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Reproductive health and family planning survey on knowledge, attitude and practice among male adolescents in the Gaza Strip

A thesis submitted as partial fulfillment of the requirements for the degree of Master of Public Health

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Dedication

I would like to forward this study to my beloved children and wife who endured my absence to conduct this work, and who gave me every opportunity of success.

ABSTRACT

The overall objective of this study is to explore the knowledge, attitude and practice of reproductive health among male adolescents in the Gaza Strip. The Specific objectives were identifying the knowledge on the components and the concepts of RH, the adolescents' needs and demands of RH services and the importance of RH services provided in the MoH facilities. The objectives also included measuring the size of adolescents' utilization of RH services provided in the MoH facilities, and testing variations between localities and age groups in relation to knowledge, attitude and practice on RH. The design of study was cross sectional. The setting of the study was at the schools of preparatory and secondary grades in Gaza City East, Gaza City West and North of Gaza. The sample of the study was 300 male adolescents of pupils at the schools of the mentioned areas. The distribution of the sample was 100 of the 9^{th} grade, 100 of the 10^{th} grade and 100of the 11^{th} grade. The sample method was a stratified systematic random. The used tool of study was an interview-structured questionnaire.

The results were as follows:

1) The knowledge of RH components among the study population was found to be antenatal care 34.3%, post-natal care 32% and FP services 26%. Of the study population 81.7% knows contraceptive pills, 47.7% knows loops and 10.3% knows the withdrawal method. Of the study population, 33% thought of FP as spacing between births and 17.3% thought of it as good health care for children. Of the study population, 75% reject consanguineous marriage. 2) Of the study population, 73% does not know any thing about STD's. Hepatitis B and AIDS are the main two diseases known by adolescents in this study. The

study population knows that the main providers of RH services are government 65.7%, UNRWA 42.3% and private 17.3%. 3) Teachers, friends and Media (63.3%, 52.3% and 49.7% respectively) are the main 3 sources of knowledge about sex. The parents were found to be 8.7% only. 4) Of the study population 74% never attended any awareness sessions on reproductive health. Of those who attended awareness sessions, the 78 adolescents, 83% had attended those sessions at schools and summer camps. 5) Of the study population, 90% said that RH service is important and 10% showed indifference to it. Those who thought of FP service is important was 70% and 12% said that it is not important. 6) The reasons as said by the study population to use FP services were improving living circumstances due to reducing the number of children (64%), preserving a better health for mothers (24%) and giving better opportunities for mothers to give care to their children (12%).

The main recommended actions were emphasizing the need to implement raising awareness activities on RH, supporting the school health teams to expand its activity for further coverage, and encouraging parents to be involved in educating their children on sex.

الخلاصة...

الهدف العام من هذه الدراسة هو استكشاف المعرفة والمواقف والوجـــهات والممارســـة للصحة الإنجابية بين المراهقين الذكور في قطاع غزة.

وهناك مجموعة من الأهداف الخاصة هي: تحديد المعرفة لدى المراهقين حول مكونات الصحـة الإنجابية، وتحديد مفهوم الصحة الإنجابية لدى المراهقين ومدى اقتناعهم بأهمية خدمات الصحـة الإنجابية المقدمة من خلال وزارة الصحة في قطاع غزة، وقياس حجم المستفيدين بين المراهقين من خدمات الصحة الإنجابية المقدمة من وزارة الصحة، وتحديد احتياج ومتطلبات المراهقين من خدمات الصحة الإنجابية المقدمة من وزارة الصحـــة، وفحـص المتغـيرات بيـن المنـاطق والمجموعات العمرية وعلاقتها بالمعرفة والمواقف والتوجهات والممارسة لمكونـــات للصحـــة الإنجابية.

وهذه الدراسة للوضع القائم قد تمت في غرب وشرق مدينة غزة والمنطقة الشمالية، وقد شملت المدارس الإعدادية والثانوية في هذه المناطق.
وبلغت عينة البحث 300 طالب ، 100طالب من كل شريحة دراسية مـــن الشـــرائح الثـــلاث المستهدفة وهي الفصول التاسع والعاشر والحادي عشر.
وكانت طريقة اخذ العينات بطريقة عشوائية منتظمة من فئات عمرية محددة، وتم ذلك مـــن خلال مقابلة وتعبئة الاستبيان المعد لذلك.

وقد كانت النتائج كما يلي:

- (33%) من عينة البحث كانوا يعتقدون ان تنظيم الاسرة يعنى المباعدة بيـــن الحمـــولات، بينما (17.3%) كانوا يعتقدون أنها الرعاية الصحية الجيدة للأطفال.
- المعرفة بمكونات الصحة الانجابية بين عينة البحـــث كـــانت تشـــكل (34.3%) للرعايـــة الصحية للحامل قبل الولادة، (32%) للرعاية الصحية بعد الولادة، (26%) لخدمات تنظيـم الاسرة.
- (74%) من عينة البحث لم يشاركوا في أي لقاءات للتوعية حول الصحة الانجابية.

- (78) طالب الذين شاركوا في لقاءات توعية حول الصحة الانجابية من عينة البحث،(83%) منهم كانت مشاركتهم في اللقاءات التي تمت في المدارس والمعسكرات الصيفية، (50%) منهم شاركوا في 1-3 لقاءات (30%) شاركوا في 4-6 لقاءات.
- من مجموع عينة البحث (81.7%) يعرفون الحبوب من وسائل منع الحمل، (47.7%) يعرفون اللوالب، (10.3%) يعرفون طريقة القذف خارج الرحم، (5%) لا يعرفون أي وسيلة من وسائل منع الحمل.
- كان هناك 3 مصادر رئيسية للمعرفة الجنسية هم المدرسون ويشكلون(63.3%)، الأصدقاء ويشكلون (52.3%)، ووسائل الاعلام وتشكل (49.7%)، بينما الوالدين يشكلون (8.7%) فقط.
- (73%) من مجموع عينة البحث لا يعرفون شيئاً عن الامراض المنقولة جنسياً، التهاب الكبد الوبائي (ب) ، والايدز كانا أبرز مرضين معروفين لدى عينة البحث.

وكان معظم الذين يعرفون الامراض المنقولة جنسياً يعرفون أن الاتصال الجنسي، الدم وافرازات الجسم هي أهم طرق انتقال هذه الامراض.

- (75%) من عينة البحث يرفضون زواج الاقارب.
- السن المثالي للزواج من 20- 30 سنة للذكور كانت اجابة (95%) من عينة البحث وللإناث من 15-19 سنة كانت اجابة (49%) ومن 20 - 25 سنة كانت اجابة (50%) من عينة البحث.
- (90%) من عينة البحث أجابوا بان خدمات الصحة الانجابية مهمة بينما 10% لم يهتموا بها. بينما أجاب 70% على أن خدمات تنظيم الاسرة مهمة و 12% أجابوا بانها غير مهمة.
- الأسباب وراء استخدام خدمات تنظيم الأسرة حسب اجابات عينة البحث، (64%) قالوا لتحسين الظروف المعيشية وذلك بخفض عدد الاطفال، (24%) قالوا لتوفير ظروف صحية أفضل للأم 12% لاعطاء الفرصة للأم للعناية بالطفل.

من أهم الإجراءات التي يجب تطبيقها برامج توعية في مجال الصحة الانجابية لهذه الشريحة المهمة من المجتمع الفلسطيني، كذلك نتائج هذه الدراسة تؤكد على الحاجة لاعطاء الدعم لفرق الصحة المدرسية لتوسيع وتكثيف نشاطاتها لزيادة التغطية في هذا المجال وطرح أنماط جديدة أخرى في هذا الاتجاه لتشمل اعداد اخرى من المراهقين بواسطة مقدمي خدمات آخرين.

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Last but not least, great thanks are sent to the adolescents who accepted to participate as subjects of this study wishing them the best of luck and success.

Jamal Husni Abd El-Latif

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Abbreviations

AIDS	:	Acquired immunodeficiency syndrome.
EC	:	European commission.
FP	:	Family planning.
GS	:	Gaza Strip.
HIV	:	Human Immunodefficiency virus.
ICPD	:	International conference on population and Development.
IEC	:	Information, Education and communication.
KAP	:	Knowledge, Attitude and practice.
MOH	:	Ministry of Health.
NIS	:	New Israeli Sheikle.
NGO's	:	Non governmental organizations.
PCBS	:	palestinian central Bureau of statistics.
RH	:	Reproductive Health.
SFD's	:	Sexually Transmitted diseases.
STI	:	Sexually Transmitted infections.
USD	:	United States Dollar.
UNFPA	:	United Nations Population Fund.
UNICEF	:	United Nations Children's Fund.
WHO	:	World Health Organization.

Chapter (1): Introduction and background

The subject of research addressed in this study is an attempt to explore the knowledge, attitude and practice (KAP) of reproductive health (RH) among male adolescents in the Gaza Strip. Since the Palestinian National Authority took over the responsibility for health in 1994-95, a great deal of efforts and resources has been invested to implement activities on RH in the Gaza Strip. These activities are still being implemented such as family planning service, health awareness in the community, training health staff, and antenatal, natal and post-natal health care.

Previous KAP studies, which were conducted in Gaza did not include the male adolescent sector in the community. This sector, to a large extent, has been unintentionally ignored in the frame of health services that relate to RH. Conducting a KAP study on RH issues among male adolescents will assist the policy makers and friend donor countries to make the appropriate decisions to allocate the needed support to programmes that aim to improve the conditions of the RH in adolescents' life span.

Birzeit University and UNICEF (1999) conducted a study on risk factors and priorities of young Palestinians. The authors indicated the vulnerability of the young people in Palestine;

"Palestinian youth suffer a double dose of marginalisation. As Palestinians, they have suffered the inequities of life under occupation and have endured a life deprived of the basic freedoms of expression and movement. As youth, they must not only contend with the usual pitfalls of adolescence, but they must cope with them in a society which traditionally does not pay enough attention to young people."

Reproductive health issues have been given a great concern in the world and have also been so in Palestine. The majority of population is contained within the frame of this title. It covers women and men before and after marriage and throughout their reproductive age and their children, in other words, it covers the family members in the community. Adolescents therefore comprise a core sector of concern in RH framework. When the researcher uses the term of reproductive health, it means the major components of this term, which includes the following:

1. Marriage and pre-marital issues such as early marriage and consanguinity.
2. Family planning service.
3. Safe motherhood issues such as antenatal, natal and post-natal healthcare.
4. Information, education and communication awareness on reproductive matters.
5. Sexual transmissible diseases or reproductive tract infections.
6. Fertility matters.

Family planning is one of the components, which will be given a special concern in this survey because it has been recently implemented in the MoH primary health care services.

1. Demography and background:

The Gaza strip (GS) is the Southern part of Palestine, elongated at the coast of Mediterranean Sea. The area is approximately 362 Km^2 comprises five provinces. The population density rate in Palestine as observed of the above figures constitutes about 3000 people per one square Kilometer taking into

account the areas of the total land which are still under the control of the Israeli army. In other words the population density rate is much more than what is appearing in the formal statistics. The GS comprises 5 provinces; it is a plain region.

The following table shows a list of significant health and socioeconomic indicators as issued by the Department of Health Management Information System at the Ministry of Health in (2000) and the Palestinian Central Bureau of Statistics (PCBS) in December 1998.

Selected demography indicators in the Gaza Strip:

Indicator	*Rate or No.*	*Remarks*
Total population	1,1196,591	
Children 0-14 yr.'s	50.2%	
Female population	1,425,177 (49%)	
Male to Female	102: 100	
Population Growth Rate	3%	
Refugee Population	73.6%	
Life Expectancy	71.8	Male: 70.2, Female: 73.4
Household Members	6.1 Members	
GNP/Capita	$1771	
Poverty Rate	50%	In March 2001
Women at bearing age (15-49)	21.9%	
Contraceptive Prevalence Rate	51.4%	Modern methods
Infant mortality rate	22.7 per 1000	
Maternal mortality rate	37.3 per 100,000	
Crude Birth rate	34.4 per 1000	
Fertility rate	5.4 per woman	
Institutional delivery	76%	
Non-institutional delivery	24%	
Cesarean Section delivery rate	10%*	
Prenatal care utilization rate	80%*	
Median age at first marriage for males	22 yr.	
Median age at first marriage for females	18 yr.	
Consanguineous marriage	50%	
Cumulative prevalence rate of AIDS	1.29 per 100,000	

** Source: Department of Health Management Information System, MoH (2000).*

The birth and fertility rates in view of the decreasing mortality rates indicate the great need for serious efforts and continuous support to avoid the possible demographic trap. That could lead to dangerous consequences as envisaged by King, M. (1990), especially in Palestine, which suffers from limited resources and a dim future of its political and socioeconomic conditions.

2. *Socioeconomic status in the Gaza Strip:*

The political and socioeconomic instability has an enormous passive effect on the Palestinian population in the GS. The socioeconomic level is considered similar to the developing countries. The World Bank reports use the poverty line estimated by the National Commission for Poverty Alleviation, approximately USD 2.1 in consumption expenditure per person per day (NIS 9.00). According to this criterion, the Gaza population who were under the line of poverty was 38.2 and 33.5 percent in 1997 and 1998 respectively, (PCPS, 2001).

The latest reports of PCBS and other International Organizations have estimated that the poverty rate has been rising from 21.1 percent in September 2000 to 31.8 percent at the end of December 2000 to 50 percent in March 2001. The latest estimates show that a very sharp and rapid decline towards poverty in the Gaza Strip. It is approaching 80 percent of the population who lies under the poverty line, (PCBS, 2001).

3. *Importance of study and justification:*

The concepts beyond the importance of researching the KAP of adolescents regarding RH can be summarized as follows:

1. The adolescents of today are the parents of tomorrow, therefore, making them at the focus of concern will facilitate a better intervention to improve the health of the Palestinian community in future. This sector of Palestinian population is a large community who comprises around 23.2% of the total population.
2. The critical socioeconomic and demographic distribution in the Gaza Strip requires an efficient short and long term planning for future. Information is the key to plan for public health interventions, as it is true for planning for other sectors.
3. Knowledge is the first step for man to develop attitudes and attitudes motivate the individual to practice a relevant behaviour. Covey, S. R. (1989) suggested three steps to develop a habit; they are to acquire knowledge, to develop a desire and, to acquire skill. Therefore, surveying the knowledge, attitude and practice of adolescents in RH would lend the investigator the opportunity to develop recommendations for public health interventions, which hopefully in turn may lead to improving the quality of health status in Palestine.

4. *The study area:*

The study area, which was selected by the researcher included East and West localities of the Gaza City and the North district. The total population of the selected study area is estimated at 650,000 inhabitants. The population

area includes urban, peri-urban, rural and refugees. The refugee population has been deeply integrated into the non-refugee localities such as Gaza City East and West. To a great extent, this area resembles the rest of the Gaza Strip population and therefore the sample is considered a representative to the male adolescent population of the Palestinian community in Gaza.

The sample of the study population was selected to be in public schools and excluded the refugee schools because 10^{th} and 11^{th} grades i.e. two thirds of the sample are in government schools. The UNRWA system does not give an access to researchers without obtaining permission from the Headquarters of UNRWA in Amman. This requires a long bureaucratic procedure that takes long time. Further, the Department of Education at the Ministry of Education administrates all schools selected according to same regulations and systems, this facilitates the accessibility to the study population. The demographic indicators described above represent the area of this study.

5. *Hypothesis:*

"Male adolescents in the Gaza Strip have little knowledge, confused attitude and poor practice in reproductive health issues."

6. Research questions:

1. What do adolescents know about RH?
2. What concepts they have towards RH?
3. How far they are convinced of the importance of RH services?
4. How far they use the RH service provided?
5. What are their suggestions and demands in respect to RH services?

7. Objectives:

The objectives, which are expected to be achieved at the end of the study, will be as follows:

1. Identifying the knowledge of adolescents (the study population) on the components of RH.
2. Identifying the concepts of RH among adolescents of Gaza and their convictions of the importance of RH services provided in the MoH facilities.
3. Measuring the size of adolescents' utilization of RH services provided in the MoH facilities.
4. Identifying the adolescents' needs and demands of RH services at the MoH facilities.
5. Testing variations between localities and age groups in relation to knowledge, attitude and practice on RH.

Chapter (2): Literature Review

2.1. Definitions and concepts:

Adolescents, as a defined population group, have until recently been given little attention by national and international public health researchers. This can partly be explained by placing this group at the low end of the risk cycle, and the lack of strong global political constituency advocating their health needs.

Adolescence refers to the time between the beginning of sexual maturation and adult hood. It is the time of psychological maturation and becoming adult. Physical emotional, psychological, social and spiritual changes all intensify the metamorphosis from free-spirited and unencumbered child to young adult of being with duties and responsibilities, (Birzeit University and UNICEF 1999; Fikry, M. M. et al 2000).

The KAP gap of high knowledge and low practice is a common problem among adolescent. Unless programmes redefine knowledge as more than awareness-raising and as an increase in functional and effective knowledge, leading to behaviour change and, in the case of service providers, to better quality services.

International health experts agree on several key components that contribute to successful reproductive health services for youth. Identifying and understanding the group to be served, involving youth in designing programs, working with community leaders and parents, and finding better ways to make services accessible are commonly cited as important considerations.

Adolescents are subjected to dramatic physical and psychological changes at this stage in their lives with special focus on their reproductive and sexual developments.

The concepts of reproductive health have been recently developed globally. The consensus reached at the International Conference on Population and Development (ICPD) marked a shift in health concepts and development concepts of reproductive health policies. Walker, G. (1999) indicated three critical choices for people at all levels of development through reproductive health that they lead to long healthy life, to the acquisition of knowledge, and to access to the resources needed for a reasonable quality of life.

These choices pertain largely to adolescents because they are at the prime developmental era in their lives. The essential elements of reproductive health package was determined by the ICPD as follows:

" . Prevention and management of unwanted pregnancy;

. Services to promote safe motherhood;

. Services to promote child survival;

. Nutritional services for vulnerable groups;

. Prevention and treatment of reproductive tract infections and sexually transmitted diseases;

. Reproductive health services for adolescents;

. Information, education, and counseling on health, sexuality, and gender; and

. Establishment of effective referral systems " (Walker, G. 1999)

The World Health Organization defines a core set of life skills as follows: (UNESCO, 1999)

. Decision making;

. Problem solving;

. Creative thinking;

. Critical thinking;

. Effective communication;

. Interpersonal relationship skills;

. Self-awareness;

. Empathy;

. Coping with emotions; and

. Coping with stress "

2.2. Magnitude of the Problem:

In a study conducted by Mongolian Medical University (1999) showed that more than two-thirds of adolescents said that they do not get enough information on STI/HIV prevention and pregnancy prevention. 92% want to get more information on sexuality. The vast majority wants to receive accurate and relevant information through a school-based program. Teenagers say that they

lack a health facility where they can get reproductive health services and counseling based on their specific needs.

Two cross-sectional surveys were carried out in November 1996 and October 1997, in Ethiopia on high school students and parents (mostly family heads) who had children aged 10-24 years. Seventy five percent of the students preferred to discuss about body changes that occur during adolescence with peers of the same sex. None of them wanted it to be with their parents. (Taffa, N. et al 1999).

Qayed, M. and Waszak, C. (1999) conducted a KAP study in Assiut-Egypt. It was found out that approximately one-fourth of the study participants were familiar with the term "reproductive health." Those who were educated, older, not married and living in urban areas were more likely to have heard the term. Adolescents' ideal age at marriage varied according to sex. The mean ideal age was 21.2 years for females and 25.6 for males. Urban residents had higher ideal ages at marriage for boys than did rural residents, but not higher ideal ages for girls. Almost all respondents knew the importance of antenatal care; this varied little by sex, education, marital status or residence. Nearly all respondents thought a physician should provide antenatal care, although they were evenly split with regard to whether they preferred a female or male physician.

Tawila, Sahar et al (1999) conducted a study in Egypt, the results of the study showed that more than 95 percent of the sample knew the term "family

planning" and had favorable attitudes towards contraception. Knowledge of specific methods varied by sociodemographic characteristics and sex. For example, 21 percent of older study participants knew about injectables, compared with 53 percent of younger participants. The attitudes about family planning did not vary by sex or sociodemographic characteristics. "Life became very expensive, and many children need a lot of money, and from where can we get money in this hard time?" one study participant asked.

2.3. Reproductive health in adolescence:

Physical changes in male adolescent biologically, an increased production of testosterone and progesterone give rise to distinct body changes; voice, body hair, breasts, pubic hair, and menarche in girls. Boys develop deeper voices, grow hair under the arms and around the genitals, and begin to show other physical signs of masculine and sexual maturity. (Guedes, A. C., 1997).

Guedes, A. C., (1997) continues indicating that boys tend to receive little information about the physical changes that accompany their transition to manhood. For example, school classes and parents may explain menstruation, to adolescent girls but often leave out the mention of wet dreams, erections, and ejaculation when talking to boys out of fear that these topics are likely controversial to be discussed openly. Boys may start to face pressure when they differentiate themselves from other members of the family. In addition, boys often face ridicule from peers if they are slower to develop physically.

Most adolescents think predominantly in concrete terms under the psychological effect of physical transformations and the onset of developed sexuality.

They relate information and experiences to what they currently know and have a hard time thinking about the future or about things they have never been exposed to. Socially, this stage in life is marked by a desire to gain independence from the family and, simultaneously, connect with various peer groups, at school, in the neighborhood , (Guedes, A. C., 1997).

Adolescents attempt to find and develop their own identities, relying for security on the discussion and analysis of solutions to their problems, which are mainly sexual in nature. During the quest for the self and an independent existence the adolescent challenges the pre-established paradigms while engaging in situations that pose a serious threat to his physical and moral integrity. (Guedes, A. C., 1997).

Among many cultures manhood is seen as a state of being earned rather than automatically conferred (Lundgren, R., 2000). During their development from boyhood to adolescents, men are often expected to prove their sexuality to their peers or elders. The behavioral expression of masculinity is not determined by biology; it is largely acquired through socialization leading to the internalization of a pattern set of "male" attitudes and values. Adolescent boys learn their society's, definition of masculinity from parents, peers, the mass media and by observing adults. Palestinian community is not an exception and what Lundgren R. says is most likely applicable to the Palestinian male adolescents.

2.4. Reproductive health common problems in adolescence:

A common problem is poor utilization of the existing data generated through knowledge, attitude and practice (KAP) studies, focus groups and socio-cultural research. This could be attributed partially to the lack of information about the availability of data or poor presentation information. For example, a review of IEC projects in Sri Lanka found that several qualitative and quantitative studies on the sexual and reproductive health of adolescent and youth had been conducted in the previous two years. However, the managers of projects dealing with the issues of adolescent reproductive health made very little use of the data, the managers were simply not aware of the existence of the studies, (Walker, G., 1999).

Reproductive health programmes must both educate and enable men to share more equally in family and domestic activities. And to accept a major responsibility for the prevention or decreasing the reproductive health related risks (UNESCO, 2000). Very little research or detailed discussion has addressed the assignment of social class to children and young people. Historically, it has been determined according to the occupation of the head of the household. Youth surveys seldom request economic information from young people directly, because few know their parents' income.

Moreover, Lundgren, R. (2000) says that some countries ask questions related to sexual behaviour for 15 year old and over, perhaps based on the belief that asking younger children is or would be perceived as inappropriate. This is almost the case in Palestine due to deeply rooted social norms; it would not be

socially likable to ask the younger adolescents about sexual behaviour. Deteriorating economic conditions increasingly leave young people exposed to various forms of risk behaviour, including the risk of abusive and unsafe sexual practice. This is further aggravated by the limited access to, reproductive health for youth and family planning services.

The age of adolescents have been determined between 10 to 19 years by El-Tawilla, S. et al (1999) and Guedes, A.C. (1997). Birzeit University and UNICEF (1999) conducted a study on risk factors and priorities for Palestinian young people. In this participatory study the adolescent age was defined to be between 10 to 22 years. The study recommended that health programs should address reproductive health awareness among adolescents in the context of biological, psychological, cultural and socioeconomic dimensions.

2.5. Information, education and communication in adolescence:

The world of young boys is often silent on issues of reproductive health and sexuality. In the area of sexuality and reproduction there is often an embarrassed silence or a moralizing attitude. Sexual life and experiences have been turned into secrets and filled with embarrassments (UNESCO, 2000).

Reproductive health education in adolescence is an educational experience aimed at developing potential capacity of adolescents. The apparent lack of knowledge and information among male adolescents on issues relating to reproductive health and responsible sexual behaviour, is one for leading causes for unsuccessful reproductive life (UNESCO PROAP, 1999).

Young people need to learn generic skills such as planning ahead, making decisions, and forming positive relationships as well as practical skills needed to avoid high-risk behaviours. For example, communication skills used to discuss topics on reproductive issues, physical and psychological changes in adolescence, healthy behavior, socio-cultural norms and values and resolution of stress, that pertains to adolescent life (UNESCO PROAP, 1999).

Programme approaches should help students learn to set goals and to communicate with family and friends, including negotiation and dealing with pressure situations. In teaching life skills, students are dynamically involved in the learning process. Methods are needs driven based on the needs of creating a complete and authentic experience readily transferable to real-life situations (UNESCO PROAP, 1999).

Walker, G. (1999) at the WHO Regional Office for Europe, organized a regional meeting on youth and reproductive health. In this meting, recommendation included that, IEC programs should be involving youth directly in planning, implementing, monitoring and evaluating youth-related projects and programmes equipping young people with pertinent skills. That is to enhance their capacities to communicate, make decisions and plan their lives improving accessibility of services. Adolescents programs included training service providers, teachers, parents, and encouraging the media and policy makers to deal with youth developing relevant reproductive health programs.

2.6. Global situation:

The evidence is very strong that the successful programs in reality treat children and youth holistically, start young, offer many enrichment, growth and development activities, and stick with youth for a long period of time.

In deciding what to do to assist youth, past efforts have focused largely on youth who have already exhibited behaviors considered undesirable by society (e.g., dropping out of school, engaging in illegal activities, engaging in violent activities, having babies without being able to support them, abusing drugs and alcohol). Programs addressing these issues typically work with youth to try to stop them from continuing these behaviors, and to reduce the consequences of these behaviors. Thus they are engaging in either secondary prevention or tertiary attention, (Burt, M.R, 1998).

There are 562,753 adolescents aged 10-19 years old in Mongolia, which represents 25% of the population. Most adolescent get information from inaccurate sources and have insufficient knowledge. A recent survey found that 87% had insufficient knowledge about reproductive health and sexuality. 98% of the respondents had poor decision-making and communication skills related to reproductive health and sexuality. Most adolescents get information on reproductive health and sexuality from sources that are not always accurate: 66% of adolescents get most of their information from their friends. TV and newspapers were also commonly named sources of information. Ninety percent of adolescent boys and 71% of adolescent girls do not talk with their parents and other family members about pregnancy prevention. The majority of

boys (80%) and girls (76%) stated that talking with their parents about sexuality is very uncomfortable.

Parents and teachers say that they are not able to talk with them due to their own poor knowledge of sexuality. Parents need to be more involved. Parents say they would like their children to be taught about sex, but most fail to do so. Many feel ill informed or embarrassed talking about the subject, and they fear being asked a question they cannot answer, (Mongolian Medical University, 1999).

Programme responses might include working with young men to reflect on their actions, offering them mentors who promote safe sex, providing them with skills, and helping them to question traditional role models, (UNFPA, 2000). In a Kenyan study, 71 per cent of parents reported having talked with their children about schoolwork in the past year, (UNFPA, 2000).

In Uganda, a broad definition of parents is used — all adults who care for children: mothers, fathers, grandparents, aunts, uncles, stepparents, guardians and family friends, (UNFPA, 2000). In recent years, UNFPA has supported a number of country-specific studies on adolescent reproductive health behaviour. In Romania, for example, the results of the Young Adult Reproductive Health Survey provided a wealth of information regarding young people's knowledge, attitudes and behaviour on matters relating to sex education, contraceptive use and sexuality.

2.7. Local situation:

A study was conducted by the Palestinian Family Planning and Protection Association (1999) in Gaza to assess the needs of sexual and reproductive issues for youth in the Provinces of Gaza. The study population groups had a consensus on the need to raise the awareness of youth on 10 issues, they were:

a) Communication skills, b) Domestic relationships, c) Psychological problems facing youth married couples, d) Social conflicts resolution, e) Pre-marriage counselling, f) Reproductive health, g) Disadvantages of early marriage, h) Gender and women empowerment, I) Islam and family planning.

A study on the risk factors to physical and mental health and well being, and the priorities of Palestinian youth, was conducted jointly by the UNICEF and the Birzeit University Development Studies Programme (1999). The goal of the study was to encourage and enable the participation of Palestinian youth in assessing their needs and priorities.

The study involved interviewing 134 children and youth between the ages of 10 and 22 through a series of focus group discussions. These workshops took place through out the areas of the West Bank and Gaza Strip. Among the many issues raised and discussed by the youth were those concerning political participation, economic situation, health education and family relationships.

The study showed that youth themselves realize that health and well being are holistic and encompass many aspects of life including reproductive health.

Palestinian youth live the unstable conditions experienced by all Palestinian people. Their feelings of deprivation therefore spring from the absence of their basic rights to security, mobility and access to information and services, among other issues. The findings of this study illustrate the vast neglect of youth issues in Palestine. The findings show that young people lack information, services and recognition.

2.8. Intervention policies:

There are a variety of models followed in South Asia, which can be grouped into two main categories. First: In some countries, special units have been established to develop IEC programmes, such as the IEC Center in the Islamic Republic of Iran, Second: in some countries IEC functions have become integrated with health education units, e. g. in the Bhutan, Maldives and Sri Lanka, where such functions have become part of heath education units, IEC responds better to substantive reproductive health issues, (UNESCO, 2000).

"*The most comprehensive reproductive health and sexual health education programmes not only cover the biology and anatomy of reproduction and sex, but also provide young people with information about, marriage and contraception. They help develop the skills necessary to resist peer pressures inappropriate sexual practices and to attain a level of maturity required making responsible decisions. They carry lessons on goal setting and career planning.*" (UNESCO, 2000).

Mass Media is frequently used as one of the major channels of communication in social marketing intervention strategies. The term mass media refers to self-

contained audio, visual or print distribution systems that can simultaneously reach large numbers of people with the same message. Examples include radio, television, computers, newspapers, and magazines.

UNESCO (2000) continues to recommend that awareness building and advocacy is necessary to youth in order to carry out and sustain successful adolescent reproductive health education programmes. It is important to build awareness and alliances with others living and working in the same community. Awareness is critical to ensure adults in the community support the idea of developing and implementing a comprehensive programme that will address the real needs of the entire spectrum of adolescents in the target group.

It has been indicated by Israel, R.C. and Nagano, R. (1998) that other relevant methods are effective interventions address the behavioral issues of young adults themselves as well as the environmental factors and social norms influencing their behavior. There is a strong correlation between environmental factors and social norms and the attitudes and behaviors of young people. Social marketing programs, therefore, need to target diverse audiences.

These include young people themselves, their parents, service providers, media planners, peer educators, business and civic leaders and policymakers. The Philippines Foundation for Adolescent Development, for example, produced an educational video for parents about the impact of their communication skills on their children. The Kenya Association for the Promotion of Adolescent Health provides an example of how this process works, (Israel, R.C. and Nagano, R., 1998).

Chapter (3): Designing methods of the study

This study has been planned to assess the knowledge, attitude and practice of reproductive health among male adolescents. The target population was selected from schools in 3 localities, they were Gaza City East, Gaza West and North Province as representative areas in the Gaza Strip. The steps of designing the study, sample size and sampling have determined to achieve the objectives of the study.

The time allocated for conducting this research as suggested by the college was to be in the period from April till December 2001. The time for data collection took place during the scholastic year from November till December 2001 from one cohort only. In this chapter, the methods of designing and undertaking the study will be described as shown in the following pages.

3.1. Type of study:

The type of this study is ***cross sectional***. Cross sectional is conducted at a point of time. It is rather quick and less costy. It rules out variations and finds out association between variables as needed. Cross sectional type of studies can best be used for prevalence of diseases, describe the researched situation and suite evaluative studies. Therefore, the researcher decided to select this type, as it is the most likely appropriate for the case of this research.

3.2. Tools of study:

The tool of study in this research is an ***interview-structured questionnaire*** for each one of the study population.

3.3. Sample size:

The sample consisted of 300 male adolescents, it was divided as follows:

Male adolescents 300 (Gaza City West: 100, Gaza City East: 100 and North: 100).

3.4. Sampling:

The sampling method was a stratified systematic random sample from the classes of schools in the study area. The schools of the three localities were listed and a random selection was undertaken by picking two schools from each locality. The lists of the targeted classes of the study population were collected from 6 schools of the 3 localities, 2 schools of each, one preparatory and one secondary. The total number of lists was 24 lists, each list contains 40-45 pupils. Of each locality, 8 lists were selected that contain about 360 pupils of three grades (9^{th}, 10^{th} and 11^{th}). The subjects were systematically selected by picking every third name on the lists. A total of 300 adolescents were then identified from the lists of the three grades, those that constituted the sample of the study and were interviewed.

3.5. Preparations for conducting the research:

After deciding upon the design of the study including the target population, localities tool of study and the sampling method, the preparations for this survey included the following:

1. Making the communications for administrative and legal approval for the conduction of the study with the Ministry of Education, (Annex 1).

2. Preparing the questionnaire (Annex 2), and the letter of invitation to each one of the subjects of study for participation, (Annex 3).
3. Making arrangements for computer software preparation for data entry.
4. Training 3 members of the staff who was allocated to participate in interviewing the subjects of study. Three sessions in one day were held to train the team.
5. Primary visits to schools for obtaining the lists of students' names of the selected classes in order to determine the subjects of the study by systemic random selection.
6. Preparing the schedule of visits including the interviewers, the schools intended and the time of activities.
7. Securing the availability of logistic needs such as transportation and stationary.

3.6. Pilot study:

The researcher and the 3 members of the interviewing team visited one of the targeted schools and interviewed 10 adolescents of the study population. Those pupils were excluded from the study and replaced from the lists of pupils' names. Some modifications were made in the wording of questions to make them simple and easier to be understood by the study population. Some elements were added to few questions to make them more comprehensive and complete.

A question about sex practice was omitted because of the social sensitivity and shy reaction of the adolescents. Speaking about sex with adolescents was

found to be hardly accepted and cause astonishing alienation of the study population due to its sentimental social values that are prevalent at this age.

The pilot study was a beneficial experience to the team who became more oriented to nature of the study. On the other hand, unifying the procedure of interviewing among the team members was secured.

3.7. Data collection:

3.7.1. Structured-interview questionnaire:

The questionnaire was prepared as the only tool of data collection in this study. It was designed to enable the researcher to obtain all relevant information needed to answer the questions of the research and therefore achieve its objectives. Many questions were prepared to be open in order to collect as much data as possible meanwhile avoiding leading the adolescents to giving wanted answers. Double-barreled-questions were avoided when the questions of the questionnaire were worded.

The parts of the questionnaire included socio-demographic data, knowledge, attitude and practice on RH among the study population. First, socio-demographic data included serial number, age group, locality, father and mother job, and number of other family members. Second, the knowledge questions included what does the term RH means to the adolescent, the components of RH, attendance of awareness settings, who provides RH services. The questions also included the related knowledge on FP, methods of contraception, and who provides FP service. The questions included the

knowledge on the signs of puberty, the sources of information about sex, STD's and the methods of transmission of AIDS and Hepatitis B.

Third part of the questions was about the attitude. The questions included consanguineous marriage, importance and need of RH and FP services and the ideal age of marriage to male and female. The fourth part of questions was about the practice of RH. It included using the RH service by adolescents and their family members and the RH needs for male adolescents.

3.7.2. Procedure of data collection:

The Researcher made the needed coordination and communication with targeted schools in the three localities to commence the phase of data collection. The participating members of the team were distributed to schools with related lists according to a schedule was prepared for this purpose. The data collection took one month until the sample was completed. The interviews took place in separate rooms individually.

After identifying participating pupils from the lists, the 4 members of the team including the Researcher sat in a room and called upon the participating pupils of the study from the class. When the interview finishes, another set of four pupils was called until the time is over at that setting of a given day. This procedure continued fluently until the data collection was completed for the whole sample in the localities.

The team members and the researcher reviewed the completed questionnaires before the departure from the school to confirm complete collection of data in each questionnaire. All questionnaires were collected and given to the data entry assistant to complete the data entry phase.

3.8. Data entry and statistical analysis:

The entry of data was completed using SPSS, then the data was cleaned and revised. The frequency tabulation was undertaken to extract all data that became readable. The answers of the open questions were sorted out manually and quantified in points and rated accordingly. Then cross tabulations were formalised and results could give the answers to the questions of research.

3.9. Ethical and administrative issues:

The Researcher considered the ethical principles as required. An invitation letter was forwarded to each adolescent of the study population to secure acceptance of participation in research, (Annex 3). Modification of questions and omitting the sensitive question that relates to sex was done respecting the social values of the study population.

The administrative procedure included addressing an official letter to the Ministry of Education to allow conducting the research in the targeted schools. The needed communication and coordination was undertaken on time with the host schools.

3.10. Literature review and references:

The literature review was collected from the available similar studies, internet resources and the publications of WHO. Harvard method was used in referencing the reviewed literature in this study. However, similar local studies are rare and could not be known or found.

Chapter (4): Results

The results of the study have been sorted out of the data collected from the study population by a structured interview questionnaire, which was the tool of this study. The following tables have been classified to show the results of which answer the questions of the research in terms of knowledge, attitude and practice on reproductive health among male adolescents at schools. The ages of the study population groups have been illustrated in the tables as school grades in terms of 9^{th} Grade (15 years), 10^{th} Grade (16 years) and 11^{th} Grade (17 years).

Three localities were selected in this study; North, Gaza East and Gaza West. The Gaza West locality is known to be the most urbanised, Gaza East is less urbanised and North is rather peri-urban. The variables of the study were tabulated according to locality and or age group as seemed to be more descriptive or useful.

4.1. Sociodemographic characteristics:

The socio-demographic characteristics selected in the study were the fathers' job, mothers' job, number of brothers and sisters and number of household members. The distribution of the sociodemographic variables is shown following Table (1).

Table (1): Socio-demographic characteristics distribution of the study population according to locality (100 adolescents in each locality).

Sociodemographic variables	North		Gaza East		Gaza west		Total	
	No	%	No	%	No	%	No	%
Fathers job - Merchant/land owner	3	3	11	11	4	4	18	6
- Highly skilled	15	15	14	14	10	10	39	13
- Professionally skilled	13	13	10	10	21	21	44	14.7
- Technically skilled	15	15	20	20	29	29	64	21.3
- Laborer	25	25	16	16	19	19	60	20
- Unemployed	29	29	29	29	17	17	75	25
Total	100	100	100	100	100	100	300	100
Mothers job - House wife	94	94	93	93	88	88	275	91.7
- Working	6	6	7	7	12	12	25	8.3
Total	100	100	100	100	100	100	300	100
Brothers and sisters 1 – 4	4	4	16	16	10	10	30	10
5 – 8	52	52	50	50	57	57	159	53
9 +	44	44	34	34	33	33	111	37
Total	100	100	100	100	100	100	300	100
Household Members 1 – 5	4	4	11	11	7	7	22	7.3
6 –10	58	58	53	53	62	62	173	57.7
11 +	38	38	36	36	31	31	105	35
Total	100	100	100	100	100	100	300	100

Table (1) shows that the unemployment is 25%, it is more in Gaza East and North than Gaza West. Generally, the percentage of women who are working outside home is low (8.3%), anyhow, in Gaza West, it is the highest in this study (12%).

Yates test of Chi-Square was undertaken to the selected socioeconomic variables, the result was not statistically significant.

The number of siblings 9 and over are more in North than Gaza East and West. The laborers are more in north than Gaza East and West. The highest number of the technically skilled are in Gaza West than Gaza East and North localities.

4.2. Results on knowledge of reproductive health:

4.2.1. Knowledge of RH components according to age group:

Of the total study population, 178 (59%) answered that they were familiar with the RH term. They mainly included the list as shown below in Table (3) distributed according to age group and in Table (4) distributed according to locality.

Table (2): Distribution of answers obtained of the study population on RH components known by male adolescents according to age group.

Reproductive Health components	9th Grade		10th Grade		11th Grade		Total		*P value*
	No	%	No	%	No	%	No	%	
1. Antenatal care service	26	26	41	41	36	36	103	34.3	0.73
2. Postnatal care service	25	25	38	38	33	33	96	32	0.87
3. Family planning service	15	15	33	33	30	30	78	26	0.13
4. Marriage issues	10	10	23	23	24	24	57	19	0.1
5. Awareness in RH	9	9	22	22	20	20	51	17	0.19
6. STD's	8	8	15	15	9	9	32	10.6	0.62
7. Infertility	4	4	8	8	8	8	20	6.7	0.67
8. Others	4	4	6	6	16	16	27	9	0.97

As shown in the above table, the ANC, postnatal care and FP are the main components of RH recognized to be known by the study population. Others (number 8) in the list includes RH in adolescence, breast feeding, early detection of breast and cervix cancer and circumcision of the female; these

components are less likely known by the study population. The 10th grade pupils were found to be the highest group who received awareness on RH matters than the 9th and 11th grades, the result showed a very high statistical significance (*p value* 0.00). The results of other variables were not statistically significant.

4.2.2. Knowledge of RH components according to locality:

As explained above, the RH components known by the study population who are familiar to RH term are shown below in Table (3). The adolescents in localities show a somewhat similarity in the knowledge of RH components.

Table (3): Distribution of the answers obtained of the study population on RH components known by male adolescents according to locality.

Reproductive Health components	North		Gaza East		Gaza West		Total		*P value*
	No	%	No	%	No	%	No	%	
1. Antenatal care service	30	30	38	38	35	35	103	34.3	0.49
2. Postnatal care service	28	28	35	35	33	33	96	32	0.55
3. Family planning service	23	23	28	28	27	27	78	26	0.69
4. Marriage issues	18	18	14	14	25	25	57	19	0.13
5. Awareness in RH	15	15	17	17	19	19	51	17	0.75
6. STD's	10	10	7	7	15	15	32	10.6	0.18
7. Infertility	6	6	6	6	8	8	20	6.7	0.81
8. Others	10	10	15	15	11	11	27	9	0.65

4.2.3. Attendance of awareness settings according to age group:

The attendance of awareness settings on RH was measured by an open question, the questions included "how many times have you attended RH awareness settings, where and who is the organising body?" The number of pupils who ever attended awareness settings was 78 (26 %) of the total study population, while 222 (74%) of the study population never attended any awareness sessions. The results were statistically tested, none of the were found to be significant.

The following tables (4 and 5) describe more details on place, number attended and the organizing body of the awareness settings. It is observed that only 3 of the study population attended awareness setting in more than one place. Of the 78 (26% of the total study population who ever attended awareness sessions), the majority of the pupils 65 (83.3%) attended the awareness sessions at schools. The 9^{th} grade are found out to have awareness in schools (94.1%) more than the 10^{th} and 11^{th} grades, meanwhile adolescents of the 11^{th} grades receive awareness in youth clubs more than those who are younger than them of the 10^{th} and 9^{th} grades (20.8%, 9.6% and 5.9% respectively.

Table (4): Distribution of awareness settings on RH issues attended by the 78 pupils of the study population according to place, number and organizer body.

Participation in Awareness Settings		9th Grade		10th Grade		11th Grade		Total		*P value*
		No	%	No	%	No	%	No	%	
Place	Schools	16	94.1	28	84.8	21	75	65	83.3	0.83
	Youth clubs	1	5.9	3	9.6	5	20.8	9	11.6	0.19
	Summer camp	0	0	2	6.1	2	7.1	4	5.1	0.45
	Total	17	100	33	100	28	100	78	100	
Number	1-3	6	35.3	13	39.4	18	64.3	37	47.4	0.03
	4-6	7	41.1	9	27.3	2	7.1	18	23.1	
	7 +	4	23.6	11	33.3	8	28.6	23	29.5	
	Total	17	100	33	100	28	100	78	100	
Organizing body	School health	11	64.7	26	78.8	19	67.9	56	71.8	0.26
	NGO's & others	6	35.3	7	21.2	9	32.1	22	28.2	0.36
	Total	17	100	33	100	28	100	78	100	

The results showed that the 11th grade that received awareness sessions was the highest among the other grades, and they were the least received 4-6 sessions, it was statistically significant (*P value 0.03*). The other results of other variables were not statistically significant.

4.2.4. Attendance of awareness settings according to locality:

Following to the above mentioned, the answers showed that 50% of the study population attended 1-3 settings, 29.5% attended 4-6 times and 20.5% 7 times and over. The main organising body for the awareness activity was found to be the school health programme at the MoH (69%), and NGO's and others were (31%). Adolescents in the Gaza West are the highest attending youth clubs (21%) compared to Gaza East (9.6% and North (4.3). The following table (5) shows the details.

Table (5): Distribution of participation in awareness settings by the study population in the localities according to place, number of settings attended and organising body.

Participation in Awareness Settings		North		Gaza East		Gaza West		Total		*P value*
		No	%	No	%	No	%	No	%	
Place	Schools	21	91.4	26	83.9	18	75	65	83.3	0.31
	Youth clubs	1	4.3	3	9.6	5	20.8	9	11.6	0.19
	Summer camp	1	4.3	2	6.5	1	4.2	4	5.1	0.78
	Total	23	100	31	100	24	100	78	100	
Number	1-3	10	43.5	14	45.2	15	62.5	39	50	0.24
	4-6	8	34.8	10	32.3	5	20.8	23	29.5	
	7 +	5	21.7	7	22.5	4	16.7	16	20.5	
	Total	23	100	31	100	24	100	78	100	
Organizing body	School health	16	69.6	22	71	16	66.7	54	69.2	0.24
	NGO's & others	7	30.4	9	29	8	33.3	24	30.8	0.41
	Total	23	100	31	100	24	100	78	100	

No statistical significance was found in all variables tested in this table.

4.2.5. Knowledge of FP term according to locality:

The knowledge of the FP was examined by questioning the study population in the three localities about what FP term means to them. The question was open to avoid leading the study population to RH components known by the researcher. The collected answers were 365, they were sorted out and listed as shown in the Table (6) below.

Table (6): Distribution of the answers obtained about what the term of family planning means to the study population according to locality

Meaning of FP term to the study population	North		Gaza East		Gaza West		Total		*P value*
	No	%	No	%	No	%	No	%	
1. Spacing between births	34	34	33	33	32	32	99	33	0.22
2. Birth control	40	40	29	29	30	30	99	33	0.24
3. Healthy and happy	23	23	25	25	32	32	80	26.7	0.21
4. Good health care for children	14	14	20	20	18	18	52	17.3	0.34
5. Don't know	16	16	15	15	4	4	35	12	0.22

No statistical significance was found in all variables tested in this table.

The above table also describes the answers of an open question, which was addressed to the study population (male adolescents). The table shows that 33% of the total answers recognises that spacing between births and birth control is what FP means in the 3 localities. Of the total answers, 26.7% and 17.3% think that FP means healthy and happy life, and good health for children respectively, and 12% of the study population answered they do not know.

4.2.6. Knowledge of contraception methods according to age groups and locality:

The knowledge of the study population on contraception methods was tested. They were asked an open question on what methods of contraception they know. The following tables (7 and 8) show that the pills are recognised without variation by the study population according to age groups and localities. The adolescents in the 11th grade were the highest to recognise loops and safe period as means of contraception methods, more than the 9th and 10th grades adolescent in North and Gaza East as can be seen in the Table (7) below.

The adolescents in the North are the least to know about the withdrawal method as compared to Gaza East and West adolescents as shown in Table (8).

The obtained answers have revealed that the majority 82% know pills and 48% know loops as methods of contraception used by women. Withdrawal method is known by 10.3% only, and 5% of the total population do not know any method.

Table (7): Contraception methods known by the study population according to age groups:

Contraception Methods known	9th Grade		10th Grade		11th Grade		Total		*P value*
	No	%	No	%	No	%	No	%	
1. Pills	60	60	100	100	85	85	245	81.7	0.02
2. Loops (IUD)	33	33	47	47	63	63	143	47.7	0.001
3. Withdrawal	8	8	10	10	13	13	31	10.3	0.52
4. Condom	3	3	7	7	3	3	13	4.3	0.52
5. Safe period	2	2	4	4	6	6	12	4	0.41
6. Vaginal suppositories	1	1	0	0	1	1	2	0.7	0.52
7. Don't know	6	6	9	9	0	0	15	5	**0.02**

Testing of the results was statistically significant at the selected variables in this table, pills (P value 0.02), Loops (P value 0.001) and don't know (P value 0.02). Other variables' results were not statistically significant.

Table (8): Distribution of contraception methods known by the study population according to locality.

Method of contraception	North		Gaza East		Gaza West		Total		*P value*
	No	%	No	%	No	%	No	%	
1. Pills	81	81	83	83	81	81	245	81.7	0.92
2. Loops (IUD)	56	56	43	43	44	44	143	47.7	0.12
3. Withdrawal	5	5	13	13	13	13	31	10.3	0.1
4. Don't know	6	6	4	4	5	5	15	5	0.81
5. Condom	4	4	6	6	3	3	13	4.3	0.57
6. Safe period	5	5	4	4	3	3	12	4	0.77
7. Vaginal suppositories	1	1	1	1	0	0	2	0.7	0.6

No statistical significance was found in all variables tested in this table.

4.2.7. Knowledge on the signs of puberty according to locality:

An open question was addressed to the study population about what they know of the signs of puberty. Table 9 below shows the details of answers obtained.

Table (9): Distribution of answers that show the knowledge of the study population on the signs of puberty in male according to locality.

Signs of puberty in male	North		Gaza East		Gaza West		Total		*P value*
	No	%	No	%	No	%	No	%	
1. Growing of hair in different parts of the body	64	64	78	78	70	70	212	70.7	0.22
2. Roughness in voice	56	56	69	69	64	64	189	63	0.28
3. Wet dreams	50	50	50	50	35	35	135	45	0.24
4. Physical Growth and nipples tenderness	27	27	32	32	26	26	85	28.3	0.26
5. Sexual arousal	19	19	21	21	16	16	56	19	0.31
6. Acne vulgaris	9	9	5	5	7	7	21	7	0.42

No statistical significance was found in all variables tested in this table.

The answers show that the majority recognize puberty in male adolescent by growing of hair in different parts of the body 70.7%, roughness of voice 63%, wet dreams 45% and physical growth and nipples tenderness 28.3%. Sexual arousal (19%) included tendency to other sex, caring for external shape, changes in reproductive system and masturbation.

4.2.8. The source of information about sex:

An open question was addressed about the sources of knowledge on sex information. The total number of answers obtained of the study population was 543. They were sorted out as shown in tables (10 and 11) according to age groups and locality.

Table (10): Distribution of the answers of the study population on the sources of information about sex according to age groups.

Sources of information	9th Grade		10th Grade		11th Grade		Total		P value
	No	%	No	%	No	%	No	%	
1. Teachers	50	50	79	79	61	61	190	63.3	0.46
2. Friends	47	47	59	59	51	51	157	52.3	0.73
3. Readings and media	35	35	60	60	54	54	149	49.7	0.2
4. Parents	11	11	09	09	06	06	26	8.7	0.22
5. Brothers, sisters & Relatives	4	4	9	9	8	8	21	7	0.23

No statistical significance was found in all variables tested in this table.

The main sources of knowledge about sex reported by the study population were from teachers, friends and, readings and media 63.3%, 52.3% and 49.7% respectively). Family members and relatives as shown above have little role on educating the adolescent about sex.

Table (11): Distribution of the answers of the study population on the sources of information about sex according to locality.

Sources of information	North		Gaza East		Gaza West		Total		P value
	No	%	No	%	No	%	No	%	
1. Teachers	57	57	66	66	67	67	190	63.3	0.27
2. Friends	66	66	52	52	39	39	157	52.3	**0.001**
3. Readings and media	51	51	61	61	37	37	149	49.7	**0.003**
4. Parents	13	13	2	2	11	11	26	8.7	**0.01**
5. Brothers, sisters & Relatives	10	10	5	5	6	6	21	7	0.35

Three of the sources of information showed statistical significance; friends (P value 0.001), readings and Media (P value 0.003) and parents (P value o.o1). Teachers, brothers, sisters and relatives were not statistically significant.

Table (11) above shows that the adolescents in the Gaza West locality are the least affected with friends from North and Gaza East localities. While the adolescents in Gaza East are the least affected by parents as for the sources of

knowledge on sex. Variation between localities is observed in terms of teachers 57% is the lowest source of sex information in the north, friends 66% is the highest in the North and readings and Media 61% is the highest in Gaza East.

4.2.9. The knowledge of STD's according to age groups and locality:

The question, which was addressed to measure the knowledge of STD's among the study population, was (what are the sexual transmissible diseases that you know?). The answers were sorted out and shown in the tables below (12 and 13) according to age groups and locality.

The tables (12 and 13) show that 73% of the study population does not know about STD's. Hepatitis B is the most common known disease transmitted by sex contact 27% as reported by the study population. AIDS is the second common known disease 10%.

As per the knowledge of Hepatitis B in Table (13), a variation can be observed that adolescents in Gaza West 35% were the highest to know more than their counterparts in Gaza East and North 26% and 20% respectively. No variation can be noticed in the 3 localities among those who do not know and those who know about AIDS.

Table (12): The STD's known by the study population according to age group.

STD's	9th Grade		10th Grade		11th Grade		Total		*P*
	No	%	No	%	No	%	No	%	*value*
1. Hepatitis B	20	20	37	37	24	24	81	27	0.35
2. AIDS	9	9	14	14	7	7	30	10	0.47
3. Gonorrhea and syphilis	2	2	7	7	7	7	16	5.3	0.34
4. Don't know	80	80	63	63	76	76	219	73	**0.04**

The 10th grade was less than 9th and 11th grades, as they don't know STD's, it was statistically significant (P value 0.04). Other variables were not statistically significant.

Table (13): The STD's known by the study population according to locality

STD's	North		Gaza East		Gaza West		Total		*P value*
	No	%	No	%	No	%	No	%	
1. Hepatitis B	20	20	26	26	35	35	81	27	0.06
2. Aids	10	10	10	10	10	10	30	10	1
3. Gonorrhea and syphilis	7	7	6	6	3	3	16	5.3	0.42
4. Don't know	80	80	74	74	65	65	219	73	**0.05**

The population of the Gaza West locality was less than North and Gaza East localities, as they don't know STD's, it was statistically significant (P value 0.05). Other variables were not statistically significant.

4.2.10. Methods of transmitting AIDS in man according to age groups and locality:

AIDS has been considered a disease of importance, therefore, a question was particularly addresses to the study population to measure how much they know about its transmission to man. The tables (14 and 15) below show that the majority of study population reported that the main two means of transmitting AIDS is the sexual contact and, blood and body fluids (86.3% and 53.7% respectively).

Table (14): Methods of transmitting AIDS to man as known by the study population according to age groups.

Method of transmission	9th Grade		10th Grade		11th Grade		Total		P value
	No	%	No	%	No	%	No	%	
1. Sexual contact	73	73	95	95	91	91	259	86.3	**0.005**
2. Blood and body fluids	36	36	63	63	62	62	161	53.7	**0.03**
3. Touch	9	9	12	12	4	4	25	8.3	0.17
4. Food and drink	8	8	5	5	5	5	18	6	0.27

Table (15): Methods of transmitting AIDS to man as known by the study population according to locality

Method of transmission	North		Gaza East		Gaza West		Total		P value
	No	%	No	%	No	%	No	%	
1. Sexual contact	76	76	91	91	92	92	259	86.3	**0.001**
2. Blood and body fluids	48	48	53	53	60	60	161	53.7	0.23
3. Touch	14	14	7	7	4	4	25	8.3	**0.03**
4. Food and drink	6	6	5	5	7	7	18	6	0.84

4.2.11. Methods of transmitting Hepatitis B in man according to age groups and locality:

Hepatitis B has been also considered a disease of importance because of its prevalence in the Gaza Strip, therefore, a question was particularly addresses to the study population to measure how much they know about its transmission to man. The study population demonstrated that blood and body fluids, food and drink and sexual contact are the main methods of transmitting hepatitis B (21.7%, 18% and 14.7% respectively) as shown as shown below in Tables (16 and 17).

Table (16) below shows that the adolescents in 9th grade were the highest to think that Hepatitis B can be transmitted by food and drink, and touch compared to 10th and 11th grade. Table (17) shows no variation between the localities in the methods of transmission of Hepatitis B.

Table (16): Method of transmitting Hepatitis B to man as known by the study population according to age groups.

Method of transmission	9th Grade		10th Grade		11th Grade		Total		*P value*
	No	%	No	%	No	%	No	%	
1. Blood and body fluids	10	10	33	33	22	22	65	21.7	**0.02**
2. Food and drink	20	20	18	18	16	16	54	18	0.26
3. Sexual contact	10	10	21	21	13	13	44	14.7	0.42
4. Touch	14	14	7	7	3	3	24	8	**0.002**

Table (17): Method of transmitting Hepatitis B to man as known by the study population according to locality.

Method of transmission	North		Gaza East		Gaza West		Total		*P value*
	No	%	No	%	No	%	No	%	
1. Blood and body fluids	23	23	22	22	20	20	65	21.7	0.87
2. Food and drink	17	17	20	20	17	17	54	18	0.82
3. Sexual contact	15	15	16	16	13	13	44	14.7	0.83
4. Touch	8	8	9	9	7	7	24	8	0.87

4.2.12. Reproductive health providers in the Gaza Strip according to age groups and locality:

The study population was asked about if they know any health providers deliver reproductive health care in their locality. The answers were sorted out and shown in the Tables (18 and 19) below. It is shown that 65.7% recognize the government, as a main health provider of RH service while UNRWA is the

second 42.3%. Of the study population 17.7% do not know any of provider of RH service.

Table (18): Reproductive Health (RH) providers in Gaza as known by the study population according to age groups.

RH service provider	9th Grade		10th Grade		11th Grade		Total		*P value*
	No	%	No	%	No	%	No	%	
1. Government	53	53	85	85	59	59	197	65.7	0.11
2. UNRWA	32	32	52	52	43	43	127	42.3	0.64
3. Private	19	19	16	16	17	17	52	17.3	0.26
4. NGO's	7	7	5	5	8	8	20	6.7	0.41
5. Don't know	13	13	19	19	21	21	53	17.7	0.52

Table (19): Reproductive Health (RH) providers in Gaza as known by the study population according to locality.

RH service provider	North		Gaza East		Gaza West		Total		*P value*
	No	%	No	%	No	%	No	%	
1. Government	64	64	71	71	62	62	197	65.7	0.37
2. UNRWA	37	37	51	51	39	39	127	42.3	0.1
3. Private	25	25	11	11	16	16	52	17.3	**0.03**
4. NGO's	10	10	6	6	4	4	20	6.7	0.22
5. Don't know	21	21	12	12	20	20	53	17.7	0.19

Table (19) shows that the study population mentioned UNRWA as the highest RH service provider 51% in Gaza East, while the highest RH service provider in the North is the private sector 25%. The private is the least in Gaza East 11%.

4.3. Results of attitude towards RH:

4.3.1. Consanguineous marriage:

Most of the study population 224 (74.6%) expressed their rejection to the idea of consanguineous marriage, 38 (12.7%) agreed and a similar number of the later showed an indifferent attitude towards that.

The group of the study population who rejected consanguinity mentioned the reasons, which can be summarised as follows:

1. Giving birth of children with anomalies and disabled.
2. Occurring conflicts and problems between the families of couples.

Those who expressed their strong agreement on consanguinity mentioned the main reason, which are the easy possibilities of solving the problems between couple relatives and their families.

4.3.2. Ideal age of marriage according to age group and locality:

The attitude towards the ideal age of marriage for male and female was tested. The study population was asked about the ideal age of marriage, as they believe. The data was sorted out in two tables (20 and 21) according to age group and locality and shown below. The 2 tables show that the majority of the study population think that the ideal age of marriage among males is 20-25 years; meanwhile the majority thinks that the ideal age of marriage among females (49%) comes between the 15-19 years. More pupils in the North are in favor of this belief as compared to other regions as shown in Table (21).

Table (20): The marriage ideal age for male and female as thought by the study population according to age group.

Ideal age for marriage		9th Grade		10th Grade		11th Grade		Total		*P value*
		No	%	No	%	No	%	No	%	
Male	15-19	5	5	7	7	3	3	15	5	0.82
	20-25	68	68	76	76	87	87	231	77	0.62
	26-30+	27	27	17	17	10	10	54	18	0.53
Total		100	100	100	100	100	100	300	100	
Female	15-19	53	53	55	55	39	39	147	49	0.73
	20-25	47	47	43	43	59	59	149	49.7	0.67
	26-30+	0	0	2	2	2	2	4	1.3	1.4
Total		100	100	100	100	100	100	300	100	

Table (21): The marriage ideal age for male and female as thought by the study population according to locality.

Ideal age for marriage		North		Gaza East		Gaza West		Total		*P value*
		No	%	No	%	No	%	No	%	
Male	15-19	1	1	8	8	6	6	15	5	0.18
	20-25	83	83	76	76	72	72	231	77	0.14
	26-30+	16	16	16	16	22	22	54	18	0.16
Total		100	100	100	100	100	100	300	100	
Female	15-19	56	56	39	39	52	52	147	49	0.16
	20-25	43	43	59	59	47	47	149	49.7	0.18
	26-30 +	1	1	2	2	1	1	4	1.3	0.6
Total		100	100	100	100	100	100	300	100	

4.3.3. Importance of reproductive health according to age groups and locality:

The importance of RH as the study population believes, was tested. Tables (22 and 23) below show that the majority of the study population 79% recognizes the great importance of reproductive health services while 10% said it is not important. However, the study population in the North was the highest 84%.

Table (22): Importance of reproductive health as thought by the study population according to age groups

Importance of reproductive health	9th Grade		10th Grade		11th Grade		Total		*P value*
	No	%	No	%	No	%	No	%	
Very important	77	77	75	75	84	84	236	78.7	0.24
Important	15	15	13	13	7	7	35	11.7	0.25
Not important	8	8	12	12	9	9	29	9.6	0.27
Total	100	100	100	100	100	100	300	100	

Table (23): Importance of reproductive health as thought by the study population according to locality.

Importance of reproductive health	North		Gaza East		Gaza Wes		Total		*P value*
	No	%	No	%	No	%	No	%	
Very important	84	84	80	80	72	72	236	78.7	0.31
Important	4	4	10	10	21	21	35	11.7	**0.01**
Not important	12	12	10	10	7	7	29	9.6	0.24
Total	100	100	100	100	100	100	300	100	

The reasons behind the great importance of RH as expressed by the majority of the study population were as follows:

1. Preservation of the mother and child health, 126 (42%).
2. Raising the awareness of people on health matters related to reproductive life, 59 (19.7%).
3. Assisting families to regulate their reproductive life, 37 (12.3%).

4.3.4. The need for family planning service:

Of the total population 70% expressed their high agreement on the need for family planning (FP) and conveyed the attitude of the community they know that 70% of people seek the FP service when needed. As said by the study population, the community who rejects the FP service reaches 19%, and of the total number of the interviewees 37 (12.3%) do not see the FP is needed.

The Reasons of agreement on the need for FP as mentioned by the majority of the study population were as follows:

1. It provides the opportunity to rear and raise children properly, 93 (31%).
2. Socioeconomic reasons, 76 (25.3%).
3. Providing better opportunities for comfort and health for mothers 47 (15.7%).

4.4. The results of utilizing RH services:

Of the 300 adolescents who were interviewed, 257 (86%) never used any reproductive health service. The total number of family members of the study population who used reproductive health was 276 (92%). Mothers 184 (66.7%) are the main users of FP in the family. Sisters and wives of brothers 16% each

are the second category using FP. The services they received were ANC, child health care and FP (50%, 38% and 12% respectively).

The reasons behind using family planning service by family members 101 (33.7%) as mentioned by the study population were as follows:

1. Improving the living circumstances of family due to reducing the number of children, 65 (64.4%).
2. Preserving better health for the mother, 24 (23.7%).
3. Lending the opportunity for caring of the younger children, 12 (11.9%).

4.5. Users of reproductive health among the study population:

The study population was asked whether the practiced any form of RH. Of the total population 43 male adolescents (14.3%) received RH service; types of service were awareness in RH issues [of the 43] 34 (79%), and medical tests and treatments were 9 (21%). The tables below show that the government (72.1%) is the main provider of RH service and UNRWA (16.3%) is the second as mentioned by the study population. Details are shown below in Tables (24 and 25).

Table (24): The RH service providers who provided the service for the 43 users of the study population according to age group.

RH service provider	9th Grade		10th Grade		11th Grade		Total		*P value*
	No	%	No	%	No	%	No	%	
1. Government	4	57.1	15	75	12	75	31	72.1	0.06
2. UNRWA	0	0	4	20	3	18.7	7	16.3	0.24
3. NGO's	1	14.3	0	0	0	0	1	2.3	0.28
4. Private	1	14.3	0	0	0	0	1	2.3	0.28
5. Don't know	1	14.3	1	5	1	6.3	3	7	0.1
Total	7	100	20	100	16	100	**43**	100	

Table (25): The RH service providers who provided the service for the 43 users of the study population according to locality.

RH service provider	North		Gaza East		Gaza West		Total		*P value*
	No	%	No	%	No	%	No	%	
1. Government	15	75	8	66.7	8	72.7	31	72.1	0.2
2. UNRWA	2	10	2	16.7	3	27.3	7	16.3	0.86
3. NGO's	1	5	0	0	0	0	1	2.3	0.37
4. Private	0	0	1	8.3	0	0	1	2.3	0.37
5. Don't know	2	10	1	8.3	0	0	3	7	0.36
Total	20	100	12	100	11	100	43	100	

4.6. Users of reproductive health among the family members of the study population:

The study population was asked whether any of their family members used any form of RH. It was found that 252 (84%) of the study population have had members of their families used RH service, they were mainly mothers, sisters or sisters in law. Tables (26 and 27) below, show that the government (48.8%) is the main provider of RH service and UNRWA (38.5%) is the second as mentioned by the study population.

Table (26): The RH service providers who provided RH service for the 252 family member users of the study population according to age group.

RH service provider	9th Grade		10th Grade		11th Grade		Total		*P value*
	No	%	No	%	No	%	No	%	
1. Government	34	51.5	44	43.6	45	50	123	48.8	0.5
2. UNRWA	21	31.9	47	46.5	29	32.2	97	38.5	0.06
3. Private	9	13.6	6	5.9	4	4.4	19	7.5	0.14
4. NGO's	1	1.5	2	2	2	2.2	5	2	0.91
5. Don't know	1	1.5	2	2	5	5.6	8	3.2	0.19
Total	66	100	101	100	90	100	252	100	

Table (27): The RH service providers who provided RH service for the 252 family member users of the study population according to locality.

RH service provider	North		Gaza East		Gaza West		Total		*P value*
	No	%	No	%	No	%	No	%	
1. Government	51	50	41	50	31	45.6	123	48.8	**0.02**
2. UNRWA	34	33.3	34	41.5	29	42.6	97	38.5	0.68
3. Private	12	11.8	2	2.4	5	7.4	19	7.5	**0.01**
4. NGO's	2	12	2	2.4	1	1.5	5	2	0.82
5. Don't know	3	2.9	3	3.7	2	2.9	8	3.2	0.88
Total	102	100	82	100	68	100	252	100	

4.7. Reproductive health needs for male adolescents:

The answers of the study population on RH needs for male adolescent were as follows:

1. Health education and promotion
2. Medical care and treatment.
3. Psychosocial support and counselling for students.

The job held by the student researcher lends him the opportunity to know about the health services provided to adolescents at schools that they include the following:

1. Health education;
2. Counselling;
3. Health surveys and tests;
4. Vaccination;
5. Environmental care;
6. Social and psychological service;
7. Reproductive health and
8. Oral health

Chapter (5): Discussion

This KAP study on reproductive health among male adolescents was conducted in the West and East localities of Gaza City and the North Province of the Gaza Strip. The study population was 300 male pupils at the ninth, tenth and eleventh grades of ages15, 16 and 17 years respectively. The results of this study came out to answer the questions and to achieve the objectives of the study. The nature of study is a descriptive. That is to give a true picture of the reality about knowledge, attitude and practice of RH among this important sector of the Palestinian community.

The results of this study show that 25% of the fathers of the study population are unemployed; it was 4.2% in 1997 according to the Palestinian Central Bureau of Statistics (PCBS, 1998). This can be considered an obvious deterioration in the socioeconomic situation in Gaza. It is attributed to the present political and insecurity situation endured by the People in Palestine. Table 1 and 2 in the chapter of results describe the expected status of the localities as known to be that Gaza West is more urbanised than Gaza East and North. The socioeconomic level of Gaza East can be graded between Gaza West and North.

The results showed that 90% of families have 5 children and over. The majority of families (70%) have a favourable attitude to practice FP because of the high number of children as they indicated of reasons to have enough time to rear children. Of the users of service 31% states this reason.

This can be considered a rational reason to use FP service. This goes in line with the results of the study conducted by Ismail, N. and Shaheen, M. (1996) who found out that women seek FP service when they get enough number of children, which was up to 5 children is satisfactory to the Palestinian family. This conceptual social attitude seems not changed among Palestinians since 1996.

Among the different results obtained on the socioeconomic indicators, which attract the attention was the job of the mother. In reference to the survey conducted by PCBS in the year 1997, it was found to be 4.2% of women in the Gaza Strip works outside home, it seems that the trend is rising in this study as those who work outside home was 8.3%. This might be an indicator of social change that is coming up slowly in the life of women in Gaza. However, this can not be generalized because the sample is not large enough to represent the whole community in the Gaza Strip. This need a further specialized study to rule this observation out.

The figures in Table (1) reflect the variation in the economic status between the 3 localities as Gaza West and Gaza East are better than the North. The results show that Gaza population is higher in the merchant category and highly skilled than the North while the latter higher in laborers. The number of siblings (9 and over) in North than Gaza. These results confirm the prevalent known idea that Gaza West is the best socioeconomic status, Gaza East is lower and the North is the Lowest in this study.

The main answers collected on what the study population thinks of family planning means spacing between births 33%, good health care for children 17.3% and birth control according to economic situation. There was no difference obtained between the 3 age groups on the meaning of FP to them. The study which was conducted in Egypt by Qayed, M. and Waszak, C. (1999) to a similar population showed that 25% of the study participants were familiar with the term of reproductive health, however, that study did not mention the details of knowledge on the components of RH. Other components were little known by the study population in this study, and 10% said that they do not know. However, the results show little variations between the groups in the 3 localities with vague or limited knowledge of FP. This outlines the emphasis on the need to implement raising awareness activities on RH to this sector of community.

Of the answers on RH components known by the study population, the antenatal care, post-natal care and family planning services are the major components identified (34.3%, 32% and 26% respectively). This result comes on line with the previous result mentioned above. The study population does not seem to have an idea about some RH components such as RH in adolescence, breast feeding, early detection of breast and cervix cancer and female circumcision.

Of the study population 74% never attended any awareness sessions on RH. This interprets the shortage in knowledge in spite of the little numbers who know other components of RH, the result shows deficiency in knowledge of

those other components. However, the study population is not expected to know these details because of age, knowledge and experience limitations. This adds further emphasis on the need to do awareness activities.

The majority (83%) of the 78, who ever attended awareness sessions on RH, had attended those sessions at school and summer camps. The school health team of the MoH carries out the only programme implemented at schools on awareness on RH issues. It is partially supported by the EC Project for Women's Health and Family Planning Programme.

Of the 78 (26% of the total study population) pupils who ever attended awareness sessions on RH, 47% attended 1-3, 23% attended 4-6 sessions and 30% attended 7+ sessions. The school health teams covered 72% of those sessions. This suggests the need to give more support to the school health teams to expand its activity for further coverage and examine other approaches of awareness programmes to cover more adolescents in the community by other providers.

The 9th grade was found to have more awareness settings in schools more than the 10th and 11th grades, while the 11th grade attended awareness settings in youth clubs more than the lower grades. These results seem logical because of school health education programme focused on the 9th grade this year more than the other two, as known to the researcher through his job status. The Gaza West adolescent population is the highest to attend youth clubs compared

to Gaza East and North. This is also attributed to the socioeconomic status of this locality compared to the other two.

The knowledge of contraception methods was examined among the male adolescents in this research. It was found that the majority of the study population knows pills, loops and withdrawal methods (81.7%, 47.7% and 10.3% respectively), while 5% does not know any method. This may be logically understood in view of the fact as found out in the result of utilisation of FP was 12% by the relatives of the study population. Further, of the study population 86% never used any RH service. However, the answers of this question may give an idea about the knowledge of male adolescents about contraception methods and can hardly be possible to measure the knowledge accurately.

The majority of the study population recognize puberty as main signs in terms of hair growth in certain areas of the body 70.7%, roughness of voice 63% and wet dreams 45%. This does not show any difference from what may be expected to be known by such sector of the community without RH education.

Teachers, friends and media are the main three sources of knowledge about sex (63.3%, 52.3% and 49.7% respectively). Parents were found to be 8.7%. However, adolescents in Gaza West in this study obtain sex information mainly from teachers 67%, in the North from friends and in Gaza East from readings and Media. This variation corresponds to the variation of socioeconomic status between the localities.

In the study conducted in Ethiopia by Taffa, N. et al (1999) it was found that 75% of the study population preferred to discuss sex issue with peers of the same sex, and none wanted to discuss the subject with parents. In a Mongolian study (Mongolian Medical University, 1999) it was found that more than two thirds of adolescents do not get enough information about STD's and HIV, the majority 92% want to get more information on safe sex at school. This shows the great need to encourage parents to be involved in educating their children on sex.

The majority of the study population 73% does not know any of the STD's. Hepatitis B and AIDS are the main two diseases known to adolescents. Gonorrhea and syphilis are known only to 5.3%. The majority was found to know that the main methods of transmission of AIDS are sexual contact 86.3% and of Hepatitis B 14.7%, and through blood and body fluids AIDS and Hepatitis B 35% and 29% respectively. The knowledge of adolescents of Gaza West on Hepatitis B was found to be more than Gaza East and North. As per AIDS there was no variation between the 3 localities. These results assert on a great need for awareness programmes to adolescents.

The study population showed according to age groups that the government 65.7%, UNRWA 42.3% and the private 17.3% are the main providers of RH service. However, according to locality, it was found that UNRWA is the main provider of RH service in Gaza East, the Private is the main in North, while the government still high in the 3 localities. This goes in line with the reality, as the case is so in the Gaza Strip as known by the researcher through his job status and personal experience.

The rejection of 75% of the total population to consanguineous marriage is considered a satisfactory result at this age that could reason their understanding by that it causes anomalies in offspring and conflicts amongst families. This demands continued efforts to raise this rate to cover all population as consanguineous marriage reaches 50% in Palestinian community, (Department of Health Management Information System, MoH, 2000).

The ideal age for marriage as thought to be by 95% of the study population was found out to be for male 20-30 years. It was thought to be by 49% for female 15-19 and by 50 % was 20-25 years. This reflects the way most people think and it resembles the results of the study conducted in Egypt (Qayed, M. and Waszak, C. 1999).

Despite the 90% of the total population think that the RH service is important, 10% still show indifference attitude towards it. This indicates the great importance of raising the RH awareness of the community with particular emphasis on adolescents who will be the reproductive community in the very coming future. This result goes in line with other result that shows 12% of the study population do not see FP service is important although 70% say it is important and families seek it when needed.

The utilization of FP service by closed relatives such as mothers, sisters or sisters in law reaches 92% while 86% of the study population never used any RH service. This may be attributed to the prevalent trend that the FP service is mainly addressed to married women in reproductive age. The adolescent sector - as may be concluded in this study - is given little attention in this regard.

This raises the need to give a new look to improve the accessibility of RH service to adolescents.

The reasons that were mentioned by the study population to use FP service included improving the living circumstances due to reducing the number of children (64%), preserving a better health to mothers (24%) and giving a better opportunity for rearing children (12%). This shows a logical rationalisation especially for the major users of FP service who seek it when they complete the average of the satisfying number of children to the Palestinian family, that is up to 5 children (Ismail, N. and Shaheen, M. 1996).

The Government was found to be the main RH service provider for the study population (72%) and their closed relatives (50%). The second provider is UNRWA to the study population (16%) and the relatives (39%). This result seems reflecting the reality in the Gaza Strip where the two main providers of RH are the MOH and UNRWA.

The study population identified the adolescent needs that included health education, medical health care and psychological support. The researcher agrees on such demands, which promotes the status of health of this important sector of the Palestinian community.

Chapter (6): Conclusions and recommendations

6.1. Conclusions:

This study is concerned with exploring the knowledge, attitude and practice on reproductive health among male adolescents in Gaza. This research is one of a set of necessary studies come in the context of assessing the RH after several years of implementing RH programmes. Therefore, planning for future is based on scientific ground for a better status of health in Palestine.

The objectives of this study included identification of the knowledge, attitude and the size of practice that pertain to RH among male adolescents in three localities in the Gaza Strip. They were Gaza City West, Gaza City East and the North of Gaza. The study also aimed at identifying the adolescents' RH needs and to test if there is variation between localities and age groups in relation to knowledge, attitude and practice on RH.

The design of study was cross sectional. The tool of study was a structured interview questionnaire. The study sample was 300 adolescents who attend schools at the ninth, tenth and eleventh grades aged 15, 16 and 17 years respectively. The method of sampling was a stratified systematic random selection. The data was collected by a team of nurses that work at schools after having orientation and training on interviewing skills and filling the questionnaire.

A pilot study was conducted prior to the major phase of data collection. A few changes and amendments were made to the questionnaire.

Ethical considerations were taken into account and appropriate communication was undertaken accordingly with the Ministry of Health Education. The data were treated by the SPSS in the computer. The sources used for references were related Internet web-sites, relevant studies and reports.

The results were as follows:

- Unemployment among the parents of the study population in this study was 25%. The percentage of women who are working outside home is low (8.3%), it is the highest in Gaza West (12%).
- Of the study population, 33% thought of FP as spacing between births and 17.3% thought of it as good health care for children.
- The knowledge of RH components among the study population was found to be antenatal care 34.3%, post-natal care 32% and FP services 26%.
- Of the study population 74% never attended any awareness sessions on reproductive health.
- Of those who attended awareness sessions, the 78 adolescents, 83% had attended those sessions at schools and summer camps. The number of sessions attended by 50% was 1-3 sessions and 30% attended 4-6 sessions.
- Of the study population 81.7% knows contraceptive pills, 47.7% knows loops and 10.3% knows the withdrawal method. Five percent said they do not know any contraceptive methods.

- The utilisation of FP by the family members of the study population was 12%.
- The majority of the study population recognizes the signs of puberty as growing of hair in certain areas of the body, roughness of voice and wet dreams.
- Teachers, friends and Media (63.3%, 52.3% and 49.7% respectively) are the main 3 sources of knowledge about sex. The parents were found to be 8.7% only.
- Of the study population, 73% does not know any thing about STD's. Hepatitis B and AIDS are the main two diseases known by adolescents in this study. The majority of those who know about STD's know that sexual contact and blood and body fluids are the main methods of transmission.
- The study population knows that the main providers of RH services are government 65.7%, UNRWA 42.3% and private 17.3%.
- Of the study population, 75% reject consanguineous marriage.
- The ideal age for marriage is thought to be 20-30 years for male by 95%, for female, 15-19 years by 49% and 20-25 years for female by 50%.
- Of the study population, 90% said that RH service is important and 10% showed indifference to it. Those who thought of FP service is important was 70% and 12% said that it is not important.
- Closed relatives of 92% of the study population utilised RH service, while 86% of the study population never used any RH service.
- The reasons as said by the study population to use FP services were improving living circumstances due to reducing the number of children

(64%), preserving a better health for mothers (24%) and giving better opportunities for mothers to give care to their children (12%).

- The government was found to be the main RH service provider (72%), UNRWA was (16%).

The results in this study could answer the questions of research and therefore objectives are most likely achieved. The study population demonstrated little knowledge on RH and particularly STD's. The awareness activity is mainly taking place in schools but could not cover the majority of adolescents. Parents are the least source of knowledge to their children who may obtain wrong knowledge and concepts on sex from friends; this may lead to an unlikely accepted delinquent behaviour in adolescence.

6.2. Recommendations:

1. Emphasis should be applied on the need to implement raising awareness activities on RH to male adolescents as an important sector of Palestinian community.
2. The results of this study suggest the need to give more support to the school health teams to expand its activity for further coverage and examine other approaches of awareness programmes to cover more adolescents in the community by other providers.
3. There is a great need to encourage parents to be involved in educating their children on sex.
4. There is a great need to give a new look to improve the accessibility of RH service to adolescents.

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ANNEXES

وزارة الصحة كليـــة الصحـــة العامـــة جامعة القدس

School of Public Health

القدس - فلسطين

2001/04/30

حضرة الدكتور عبد الله عبد المنعم المحترم

وكيل وزارة التربية و التعليم حفظه الله

السلام عليكم و رحمة الله ،،،

الموضوع بحث لرسالة ماجستير حول مفاهيم الصحة الإنجابية بين طلاب المدارس

تهديكم كلية الصحة العامة تحياتها .

نرجو التكرم بالعلم بان الطالب جمال حسني عبد اللطيف طالب بماجستير الصحة العامة بكلية الصحة العامة و من ضمن متطلبات منحة درجة الماجستير بالصحة العامة و التخرج عمل رسالة ماجستير واختار الطالب عنوان حول مفاهيم الصحة الإنجابية بين طلاب المدارس و هذا يتطلب زيارة بعض المدارس ضمن البحث الميداني . نرجو من سيادتكم التكرم بالإيعاز لمن يلزم لتسهيل مهمته.

علماً بان الأخ جمال هو من ضمن طاقم إدارة الصحة المدرسية

مرفق طيه مقترح الدراسة.

شاكرين لسيادتكم حسن تعاونكم،،

و اقبلوا التحية ،،

عميد كلية الصحة العامة

د. يحيى عابد

إستبيان حول الصحة الإنجابية لدى المراهقين الشباب

رقم مسلسل : _____ *تاريخ المقابلة:* _____

المعلومات الشخصية

1. السنة الدراسية : 1) ☐ ثالث إعدادي 2) ☐ أول ثانوي 3) ☐ ثاني ثانوي

تاريخ الميلاد : _____ العنوان : _____

2. عمل الأب : _____ 3. عمل الأم : _____

1) ☐ تاجر أملاك
2) ☐ مهني مرتفع
3) ☐ مهني بمهارة/فني
4) ☐ مهني متوسط
5) ☐ عامل
6) ☐ عاطل عن العمل

1) ☐ ربة بيت
2) ☐ تعمل خارج البيت

4. عدد الأخوة والأخوات : _____

1) ☐ 4-1
2) ☐ 8- 5
3) ☐ +9

5. عدد القاطنين في المنزل : _____

1) ☐ 5-1
2) ☐ 10-6
3) ☐ 10 <

المعرفة بالصحة الإنجابية :

6. هل تعبير الصحة الإنجابية مألوف لديك؟

1) نعم ☐ 2) لا ☐

7. إذا كانت الإجابة نعم فما هي مكونات الصحة الإنجابية ؟

1) ☐ خدمات تنظيم الأسرة
2) ☐ خدمات رعاية الحوامل
3) ☐ خدمات رعاية الأم بعد الولادة والطفل
4) ☐ الأمراض المنقولة جنسياً
5) ☐ قضايا الزواج من قبل ومن بعد
6) ☐ العقم عند الأزواج
7) ☐ التوعية الخاصة بالصحة الإنجابية
8) ☐ الصحة الإنجابية للمراهقين
9) ☐ الإكتشاف المبكر لسرطان الثدي وعنق الرحم
10) ☐ الرضاعة الطبيعية
11) ☐ ختان الإناث
12) ☐ كل ما سبق

8. ما هو السن المثالي في رأيك للزواج: عند الذكور _____ عند الإناث _____

عند الذكور	عند الإناث
1) ☐ 19-15	1) ☐ 19-15
2) ☐ 25-20	2) ☐ 25-20
3) ☐ 30-26	3) ☐ 30-26
4) ☐ + 30	4) ☐ + 30

9. هل شاركت في ندوات أو محاضرات أو ورشات عمل خاصة بالصحة الإنجابية ؟

1) نعم ☐ 2) لا ☐

إن كانت الإجابة نعم :

أين تمت: 1) ☐ المدرسة 2) ☐ نوادي شبابية 3) ☐ مهرجانات شعبية 4) ☐ معسكرات صيفية

عدد الندوات: 1) ☐ 1-2 ندوة ، 2) ☐ 3 -6 ندوة ، 3) ☐ 7-10 ندوة ، 4) ☐ > 10

الجهة المنظمة : 1) ☐ الصحة المدرسية 2) ☐ منظمات أهلية 3) ☐ جهات أخرى

10. ماذا تعني خدمات تنظيم الأسرة لديك:

_____

_____

_____

11. ما هي علامات البلوغ عند الذكور:

_____

_____

_____

12. ما هي مدى موافقتك على زواج الأقارب :

1) موافق جداً ☐ 2) موافق نوعاً ☐ 3) لا أوافق ☐

إذا كانت الإجابة لا أوافق أذكر الأسباب:

_____

_____

_____

13. ما هو مصدر المعلومات الخاص بالجنس لديك :

1) ☐ الوالدين
2) ☐ الأخوة
3) ☐ الأصدقاء
4) ☐ المعلمون - المدارس
5) ☐ الأقارب
6) ☐ القراءة والإعلام الرسمي

14. ما هي الأمراض المنقولة جنسياً التي تعرفها :

1) ☐ لا أعرف
2) ☐ الايدز
3) ☐ التهاب الكبد الوبائي
4) ☐ الزهري والسيلان
5) ☐ 2 +3
6) ☐ 4 + 6
7) ☐ الجميع

15. كيف ينتقل مرض الإيدز للإنسان ؟

1) ☐ عن طريق الجنس
2) ☐ الدم وسوائل الجسم
3) ☐ الأكل والشرب
4) ☐ الملامسة
5) ☐ 1 +2
6) ☐ 5 +3
7) ☐ 6 +4

16. كيف ينتقل مرض إلتهاب الكبدي الوبائي للإنسان ؟

1) ☐ عن طريق الجنس
2) ☐ الدم وسوائل الجسم
3) ☐ الأكل والشرب
4) ☐ الملامسة
5) ☐ 1 +2
6) ☐ 5 +3
7) ☐ 6 +4

17. هل تعرف من يقدم خدمات صحة إنجابية :

1) ☐ لا أعرف أحد
2) ☐ الحكومة
3) ☐ الوكالة
4) ☐ مؤسسات خاصة
5) ☐ مؤسسات غير حكومية
6) ☐ 2 + 3
7) ☐ 6 + 4
8) ☐ 7 + 5

18. هل يوجد في المنطقة التي تسكن فيها خدمات تنظيم الأسرة:

1) نعم ☐
2) لا ☐

إن كانت الإجابة نعم :

19. من يقدم هذه الخدمة :

1) ☐ الحكومة
2) ☐ الوكالة
3) ☐ مؤسسات خاصة
4) ☐ مؤسسات غير حكومية
5) ☐ 1 + 2
6) ☐ 3 + 5
7) ☐ 4 + 6

20. ماذا تعرف من وسائل منع الحمل ؟

1) ☐ الأقراص
2) ☐ اللوالب
3) ☐ العازل الطبي
4) ☐ التحاميل
5) ☐ العزل الطبيعي
6) ☐ تجنب الجماع فى فترة التبويض
7) ☐ لا شئ
8) ☐ 2+1
9) ☐ 3+8
10) ☐ 4+9
11) ☐ 5+10
12) ☐ 6+11

21. مفاهيم الصحة الإنجابية :

حسب اعتقادك ، ما مدى أهمية خدمات الصحة الإنجابية

1) ☐ مهمة جداً 2) ☐ مهمة نوعاً 3) ☐ غير مهمة

إذا كانت الإجابة (1،2) فلماذا ؟

---

22. هل أنت مقتنع بالحاجة إلى خدمات تنظيم الأسرة ؟

1) ☐ مقتنع جداً 2) ☐ مقتنع نوعاً 3) ☐ غير مقتنع

إذا كانت الإجابة (1،2) فلماذا ؟

---

23. حسب ما سمعت أو جربت ، ما هو مدى اقتناع الجمهور فى خدمات تنظيم الأسرة :

1) ☐ يقبل عليها برغبة قوية
2) ☐ يقبل عليها الجمهور عند الحاجة
3) ☐ يرفضها الجمهور

24. هل استخدمت خدمات صحة إنجابية (يشرح مجري المقابلة السؤال موضحاً ما هي خدمات الصحة الإنجابية المقصودة):

1) نعم ☐ 2) لا ☐

إذا كانت الإجابة نعم

25. ما هي الخدمة التى حصلت عليها:

---

26. ما هي الجهة التى قدمت الخدمة :

1) ☐ لا أعرف أحد
2) ☐ الحكومة
3) ☐ الوكالة
4) ☐ مؤسسات خاصة
5) ☐ مؤسسات غير حكومية
6) ☐ 2 + 3
7) ☐ 4 + 6
8) ☐ 5 + 7

27. هل استخدم أحد من أسرتك خدمات صحة إنجابية:

1) نعم ☐ 2) لا ☐

إذا كانت الإجابة نعم

28. من الذي تلقى الخدمة :

1) ☐ الأم
2) ☐ الأخت
3) ☐ الأب
4) ☐ زوجة الأخ
5) ☐ 2 + 1
6) ☐ 3 + 5
7) ☐ 4 + 5

29. ما هي الخدمة التي حصل/ ت عليها :

1) ☐ تنظيم الأسرة
2) ☐ رعاية حوامل
3) ☐ رعاية بعد الولادة
4) ☐ أمراض جنسية
5) ☐ قضايا الزواج
6) ☐ العقم
7) ☐ التوعية

30. إذا كانت الخدمة تنظيم أسرة ، فما هي الدوافع او الأسباب :

---

31. ما هي الجهة التى قدمت الخدمة :

1) ☐ لا أعرف أحد
2) ☐ الحكومة
3) ☐ الوكالة
4) ☐ مؤسسات خاصة
5) ☐ مؤسسات غير حكومية
6) ☐ 2 + 3
7) ☐ 4 + 6
8) ☐ 5 + 7

32. ما هي الخدمات التي تقدم للمراهقين :

1) في المدارس:

1) ☐ التثقيف الصحي
2) ☐ استشارة (المشرف الاجتماعي)
3) ☐ الفحوصات (والمسح الصحي)
4) ☐ التطعيمات
5) ☐ رعاية البيئة
6) ☐ خدمة صحة نفسية وإجتماعية
7) ☐ خدمة صحة انجابية
8) ☐ صحة الفم والأسنان

2) في عيادات الوزارة :

1) ☐ علاجية 2) ☐ تشخيصية 3) ☐ غير ذلك /أخرى

33. ما هي احتياجات المراهقين من خدمات الصحة الإنجابية :

_____

_____

_____

شكراً لتعاونكم،،

Annex 2

Reproductive health issues among male adolescents questionnaire

No.:_____ Date:_____

Personal Data:

1. scholastic year: 1) 9th ☐ 2) 10th ☐ 11th ☐

Birth date:_____

Address:_____

2. Father occupation: _____ 3. Mother occupation:

_____

1) ☐ Merchant / land owner
2) ☐ Highly skilled
3) ☐ Professionally skilled
4) ☐ Technically skilled
5) ☐ Laborer
6) ☐ Unemployed

1) ☐ House wife
2) ☐ Working

4. Number of siblings: _____ 5. Household Numbers: _____

1) ☐ 1-4
2) ☐ 5-8
3) ☐ 9+

1) ☐ 1-5
2) ☐ 6-10
3) ☐ 10+

Know ledge of RH:

6. Are you familiar with the RH term?

1) ☐ Yes 1) ☐ No

7. If the answer is yes what are the RH comonents?

1) ☐ F.P
2) ☐ Antenatal care
3) ☐ Post natal care
4) ☐ STD's
5) ☐ Marriage issues
6) ☐ Infertility
7) ☐ Awareness in RH
8) ☐ RH for adolescents
9) ☐ Early detection of cancer breast and cervix
10) ☐ Breast feeding
11) ☐ Mutilation of female
12) ☐ All of the above

8. The ideal age of marriage:

For Male: _____

1) ☐ 15-19
2) ☐ 20-25
3) ☐ 26-30
4) ☐ 30+

For Female: _____

1) ☐ 15-19
2) ☐ 20-25
3) ☐ 26-30
4) ☐ 30+

9. Attendance of awareness settings on RH.

1) ☐ Yes 1) ☐ No

If yes:

Were: 1) ☐ school 2) ☐ youth clubs 3) ☐ public meetings

4) ☐ summer camps

No. of settings: 1) ☐ 1-2 2) ☐ 3-6 3) ☐ 7-10 4) ☐ 10+

Organizing body: 1) ☐ school health 2) ☐ NGO's 3) ☐ others

10. What are the term of family planning means for you?

_____

_____

_____

11. What are the signs of puberty in male?

_____

_____

_____

12. Agree or reject the consanguineous marriage?

1) ☐ Strongly agree 2) ☐ Agree 3) ☐ Reject

If you reject mention the reasons:

_____

_____

_____

13. The sources of information about sex:

1) ☐ Parents
2) ☐ Brothers, Sisters
3) ☐ Friends
4) ☐ Teachers
5) ☐ Relatives
6) ☐ Reading and media

14. The STD's you know:

1) ☐ Don't know
2) ☐ Aids
3) ☐ Hepatitis B
4) ☐ Gonorrhea and syphilis
5) ☐ 2+3
6) ☐ 4+6
7) ☐ All of the above

15. Methods of transmitting Aids:

1) ☐ Sexual contact
2) ☐ Blood and body fluids
3) ☐ Food and drink
4) ☐ Touch
5) ☐ 1+2
6) ☐ 3+5
7) ☐ 4+6

16. Methods of transmitting Hepatitis B:

1) ☐ Sexual contact
2) ☐ Blood and body fluids
3) ☐ Food and drink
4) ☐ Touch
5) ☐ 1+2
6) ☐ 3+5
7) ☐ 4+6

17. Reproductive health providers know by the study population:

1) ☐ Don't know
2) ☐ Government
3) ☐ UNRWA
4) ☐ Private
5) ☐ NGO's
6) ☐ 2+3
7) ☐ 4+6
8) ☐ 5+7

18.There is family planning services in your locality?

1) ☐ Yes
1) ☐ No

If yes:

19. Mention the provider:

1) ☐ Government
2) ☐ UNRWA
3) ☐ Private
4) ☐ NGO's
5) ☐ 1+2
6) ☐ 3+5
7) ☐ 4+6

20. what types of contraception methods you know?

1) ☐ Pills
2) ☐ Loops (IUD)
3) ☐ Condom
4) ☐ Vaginal suppositories
5) ☐ With drawal
6) ☐ Safe period
7) ☐ Non of the above
8) ☐ 1+2
9) ☐ 3+8
10) ☐ 4+9
11) ☐ 5+10
12) ☐ 6+11

Concepts of R.H:

21. Importance of R.H:

1)☐ very important 2)☐ important 3)☐ not important

If the answer (1,2) why?

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22. The need of family planing:

1) ☐ high agreement 2) ☐ moderate agreement 3) ☐ no agreement

If the answer (1,2) why?

---

23. The level of public agreement of family planing:

1)☐ high agreement 2)☐ according to the need 3)☐ reject

24. Using R.H services by the study population:

1) ☐ Yes 1)☐ No

If yes:

25. What is the service?

---

26. The service providers:

1) ☐ Don't know
2) ☐ Government
3) ☐ UNRWA
4) ☐ Private
5) ☐ NGO's
6) ☐ 2+3
7) ☐ 4+6
8) ☐ 5+7

27. Using RH services by the study population family members:

1) ☐ Yes
2) ☐ No

If Yes:

28. Who uses the service:

1) ☐ Mother
2) ☐ Sister
3) ☐ Father
4) ☐ Sister in law
5) ☐ 1+2
6) ☐ 3+5
7) ☐ 4+5

29. What is the service they used?

1) ☐ Family planing
2) ☐ Antenatal care
3) ☐ Postnatal care
4) ☐ STD's
5) ☐ Marriage issues
6) ☐ In fertility
7) ☐ Awareness

30. If service is F.P, what are the causes?

31. Who is the provider?

1) ☐	Don't know	5) ☐	NGO's
2) ☐	Government	6) ☐	2+3
3) ☐	UNRWA	7) ☐	4+6
4) ☐	Private	8) ☐	5+7

32. The service provided for adolescents:

A) At schools:

1) ☐	Health education	5) ☐	Environmental care
2) ☐	Counciling	6) ☐	psychosocial care
3) ☐	Medical screening	7) ☐	R.H
4) ☐	Vaccinations	8) ☐	Oral health

B) At clinics

1) ☐ Curative 2) ☐ Diagnostic 3) ☐ Others

33. What are the adolescents R.H needs?

_____

_____

_____

Thanks for cooperation …

وزارة الصحة

جامعة القدس

كليـــة الصحـــة العامـــة

School of Public Health

القدس – فلسطين

عزيزي الطالب المشارك :- _____ المحتـرم

الهدف من هذه الاستبانة هو التعرف على مدى المعرفة والتوجه والممارسة لديك في مجال الصحة الإنجابية حيث أننا بصدد معرفة ما تم إنجازه في الفترة السابقة من خلال المجهودات التي بذلت من خلال برامج التوعية في هذا المجال، وتحديد جوانب الضعف في هذه البرامج للتعامل معها ، وتعديلها حسب ما تتطلبه الحاجة لذلك.

لذا نرجو التعاون معنا في الإجابة على مجموعة الأسئلة الموجودة في الاستبيان الخاص بذلك، علماً بأنه لن يتم ذكر أسماء ، وستكون جميع المعلومات التي تدلى بها سرية ، ولن يكون بالإمكان التعرف عليك من خلال إجابتك.

وشكراً لتعاونكم،،،

الباحث

جمال حسنى عبد اللطيف