in Gaza versus 14.5% in West Bank.

The percentage of currently married using modern methods by source of methods was found to be private doctors (44.6%), MCH centers (13.0%), family planning centers (11.3%), private hospitals (8.6%), pharmacies (7.1%), government hospitals (6.7%), private health centers (6.3%), and government health centers (2.4%) (PCBS 1997:154).

On benefits of family planning, the highest percentage said "it saves money" (59%), followed by "it's better for mother's health" (24%). 98% of women surveyed wanted to have spacing between births. The average interval of birth spacing perceived by women was 2.5 years. Reasons for having many children included "family strength" (38%); they simply like having many children (22%); it prevents husbands remarriage to a second wife (10%), they want children to provide care for their families (4%); and children are a

source of income (3%). 88% thought that religion does not object to family planning (meaning use of contraceptives), while 12% thought it does (PCBS 1997:20).

Other recent family planning surveys (Ismail and Shahin 1996, Dakkak 1996) as well as a study using "intercept" or "exit interview" methods (Kaileh 1996), produced similar findings.[7] For example, the survey conducted by Ismail and Shahin (1996: 7-8,18) showed that: the average age of marriage was 19; wives are usually 5 years younger than husbands and they have finished 9 years of schooling. Women would like to have 5 or 6 children and would prefer average spacing of 30 months between. About 70% of married, non-pregnant women wished to postpone or stop childbearing; 39% of this group was using an effective contraceptive method. Only 17% of women were advised about family planning services and methods after their last delivery. On perceptions of "family planning," 31% of women thought it means having births whenever they wish; 28% said it meant limiting the number of births, others perceived family planning as having more time between deliveries; still others saw it as enabling mothers to raise and educate their children given limited income; and lastly, women perceived FP as the ability of mothers to rest physically and rebuild their health.
Regarding this last question, Dakkak (1996) found much the same thing. Only 4% of respondents in that survey thought that family planning means "to rest between pregnancies;" 75% thought it means "to have children when we/they want them", 7% "to stop reproduction" 8% "spacing between pregnancies." The remaining responses were 3% or less: "planning the number of children;" and limiting children for "better socioeconomic and educational opportunities for children."

Findings from Qualitative Study:

Birth Spacing

A mother usually believes that a 2-3 year interval would be best for her health and that of her baby, in fact men usually believe this as well. Most interviewees understood that a woman needs a period to recover from her last pregnancy and childbirth and to regain her strength. Health workers and others interviewed maintained that Palestinian women have understood traditionally the value of birth spacing by at least 2 years; such awareness is not recent nor due only to health education efforts. Even a 90 year old Imam interviewed commented that "God says two years" for birth spacing.

Quite a high proportion of women, and some men, said that mothers should rest even longer, for 3-5 years, between pregnancies. Such spacing is also understood to allow the mother to properly care for her last child, including an adequate period of breastfeeding. Other reasons to space births mentioned by 2-3 or more years include: it allows time for

[7] Certain key statistical findings, e.g., the type of contraceptive method preferred, and the relationship between parity and contraceptive use, do not differ much from population-based surveys using random samples. This serves to validate the use of intercept methodologies, except when there is logical or empirical reason to suspect bias from interviewing only those mothers who come to health facilities.

the husband to make money to be able to meet the costs of having another child; it provides a "psychological rest" for the mother; it preserves a woman's beauty; it restores"family vitality;" and it provides time for the wife to care for her husband ("the husband needs care too").

A representative comment:

> There should be a 3–4 year rest period between a child and the next one...(It) is essential for the mother's health and in order for the womb to return to its normal state. It is also important in order to enable the mother to raise the (last) child and offer him sufficient breast–feeding." (Midwife, age 30, Al–Amari Refugee Camp)

But attitudes and practice may differ. In practice, the husband and his family often pressure the wife to have successive babies quickly, with less than 2 years between births, especially, it seems, in Gaza. (Recall that 47% of Palestinian women had a birth interval of less than 2 years in 1996). A number of female respondents admitted that in spite of knowing what is best, they themselves were not able to rest for as much as 2 years due, in the words of one, "to ignorance and lack of awareness of the importance of the rest."

In one Gaza focus group consisting of 6 women refugees, participants all agreed that the best period for resting is 2 years. Yet none were given a "grace period" of this length, nor were any aware of negative health consequences to conceiving again in less than 2 years. These women, all poor, receive health care at UNRWA clinics. They mentioned that UNRWA provides 1 kg. of flour, sugar, beans, and rice, both when a woman is pregnant and after she has delivered, easing (however slightly) the economic burden.

As discussed below (**Implications**), there seem to be fewer health consequences of closely spaced births in Palestine than those usually found in developing countries. It therefore becomes less convincing to use health reasons and (familiar, believable) examples in educating Palestinians about the dangers of close birth spacing. One MCH/FP nurse in East Jerusalem commented, "We have to teach mothers using the approach of economics: the cost of school fees, food and clothing, and how spacing will help them achieve a better life, more income, better health."

Some representative comments of respondents:

> "The ideal rest period is 5 years. But pressure comes from outside, from the husband's family, neighbors, and mother-in-law, to reduce this period of resting. They say, 'You should bring more children!" "What are you waiting for? Go ahead!.' (woman from Betrima village, near Ramallah)

> "Women in Gaza don't depend on rest between pregnancies. If mothers become pregnant after 40 days, it doesn't matter." (man from Gaza)

"Nowadays it's acceptable for all mothers to rest for 2 years. She can use contraceptives. This is due to the increase of awareness among the new generation because of education and mass media, besides the economic burden. If you have more children, this will increase your monthly expenditures." (man from village in northern West Bank, age 40 with diploma after secondary school)
"Two years. God says two years." (Imam, age 90)

"A woman has no rest between pregnancies except for her breastfeeding period. Any rest period is curtailed by the husband and his family. Women want more rest but they can't get it." (comment by women during focus group discussion in at Heker El Jame, Gaza.)

"It has been a long and difficult process of health education, but births are starting to be spaced a little longer." Village health worker, Al Mughair, West Bank)

Decision to have the next Baby

Traditionally, or normatively, the decision about when to have next baby is or was made primarily by the husband, with his mother often influencing the decision. The husband's father may also influence this decision. There is a trend "among the new, more educated generation" to leave this decision with the husband and wife alone. In fact, most respondents (men and women) said it is the couple who makes reproductive decisions, and no one else influences these. Moreover, a number of women said that they themselves had most of the decision-making power.

The 1996 West Bank health survey (Ismail and Shahin 1996:21) likewise found (and listed as an issue of "policy implication"), "In contrast to widely held opinion that women rarely decide the size of the family, this survey showed that two-thirds of women indicated sharing this decision with their husbands and rarely delegate this matter to relatives beyond the couple." Another recent survey in Jenin district (CARE-UNFPA 1997) likewise found that husbands and wives together nowadays jointly decide about using contraceptives.

Other interviewees in the present study, even when they cited "husband and wife alone" or "husband and wife together," sometimes added comments to the effect that the husband has more, or far more, power in the decision making than his wife. And sometimes the influence of the mother-in-law was said to still be operating at some level, if not openly.

During an interview with a group of older village health workers in Gaza, one of the authors observed that Palestinian women, when they are young mothers, are subjected to great tyranny under their mothers-in-law. Yet some 20 years later, they themselves become tyrants toward their daughters-in-law. The VHWs chuckled and agreed that, "since we had to suffer when we were young, we make our daughters-in-laws suffer when

we are older." (See below, "Case Study. Illustration of Secretive Use of Contraceptives," for more on role of mother-in-law).

However, some respondents emphasized that the wife nowadays has quite a large amount of the decision-making power, even most of it. This seems to be the trend among better educated Palestinians.

One better educated male villager near Ramallah commented that sometimes it's the wife rather than her husband who wants to cut short the rest period and begin another child, "...because she believes if she produces more children, her relationship will be stronger with her husband. Also the emotion of the mother is stronger than the husband's in liking to have more children."[8]
(Note that this first reason is still husband-centered.)

Some comments illustrating the range of responses and underlying attitudes:

> "(The couple) start to think about another child after weaning the last child." (Male, elementary education, from Beit Qad, northern West Bank, age 65)
>
> "...the woman is the sole decision maker in this respect. Although the husband takes part in taking this decision in certain cases, the decision of the wife is the final in most cases." (housewife, Al Shati'a Refugee Camp, age 23)
>
> "...the wife has the authority to take the decision...In the (past), things were (believed to be) according to God's will, out of her belief that her reproduction is contingent on God's will and that she had no role in this affair." (housewife, age 42)

Meaning of "Family Planning"

The term family planning has positive connotation among Palestinians. Our findings parallel those noted in the literature review above: the term may mean child spacing, or use of contraceptives, or trying to have control over the total number of children a woman has. Some said the term implies having a lower total number of children.

Health workers interviewed in the present study seem to emphasize that family planning means good or adequate birth spacing, and that this is desirable for economic reasons, and for maternal and child health and survival reasons. One East Jerusalem nurse commented, "We tell them it's not cessation, it's spacing. It's not birth control." A nurse midwife from Betrima village, West Bank, observed, "Some people believe family planning means stopping childbearing (forever). Those who believe this say they will not use it because religion is against it."

[8] There is a Palestinian proverb to the effect that its the women, more than the men, who want to have more children.

From earlier surveys that asked this question (Ismail and Shahin 1996, Dakkak 1996), we see that family planning, as relating to mothers' need to rest physically and rebuild their health, was infrequently cited, or cited last. In 1996 at least, it seems that the message of family planning education, viz. "mothers need to rest physically and rebuild their health," had not been delivered and/or understood adequately. Yet this message seems to have gotten though better in the last 3-4 years; a great many women cited definitions that included this idea.

Some representative comments:

> "Family planning means happy life. (It means) producing more children when we are ready physically, psychologically and economically." (Man from Gaza)
>
> "Family planning means that the woman should have enough time after the delivery of each child to recuperate after delivery of the child." (Man, age 62)
>
> "It means having fewer children, less children." (Jerusalem woman)
>
> "Family planning" means to be able to determine the number of children (a woman) should have in her life. She can calculate her (number of) reproductive years and then divide this number by the number of children she wants. So if she wants 4 children, she'll wait 5 years between each birth." (University-educated woman, Taybeh village, West Bank)
>
> "It means having fewer children than in the past. This is through child spacing." (male from Faqouaa, West Bank, age 40)
> "(It means) stop reproduction for a certain period until the economic status and the mother health improve." (housewife, Al Shati'a Refugee Camp, age 57)
>
> "(It means having) up to or less than four children... Reproduction after some rest, without stopping it." (refugee housewife, age 24)
>
> "Family planning (means) less number of births leading to better education and provision of the (the best) conditions for the children. Greater spacing between one child and the next." (woman, age 38, from Al–Eizareyeh)

Contraceptive Methods

Our findings conform to survey findings about most popular methods: the IUD was found to be the most popular method, followed by oral contraceptives (OCs). (Surveys show that the IUD tends to be favored over OCs, on the order of between 3 to 1 and 6 to 1). Much smaller numbers of women use the injection or foaming tablets, or their husbands use condoms (the last was rarely mentioned). A village health worker reported that condoms are not available in all areas, such as her own village.

A number of health workers and interviewees from the general public observed that the IUD is the best and most popular method because it has the fewest side effects, it is the most reliable, and it does not affect sexual relations.

Some women use natural family planning methods, i.e., breastfeeding, withdrawal and safe period ("counting the days"). The latter two "...are not favored by men because they require restraint or withdrawal," in the words of a male health worker at a maternity hospital in Al-Bireh, West Bank. Condoms are likewise not popular with men due to diminished sexual pleasure. One man said condoms are "unhealthy." It is noteworthy that a few respondents included condoms among "natural methods." There was a mention of "temporary separation," which probably refers to the 40-day postpartum restriction against sexual intercourse. All respondents acknowledged this restriction, therefore a question about its existence was dropped at an earlier stage of the study.

> "There are natural contraceptive (methods)...which are not secure all the time. The monthly period should be regular in order for this (safe period) method to succeed. Ejaculation outside the vagina is a successful contraceptive." (midwife, age 30, Al–Amari Refugee Camp)

A number of respondents said the IUD (or "spiral") is the best type of contraceptive because it is "comfortable," "safe" and "it lasts for a long period." The term safe was used by respondents to denote both reliability (i.e. it prevents pregnancy) and lack of physical harm. OCs were sometimes described as unsafe in the sense that women forget to take them and then become pregnant, and unsafe because they can cause sterility and other physical side-effects.

> "The spiral is the best type of contraceptives because it is the safest. The tablet is the least frequently used type of contraceptive. It could cause impotency. Sometimes, irregular use may cause pregnancy. It's unsafe." (woman, age 20)

> "The least frequently used type of contraceptives is the condom, because it is rejected by the husband since it does not provide enough satisfaction." (Male nurse, Hebron, age 28)

Health workers sometimes commented that they did not really know whether condoms, when they are requested, are used for STD/HIV prevention or family planning.

Health workers including village health workers say they screen women for high blood pressure or varicose veins. Those with either condition are advised to use the IUD or condom rather than hormonals.

Perceived Side Effects, Reasons not to Use Contraceptives.

Some people believe that injections and OCs cause permanent infertility. A number of health workers and general respondents commented that this is the least popular method. Some believe OCs cause obesity, nervousness, headaches, swelling, decrease in breastmilk (or "drying the milk glands in the women's breast"), irregularity of menstruation, congenital abnormalities, cancer, harm to women's eyes and back, or even permanent infertility. (This represents a composite list of fears compiled from many responses; no one respondent mentioned all of these. Usually one or two perceived side effects were mentioned by a single respondent.) Another problem with OCs is that a woman may forget to take her pills and so get pregnant. One health worker observed that some women may be ambivalent or unsure about wanting to avoid pregnancy, and it's easy to simply stop using the pills. Stopping this method doesn't require a health facility visit.

A small number of respondents expressed fear that IUDs cause bleeding, but most had only positive comments about this method.

Apart from believed or perceived side effects, reasons for not using contraceptives include: husband's opposition (most often cited) opposition from others in the husband's family (the mother-in-law is often cited specifically); or the woman herself might not want to use contraceptives--usually because all of above want to have more children. Other reasons include: perceived conflict with religion, "inconvenience;" and the belief that "God will help economically if a second child is coming," or "God will provide" so it is unnecessary to use contraceptives. A women's husband or family might oppose contraception either because of their desire for more children, or because they believe contraceptives might harm the woman.

Regarding the perception by a few respondents that Islam is against family planning, the position of Palestinian religious leaders has been stated in mosques and via mass media quite frequently of late, and the position is that (modern) contraception to ensure adequate child spacing, and to ensure the health of the mother, is fully supported by Islam. The great majority of people interviewed seem aware of this position.

Case Study. Illustration of Secretive Use of Contraceptives

A 17-year old woman born in Jordan was forced against her will into an arranged marriage in a West Bank village. She came to the local clinic and asked the doctor for oral contraceptives. In Jordan, the law states that a woman cannot use contraception unless she has the explicit, written consent of her husband. In Palestine, the law is more relaxed, and if a woman merely tells health workers that her husband concurs, they will give her contraception without seeking further proof. However, this 17-year-old wife admitted that her husband was against it. Yet she pleaded that she knew that the marriage would not work, in fact she wanted a divorce and therefore did not want to become

pregnant. The wife's mother-in-law had other plans, and so she always followed her daughter-in-law to the clinic to make sure she didn't get contraceptives.

This threw the local doctor into a dilemma. He didn't want to knowingly give contraception to a woman whose husband was known to oppose it, since this could backfire and make the whole community suspicious about what women do when they go to the clinic. Yet he sympathized with the young wife's situation. In the end, he let the local VHW (village health worker) know that he sympathized with the wife and he suggested that maybe a third party could be to the clinic sometime to get OCs for her. As of the time of interviewing, the VHW reported that the young wife had so far not managed to evade her mother-in-law in order to obtain contraceptives, even through third party.

Choice of Contraceptive Method

Do women choose their contraceptive method, and if so, what determines their decision? Respondents often answered this question by saying they usually defer to the doctor or health worker. The next most common response was that the woman chooses the methods herself, sometimes based on what she has heard from friends, neighbors, or relatives. Some respondents commented that Islam requires the husband and wife to decide together. A health worker observed, "The husband has to be part of the decision. He will divorce his wife if she uses a contraceptive without telling him."

It was admitted that some women may use contraception without their husband's knowledge, and the case study above exemplifies this. Yet this seems to be the exception. Many respondents commented that husbands are part or the decision, although more in whether to use contraceptives, rather than in which method to use.

A Jenin health worker explained:

> "Some (women) are open to medical advice when they come to a clinic or hospital, while others come asking for a specific method, or they come announcing which method they don't want because of some experience on the part of a friend or neighbor with that particular method...The husband influences this decision)."

Another nurse outreach worker in a small town near Jenin clarified:

> "Most women come asking for the IUD. They usually learn about this method from other women informally. The second most favored contraceptive method is the OC. Some women get professional advice from health workers, and so this helps determine their choice."

A representative respondent said:

> "The woman herself decides upon the method, but the specialized doctor in the clinic influences her selection of the method due to the fact that the doctor knows well the best contraceptive that minimizes the risks of infections and complications." (Refugee housewife, age 23)

The basis of choice, if it is the women's, relates to her or her husband's beliefs and perceptions about effectiveness and safety, about possible side effects, discussed above, or less frequently mentioned, about degree of satisfaction in sexual intercourse.

Since women and their husbands defer to medical advice on choice of contraceptives, and since so few methods are currently used, it seems clear that there is a need to better educate health providers about the range of temporary methods available. Health providers need to promote methods other than the IUD to a far greater extent, and promote them earlier in parity.

When Women use Contraceptives

The 1997 PCBS health survey showed that among age group 30-49, first contraceptive use (ever-use) tends to have begun only after the fourth child; 38.1% in this group first used a contraceptive only after 5 or more children (PCBS 1997:147). However, among the under-30 group, first contraceptive use may begin after 1 or 2 children (67.2% report first use after first 2 children). Thus, the trend is toward lower-parity contraceptive adoption.

Our findings parallel the PCBS finding that many women first use contraceptives only after their fourth child. However, we also found that many women--especially younger, more educated--would like to use contraception at an earlier stage of parity, and some in fact do this. Even if they have their first baby without delay, they may nowadays adopt contraceptive use after one or two children. Some such women might even resist the considerable pressure to have the first baby right away.

Yet various interviewees, a nurse at an UNRWA clinic, and women in focus groups in Gaza still spoke of women who only adopt contraception after 7, 8, 9 children. Various respondents mentioned that contraceptive adoption depends on the sex of the existing children: if there are only or mostly girls, contraceptive adoption may be postponed until there are two boys.

Health workers teach that contraception should begin right after the 40-day postpartum period. Some women come to facilities to seek contraceptives before 40 days if they have had experience in the past with their breastfeeding not working as natural contraception. Others who trust the contraceptive function of their breastfeeding might seek contraceptives after they breastfeed for 3 or 4 months.

Access to Contraceptives

A national survey in 1992 found that "only a small share of health services provide family planning assistance" (Heiberg and Ovensen 1993:113-114). Access to at least contraceptives seems to have improved greatly since, as our review of PCBS and other survey findings show.

Many interviewees in the present study mentioned that contraceptives were obtained free. Places mentioned include UNRWA clinics, foreign and Palestinian NGO clinics, MCH and family planning clinics, private and "specialized" doctors and clinics, and "governmental institutions." Many mentioned that contraceptive costs were affordable or even "symbolic." In fact, not a single respondent mentioned prices of contraceptives being other than "marginal" or minimal, except for one who commented that contraceptives "could be expensive if purchased from the pharmacy."

In short, few if any problems were expressed concerning contraceptive access, availability or cost, at least for the two popular methods. Obstacles to achieving higher contraceptive use levels appear to be found more in pronatalist attitudes, including those of husbands and older family members.

Village health workers (VHWs) are said to resupply oral contraceptives to women who have been examined and already had OCs prescribed, at least in some areas. This appears to be the only type of community based distribution of contraceptives. It seems that medicines, even aspirin or vitamins, are rarely available in smaller villages, at least in some parts of Palestine. People have to travel to the nearest town or city to get these.

In conclusion of this section, there is a clear need to promote a range of temporary methods and to get accurate information as well as contraceptives to the broad population. Messages will need to be consistent and mutually reinforcing, and be sent though a wide variety of channels (see below, Health Education Approaches and **Media Habits**).

C. PREGNANCY, CHILDBIRTH, PERINATAL CARE

Literature Review: Infant Health

The leading cause of death during the first year of life, as of 1997, is "congenital anomalies" (18.6%), followed by prematurity (14.2%) and respiratory conditions (9.5%). Diarrhea (classified under "gastroenteritis and dehydration") has dropped off as a cause of death in recent years, to 3.3% of infant deaths (MOH 1998:82).

According to the 1997 PCBS survey, most (94% overall) babies are weighed and measured in West Bank and Gaza, with little difference found by residence (city, camp, or village).

A recent survey of children in Palestinian refugee camps in West Bank, Gaza, Syria, Jordan and Lebanon showed 67% to be anemic, with rates in Gaza, Syria and Lebanon among the higher rates. Factors associated with anemia included lack of breastfeeding, male sex, maternal illiteracy, stunting, and recent episodes of fever or diarrhea (Hassan et al 1997).

A study of children in Gaza found 15.1% to be underweight, there was wasting in 5.7%, and stunting in 14.2%. No significant differences were found between the sexes (Kumar 1995). Several other recent studies have also found no significant gender differences were found between babies and young children.

For example Schoenbaum et al (1995) found no consistent gender differences in nutritional treatment of children and anthropometric outcome for infants of different socioeconomic status. An earlier study (Schoenbaum, 1993) based on research conducted between 1987-89, showed a slight difference in malnutrition among infants in Gaza, in which girls were slightly disadvantaged. Breastfeeding did not vary by gender in 1987, although in 1989 boys were more likely than girls to be nursed after 12 months of age. "No gender variation was found in receiving meat to eat, but difference (not significant) was found in receiving vitamins and iron." This study found no gender differences in feeding patterns, but did yield the obvious finding that "poorer children were much more likely to be malnourished..."

According to the last national health survey (PCBS 1997), anthropometric measures have been used to assess the nutritional status of Palestinian children under 5 years; 94.7% of surveyed children have been measured for height and weight. The percentage of children under 5 years suffering stunting (height for age) in the Palestinian Territory was 7.2% (6.5% for males and 8% for females); for wasting (weight for height) 2.8%; (2.6% for males and 2.9% for females); and for underweight (weight for age) 4% (3.4% for males and 4.5% for females). For the three mentioned indices, rates were slightly higher in Gaza Strip.

Percentage of Children Classified as Malnourished

Region	Stunting	Wasting	Underweight
West Bank	6.7	2.2	3.9
Gaza	8.2	3.7	5.2
Overall	**7.2**	**2.7**	**4.4**

Source: PCBS 1998 (from 1996 Survey)

PCBS asked a question about birth weight according to mother's perception or opinion: 6% of last two births were considered below normal (less than 2.5kg), 85.7% were normal (2.5-4 kg) and 8.3% above normal (above 4 kg) (PCBS 1997). Findings of the same survey showed that the percentage of under 5 children who have had a diarrhea episode during the last two weeks preceding survey found to be 13.5%. The mean duration of diarrhea was 4 days.

Immunization statistics from 1997 from the MOH show coverage at the 95-96% level (MOH 1998). However, according to the earlier (1996) health survey (PCBS 1997), and requiring proof by seeing completed immunization cards, overall immunization coverage for all ages was 66.8%. There were also differences by age of child: coverage for babies under 6 months is fully 89.5%. This drops steadily as age of child increases, to 51.1% for children over 36 months. It appears that mothers begin conscientiously, but then may fail to keep up with immunizations as the child reaches age 3 or older. There is no difference at all in coverage by gender. Under-5 immunization coverage was highest in villages (70.9%) and lowest in camps (54.8%) (PCBS 1997:173).

Findings from Qualitative Study: Infant Health

Pregnancy is considered a natural process. In the past it was considered rather dangerous and serious, but nowadays major problems are not anticipated. Virtually all births now occur in health facilities, attended by trained health personnel. Those few births that occur at home (in West Bank only, it seems), are said to be attended by trained midwives nowadays (see **The Status of Traditional Birth Attendants**, below).

Traditional or religious healers are consulted by some if a woman cannot conceive, in order to treat infertility; but they are consulted for little else pertaining to perinatal matters (see section on traditional healers, below).

Women, and Palestinians generally, seem to have great respect for, and trust in, modern (i.e., biomedical, allopathic) medicine and practitioners. Almost all advice on matters pertaining to pregnancy, the perinatal period, and childbirth itself, comes from medical personnel rather than from traditional health practitioners, or from friends or neighbors. The availability and value of specialized nurses and (trained) midwives, as well as the proximity of clinics, was mentioned by many respondents with no need for prompting.

Our findings are corroborated by, e.g., the recent family planning survey of Jenin district (CARE/UNFPA 1997)

Virtually all respondents said that pregnant women turn to doctors (or other medical professionals) because they possess the relevant knowledge and experience, implying or stating that friends and neighbors do not posses relevant and valued knowledge and experience. We see in this context and throughout the study that Palestinians seem to have great respect for education and those of professional status, especially doctors.

Perceived Danger Signs in Pregnancy, and Response

Locally recognized "danger signs" that a pregnancy might be difficult or dangerous include high blood pressure (or headache indicating high blood pressure), low blood pressure; swelling including swollen ankles; bleeding, convulsions and anemia, diabetes, "distension or tumor, which could be a sign of pregnancy poisoning" (this from a pharmacist assistant); varicose veins; "the status of the fetus in the abdomen;" lack of fetus movement inside the womb; vomiting or dizziness; "different pains coupled sometimes with high temperature and paleness;" "back and legs pains;" visual problems, convulsion, change in the color of the women's face; "albumin," and "sensitivity."

Note that answers point to beliefs that appear medically sound, medically informed, and little-influenced by "folk" beliefs or alternative ethnomedical theories. Very few informants, male or female, failed to describe at least some danger signs, perhaps proving again strong Palestinian concerns about their children's health and survival.

People were asked what they usually do when they observe and danger signs in the pregnant mother. Interviewees and key informants were essentially unanimous in saying that she should be taken, and is taken, to the nearest health facility. Typical comments were:

"If the situation dangerous, she should go to hospital right away." "She should consult a doctor, especially in cases of high fever."
"She immediately goes to the clinic in order not to have any complications."
"(She) goes to the nearest clinic and then to the doctor."
"She immediately goes to the emergency section."

A more detailed answer that refers to care-seeking personal history:

> "In case of serious syndromes, I immediately go to the doctor. Once I had bleeding and did not know what to do although I am educated and aware of many matters concerning this issue. In the end, I went to the doctor. Also, the woman should be fully aware of the blows or strikes the fetus may face, for fear of internal bleeding. People should not take such things lightly because they may cause meningitis if the body does not absorb the blood." woman, age 38, Al – Eizareyeh

A rare answer:

> "I consult people around me such as friends and relatives." woman, age 20 (residence not available)

Sometimes the urgency expressed about getting the woman to a medical facility without delay is because of concern with the woman, but it may also be because of concern for the fetus, as this response shows:

> "In case of serious syndromes, the woman must immediately go to the doctor in order to examine the fetus and assure its proper health." (male doctor, Al –Eizareyeh)

In sum, it appears that women and their husbands do not fail to realize dangers signs during pregnancy; they do not hesitate to take the woman to a nearby health facility if such dangers signs are observed; health facilities are not far away, and there appear to be no serious barriers to service utilization relating to perceptions in treatment and quality, at least from the perceptions of consumers (see below, Health Facilities Utilization). The danger to the woman is, at least nowadays, appears to be a major consideration--not just the survival of the fetus.

Diet During Pregnancy

Pregnant women essentially follow their regular diet, although they often increase consumption of meat, fish, milk and dairy products, eggs and vegetables, a pattern also found in a recent Gaza health survey (Ard El Insan/Terre des Hommes 1998:29). There seem to be few traditional beliefs about special foods intended to nurture the mother or babies. There seem to be few if any indigenous beliefs about foods or drinks that make for ease of delivery. No special dietary prescriptions or proscriptions arose in interviews, other than a widely held conviction that pregnant women should avoid any medicines not prescribed by a doctor.

Diets during pregnancy mentioned or recommended by respondents appear to be beneficial and medically sound: milk and dairy products including yoghurt, eggs, vegetables including spinach, liver, lentils, Khabiza bread and fresh fruits. Fresh fruit juices and vegetable soups are also considered good. Respondents commented that pregnant mothers should eat more of these foods for the health of her fetus. One woman mentioned that eating khabiz (local bread) and salty foods are good because it makes the breastfeeding women take more liquids, "which is essential to increase mothers' milk."

Calcium, iron, and vitamin supplements were frequently mentioned as well, and sometimes honey. Low-income women mentioned that they get vitamins and iron tablets free from UNRWA clinics. Such women, including those in an income generating group of refugees in Gaza, explained that knowing and affording are different. What they'd like to eat when pregnant are milk, eggs, meat, fish, chicken, beans, cheese and yoghurt, but they cannot afford much of these. In the words of one woman, "It depends on how much

money you have. If you have no money, you eat only beans." As mentioned elsewhere, UNRWA provides some free foodstuffs to pregnant and postpartum mothers, but not nearly enough for optimal maternal health.

Respondents sometimes mentioned that Palestinian women--like women everywhere, develop cravings for unusual foods (or unseasonable, hard-to-get foods). The women's in-laws tend to indulge these cravings. They give her meats including a lot of organ meats such as kidneys and livers.

It appears that liver and organ meats are recognized as good for mothers and babies, and respondents sometimes specified that these are high in iron. However, these foods are not necessarily given to pregnant women, rather to women who have given birth. It might be a worthwhile health education strategy to promote organ meats for pregnant women to avoid anemia, although these are relatively expensive.
While it is known, or believed, that Palestinians in general are turning increasingly to western diets of high sugar, salt, fat, and "junk food," little if any evidence was found of unhealthy dietary beliefs or practices surrounding pregnancy.

A representative comment:

> "She (the pregnant mother) requires an increased quantity of foods, mainly proteins, milk and fruits. This is good for the health of the mother and the child. The husband should play a major role in encouraging his wife to increase the quantity of food, for her health and the fetus's health. The pregnant women needs iron tablets to avoid anemia. Also...in the case of breastfeeding (she needs) to increase the quantity of food. Also meat, diary products and fruit are good postpartum." (Male, age 40 from Faqouaa, near Jenin)

Consumables to be Avoided During Pregnancy

Consumables to be avoided during pregnancy include fried foods, spicy foods and hot peppers, drinks with caffeine (coffee, tea and soft drinks were all mentioned), legumes (they "cause abdomen swellings and inflammations", and /or "onion, cauliflower and all things that may cause distension for the mother."

A surprising proportion of respondents mentioned without prompting that all drugs and medicines should be avoided by pregnant women, unless specifically prescribed by a doctor. Some respondents specified what should be avoided (which proves some insight to commonly taken medications): sleeping pills, aspirin, Acamol (Paracetamol), anti-depressants, cough syrup, valium, even oral contraceptives (said by some to decrease or stop breastmilk). It would be interesting to compare the frequency of this (volunteered) comment with comparable findings from studies in Europe and America. It is our impression that Palestinians are unusually well educated on this point.

A number of respondents were also emphatic in stressing that alcohol and smoking are prohibited during pregnancy and breastfeeding, suggesting that some more modern, secular women practice these when not pregnant.

> "She should not take any kind of medicine except through medical prescriptions because it may affect the fetus. Smoking is among the most dangerous risks, which also applies to drinking alcoholic drinks. She should watch the food she eats, especially those types that may cause distension or diarrhea." (woman, age 38)

Some local health workers reported that mothers are supposed to avoid cinnamon tea during their last trimester of pregnancy, because it is supposed to cause abortion or miscarriage, that is, it is believed to have an emetic property. On the other hand, the newly-delivered mother is supposed to drink cinnamon tea after giving birth in order to "clean everything out" of her reproductive system.

When asked about diet including whether or not any special drinks, teas, etc. are good for breastfeeding women, respondents often mentioned that women should increase their liquid intake. They said women should drink more milk, grape juice, soups, etc. Marmalade, halva, caraway sees, dates, rabbit and chicken meat were also occasionally mentioned as being good, as were milk, eggs, yoghurt, cheese, fruit juice. Halva (halvah) was said to increase breastmilk.

Sometimes respondents said that breastfeeding women should increase the quantity of food, but only "essential", "nutritious" food.
And again the warning: "(The woman) does not take medicine unless through medical prescriptions because it may affect breastfeeding."
Mentioned as good for pregnant or breastfeeding mothers: anise, camomile, mint, thyme, fenugreek, merameyah. The mother should also drink milk herself.

Some respondents said that a woman should not do exercises during pregnancy for fear of harming the fetus, but most said that light exercises such as walking are beneficial, perhaps especially after the sixth month. Some warned against lifting heavy things. Some specified that the pregnant mother should practice light exercises such as standing, sitting down, sleeping on her back, and raising her legs. This will help make delivery process easy. Raising legs was said to reduce swelling edema, "especially if she stands for a long time."

Note on Use of Herbs

The Palestine Ministry of Health seems not to discourage the use of medicinal herbs. They are regarded as basically beneficial.[9] Herbs are either grown at home or obtained at

[9] One West Bank nurse interviewed said she discourages any infant tea drinking, advising mothers that it may prevent babies' absorption of iron. See "**Is Breastfeeding Exclusive**" section, below, for discussion of related issue of giving sugar and water to infants.

pharmacies or markets. Most Palestinians including doctors drink herb teas, such as mint (nana) and chamomile (babonage). The impression that nothing about herbs is regarded as harmful emerged in discussion with respondents including health workers at all levels. Medicinal herbs in Palestine--at least those commonly used for babies--seem to be classifiable as common culinary herbs. This is very different from the situation in, e.g., sub-Saharan Africa, where doctors and MOHs often warn the public against the toxicity, overdose, etc., of local herbs, many of which are in fact dangerous. There seems to be no need for such a policy in Palestine.

Childbirth

Almost all births nowadays occur in health facilities. If a small percent in West Bank villages still occur at home, it is likely to be due to the choice of an older woman, who is not having her first child, and who will be attended by a trained midwife or TBA whose skills have been upgraded. To understand changes in MCH health status in recent years, it is important to note that many births occurred at home, attended by untrained dayas, in the recent past. Women in focus groups said that the government "does not allow home deliveries" in Gaza. Even an 80 year old nonliterate daya (TBA) made this unprompted observation about Gaza:

> "(Births now occur) in the hospital. It is safer, more equipped, and can take care of emergencies that the mother or the child might have. There are no deliveries at home these days. In the past most deliveries were at home."

Other representative comments:

> "There are no deliveries at home in this area...this situation has changed because scientific advances made all people prefer to have delivery at hospitals or clinics rather than home delivery; the former is safer." (Housewife, age 57, no formal education, Al–Shati'a Refugee Camp.)

> "The hospital is better because it is equipped in a way that makes it ready to handle emergency cases that may face the woman and the child. Currently, no deliveries take place at home, which was prevailed in the past." (Imam, age 90, Ayda Refugee Camp)

> "The hospital...is preferred because it is more secure in case of complications. No deliveries take place at home. Yes, there is a difference from what it was in the past due to the unavailability of doctors in the areas (then), as well as transportation difficulties." (16-year old mother, elementary education, Alyamun)

> "I used to deliver at home under the supervision of a well- known midwife in this area." (75-year old mother-in-law, Al – Eizaryah)

Other representative comments:

"...the current generation prefers delivery at hospital."
"the hospital...is better in terms of health care and availability of everything the woman needs in emergency cases."
"the hospital is better in terms of optimal safety and cleanness."
"The majority of deliveries take place in the hospital. 10 or 20 years ago, deliveries were taking take place at home under the supervision of the midwifes."
" Pregnant women prefer to deliver at hospitals because of competition. If a neighbor delivers at hospital, she wants to also."

Women were said to rest in the place of delivery for 1-2 days. This place is almost always a health facility, except in a few areas of northern West Bank. If the woman has a caesarian delivery, she might stay for 3-7 days. The 1996 West Bank health survey (Ismail and Shahin 1996:22) found a 10% rate of caesarian deliveries, and the authors suggest that the MOH might need to develop and enforce guidelines regarding its use. The present study also noticed that caesarians are mentioned quite often. Morbidity statistics from hospitals such as Shifa (Gaza) and Naser also show quite high numbers of caesarians (see below, **Problem Areas that Still Need Exploration**).

Danger Signs Recognized In Newborns, and Response

Respondents were asked questions designed to learn if they recognize any signs or symptoms that suggest a newborn baby is not well, or in danger. By far the commonest answer was bluish or yellowish skin color, or paleness of skin or face. The following are other responses (the typical respondent gave 2-3 examples, sometimes more): too much crying at birth; "the inability of the newly born to cry;" breathing difficulties or irregular breathing or panting; increase or decrease of heartbeats; lethargy, muscle weakness; yellow eyes, diarrhea, dehydration, fever, grippe, convulsions, swollen kidney or liver or head or abdomen; physical malformation or obvious handicap; muscles weakness; "laziness and lack of movement;" low temperature; vomiting (said to be evidence that the mother drank wrong liquids during pregnancy); unusual "movements of hands and legs"; and abnormal-looking eyes.

One 24-year old housewife mentioned that "sleeping for long hours" after being born is a sign of good health. A Gaza man observed that pink skin color of baby and crying are good signs.

A representative response:

> "The child would be in good health if the color of his eyes and face is normal as well as if his weight is in the normal range. The child would be in a bad health condition if the color of his face is yellow–-pale--and the lips blue (or) pale as well or if his weight is below the normal range." (Housewife, age 42)

As with comments about danger signs in pregnancy, these answers again point to beliefs that appear medically sound, medically informed, and little-influenced by "folk" ethnomedical beliefs or alternative ethnomedical theories.

People were asked what they usually do when they observe and danger signs in the infant. As with mothers showing danger signs, babies are brought to the nearest health facility. There seemed to be no significant barriers for most people here, whether geographic, financial, quality of service perceptions.

Postpartum Rest and Return to Chores

A recently delivered women normally rests at home for a few days after delivery, but there seems to be great variation as to the length. The range was 1 day (for a woman alone, with no one to help her) to 20 days. Quite a few respondents said a week, and another fairly large group said 20 days. For the wife who has no sisters or other daughters to help her with routine household duties, the rest period is closer to 1-2 days, or perhaps even less. In any case, it seems that women work hard during at least the latter part of the 40-day postpartum period.

Some mentioned that neighbors come to help the postpartum mother with her chores, for up to a week.

Regarding bathing, mothers often bathe newborns soon after birth, although some health workers mentioned that they advise women to wait for three days before bathing the child. A health worker informant suggested that washing a baby directly after delivery may cause infection of the umbilicus.

Regarding keeping the baby warm, some prevailing practices or financial or environmental constraints may result in inadequate clothing or an environment inadequately heated.

In most Muslim countries and cultures, a postpartum rest period of 40 days is considered essential for the mother's rest and the protection of the infant (Coeytaux 1989). It is often celebrated as an important landmark for the survival of the infant. The woman is not allowed to resume sexual relations with her husband until after this 40-day period.

Among Palestinians, the present study found no other significant religious or other restrictions other than that concerning sexual intercourse during the 40-day postpartum period.

The newly delivered mother is often encouraged to drink herbal teas made from alhaba alsawda, cinnamon (canar), almond (allos), and walnuts (aljaws). These seem to be ritual teas for "raising the blood" of the mother. Such herbal teas for newly delivered mothers seem to be common in Muslim cultures during the 40-day postpartum period (Coeytaux 1989:5). The Palestinian mother is also given hot soups made from rice, meat, vegetables

and green wheat specially prepared called friki, at least in northern West Bank. Friki may be eaten with a small dove, as well as fruits, olive oil and a sweet plant (Arabic name available). All these are considered good for breastfeeding, for supplying iron or preventing anemia, and for energy.

One health worker said she believed anemia may be exacerbated by too much tea drinking (the tannins of which can prevent iron absorption), poor food preparation, too much food drying, as well as by local food washing practices. This informant said that women often make salads in the home too early before eating; she feels that iron is lost this way.

Among the very few phrases that arose that might suggest folk-medical concepts, we encountered "increasing the blood" and "raising the blood." Both arose in connection with teas or diet or iron tablets, thought to be good for pregnant or postpartum mothers. Exactly what these phrases mean should be further researched, since they might prove useful in nutritional and other health education aimed at pregnant and postpartum women. Yet they both seem to refer to raising the hemoglobin level of the blood, or avoiding anemia.

The Wrapping" or Swaddling custom.

Traditionally, Palestinian babies are wrapped up tightly for a period of weeks or even months, after they are born. This custom, known as *Kofalia* or *Lafa*, was explained in several ways: (1) it keeps the baby warm in winter (babies in winter might be kept wrapped for 4-5 months, compared to 1-3 months in summer); (2) it prevents bones breaking or limbs being twisted, this danger mostly coming from relatives and neighbors who pick up and handle the baby and exclaim, "What a pretty baby!"; (3) it "tightens" and strengthens the baby's muscles and bones and limbs; (4) it prevents babies from putting things in their eyes or mouth; (5) it "keeps the baby physically fit and without abnormalities;" (6) "it helps the woman to carry the child on her back while doing some housework"; (7) it helps carry the baby in the best way; (8) babies cannot hurt themselves while asleep at night.

Some babies are so wrapped up in the summer months that they are said to get heat rashes from the wrapping. One informant observed that babies seem shocked to see their own limbs moving when they are first unwrapped. "It's like a second birth."

Swaddling is declining with urbanization and modernization. Some people compromise with tradition by only wrapping the baby's body and not its arms.

It is not known to the research team exactly what the health consequences of swaddling are. Yet there seem to be some negative health consequences because UNRWA has developed health education advising against the practice.

Literature Review: Breastfeeding

According to PCBS (1997), almost all (96%) mothers breastfeed their babies, whether or not exclusively. This declines by 3-5 months to 88.8%, then by 6-8 months to 73.9%, by 9-12 months to 60.2%, by 15-17 months to 38%, and by 18-20 months to 16.3%.

Differentials in the Prevalence and Duration of Breastfeeding Among Children

Region	Percentage ever Breastfed	Percentage weaned within 1st 3 months	Continued breastfeeding rate
West Bank	95.5	8.8	56.9
Gaza	97.0	4.9	60.1
Overall	**96**	**7.4**	**58.3**

Source: PCBS 1998 (from 1996 Survey)

Breastfeeding continues for a mean average of 12 months (if women have elementary or no education), or 11 months (secondary education or above).

The recent MCH survey in Gaza likewise found in its random sample of women that 96% said they had breastfed their last child. The average age of introducing artificial milk was about 2 months (Ard El Insan/Terre des Hommes 1998:16-19).

Returning to PCBS findings, longer breastfeeding is associated with higher education, except that those mothers with no education breastfeed longer than those with the lowest level of formal education (PCBS 1997:122). Mothers in camps are more likely to continue breastfeeding than those in cities or villages.

Most (62%) mothers breastfeed within first 3 hours postpartum. Mothers in camps are somewhat more likely to follow this recommended practice.

It is fairly common (43%) to give powdered milk to a child under 12 months old. In another PCBS table, there is a finding that 45% of children 6 months or under are given powdered milk (PCBS 1997:134). By far the most common liquid other than breast milk given to children 6 months and children is "herbal drinks" (78.6%). Giving fruit juice and "home-made baby food" are also quite common for this early age group (47% and 44% respectively).

The most common reasons for weaning babies at less than 6 months are "insufficient milk" and "the child refused the breast", followed by mother's illness (PCBS 1997:137). Fully 28.2% of all mothers reported weaning the last two babies at the time they did, due to being pregnant again.

The PCBS health survey (PCBS 1997) found that 24% of mothers initiate breastfeeding more than 6 hours postpartum, but "more than 6 hours" was the last response category, thus this survey does not provide evidence that some women delay breastfeeding up to 2-3 days or more (see qualitative findings below). However, the 1998 MCH survey in Gaza employed more discerning response categories and found that 5.6% of women reported breastfeeding initiation on the second day postpartum, and 3.4% began after 2 days, and 1.7% did not breastfeed at all (Ard El Insan/Terre des Hommes 1998:16). A study in neighboring Egypt (Hossain et al 1995) also found evidence of delayed breastfeeding. Cross-culturally, delayed breastfeeding decreases the likelihood of exclusive breastfeeding and is associated with a shorter duration of breastfeeding (McDivitt at al 1993).

The MCH survey in Gaza (Ard El Insan/Terre des Hommes 1998) found that of the nearly 60% of a random sample of mothers who admitted they gave their last baby fluids other than milk before 4 months postpartum, 34% gave water and sugar; 40% gave herbal drinks (starting at a median age of 1.5 months); 11% gave water (starting at a median age of 2.1 months); and 30% gave juice.

Qualitative Study: BreastFeeding

According to our findings, the great majority of women breastfeed, and they begin this almost immediately after delivery. Many women said the mother usually waits 1-2 hours (sometimes 3-4 hours) after delivery "in order for the mother to have some rest after delivery as well as to accumulate sufficient quantities of milk." There are also those who say they cannot produce milk, or enough milk. There are also said to be woman nowadays who don't breastfeed out of vanity (not wanting their breasts to sag), or because they think bottle feeding is "modern" (these comments usually from community level health workers).

Breastfeeding is believed to be very good for the baby, and even for the mother, as this characteristic answer illustrates:

> "Women start after one or two hours after delivery and continue up to 10 months up to one year. In the past this period was higher than nowadays. Breastfeeding is very useful and good for the child and the mother. This will supply the child with a full diet, a healthy diet, and supply him with immunity, because the milk can't be polluted such as with prepared food. Mothers do not delay breastfeeding more than 2 hours. Rarely she delays by more than 6 hours due to medical reasons, such as sour nipple or if she's under certain medical treatment, taking drugs. (Male, age 40, Faqouaa village, northern West Bank)

A number of reasons were given why breastfeeding is good and should begin without delay.

"Breastfeeding should begin immediately after delivery because it helps in returning the womb into its original position. Also, the child should be fed because he is born hungry." (Housewife, age 23, Al–Shati'a Refugee Camp, Third Preparatory Class education)

Others said breastfeeding diminishes the pain of delivery. Women with little education in a Gaza focus group discussion commented that breastfeeding is good because it keeps the baby warm internally ("the baby is filled with warmth when it's on the breast") and because baby gets to know its mother that way. They added that it's important to start this quickly so the baby learns how to breastfeed.

Some health workers said that they emphasize that breastfeeding is free, while artificial feeding costs money. Several women in the general public made this point as well.

The period for breastfeeding mentioned by most is about one year (MOH and NGO health education promotes a longer period). However, there was great variation found in reported duration of breastfeeding, ranging between 6 months and 3 years even among 5 women in a single focus group discussion. The mean durations of 11 or 12 months (depending on education level) reported by the PCBS health survey obscures this wide variation.

Some employed women admitted that it was easier to bottle-feed their babies; they tend to report shorter breastfeeding periods, or irregular breastfeeding (e.g., breastfeeding only when not at work). A village health worker told interviewers that many women in her West Bank village nowadays bottle-feed because "They have taken on the modern ways." Also they can afford artificial feeding, and "they are vain and want to maintain their breast shape". This VHW and other health educators have tried to promote breastfeeding, but the experience has been that once a baby has tasted the "sweeter milk from a bottle", it will not be interested in breastfeeding.

It should be noted that some West Bank villages have strong migratory links with communities in other countries, with villagers going back and forth to visit Palestinian emigrant relatives, to emigrate themselves, or to return home for good. The village just referred to had links with Argentina, and a number of villagers spoke some Spanish. Another village in the area had similar links with Brazil; some Portuguese words might be heard there. The VHW just quoted thought that "modern ways" of bottle feeding had been picked up through visits to Argentina, rather than through contact with Palestinian or Israeli cities.

VHWs from other villages claimed that virtually all women breastfeed, and most do so with little or no delay. One explained, "Most women here breastfeed. It's much cheaper than artificial feeding. They breastfeed right away, in part because they know that the earliest milk, including the colostrum, is very good. There's not really a bottle problem around here." Once again, we see great variation in breastfeeding behavior.

Interviewers occasionally heard that some women start breastfeeding only after 1, 2 or even 3 or more days because they believe "there is no breast milk until then", or the early milk is too "light," or "thin," or "impure." Such answers tend to be from women with little or no education. Sometimes the reason was given that the woman is sick, or had a caesarian operation and had anaesthesia in her system, or was "broken with fatigue," or had pain in her breasts. Sometimes the baby was said to be the cause of long-delayed breastfeeding: "It could be due to the child suffering from health problems (such as) immaturity or breathing problems, or lip malformation." A midwife from Hohm mentioned some of the reasons just listed, then added that delayed breastfeeding might be due mothers' "superstition" that the first breastmilk is of poor quality: "That is why women may get rid of the first milk, due to impurity, to its impure color." (See next section on colostrum; a few interviewees thought this does not appear for 2-3 days or longer).

Another health worker, a nurse, observed that:

> "(breastfeeding delay) could be due to believing certain superstitions stating that if any of the grandfathers is dumb or blind, then the dumbness or blindness will be transmitted to the child through breastfeeding. That is why the family may look for another breastfeeder to feed the baby before his real mother breastfeeds him."

One woman said that she herself delayed breastfeeding by 24 hours to give herself a rest, a practice she said she learned in Israel, where she had her recent deliveries. She thought that a women's fatigue might affect the baby through breastmilk transmission. A second woman affirmed this pattern of one-day delay for recuperation, and observed that it is a pattern from former days.

How common is a delay of 1-2 days? Recall the Gaza survey finding that 9% of randomly surveyed women fell into this category (Ard El Insan/Terre des Hommes 1998:16). Judging by the frequency of comments or admission about breastfeeding delay in our study, this seems about right, or slightly higher than what our findings point to.

Far more often, women in our study felt that a rest and recuperation period of 1-2 hours was sufficient, and also useful in that it prepares and strengthens the mother for a long breastfeeding period. One respondent said a 2-hour delay "allows the child to breathe away from the mother's breast."

Breastfeeding is mostly exclusive for the first four months, except that the new baby is usually given water with sugar or honey. It appears that honey may be given to the newborn, even without water. The purpose of this was sometimes said to be "to clean the baby" or "to lubricate his intestines." Newborns may also be given 3 or 4 herbs (including marami) as routine calming or preventive medicines. At least one of these herbs is supposed to be good for the stomach. No evidence arose in our study or literature review that these herbs are in any way injurious. Most respondents claimed that water given to newborns (with herbs, sugar or honey) is always boiled, but some health worker

informants said this water may not always be boiled and so it may introduce "germs" or amoebas.

The Colostrum

The colostrum (labatha) is regarded as very good, both traditionally and nowadays. Some interviewees mentioned that they knew about colostrum because the knowledge was handed down from their mothers and grandfathers. It is said to "strengthen the baby" and help it avoid diseases. Virtually every interviewee, whether illiterate, 90 years old, a traditional healer, a daya, a fortune teller--knew that colostrum provides "protection" or immunity against disease for the baby, and if the answer was less specific, at least that it was very good.

The only problematic finding in light of this universal approval is that some women delay breastfeeding by 2-3 days, and one of the several reasons given for this is that the first milk is considered "impure," or "too light" or thin. A few respondents expressed the belief that colostrum does not appear for the first 3-4 (even 7) days postpartum, and this was given as a reason to delay initiation of breastfeeding.

One nurse reported that some villagers believe colostrum only appears 3 to 7 days postpartum. In fact, we found great variation in beliefs concerning how long colostrum is normally available, ranging from a few hours to 40 days. Most however thought it was available for the first 3 days after delivery.

The following are representative comments that illustrate why colostrum is believed to be good. Note the comment that it is even good for the mother herself:

"The colostrum is very beneficial because it safeguards the child from diseases, from a scientific point of view. It is very nutritional, and since it is granted from God, it must be very important and beneficial."
"It contains the most beneficial elements for growth and development... "
"It contains most of the elements essential for the child."
"It safeguards the child from many diseases and the first drops of mothers' milk are the most beneficial of all."
"It contains the materials that give the child natural immunity against diseases. Also, this milk is clean and of a medium temperature."
"It is good for the mother's recovery of her health."
"It is good, it cleans the intestines and contains vitamins."
"It strengthens the baby."
"It protects the baby from any disease."

Breastfeeding was said to have been longer in the past. It was said to be "up to 2 years;" "In the past it was 2 years, according to the Koran."). A reason given for longer

breastfeeding in the past is that because there were no nutritional supplements or artificial milk alternatives then, or they were less available.

Is Breastfeeding Exclusive?

The MOH and its NGO partners promote exclusive breastfeeding for the first four months postpartum, a policy that has a basis in regional research on infant growth patterns (viz. Hijazi, Abulaban, and Waterlow 1989). As already noted, many or most mothers give newborns sugar or honey and water. Most interviewees including health workers said that water given to infants is always or usually or nowadays boiled. Yet a VHW in the West Bank village of Turmosaia reported that she sees amoeba infections in infants of between 2 and 4 weeks old (the visiting doctor confirmed this). She explained why local drinking water was not very good. First, there is no piped water in this village (due, we were told, to Israeli policies). Many people store water in tanks on their roofs, in fact in open tanks into which insects, dead birds and debris fall. This VHW thought the amoebas found in infants were caused by giving infants sugar and unboiled water.

A few interviewees in various locations mentioned that doctors discourage giving infants sugar and water, which can be taken as indirect evidence that babies may be given unclean water.

It seems that the practice of giving water with honey or sugar, or other supplements, is associated with the belief by some women that exclusive breastfeeding does not provide enough for a growing baby.

> "After a week (she supplements) because the mother's milk does not suffice to meet the child's necessities. I feed my child with other liquids such as anise, caraway or pasteurized (cow's) milk." (housewife, age 57, 9 children, Al–Shati'a Refugee Camp)

Some begin to give herbs (e.g., yansun, fenugreek,) after 40 days perhaps to "clean the insides." We found no evidence of babies being given black tea, i.e., tea with caffein and tannins, but this might need to be further explored. Natural fruit and vegetable juices may also be introduced. Others introduce small amounts of food as well. For example, a woman in a focus group in Gaza said that after her baby was 40 days old, she gave it tiny amounts of various foods on her finger tip in order to help it "learn how to eat" and to "become accustomed to different tastes." She thought that her baby would spit out food if she waited until 4 months to introduce it.

Another woman at the same focus group reported that she waited fully 8 months to give her firstborn anything other than her breastmilk. This, she said to the amusement of all, is because nobody told her anything different. When this baby reached 8 months, it began to seek out and "eat food regular on its own."

It appears that the water in herbal teas is boiled, according to interviewees including health workers. One VHW specifically pointed out that herbal teas present no health problems because mothers always boil the water. However, it is possible that utensils

washed with unclean water could be a source of pathogens. Still, we might conclude that while herbal teas do not ordinarily introduce pathogens to infants, the practice of giving sugar or honey with water to newborns and infants can present a gastrointestinal problem when the water is not boiled, which sometimes it is not.

Those who breastfeed exclusively for 3-5 months (except perhaps for sugar, honey and water), begin to supplement breastfeeding with: yogurt, mashed rice, mashed potato, fruit juice and soft or mashed fruit (e.g. banana), boiled egg or egg yolk, baby formula, custard, cereals (Cerelac), pureed soups, and herbs such as chamomile, peppermint, cumin, mostly given for colic and abdominal cramps. A few women mentioned biscuits and small amounts of adult food as early weaning foods.

A few respondents mentioned that there is more exclusive breastfeeding in their areas nowadays because health workers have recommended this. In earlier days, some pointed out, women did not know there are dangers associated with non-exclusive breastfeeding. Still, herbal teas and sugar/honey and water seem not to count as exceptions to exclusive breastfeeding, for these and most women.

D. Health Facilities Utilization and Home Health Care

Literature Review: Health Facilities Utilization

In a major conclusion section of the excellent report by Giacaman et al 1995:33, some useful general observations are made:

> "The least developed clinics are governmental clinics, with the highest number of clinics with strictly curative services, minimal staffing, and the least variety of health human resources.
>
> Rural areas are the most disadvantaged in terms of the types and range of programs available. Towns are the second most disadvantaged. UNRWA clinics were found to have more extensive services than clinics of the other sectors.
>
> Regional differences are evident. Central West Bank and Gaza clinics appear to be better developed than clinics located in the north and the south of the West Bank. The north appearing to be the least advantaged region of all, especially the rural areas of the north."

These generalizations seem to point to differences that are useful to keep in mind, except that, just five years later, rural health services and health indicators have improved significantly, to the point that key health indicators are now better in villages than in urban areas (PCBS 1997; and see **below, Changes in Health Care at the Village Level** for summary of evidence).

According to the 1996 PCBS health survey, (PCBS 1997:92), most (92.9%) pregnant women reported having attended antenatal care (94% urban, 90.2% village, 96.5% camp) during their last two births. The mean number of antenatal visits is six and about 50% of pregnant women start their antenatal visits after the third month of pregnancy. Most mothers, especially if younger, used a private "doctor clinic," followed by a health center/MCH.

Since the rate of prenatal care is a subject of some debate and controversy, it should be mentioned that a PCBS press release in the series Selected Statistics dated 11/24/98 states an antenatal care figure of 80.5% for currently pregnant women. The Director of Health Statistics explained that this lower figure was found because some women in the sample of pregnant women were only in the first 1-3 months of pregnancy at the time of interviewing, and some (c. 50%) women wait until after 3 months for their first prenatal visit.

Stated reasons for not using prenatal services fails to tell us as much as we would like to know. Reasons include: "had no complaints" (54%), previous experience (was it bad?) (32%), cost too much (9%), service not available (<4%), service not satisfactory (1.3%) (PCBS 1997:113). Still, it would seem that neither cost, distance nor perceived quality of service are significant factors. There appears to be a need to discover and probe reasons such as perceptions of quality of service; felt need for service, gender of provider, etc. Hundt et al (1997), in a survey in Gaza that also included qualitative methods, found that 95% of women attended prenatal care.

In the West Bank, during the same year, Ismail and Shahin (1996) found that 92% received some antenatal care. Even as far back as 1992, most women were found to go for prenatal care:

> "When asked about their pre- and post-natal history in relation to the last child, 69% report having had pre-natal care, making 3 or more visits during the pregnancy, whereas 22% made 1-2 visits and the rest made but a referral visit or had no care at all (9%)." (Heiberg and Ovensen 1993:115)

This care in 1992 was provided by a gynecologist/obstetrician (64%), a certified midwife (38%), a general practitioner (15%), and a traditional birth attendant (1%). The authors observed, "This indicates the end of the era when traditional birth attendants figured prominently in local communities" (Heiberg and Ovensen 1993:115), a general conclusion supported by the present study.[10] Heiberg and Ovensen also observe from their findings that "when services are accessible...women tend to use them."

Returning to more recent PCBS statistics, only 33.5% of mothers received tetanus toxoid (TT) during recent pregnancy, with highest percentage in camps, followed by village,

[10] Note this quote refers to prenatal care. It is not clear if prenatal consultation was part of the role of the Palestinian TBA.

then city last (contrary to expectation). Compliance with TT increases with mother's level of education, as expected. Age of mother is apparently not an associated factor (PCBS 1997:94). Some interviewees indicated having received the TT injection but not knowing why they needed it.

Only 20% of women attended postnatal care in 1996, during the 5 years preceding the survey. There was no significant difference between city, camp or village residence, or even age or educational level of the mother, except, contrary to expectation, those with the most education were the least likely to attend (PCBS 1997:112).

Of pregnant mothers who have health problems, most (39%) have persistent headaches, followed by infections (34%), swollen ankles (34%), blood pressure problems (20%), convulsions (6%), and bleeding (5%).

Of pregnant mothers who take medicines/supplements, 50% take iron supplements (10% higher in West Bank than Gaza), and 42% take vitamins (5% higher in West Bank than Gaza). Usage of both rises proportional to level of education. The Ard El Insan/Terre des Hommes [1998] survey in Gaza found that 72.5% of mothers took iron supplements when pregnant.)

Most recent births take place in government hospital (45%), followed by private hospital (23%), doctor's clinic (11%), at home (10%), MCH health center (8%), UNRWA hospital (3%) (PCBS 1997:99). Births at home rise to 15.6% in villages, and are associated with women being older and having less education. The MCH survey in Gaza found that when a random sample of women in Gaza were asked where their last child was born, 41% said hospital, 39% said clinic, 17% said private doctor, 1% said at home with midwife, and 0.8% said at home without trained midwife (Ard El Insan/Terre des Hommes 1998). Thus, these findings were comparable with those of PCBS, except that far fewer were born at home, with or without a trained midwife (2.2%) (Ard El Insan/Terre des Hommes 1998:15).

Returning to PCBS findings, most recent births were assisted by a specialized doctor (54%), followed by a nurse/midwife (39%), other (6%), etc. Dayas were not specified, but may be among "others" or "friends/relatives." As might be expected, a specialized doctor is more likely to attend urban births. Women with the least education are most likely to be attended by "others" or "friends/relatives."

Of the some 10% who gave birth at home, most (56%) did this out of preference, saying this was because "home is better" than a health facility. This reason was followed by premature delivery (22%), and health facility costs too much (17%). Distance of health facility was cited by only 3%. Even more urban mothers than rural mothers cited "home is better."

Of recent births, 75.8% were classified as normal (West Bank & Gaza being the same); 9.5 required episiotomy, 6% a Caesarian, 6% induction of labor, and 3% suction and

forceps. Non-normal births were associated with age under 20 (age category 14-19), but not with residence or education (PCBS 1997:106).

Just under 20% of mothers went for some sort of post-natal care in the last 5 years, after birth of last 2 children, most to a doctor (18% of all mothers). Only 1% cited daya or midwife.

89% do not have a (self-reported?) chronic health problem. About half in the PCBS health survey sample have health insurance.

Reasons for not using an MCH health service include not currently being pregnant or not having a young child.

Among health facilities, 63% prefer UNRWA health services; 5.2% prefer NGOs; 3.8% prefer government services (where is private?); and 28.3% use more then one type of service.
53% of respondents in Gaza had a (recent) health education visit in their home. Almost all say such visits were viewed as "important" or "very important" (WAC 1999). These were made presumably by VHWs or community health educators.

Qualitative Study Findings: Health Facilities Utilization

Home Remedies

Before turning to health facility utilization, it is useful to look at which problems related to maternal and infant health are taken care of at home, as well as how they are taken care of, and by whom.

Common infant ailments are usually treated at home. These include colic (which may be treated with cinnamon, chamomile), coughing, stomach ache, colds and flu, fever, chest pains, headache, grippe, mild or "light" diarrhea, dehydration, toothache, constipation, simple wounds and injuries.

Common herbs or foods are used in treatment, such as chamomile, thyme, cumin, fenugreek, anise, alba, Merameyah, sheih, jadi, jadeh, yansun, Zeheif, water of zahl, hilba, Artemisia herba, zatel, sherbat (for "cleaning the stomach), Teucrium polium, honey, halva, salt, drops of lemon juice, tea, yogurt, banana, mashed potato (for abdominal problems), mashed apple, rose water. A pharmacist assistant mentioned that she uses parsley for the treatment of "urinary system inflammations" (various informants reported that pharmacies and markets sell common medicinal herbs and staff of these often recommend herbs for common, simple health problems).

Rice water may be given for dehydration; also starch and lemon; water, sugar, lemon, and salt; sugar and water alone, apple and rice water, increased liquids. Breastfeeding was

mentioned as helping a baby overcome nausea and vomiting. Cold or warm packs or warm baths may be used for fever. Hot oil packs might be pressed against the chest of those with colds or coughs. Castor oil and epsom salts may be used as emetics, i.e., to "clean the stomach."[11] Massage with olive oil seems common. Over-the-counter medicines such as aspirin, Acamol (Paracetamol), and various ointments are also used.

> "There are health problems that could be cured without the involvement of the doctor, such as grippe (the child is given warm solutions such as chamomile and anise); light diarrhea (rice water, boiled potato, yogurt), inflammations (olive oil ointment); and mild flu (warm liquids, which are better than medicine)." (midwife, age, 30, Al–Amari Refugee Camp)

Many respondents mentioned without promting that if these home remedies do not work, the baby should be taken immediately to a doctor. A few said they take their baby to the doctor at the first sign of trouble without trying any home remedies.

The question/topic about home remedies was not intended to be only about the baby. Yet the great majority of respondents answered the question this way, showing once again that the baby's health is of more concern than the mother's, even to the mother herself. Only very occasionally was there a comment about a remedy for mothers, e.g., chamomile is good for "breast aches."

Health workers sometimes mentioned in this context that women go to traditional healers or "magicians" for treatment of infertility, using herbs, olive oil, vaginal suppositories, etc. Healers confirm this (see below, **Note on Traditional Healers**).

Health Facilities

Few people interviewed complained about or even mentioned problems of access to health facilities. (Recall the survey finding that only 1.3% of women said "service not satisfactory" as a reason they did not use prenatal services in 1996 [PCBS 1997:113]). Palestinians in fact live within 5 km. of a health center (1997 World Bank finding), therefore physical access should not be problematic. A few villagers in the West Bank complained that there was no clinic or hospital in their particular village, but a facility was not more than 2-3 km. away.

Interviewees were sometimes critical, but not outspokenly so, of health services, perhaps partly or sometimes out of politeness. It may be that a more candid and accurate depiction can be given by a community-level health worker, as discussed above under methodology. As one health worker phrased it,

[11] A PCBS health researcher and a medical informant thought this is not a common practice, especially with babies. Its more something for older children, age 5-7, that might be done once a year.

"Government health facilities offer sub-standard services. All the people are complaining. Private clinics are the best, although they are costly. UNWRA facilities are okay but they are only for refugees. An example: If you go to visit a doctor at a government health facility, his behavior is different than if you visit this same doctor at his private clinic. I assume this kind of behavior difference is due to the increased number of insured people at the government clinic, which leads to overcrowding. A doctor has more time in his private practice, and fewer patients. Also the routine or bureaucracy of the government clinic is complex and demanding. The people have to wait longer...they are told go here, go there, wait, etc." (nurse midwife, village of Betrima, West Bank).

Government health facilities were judged to be anywhere from good, fairly good or "O.K", to poor in quality. There was strong general agreement that private doctors and clinics--especially specialists--are better than what the government offers. If people can afford private health service, they choose that option.

"Governmental health clinics need to improve. There one finds unavailability of beds and medicines, and the more expensive medicines are not available. Private sector facilities are excellent and offer services that give value for what's paid for." (woman, kindergarten teacher, Taybeh village, West Bank)

Regarding relative costs, the Coordinator of the 1999 MOH Survey of TBAs told one of the authors (May 29, 1999) that whereas dayas (TBAs) charge between 50 and 100 NIS for a home delivery, government hospitals charge about 500 NIS (other informants said the cost was lower, as low as 200 NIS), and private doctors charge up to 1,000 NIS. A doctor who makes regular visits to a West Bank village estimated that 65-70% of people in this village have health insurance. In this central West Bank village (Al Mughair), about 45% have health insurance. The doctor commented that many people would prefer to pay a small amount of money on a regular basis in order to be secure in the knowledge that they have health services when they need them. He said that the uninsured are able to afford deliveries at government hospitals since the cost is considerably lower than the cost at private clinics.

A Gaza doctor interviewed said he prefers to work in health centers with specialized clinics for many reasons including: integrated supervision from more than one doctor; availability of laboratories to carry out medical tests; and availability of an X–ray center.

As elsewhere in the world, the study showed that people believe one gets what one pays for. The exception to this near-universal rule is that UNRWA also provides care described by most interviewees as good or very good, and it is free of charge. Gaza women specifically mentioned UNRWA providing good prenatal care and delivery services.

Poorer women tend to prefer UNRWA clinics because they are free. UNRWA distributes IUDs, iron supplements, calcium pills, vitamins, etc. without cost. UNRWA also gives 1 kg. of flour, sugar, beans, rice, etc. free to a woman, both when she is pregnant and after

she has delivered (at least in Gaza). However, some women prefer government hospitals for deliveries, especially if it has a female doctor. UNRWA is said to use nurses for routine deliveries, and if there is a problem, they send women to the government hospital. Women in one focus group felt they might as well be there in the first place.

It is worth pointing out that consumers currently have a choice of facilities, at least if they have money. As a Hebron nurse pointed out, "There are private physicians, governmental clinics, mother and child health care centers, and charitable societies."

Women prefer a doctor to a nurse. The great preference is for a female doctor, but a male doctor is usually preferable to a female nurse. In other words, the degree of health qualification level is more important than the gender of the health professional.

Mothers who can afford it tend to prefer going to private doctors and clinics, but some of these (in Gaza) have been accused of keeping the postpartum mother for too short a period.

> "I go to a private hospital, which is better in terms of better health care services. I stay in a special room in which I get enough care and attention. Also, I go to the hospital to take the pre-delivery injection. The hospital provides better mother and child care; that is why I prefer it. The majority (here) go to the public hospital due to cost – related reasons. No midwives work in the area. Currently, most of the deliveries take place in hospitals. In the past, a great percentage of the deliveries used to take place at home." (employed woman, age 38, Al–Eizareyeh)

Prenatal Care

The great majority of women go for antenatal care, as national and regional surveys have also shown. Stephenson (1996:21), citing Pappagallo and Bull (1996), claims "...the majority of women register for prenatal care late in pregnancy (if at all) and their attendance at routine prenatal check-ups is irregular." However, the study cited was a retrospective survey (looking how far back?) of 1,267 antenatal records taken from health centers located in Syria, Jordan, and Lebanon as well as the Palestinian Territory, and so overall findings might not be expected to accurately characterize women in Palestine today. Surveys in 1996 show that 92% of Palestinian women attend prenatal care (PCBS 1997; Ismail and Shahin 1996) and this qualitative study findings suggest a somewhat higher overall attendance level.

Our study also suggests that perhaps a majority of women attend once a month, and that they go to ensure the mother's health as well as that of the developing fetus. Even a 90-year-old Imam from Gaza reported that local women "go to the UNRWA clinic on a monthly basis throughout the pregnancy period in order to get iron tablets, have a comprehensive blood check and measure their blood pressure." Other interviewees said that the number of prenatal visits might only be 4-5 times during a pregnancy, or that it

depends on how a mother feels about her health (a factor that is even more important in postnatal care attendance).

> "(Prenatal care) depends on her financial status. If good, she goes to the doctor. If bad, she goes to a free clinic. The number of visits depends on her health status." (woman, age 44, elementary school education, Nablus)

A nurse living in Al–Diheisheh Refugee Camp, and working in Al–Amari Refugee Camp, reported that camp women "visit the UNRWA clinic as well as the specialized doctor throughout the pregnancy period in order to assure her proper health and pregnancy." Although occasionally we heard of a woman attending prenatal care only very late in pregnancy, we found very little evidence of women not attending antenatal care at all, a finding compatible with survey findings from 1996 and assuming a slight improvement in overall attendance since then.

A male health worker at the maternity hospital in El-Bira, near Ramallah, observed:

> Most women visit the private doctors each month for the health of the fetus, not for the health of the women. They generally go to find out the sex of the child. This is an incentive for them to go."

Occasionally we found evidence of women in smaller, more isolated West Bank villages not attending prenatal care, but they appeared to be reached through community outreach efforts, by trained village health workers. Recall the Gaza survey finding from 1996 that 53% of women had recently had a home visit by some sort of health educator, and that this visit was considered "valuable." One older male informant from a village near Ramallah said there were a few women who did not attend prenatal care due to "poverty" and "ignorance" on the part of their husbands, who lack money to pay for health services. "Some men prefer smoking cigarettes and playing cards to paying (for prenatal care)." He further observed that some husbands think it is "women's nature" to go through the difficulties of pregnancy alone, a traditionalist, fatalist view rarely encountered in the present study.

One health worker commented that fear of miscarriage is a prime motivating factor that makes women come for prenatal care. This seems highly likely in light of all the evidence in the present study pointing to great love of children, and concern over producing and raising many healthy ones. Moreover, rates of miscarriage seem relatively high.

A health worker who visits smaller West Bank villages told the study team that only a very few women "slip through the system" and don't have their anemia treated, if this is indicated in prenatal care. A few women reported being given iron tablets during prenatal care, but not actually taking them. Some said they experienced side effects with iron tablets, and had not been expecting these and "weren't told about them." Reported side effects included nausea and stomach pains.

Some interviewees described the prenatal service they receive: they are tested for anemia, hypertension and diabetes. Some informants simply described having "blood tests" and "urine tests." They are given iron and calcium supplements. They are advised to minimize coffee and tea consumption and to eat food high in iron, and to "avoid trouble with their mothers-in-law" (in the words of one respondent).

A few women go to private doctors to find out the sex of their fetus.

Immunization with tetanus toxoid (TT), while it is officially an MOH responsibility, was said to be available at NGO clinics.

Regarding health care in the last month of pregnancy, the majority of interviewed women said they consulted a private doctor or specialist nurse (MCH, midwife, ob/gyn) at least once in order to assure her proper health and the well-being of the fetus. Some women mentioned they go several times due to fear of bleeding or even poisoning. Women respondents mentioned receiving information concerning the expected timing of the delivery. An insignificant percentage of these women noted that they receive advice from their mothers, mothers–in–law, midwifes, or nurses on what to do at and around the time of delivery.

Representative comments:

> "(I chose) the specialist nurse in the clinic in order to assure the proper health for me and my child. I chose the nurse because she follows up the mother's health, not forgetting that the mother knows well what is right and what is wrong." (housewife, age 23, 2 children, Al – Shati'a Refugee Camp)
>
> "(A woman) goes to the doctor once a month in normal cases and several times in risky pregnancies to assure her proper health. (nurse, age 25, Delivery/Obstetrics Section, Ali Al–Muhtaseb Hospital)
>
> "In the last month, she consults the specialized doctor twice a month in the normal cases in order to assure the well-being of the mother and fetus, and to get ready for delivery and for the forthcoming birth, including how to deal with (the baby) and prepare for the new life." (female nurse, age 35, Al–Amari Refugee Camp)

A number of women from the general public specified that they went 2, 3 or 4 times for prenatal care during the last month of pregnancy.

A non-representative comment:

> "If the time of the delivery passes, I consult a doctor experienced in delivery affairs...I do not need any medical consultation except in relation to late delivery." (housewife, age 24, second secondary class education, Al–Shati'a Refugee Camp)

Postnatal Care

PCBS findings from 1996 show that only about 20% of women attend postnatal care, a finding corroborated by the West Bank survey of the same year (Ismail and Shahin 1996:17). Our findings suggest some improvement since 1996, to the point that about half of women or more may now make use of this service or receive it during a home visit. For those who do not attend, the prevailing belief seems to be: If the mother is well, what need is there? Some women commented that if there was something wrong with them, they would go, or did go, in a recent pregnancy.

Recall that child immunization rates are at about the 97% level. This means that mothers are having contact with service providers soon after giving birth. It would appear that this would be the opportunity to both raise the mother's awareness of the value of postpartum care, and an opportunity to provide it.

A few interviewees said they got their postnatal advice from family and friends:

> "I don't go for postnatal care. I see no need. My delivery was normal. I am well. I am healthy." (Woman from Betrima village near Ramallah). (This same woman said she went 7 times for prenatal care, but admitted she did not take the iron pills given to her).

A man working in a maternity hospital in Al-Bireh, near Ramallah, observed that most postpartum women don't visit a doctor until she becomes pregnant again.

However, a little over half of women said that they attended postnatal care, or generalizing about other women in the area, said that others do. Some pointed out that the service is not just for the purpose of immunizing the baby, but for the mother. A typical response of this sort:

> "Yes, (she attends) for the child, to take vaccination. And for the mother, to get advice on family planning and to learn how to take care of her child." (housewife, age 23, Al–Shati'a Refugee Camp)

Some interviewees described the nature of postnatal service: they are tested for hypertension, anemia, and diabetes, as in prenatal care. They are given advice about the need for "timely vaccinations for the child," on infant nutrition and breastfeeding, on taking care of babies in general, on the need for "supplements for the mother," and on family planning. They are given iron and calcium supplements. They are advised about the need for periodically weighing the baby. Note that postnatal care for mother and for baby are often seen as one service. This may be because some degree of postnatal care for the mother is provided when she brings her baby for vaccinations, with little or no thought on the part of the mother that she herself needs services.

Indeed, there may be more to a complete and accurate understanding of postnatal and related care, as discussed in the section to follow.

Changes in Health Care at the Village Level

This is the place to raise two cautions about interpreting statistical findings on the relatively low postnatal attendance rate. One is that women may receive postpartum advice and services when she brings her baby in for immunization--which most women have been found to do in the last PCBS survey--yet this might not be counted as postnatal care. The other caution is that poorer women and village women might not go to a health facility, but they might receive home visits by VHWs, health educators, or trained (i.e., upgraded) TBAs or dayas, and they might receive advice, nutritional supplements and the like in this way. In the words of the Coordinator of the Directorate of Women's Health at the MOH, Nablus:

> "After delivery, the daya visits the woman at her house for a few weeks, advising about high protein foods like milk, eggs, meat, bathing. She gives good nutritional advice. The daya is advised to refer the mother for care if any complication occurs."

The dayas referred to would have been upgraded though training. Interviewers in the present qualitative study were also told by VHWs in remoter villages that they themselves made postnatal home visits, and we picked up evidence of this from interviewees from the general public. How common are such postnatal home visits? A sample survey in Gaza found that "33% of new mothers received a home visit by a daya during the postnatal period" (Hundt et al 1997, quoted in Barghouti, Fragiacomo and Qutteina 1999:118). There is the finding, already quoted, that 53% of women have had a recent health education visit in their home (WAC 1999).

How many villages (or poor communities in camps and cities) may be benefiting from home visits? Answering this question was beyond the scope of the present study, but The Center for Development in Primary Health Care, for example, recently completed a 2-year training of 90 women VHWs "working in different remote and disadvantaged villages of the West Bank" (CDPHC nd.). Another Palestinian umbrella NGO, UPMRC, also trains VHWs for two years. A 1998 newsletter from UPMRC mentions 140 VHWs trained over the previous 14 years (UPMRC 1998:8), although that number may now be 200 or so (Joyce Jubran, UPMRC, personal comm.)[12]

Several international NGOs train and support VHWs and related personnel (community health educators). A 1995 document noted:

"In the West Bank and to a lesser extent Gaza Strip, community health and rehabilitation workers are currently important human resources engaged in the provision of primary

[12] This UPMRC newsletter contains useful information about the role, training, etc. of VHWs, as well as the erosion of traditional values and practices such as cousin marriage.

health and rehabilitation care. It is estimated that there are 250-300 such workers operating in the country, some within the context of very successful schemes" (Giacaman et al 1995).

This refers to a period before recent training just mentioned.

UPMRC reported that its VHWs made 11,000 home visits in 1993 (UPMRC 1994:22).

The impact of VHWs and related health personnel might explain why nationally, women in villages have higher contraceptive prevalence rates than women in camps or towns (PCBS 1997:144); or why village women have higher tetanus toxoid injection coverage than city women (PCBS 1997:94); or why under-age-5 immunization coverage was highest in villages (70.9%) and lowest in camps (54.8%) (PCBS 1997:170). Informants explained that it is relatively easy to mobilize whole populations of villagers through the likes of VHWs. For immunizations, e.g., the names of all women with young babies are called over a loudspeaker, perhaps by local leaders (muktars), and virtually all women appear with their babies for immunizations. This is harder to accomplish in the urban areas.

Contrary to the foregoing evidence, a very rapid assessment of health care quality reported that "No antenatal outreach services were provided in the area of the West Bank or in Gaza. Postpartum outreach services were not yet established in Gaza and were symbolic in the West Bank" (Younis and Hassanein 1999:18). The report does not make clear how this conclusion was reached. The fieldwork for this report was extremely brief and the findings are at odds with the present study and with random sample health surveys of the past four years. On the other hand, perceptions on the consumer or patient side may not reflect problems that may actually prevail on the provider side.

Returning to improvements in MCH/FP status in villages, there is a widespread perception among Palestinians and donors that "Rural areas are the most disadvantaged in terms of the types and range of programs available" (Giacaman et al 1995:33). This no doubt was the situation when these words were written and earlier, but there seem to have been major improvements in village health care in the past five years. There deserves to be a study of these changes and especially of the role of the VHW, the upgraded TBA, and any other community-based health worker.

Since findings pointing to improvements in village health indicators may come as a surprise to many, it is worth remembering that much of greatly improved health services in Palestine are foreign donor-funded, and therefore may not be sustainable. There are reports that NGOs are in fact cutting back on the number of health facilities (Barghouthi and Lennock 1997:18-19; Barghouthi and Dailbes 1993). (Although this may be referring to the Gulf War period when Saudi and Kuwaiti financial support to Palestine was curtailed.)

Having discussed health status in villages, we should comment on refugee camps. Foreign donors and outside agencies might assume that refugees have lower health status and perhaps less access to health care than other Palestinians. This seems not to be the case. The PCBS health survey showed, e.g., that refugee women have the highest rate among Palestinians of receiving prenatal care, and other statistics show that refugees often lead in health service access. This was so even in 1992:

> "Refugee status does not seem to influence the rate of reported illness and injury. Nor do refugees in camps report significantly different rates of illness than others living in the same area, be it Gaza or the West Bank." (Heiberg and Ovensen 1993:107) Furthermore, "Refugees both inside and outside camps seem to consult health personnel and institutions as frequently as others do. The difference is that they utilize UNRWA services to a greater extent." (Heiberg and Ovensen 1993:113)

However, UNRWA will not be operating indefinitely, therefore the sustainability of refugee health services remains an issue.

What can be concluded is that at present, considering the three major Palestinian residential settings (city, camp and village), need for improvements in MCH may be greatest in poor, urban areas.

Decisions about Family Health Costs

Most respondents said husbands decide on what to pay for health expenditures. This may follow from the husband normally being the wage-earner. The second most common answer was that husbands and wives together make such decisions, a trend among younger, more educated Palestinians that was also found in the recent West Bank health survey (Ismail and Shahin 1996:21). A third answer was that wives alone decide on health expenditure. As pointed out by some respondents, and seen above, the family's income level helps determine which type of health serves is sought. But financial sacrifice will be made in cases perceived as emergency or important. As a 40-year-old man from Faqouaa village (northern West Bank) put it, "The health of a human being is more important than money." Exceptional or serious health problems are considered a priority; people will find the money to address these, whether or not they can normally afford it.

If a baby needs to be taken to a health facility, either the wife or husband will take the child, depending on who is available.

The Role and Status of Traditional Birth Attendants

There are said to be about 270 dayas (TBAs) in the West Bank. By mid-1999, all but about 20 were said to have undergone upgrading of their skills in the form of 6 months of hospital training. We did not ascertain the exact number of dayas in the Gaza Strip, but

virtually all seem to have been upgraded through MOH or UNRWA training. TBA upgrading training may have occurred in the mid-1980s (in the case of the West Bank), and it was not learned how much TBAs are supervised after initial training. A full research report on TBAs in West Bank should now be available through the MOH in Nablus.

Some Palestinian women, especially older ones, prefer to have a daya attend their birth at home for reasons of privacy, dealing with a same sex practitioner, dealing with an experienced, respected practitioner known to the mother; avoiding the impersonal treatment of a hospital; avoiding the indignities of having to wait and be put off by bureaucrats at the hospital; as well as "culture and tradition." However, the great majority of deliveries in West Bank (90% in 1996) and Gaza (98% in 1998) are nowadays in health facilities.

The few deliveries at home are attended by licensed midwives or upgraded dayas. Nowadays, the formally trained daya carries out pre- and post-natal care as well as attending deliveries. Prenatal care consists of monitoring blood pressure, checking the quality and size of the abdomen, etc. She knows the signs of a complicated pregnancy and is good at referring such cases to a health facility. During childbirth, the daya cuts the umbilical cord and conducts vaginal checks during and after delivery. Dayas are now supervised by the MOH to ensure a certain minimal quality of care. Along with this supervision and MOH training goes licensing of dayas. However, the MOH does not pay daya salaries, even though dayas requested these after they had been trained. For now at least, dayas are private practitioners and they charge for their services. This in fact might be better for sustainability of the service.

A woman doctor from the MOH observed that one of the strengths of the daya (TBA) is that she is concerned with the mother's health. "Everyone else, including the mother herself, only thinks of the health of the fetus or the baby." Dayas, this informant said, encourages the newly delivered mother to eat plenty of nutritious foods for the purpose of "building up the mother's strength." And she did this even before the recent upgrading of TBAs through training. (A daya practices in the village of this doctor, so the doctor has observed her in practice and learned even more from having patients in common).

The Role and Status of Traditional Healers

Traditional healers are called sheikhs, arrafin, awllya Allah Asalehem, or (rarely) hakim. They are said to have religious power (at least "the good, respected ones") and are considered "closer to God" than ordinary people. They work with herbs and they also take prayers from the Quran (Koran). Some call themselves fortune tellers. In an example of faith healing practice, slips of paper with Koranic prayers may be dipped into a glass of water, and the water is given to drink. Others under treatment may wear little Koranic prayers in amulets or medallions around their neck or elsewhere on the body.

These healers may treat mental illness, and sometimes (at least in Gaza) conditions in children (such as "crying too much in the night," or other conditions "that doctors can't cure."

A 65-year-old TBA from Gaza explained that religious healers treat:

> "...children's diseases, especially by massaging, and when a child has paralysis from fear. Also abortions. Or to advise on abortions--to drink something, or run, or jump. All these treatments are done by help and power of the Holy Quran. Because of the advancement of science there are fewer people going to healers."

"Arafin" seem to be more active in Gaza than in West Bank, but even there, they do not ordinarily provide treatment for pregnant mothers or babies. One exception might be that parents would go to a healer for special medicines to ensure that the baby will be a boy. Arafin also give herbs to treat childhood illnesses such as "stomach problems." People in Gaza might also go to an araf for fortune telling.

A major health service provided by traditional practitioners is the diagnosis and treatment of infertility and, less often mentioned, impotence. This can be taken as further evidence of Palestinian pronatalism. Even those who may not ordinarily use such practitioners might consult one if doctors and clinics cannot overcome infertility or sterility. The treatment for this may be by rubbing the abdomen of the woman with olive oils, and giving herbs and perhaps amulets to the sufferer. Healers may also treat stomachaches and headaches in adults.

One woman herbalist interviewed revealed that she usually charges 2 NIS to tell a fortune, and 10 NIS for treatment.

The traditional healers and dayas interviewed in the present study were all either nonliterate, or had minimal education.

From interviewing traditional healers, TBAs and the general population, no evidence arose suggesting significant competition or conflicts between traditional specialists and modern health care providers. Healers and TBAs seemed to approve of pre- and post-natal care, modern contraceptives, birth spacing, breastfeeding, etc. about the same as other more conservative Palestinians.

From interviewing the general public and a few healers, it seems that "demand" for their services has diminished with the expansion of modern health care, urbanization, higher education, and other modernizing influences. Their role seems to be decreasingly concerned with health matters (except for infertility) and increasingly with magico-religious diagnosis, divination and intervention. Indeed, the role of the traditional healer seems to be much on the wane, and their numbers are small and apparently diminishing. It is unlikely that they will disappear, because there is always a demand for divination, magico-religious cures, and treatment of chronic problems that resist modern biomedical

treatment. Such healers are found in the United States and other more economically developed countries.

Only about 1 out of 10 respondents reported that a traditional healer of any sort (not including TBAs) worked in their community, or in the general area. Some respondents mentioned that there used to be one, but not at present. This low frequency is unlikely to be due to shyness about reporting because when healers were mentioned, their full names (unasked for) were usually provided as well. Moreover, as mentioned, there seems to be little antagonism between the government including the Ministry of Health, and traditional healers, therefore respondents would not be inhibited about answering frankly.

Media Habits

The great majority of Palestinians have access to radio and television. Between 7:00-8:00 pm seems to the best time for reaching women via TV, if not radio. Magazines, newspapers, and radio are other stated sources of health information, as are UNRWA, NGOs, and government health personnel.

Interviewees made a number of spontaneous comments pertaining to mass media, such as:

"In the past – there were no T.V. and radio sets that help in educating the girls..."

"In these days, awareness increased; T.V sets spread and girls' awareness increased and consequently they refuse early marriage."

"In the present, there is a sufficient expansion of awareness, science, culture, and health education that are promoted by schools, T.V. and health education. These factors have played a role in a high level of maturity and awareness among the Palestinian girls, which led to delaying marriage age."

Women in a focus group in Gaza mentioned a TV show called "Whole Health," a religious program on Fridays that had recently discussed family planning; and a TV health program every Saturday and Tuesday were also mentioned. All women in this focus group had a TV in their home. A CARE officer who works with low-income women mentioned that TV ownership was a very high priority among these women, and that most people have them (one rather poor looking house interviewers visited that day had both a TV and a video player). Even a remote West Bank village lacking electricity was found to have generators that run after sundown, allowing most people to watch TV.

Health education from print media were also mentioned, e.g. an Arabic magazine called "Know Yourself. "

Thus, all channels for health education (face-to-face, electronic, print) are being used and can be used in the future, and exposure to mass electronic media is at a high level.

Analysis and Conclusions

General Status of Maternal and Child Health Today

Mustafa Barghouthi (1993) wrote an assessment of Palestinian health problems seven years ago, in which he indicted Israel for creating and perpetuating conditions that obstruct the development of health services. He cited an infant mortality rate of over 50/1,000, evidence of child malnutrition, the rise of infectious diseases such as brucellosis, and the failure to eradicate epidemic diseases such as hepatitis, typhoid, and meningitis.

With the exception of the eradication of diseases in Palestine that have not been eradicated elsewhere (e.g., the USA has 4 million cases of hepatitis C alone among varieties of hepatitis), there has in fact been significant progress in many health areas, from brucellosis[13] to morbidity and mortality of women and infants (the focus of the present study). Indeed, recent health analysts agree that Palestine has undergone health transition in which "deaths caused by infectious diseases have decreased significantly, while deaths caused by chronic illnesses have risen..." (Abdeen 1997:20), an observation made earlier by Heiberg and Ovensen (1993:100).

Perhaps leading this health transition has been progress in maternal and infant health status in recent years. The findings of the present study as well as those of recent sample surveys by PCBS and others all point to this conclusion. Why would MCH improve even more than other areas of health? Almost certainly because this has been an area--even the area--of health care emphasis by foreign donors, national NGOs, UNRWA, and government preventive health services. And secondly because of the very high value and priority Palestinians place on having and raising healthy babies. We encountered indirect evidence (from the results of a village based study) of people letting ear infections go untreated to the point of permanent hearing loss. Palestinians would be far less likely to risk a baby's health or survival. We found strong evidence that people bring their babies to health facilities when problems or danger are even suspected.

It becomes important to examine the likely factors that have contributed to this improvement. In fact, improvement in child health has been sufficiently rapid that, as early as 1993, it provoked a flurry of letters published in the British Medical Journal from contributors who suggested factors that might explain it (cf., e.g., Shani and Tulchinsky 1993).

[13] See comment in UPMRC 1998:5 on "the astounding results" of a health education campaign to reduce brucellosis. Annual cases in one epicenter village, Al Mughair, from over 250 cases in 1991 to one case in 1997.

Factors Contributing to Improved Health Status

The following comes from the present study as well as a comprehensive review of recent studies in Palestine. Keep in mind that while the factors to follow seem to account for recent improvements in health status among women and infants, this is not at all to suggest that further improvements are not desirable.

First, there is little problem of access to health care. Palestinians live within 5 km. of a health center (a 1997 World Bank finding), and they seem to have high reliance on, and respect for, (Western biomedical) professional health care and practitioners. Health care is available, free or at low cost, from the MOH, UN organizations such as UNRWA and UNICEF, various health NGOs supported by foreign donors, and local NGOs, notably the UPMRC. (UPMRC, the Union of Palestinian Medical Relief Committees, concentrates its efforts in poor, remote areas and with disadvantaged people, setting up clinics, outreach services, preventive education, and mobilization of communities. It began services in 1979).

There are virtually no untrained TBAs still in practice, and traditional healers play little role in routine health care, or in health care at all, strictly speaking.

Almost all women now give birth in health facilities, all births are registered, and almost all babies are followed up--and sought out in the community if necessary--for immunizations. Almost all women attend prenatal. Women are tested for anemia during prenatal care, and then take iron folate to correct problems. Only a very few slip through the system and don't have their anemia treated. (Yet anemia rates still appear to be higher in women than would be expected from what is known of treatment and nutrition. Excessive tea drinking has been mentioned as a possible contributing factor).

Most villages seem to have a village health worker (VHW). Both reproductive and perinatal health are areas of VHW emphasis. VHW programs fail in many countries due to lack of salaries or other compensation, inadequate training and supervision, confusion over curative versus preventive duties, lack of transportation, poor selection processes, and several other common problems (cf. Green 1996 for summary of these issues). Palestine does not seem to suffer from these common problems. Palestinian VHWs are locally selected, they are trained for fully two years, followed by guided practicums; they seem to be adequately supplied and supervised; and they divide their time between curative and preventive services. Palestine in fact provides the unusual example of a national VHW program that seems to function well, even if it is funded largely by foreign organizations and therefore is unsustainable. Their impact, as noted above, has been to raise health status in villages to the point that, in key MCH indicators, it is superior to that found in urban areas.

There seems to be nearly full immunization coverage nowadays by systematically following up women who have given birth (1997 MOH immunization coverage statistics [MOH 1998:77] show coverage in the 95-96% level).

Another factor explaining improved health status is probably the impact of Israeli health services before the establishment of the Palestinian Authority.

A recent Palestinian study (Bresoli et al 1998) found little evidence of mother and infant malnutrition, and reported widespread availability of health services. In their conclusions, they note:

"The findings were typical of an intermediately developed society, similar to neighbouring countries." (They also caution: "The multiplicity of health services available and their lack of coordination could make the application of a unitary health policy in the area difficult," a point also made by Giacaman et al 1995.)

There seems to be nothing that can really be called an indigenous ethnomedical system, in the sense of a health belief/knowledge system that differs fundamentally from Western biomedicine and competes with it. Even hot/cold humoral theory, found in some neighboring countries, seems absent nowadays. Palestinians are relatively well-educated, perhaps especially in health areas.

Indeed, still another factor has been health education in recent years that targets women and children issues. In some of health education media programs,

> "Senior health professionals are interviewed in response to current health issues and they have to respond to public questions. (Furthermore) Women's organizations and women's support groups have been increased and encouraged to empower and improve the status of women in Palestine." (MOH 1998:16)

The avowed focus of at least one of the major Palestinian NGOs mentioned above, and responsible for training VHWs, UPMRC, is "the empowerment of Palestinian women," a goal with which the MOH either concurs or is in sympathy.

Shani and Tulchinsky (1993) pointed to most of these factors seven years ago, in a review of factors that explained Gaza's decline in infant mortality, and added some others: infant growth monitoring services, iron and vitamin supplementation for children, improvements in safe drinking water and electricity in the homes, and the high-quality training of Palestinian doctors and nurses in Israeli teaching facilities since 1985. UNRWA deserves credit for improving MCH through its range of services to refugees. And as Sabbagh (1994) has pointed out, "Educational levels among Palestinian women in the West Bank and Gaza have risen markedly in the last few years."

For completeness, it should be noted that an occasional report portrays a very different situation, perhaps because source material is older and now outdated, or perhaps in order

to convince donors of the need for increased funding. For example, Stephenson (1996:28), basing her information on unnamed women's groups, writes that health services for women, while they may appear good, are "either substandard, unaffordable, inaccessible or nonexistent." This conclusion is at odds with the present in-depth study as well as all high standard sample surveys of late.

There is also a recent--although very quick--assessment of the quality of health care in Palestine. This report (Younis and Hassanein 1999) can be criticized for being based on a very short length of fieldwork, and for drawing conclusions based on an extremely small and perhaps unrepresentative sample of health facilities and personnel. Nevertheless it found physicians "inadequate" in some technical areas such as prenatal care and diabetes in pregnancy, and in general health education skills. On the other hand, health workers (who in fact do more health education than physicians and handle other preventive services), were found to be "very active, well-oriented and with wonderful attitude toward the clients (Younis and Hassanein 1999:17). This assessment only interviewed 11 clients of health services. Recall that neither the present qualitative study nor the 1996 PCBS national health survey found more than scant evidence of significant client dissatisfaction with medical services in general, and MCH/FP/OB/GYN services specifically.

In sum, by regional, middle east standards, health-related knowledge and practices of Palestinians are quite good, a conclusion shared by the World Bank (World Bank 1998). The exceptions are wanting and having too many children (especially in Gaza), having short birth intervals (although this is changing and the advantages of this are quite well understood), not breastfeeding exclusively long enough, and--in perhaps 8% of women--a practice of delaying breastfeeding for 1-3 days after delivery. There are not many unhealthy or damaging health practices that need correction, compared to what is found in less-developed countries (which Palestine is not).

To put overall findings in regional perspective, it is useful to compare Palestinian (WB/G) infant and maternal mortality rates (IMR and MMR) with those from other countries in the region. We see that Palestinian IMR and MMR are quite low by regional standards. If East Jerusalem data were added, statistics would probably improve further.

Note that the higher of the two IMR figures for Palestine are close to those of Syria and Jordan. Those who do not believe even the higher IMR for Palestine, 28, should ask themselves if Palestine would be expected to have an IMR higher then Syria's, given the review of factors just considered.

Note also that however much IMR has decreased in recent years, Palestine compares regionally even more favorably in maternal mortality. It has the lowest rate by far of regional countries presented in the table.

Palestinian MCH Statistics in Regional Context
(Based on 1999 UNICEF statistics from its Website)

Country	Infant mortality	Maternal mortality
Egypt	64	170
Jordan	21	150
Lebanon	33	300
Iraq	94	310
Lebanon	33	300
Libya	50	220
Saudi Arabia	25	130
Syria	28	180
West Bank/Gaza*	PCBS fig.: 28 MOH fig.: 13-20	PCBS fig.: 75 MOH fig.: 37 (Gaza only)
Israel**	"Jewish" 4.7 "non-Jewish" 8.7	(not available)
Yemen	78	1,400

* West Bank and Gaza data combined. UNICEF data in accord with PCBS
MOH figure based on reported cases (MOH 1998:48-49).
** Israeli Central Bureau of Statistics, 2000

Note on IMR and MMR data

As can be seen, there are two official IMR figures for Palestine: a higher figure from PCBS, and a lower figure from the MOH. The lower figure is based on reported deaths, and the MOH thinks these is an underestimate due to under-reporting (MOH 1998:48).

The PCBS figures are not based on reported cases. They are taken from PCBS' population-based demographic survey. PCBS uses a "sisterhood method" of indirect questioning for its MMR estimate. This consists of a series of questions, the first of which determines how many sisters a randomly selected female informant has had (whether or not living or dead at present). She is then asked whether any of these sisters died within 40-day postpartum, or indeed during the time she was pregnant. It would seem that a woman who died from an infectious disease during her first week of pregnancy might be included in this maternal mortality rate. The resulting figure from these questions is then calculated based on the denominator of 100,000 for MMR, and on 1,000 for IMR.

According to official MOH statistics ("The Status of Health in Palestine: Annual Report 1997 (September 1998)," the IMR for West Bank is 12.6, and for Gaza it is 20.1. The MMR for Gaza is 37, and for some reason there is no MMR for West Bank (although the report opines that the figure is probably higher due to "inaccessible villages," lack of outreach services, high mountains and other conditions that are surely exaggerated when

compared to other countries in the region). In making a regional comparison we should ask: Are the figures from countries like Syria and Egypt official MOH figures based on reported deaths, or do these countries also take the trouble to conduct more sophisticated population based demographic surveys, like Palestine?

How accurate is either the MOH IMR of between 13-20, or the PCBS rate of 28? A brief article published in the British Medical Journal (Shani & Tulchinsky 1993) refers to a UNICEF study in Palestine which indicated a decline in IMR from 76/1,000 to 40/1,000 by 1991. Likewise, a 1992 Norwegian funded national Palestinian survey based on a sample of 2,500 households (Heiberg and Ovensen 1993) suggests that the IMR declined from 82 in 1976 to 48 by 1990. These authors note that official Israeli statistics show a decline in IMR in West Bank from 38.1 to 22.0 between 1975 and 1990, and for Gaza Strip, a decline from 86.0 in 1970 to 26.1 in 1990. However, there is a suspicion that the official Israeli figures are too low, something of a whitewash of actual health conditions.

Still, an IMR of somewhere between 13-28, but closer to 28, seems reasonable 10 years later, given the efforts of UNRWA, foreign NGOs, the PA, UPMRC, increases in women's education, the very high percentage of births occurring at health facilities, the upgrading of TBAs, even the impact of Israeli health services before the establishment of the Palestinian Authority during the intervening years. A.G. Hill (1982) gives historical perspective for this "clearcut" and "extraordinarily rapid" decline in IMR among Palestinians, especially after 1960, even among those of low incomes living in camps. He credits UNRWA services for decline of IMR in refugee camps. Heiberg and Ovensen (1993:61) concluded seven years ago, "Childhood mortality in the occupied territories seems to have been declining rapidly in the last 15 years. The decline is not expected to continue as fast in the future since health-related improvements become harder to achieve after they have reached a certain level."

Yet some (e.g. Barghouthi and Lennock 1997:7) do not believe that the IMR could have declined as much as the most recent statistics indicate, given the political and economic problems of Palestine. Therefore, some level of debate over the accuracy of Palestinian IMR is likely to continue.

Problem Areas that Still Need Exploration

Neither recent sample surveys nor the present qualitative study explored miscarriage, abortion (spontaneous or induced), or stillborn deaths. Some women in focus groups mentioned their own miscarriages. Morbidity statistics from hospitals such as Shifa (Gaza) and Naser, reported to the MOH in 1997 (MOH 1998:90-93) show fairly high numbers of cases of "missed abortion," (241 cases in Shifa, 79 cases in Naser); "other abortion unspecified," (1,043 cases in Shifa, 568 in Naser); "other pregnancies with abortive outcome," (107 cases in Shifa, 58 in Naser); "other complications of pregnancy and delivery," (2,263 cases in Shifa, 566 in Naser); "single and multiple delivery by caesarean," (1,708 cases in Shifa, 457 in Naser). If these statistics are not atypical, then there may be problems of fetal wastage and perhaps overuse of caesarean operations (as

suggested by Ismail and Shahin 1996:22) that ought to be explored further. These pregnancy outcomes might be related in part to age of mothers and narrow birth spacing, health service utilization or quality of care in facilities, general health and nutritional practices, and other behaviors included in the present study.

An earlier (1993) study from one hospital, Makassed Islamic Hospital, found that neonatal sepsis affected 10.5% of all patients that year (Khammash et al 1994). This may reflect the period when TBAs were performing more home deliveries, and before they were upgraded through training.

Implications of Findings

To put overall findings of the qualitative study and literature review in broader perspective, it seems useful to consider the various factors that account for newborn and maternal deaths in poorer countries. Tables summarizing these factors are taken from Promoting Quality Maternal and Newborn Care (Ross 1998). It is useful to consider these factors (e.g., access to medical services, role of traditional health beliefs, nutritional status, etc.) in light of facts and findings in Palestine. Palestine in fact measures up comparatively well on most of these factors, which explains why its health statistics--apart from TFR and birth intervals--are relatively good by regional and very good by developing country standards.

The main purpose of this exercise is to guide USAID and its partners in focusing resources where they are needed most--in this case, indicated by maternal and child mortality factors noted with an asterisk (*).

Reasons for newborn deaths (from Ross 1998):

Combination of socio-cultural factors such as:

Frequent pregnancies/high fertility rates/short birth intervals (*)
Young pregnancies (*);
Desire for small babies
Gender discrimination beginning in infancy.

Delay in problem recognition due to:

Traditional beliefs
Low knowledge of danger signs
Maternal death
High rates of unattended home births with/without untrained attendants

Delay in deciding to seek care due to:

Traditional beliefs
Low knowledge of medical conditions/consequences

Delay in reaching the health facility due to:

Lack of resources to pay for services
Inadequate communication and transportation systems
Low knowledge of where to go and how to get there

Delay in receiving quality treatment at the health facility due to:

Lack of trained personnel to deal with low birth weight and neonatal infections
Lack of supervision and information system
Lack of outreach and follow-up systems
Lack of medicines and supplies to properly treat complications

Reasons for maternal mortality/morbidity (from Ross 1998):

Combination of socio-cultural factors such as:

Harmful practices, e.g., FGM (female genital mutilation)
Poor nutrition and associated factors
Low women's status/empowerment/decision-making
Frequent pregnancies/high fertility rates/sort birth intervals (*)
Early marriage and adolescent pregnancies (*)
Heavy workload
Reliance on traditional medicine and healers
Desire for small babies
Emotional abuse/violence

Unmet need for family planning services due to:

Traditional beliefs/practices
Lack of knowledge
Inaccessible or poor quality services

Delay in deciding to seek care due to:

Low women's status/participation in decision-making (*)
Lack of birth planning/preparedness

High rates of unattended home births and untrained attendants
Poor quality (perceived or actual) of health services

Delay in reaching the health facility due to:

Geographic distance
Lack of resources to pay for services
Inadequate communication/transportation systems
Inadequate knowledge of where to seek care and
how to get to a facility

Delay in receiving quality treatment at the health facility due to:

Lack of medicine, supplies, blood and equipment to treat complications
Cumbersome administrative processes
Lack of competent, motivated personnel
Lack of adequate supervision and management
information systems
Lack of outreach and follow-up mechanisms

The intent of this exercise is not to give the impression that health problems in Palestine are now minor, but rather to focus resources where they are most needed. Another intent is to give credit to the agencies and organizations (and community-level efforts) that seem to have accounted for such significant health gains in recent years. We should also keep in mind that the high level of foreign assistance currently received by Palestine is not sustainable in the longer term, therefore much remains to be done to ensure the present level of health services can be continued by Palestinians, using Palestinian resources.

Another purpose of the present exercise is to identify areas that are amenable to change through the efforts of a USAID-funded MCH project. The relatively low status of Palestinian women (by Western, not necessarily Arab, standards) is an example of a MCH factor that is not easily amenable to influence by short-term health project interventions (although the woman empowerment orientation and activates of NGOs like UPMRC through VHWs deserves careful evaluation, and probably credit as well). Frequent pregnancies/high fertility rates/short birth intervals are related factors that are more amenable to influence by project interventions.

Dr. Mustafa Barghouthi (1993:6) wrote seven years ago: "True health development cannot be achieved without a political solution to the Palestinian problem..." As we have seen, there has in fact been considerable development in health status since those words were written. Yet his observation is on-target. Perhaps health status, with the exception of the priority problem areas outlined in the next section, has by now developed almost as far as it can develop without the environmental, economic, stress-reduction, and other

improvements and benefits that would follow "a political solution to the Palestinian problem."

Indeed, considering the political and economic factors mitigating against good health status, the wonder is that Palestinian maternal and infant health is as good as it appears to be. When Gaza Strip embarked on limited self-rule six or so years ago, an article in The Lancet noted:

> "Its people inherit a health-care system provided by four sectors--the Israeli government, the UN Relief and Works Agency, non-governmental organizations, and private facilities. They also inherit a legacy of health indices comparing unfavourably with those of Israel, huge numbers of refugees, a looming water crisis, civil unrest, and a health care expenditure bill (as a proportion of gross domestic product) that will be unsustainable." (Schnitzer and Roy 1994:1614)

Implications for Focusing Future Project/Program Resources

The problems with the most serious implications to maternal and infant health, and that are amenable to modification by health project interventions, were found to be:

- High fertility rates
- Frequent pregnancies
- Relatively short birth intervals
- Over-reliance on one or two contraceptive methods
- First contraceptive use not occurring early enough in parity
- Relatively early marriage
- Mothers not breastfeeding exclusively long enough
- A small percentage of mothers who delay breastfeeding 1-3 days, or do not breastfeed
- Many women not attending postnatal care, nor understanding the need for this
- Women returning to household work duties too soon after delivery
- "Cousin marriages" among a decreasing but still significant proportion of the population, leading to congenital health problems

- Introduction of water-borne pathogens by some mothers giving sugar and unboiled water to babies

- Fetal loss (miscarriage, stillbirths)

These are areas where USAID or other programs ought to focus MCH resources, since these are the areas of greatest current need. Since other areas of MCH appear to not be as problematic as was the case only a few years ago, this ought to be good news to donors and partners. One can have more impact within the time period of a project if problem areas are concentrated rather than universal, or scattered in all areas.

Another problem area not specifically investigated but nevertheless important for program planning and implementation relates to problems coordinating several major service delivery players in the health sector: the Palestinian Authority/Ministry of Health; the UN Relief and Works Agency, and the robust non-governmental organization sector, both national and international (cf. Giacaman et al 1995.). Coordination between these players will be important when USAID and its implementing partners develop behavior change and communication (BCC) strategies. For example, health education messages will need to be consistent and mutually reinforcing and be sent though a wide variety of channels. Those from USAID partners cannot conflict with those from any other sector or program.

Sustainability Focus

One of the most important things USAID can do is to improve the sustainability of the recently improved health services that are currently funded by foreign donors, and that help account for the improved health status of women and infants (along with improvements in health-related beliefs and practices). This will require a gradual weaning of Palestinian health consumers from dependency on free or highly-subsidized health services. This can be done through introduction or intensification of fee-for-service, CBD (community-based distribution), social marketing, and similar programs. The present study found evidence of willingness to pay for good or improved health services. According to PCBS (1999:14), medical and health care accounts for 3.57% of average monthly per capita spending, or $4.25 per month.

One interviewer discussed with West Bank health workers the idea of social marketing or commercial community based distribution of contraceptives, iron pills or vitamin A. Officially, the MOH is responsible for giving tetanus toxoid shots and providing iron folate. Yet the MOH contracts out much of its work to and through NGOs. Our study found that immunization with tetanus toxoid (TT) was widely available through NGO clinics and UNRWA facilities.

There would seem to be a possibility of VHWs not only distributing, but supplementing their salary through the sale of, iron and vitamin A in their villages. Health workers near Jenin thought this is a good idea. Their only concern was the role of the MOH and that the price not be higher than what these pills would cost in a store. Even if iron pills are available free from the MOH, people might prefer to pay a small, subsidized price in order to have the pills locally available and to be able to avoid transportation and time costs.

Interviews in Gaza and villages in West Bank suggest that women often do not recognize health problems associated with high fertility and close birth spacing. This may be because they don't see such or experience such problems very much, with the notable exception of fetal loss (miscarriages, stillbirths). The women interviewed in Gaza thus far almost all had higher numbers of children (not even including miscarriages) than the TFR for Gaza (6.9), and most were still in their fertile years. All seemed to be in quite good health, a view shared by local health workers.) Subsequent interviews in West Bank, including with physicians and community health workers on this hypothesis, led to similar conclusions. We can also conclude from infant mortality and morbidity statistics that infants are likewise shielded to some degree from the consequences of narrow birth spacing by adequate nutrition (of their mothers and themselves) and other health interventions. Mothers in poor areas of Ethiopia or Bangladesh who marry young and have 7 or more babies closely spaced would no doubt suffer more obvious and serious health consequences, as would their infants.

This observation may be useful to keep in mind when developing health educational strategies aimed at teaching mothers about the consequences of inadequate birth spacing. One MCH/FP nurse in East Jerusalem commented, "We have to teach mothers using the approach of economics: the cost of school fees, food and clothing, and how spacing will help them achieve a better life, more income, better health."

No doubt economic hardships of having 10-12 children are felt. But refugees and poor Palestinians have basic health needs taken care of by UNRWA and other foreign organizations. So, again, there is a degree of cushioning of the economic consequences of multiple children by charitable agencies and organizations.
Those planing health education aimed at improved birth spacing should consider inclusion of discussion about links between narrow spacing and miscarriage and stillbirth.

Health Education Approaches

Study findings suggest that both face-to-face health education and mass media education are effective approaches and are having impact. Most Palestinians have access to television. Between 7:00-8:00 pm seems to the best time for reaching women via TV. Magazines, newspapers, and radio are other identified sources of health information, as are UNRWA, NGOs, and government health personnel. VHWs and other community-based health educators are transmitting messages and promoting behaviors that seem to be changing behavior, as discussed above (**Changes in Health Care at the Village**

Level). Other examples of interpersonal health education mentioned in the study were: doctors coming to schools and talking on health topics, and Imams speaking on health topics during the hour before Friday prayers.

Therefore all channels for health education (face-to-face, electronic, print) are being used and can be used in the future, and exposure to mass electronic media is at a high level.
As noted above, among the very few phrases that arose that might suggest folk-medical concepts, we encountered "increasing the blood" and "raising the blood." Both arose in connection with teas or diet or iron tablets, thought to be good for pregnant or postpartum mothers. Both seem to refer to avoiding anemia, and both could be used in health education.

More Focus on Men

Study findings suggest that the wife is the easiest person in whom to change attitudes about family planning, child spacing, age of marriage, etc. Husbands--men in general--are harder to influence, yet they are most in need of reproductive health education. Older women in the role of mother-in-law also need to be targeted specially. Still, women interviewees and health workers have mostly emphasized the need to target men for reproductive health education. Yet this is not so easy for at least two practical reasons: 1) men are not usually around in the daytime because they are working; and 2) VHWs are always women,[14] and it is not culturally appropriate for women to talk to men about sex, contraception and reproductive behavior (discussing early marriage and birth spacing in general terms seem not to be a problem). It would also not be culturally feasible for a male VHW to visit women in their homes.

How to reach men at the local level? For face-to-face education, male VHWs might visit men in the late afternoon or evening. They could be reached in the work place. Women health educators might try different approaches to reach and educate and influence men. And some health workers interviewed suggested involving local Imams. During the hour before Friday prayers, anyone can ask the Imam to talk about a topic in the public interest. For example, a local Imam recently spoke for an hour about the dangers of looking at the sun during the solar eclipse of summer, 1999. Imams tend to be cooperative when asked to talk about early marriage, family planning, and any other health topics that are in the public interest. Any such face-to-face health education needs to be supported and reinforced by print and electronic media, aimed specifically at men.

There is still a need to conduct focus group discussions on men's media habits and preferences.

Family Planning

[14] CARE International has trained a cadre of male community health workers; it may be that some other NGOs have begun to do the same. CARE's program should be evaluated with a special view toward assessing the impact of male health educators on the KAP of men whom they educate.

Since women and their husbands defer to medical advice on choice of contraceptives, and since so few methods are currently used, it seems clear that there is a need to better educate health providers about the range of temporary methods currently available. Health providers need to promote methods other than the IUD to a far greater extent, and promote them earlier in parity. There also needs to be more education, directed both at the general public and at health care providers, about the dangers of spacing births by less than two years. It may be possible to educate both groups, but at least health workers, about the relationship between short birth intervals and fetal loss.

Quality of Care Issues

Other than some complaints about quality of service in crowded government health facilities, not many problems arose in the present study, nor in the 1996 PCBS health survey. However, perceptions on the consumer or patient side may not reflect problems that may actually prevail on the provider side, as anecdotal evidence and the recent quality of care assessment by the Population Council suggest.

Since the great majority of births take place in health facilities, yet there is still a fairly high rate of negative birth outcomes (stillbirths seem to not be part of infant mortality statistics), perhaps these outcomes could be ameliorated by improvements in quality of obstetric services. These outcomes could also be improved by reducing the number of women who give birth during their early or middle teenage years, by increasing birth spacing intervals, and by reducing the frequency of cousin marriages.

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Annex A: Note on the Samaritans (E. Green)

The Samaritans appear to be one of the smallest distinct ethnic groups in the world. The main group lives in the West Bank, on a hilltop just outside of Nablus, or the Biblical city of Sechem, and they consist of about 450 people. There may be another 200 (?) Samaritans living some distance away in Holon, near Tel Aviv. Because they are such a small, endogamous group, they appear to have a lot of genetic deformities, according to informants in both Ramallah and Nablus. They are said to exhibit various physical deformities including speech and sight, plus a number of mental deficiencies.

An unpublished manuscript by Swedish missionary doctor Thord Thordson ("The Samaritans", 1995, avail. at Albright Inst., Jerusalem) reports that this once-widespread ethnic group is actually growing at present. Their population dwindled to 64 in 1927, following an earthquake and plague. He says Samaritans have the "highest inbreeding coefficient in the world," and comments that they have been the subject of genetic and demographic studies since the 1960s. He comments that Samaritan genetic defects are usually deafness and spasticity, never mental.

Samaritans speak Arabic, yet pray in Hebrew and hold Saturday as the Sabbath. They recognize only the first five books of the Old Testament, and only two prophets, Moses and Joshua. They seem to live much like any other Palestinians. Some work for the Palestinian Authority; one sits on the Legislative Council. There is a Samaritan fieldworker working for PCBS in Ramallah, and another working in a similar position for the Ministry of Health in Nablus. They are allowed to take Saturdays off from work.

According to a doctor in Nablus, Samaritans give birth in health facilities, not at home. They have no TBAs and they use contraceptives at about the same rate as other Palestinians. An older written source claims Samaritan marriages are arranged by families.

Annex B: Open-ended Interview Schedule

A. Marriage and Procreation

A1. At what age do Palestinian women usually get married in this community? What is the best age, and why? Was this age higher or lower 25 years ago? [Why do women marry when they do? Are there economic, religious, political or other forces largely influencing this?]

A2. How soon after she marries does a mother usually have her first baby? (If it is soon, or right away, probe all reasons why: where does pressure come from?)

A3. How many children does a woman like to have (or does she usually have) during her lifetime, and why? (Are there other family members who want her to have more (or less) children? Why?)

A4. Do women or their families prefer marriage between cousins? If so, which type of cousins and why? (be ready to explore inheritance rules or customs here). Is this cousin marriage good? [why/why not?]

[During this topic section, explore whether there might be a political or religious dimension to procreation and in particular, to pronatalism. If so, what? Are people aware of any Palestinian Authority (PA) or other political leaders' views or advice on having certain numbers of children, and the reasons why? Is any such advice followed? Are people aware of any Koranic (biblical) or religious leaders' views or advice on having certain numbers of children, and the reasons why?]

B. Birth Spacing and Family Planning

B1. Is it good for the mother to rest for a period after she gives birth? If so, why? (probe why, also how long the period should be, and whether the mother is in fact able to rest for the ideal period or if she is pressured to become pregnant again sooner)

B2 How is the decision made about when to have (the next) baby?
[look for how much power the mother/women alone has in making decisions about birth intervals or when to have the next baby. Who else has how much and what kind of influence in this decision-making process?]

B3. What does "family planning" mean? (probe: means having fewer babies...means having babies when you are ready for them... means having more time to rest between births, stopping permanently, etc.)

B4. Why do some women NOT use family planning? (probe reasons)

B5. If a woman uses contraceptives, who chooses (or influences the choice of) the particular method she uses?

B6. What contraceptive methods do women like most (and least), and why? [Probe reasons for liking or disliking particular methods: they are easy, they have or don't have side effects; they make a woman fat or thin, they make a woman infertile, they make a woman sick, they cause infections, they cause bleeding, they cause irregular menstruation, etc.]

B7. Are any natural contraceptive methods used (e.g. only having sex during "safe" times of the women's cycle)? Are there any traditional (non-medical, non-Western) methods?

B8. When do women who use contraceptives usually begin to use contraceptives? (probe both the stage of parity and how soon to begin contraception after the last delivery)

B9) Where do most women (or men) get their contraceptives? [Probe for any community-based distribution in the area]. Are they free or is there a cost? Are they considered expensive?

C. Pregnancy, Childbirth, Perinatal care

C2. Does a pregnant woman usually turn to family members, friends or other people for help and advice during pregnancy? Which people, and why?

C3. Are there any signs (recognized locally) that a pregnancy is going to be difficult or dangerous? if so, what signs?

C4. Are there any signs (recognized locally) that a newborn baby is not well, or in any danger? if so, what signs?

C6. When a woman is pregnant, are there any foods, medicines, herbs, vitamins, minerals, or exercises she should take/do to make her healthy...to make the baby healthy? (distinguish between mother and fetus here) What? Why are they good? [probe for iron supplementation. Is this recognized as needed, and if so, where does a woman get iron?]

[Probe same question for a breastfeeding mother. Any difference here from a pregnant mother?]

C7. When a woman is pregnant, are there any foods, medicine, herbs, vitamins, minerals, or exercises she should NOT take/do because of negative effects on her or her fetus/baby? (distinguish between mother and fetus here) What? Why are they bad?

[Probe same question for a breastfeeding mother. Any difference here from a pregnant mother?]

C13. During the period when a woman is breastfeeding, should she or does she eat more (or less) food? Why?

C14. Do all women breastfeed? When do women usually begin breast feeding? If so, for how long usually? (probe if this period has changed in recent times) Why is breast feeding the length of time stated? [Probe if some women in the area delay breast feeding for 6 hours, for a day, for 2-3 days. If so, why?]

C15. Is the colostrum considered good or bad for the baby? (why is it good or bad?)

C16. Is breastfeeding exclusive, that is, is breastmilk the only food or drink given to a baby of a certain age? (what age?). If other food or liquids are given, exactly what are these? When and why are they given?

C17 (If interviewee is a mother) How long do/did you usually breast-feed your baby (or last baby) in a 24 hour period? (probe to see if this seems often enough to suggest baby is exclusively breast-fed)

C18. Does the baby need anything right after it is born? (what and why?) (probe things like bathing, feeding, and medicines, keeping the baby warm or cool, etc.)

C19. Does the baby need anything during the first 40 days after it is born? (what and why?) (probe things like bathing, feeding, and medicines, keeping the baby warm or cool, etc.)

C20. Is there someone who usually advises the mother who has just delivered about the health and other needs of her baby? About the mother's needs? If so, who, and what does she or he advise about?

C22. Should a mother bring her baby to a doctor (or health practitioner or facility of any type) some days of weeks after birth? If so, when and exactly why? If not, why?

C23. Does the mother who has given birth need any vitamins, medicines, or injections (vaccination)? (What, when, and why?) Does the new baby need any vitamins, medicines, or injections (vaccination)? (What, when, and why?). [Ask a question about the tetanus toxoid vaccine specifically, if this was not mentioned up to now]

C24 Where do most women give birth in this area? What is the preference, and why? Any home deliveries? [If home deliveries, who attends the birth?] [Explore if there is any difference in preference of home/hospital/private doctor/MCH clinic between women who already have some children and those who have no children, or only 1-2 children].

C25)* For deliveries at a health facility, how do women stay there after delivery before returning home? How long is it usually before a mother returns to her normal duties?

D. Health Care at Home and at Health Facilities

D1. What health problems are taken care of in the home (i.e., without reliance on outside health services, e.g., giving rice water to a baby with diarrhea)?

D4. Who in the family makes decisions about how much money to spend on health care (or: health care for mothers and children)?

E1. In the months before a woman gives birth, does she usually consult a doctor or go to a clinic? Why? Does she (also or instead) go to a sheik or Awllya Allah Asalehen (traditional herbalist, etc.) or a TBA? Why?

E2. If you observe any danger signs in the baby or mother, what do you usually do? (probe: What steps are taken? Are there medicines, herbs, helpful people in the household or in the neighborhood? Is mother or child taken to a health practitioner? To whom? Where?)

E3. Do most women in this area usually go for antenatal care? Why do women go for antenatal care? Are there any incentives for a woman to go for antenatal care? [keep in mind non-monetary incentives.]

E4. Do most women in this area usually go for postnatal care? Why do women go for postnatal care? Are there any incentives for a woman to go for postnatal care? [keep in mind non-monetary incentives.]

E5. (If interviewee is a woman) During your last pregnancy, did you make any visits to a health facility? If so, how many? What care and advice is given in antenatal care? [probe for vaccinations, iron or other dietary supplements]

E7. (If yes to E5) What care and advice is given in postnatal care?

E8a). What different health services are available locally? Which ones are preferred and why? How are they ranked in preference?

[Probe private doctor's clinics, Health center/MCH, UNRWA center, private hospital, government hospital.]

[Probe factors of distance to health facility, quality of service, costs involved (money, time, opportunity, etc.]

[Probe: For familiar with private health services, is there a general feeling that one gets good service or value for what has to be paid?]

E8b) Are there any (other) things that prevent people from using: (1) government health services; (2) Health center/MCHs? What? Why?

E9. Where do most women give birth in this community? (At health facility, at home...if the former, what type of health facility is preferred and why? (See if informant can comment on whether trends in practices or preferences have changed in the past 10-20 years).

E11. In this community, are there any traditional healers or herbalists (Arafin, Sheiks, Awllya Allah Asalehem?) or TBAs? If so, what do people mostly consult them for? Does either the sheik or TBA help deal with the problem of infertility? If so, how? Are they said to be successful?