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Assessment of Traditional Home Practices Carried by Palestinian Mothers During the Neonatal Period in Jenin District

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Dedication

To my parents, who gave me everything

To my brothers and sisters, who trusted me

To my teachers, who taught me what they know

To my supervisors, who supported me

To my friends, who believed in me

Tasneem Ghalib Khader Atatrah

Declaration:

I certify that this thesis submitted for the degree of Master is the result of my own research, except where otherwise acknowledged and that this thesis (or any part of the same) has not been submitted for a higher degree to any other university or institution.

Signed

Tasneem Ghaleb Khader Atatrah

Date: December/ 2010

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Abstract

This study about Family practices and behaviors play a fundamental role in the care of newborn infants. Inappropriate feeding and other practices predispose neonates to risk of complications and delayed recognition of illness, and delayed health seeking may lead to a potentially preventable death. Hence it is of immense value to understand community perceptions about newborn health in order and explore practices towards newborn care.

The main purpose of the study is to explore positive and negative newborn care practices carried by mothers of children age 0-6 months. The study targeted three localities in Jenin district in the West Bank. The objectives were to capture patterns of mother's positive and negative newborn care practices and the main factors behind these practices.

The Methodology of The study employed qualitative design in exploring the traditional home newborn care practices of mothers of children age 0-6 months. 24 focus group discussion with mothers of children 0-6 months were conducted (8 focus groups with mother's inhabitant in Jenin City, 8 focus groups with mothers inhabitant in Selit-Al Harthia which is a village that represent rural Jenin, and 8 focus groups with mother's inhabitant in Jenin camp). Data was analyzed and categorized utilizing content analysis of responses obtained for each key question.

The key findings of the focus group discussion revealed that the situations are much more favorable for promotion of appropriate newborn care practices. Along a continuum of best practices to harmful practices, households in the Jenin urban and camp area are much closer to best practices than are households in Jenin rural area, although there is still room for improvement on a large range in Jenin urban and camp areas. Routine newborn care practices are similar across study areas including bathing pattern, caring of sick child and feeding practices. Mothers were well aware of the danger signs of diarrhea and respiratory infections. They determined the most appropriate home remedy based on this; the remedies included, among others, liquids such as salt/sugar solution, starch with lemon and water, as well as "casts" made of mint or egg yolk that was applied to the child's abdomen. Other practices included warding off the evil eye by reading from the Quran, and wrapping a comb in a sheet and tying it around the navel. If the child does not recover within the timeframe considered appropriate, s/he is taken to a doctor.

Mothers have no previous knowledge of the proper definition of exclusive breastfeeding. Herbal remedies are seen as essential in caring for the baby's health, and consequently liquids are given almost immediately after birth. Therefore, even though babies were being given liquids and a taste of some solids, most mothers reported breastfeeding "exclusively" for approximately 4 months. Most mothers reported starting their babies on solids by the 4th month that included mashed fruits, rice with milk, egg yolk with milk, fruit juices, soups, cereals, liver, and bread. Mothers expressed strong desire for knowing how to feed their children properly and complained that they do not have trustworthy sources of information that help them follow the proper feeding practices. It is a common belief that introducing herbs, cereals and formula milk are common practices and they are not aware that such practices do not contradict with proper way of feeding and breastfeeding the child.

The main source of care vary between areas; mothers resident in the city consider private doctors as the main source of care, while camp residents seek care at UNRWA's clinic and village residents seek care at NGO care provider.

Mothers for the first time are more likely to seek advice and particularly if they are experiencing "problems." Most commonly, advice is sought from mothers-in-law, but also from their own mothers.

While mothers in all groups mentioned a range of topics on which they would like to be educated, the more frequently mentioned were on nutrition for the baby and pregnant woman, how to breastfeed and appropriate weaning practices, common childhood diseases and how to care for the baby, care during pregnancy especially complicated pregnancies, and birth spacing. The most preferred mode of receiving information across all groups was through group meetings that combined "lectures" with the opportunity to ask questions and encouraged discussion.

And several conclusions and recommendations were inspired by the findings of the focus groups. In general, promoting positive newborn care practices among mothers of children 0-6 months of age requires a comprehensive community mobilization strategy based on a standardized policy on newborn care. And health care providers to promote positive practices. Moreover, proper design of messages that address bad practices and enforce good ones, provide an ongoing programs that encourage face-to-face counseling of mothers and influencers, and address factors that prevent mothers from giving the proper

care for their children. In addition, to address the socio-cultural factors that interfere in the way mothers feed their children. Mothers in law, health care providers, midwives and including herbalists should be involved in the efforts to promote proper newborn care practices among mothers.

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List of Abbreviations

ARI	Acute Respiratory tract Infection
BCG	Bacillus Calmette-Guérin vaccine
DPT	Diphtheria, Pertussis (whooping cough) and Tetanus vaccine
IMCI	Integrated Management of Childhood Illnesses
IMR	Infant Mortality Rate
ORS	Oral Rehydration Solution
PHC	Primary Health Care
PKU	Phenylketonuria Test
PNC	Postnatal Care
MARAM	A Mother Child Health project of USAID/WB&G
MoH	Ministry of Health
NGO	Non Governmental Organization
UNFPA	United Nation Fund for Population Activities
UNRWA	United Nation Relief Work Agency
WB/G	West Bank/ Gaza
WHO	**World Health Organization**

CHAPTER 1: INTRODUCTION

1.1. Introduction

The past century witnessed a revolution in health care, yet millions of women still endure the risks of pregnancy and childbirth under conditions virtually unchanged over time. Tragically, millions of stillbirths and newborn deaths result from many of the same preventable causes. Every year, 4 million babies are stillborn; another 4 million newborns die before they reach the first month of life (WHO, 2004). As with maternal deaths, 98 percent of newborn deaths occur in developing countries. While there have been significant declines in infant and child mortality in the developing world in recent decades, there has been little progress in reducing the death rate for women and newborns. As a result, newborn deaths now represent 40 percent of all deaths among children under 5 years of age (William, et al., 2002). To sustain previous health gains and meet the United Nations Millennium Development Goals, policymakers need to place much greater emphasis on proven, cost-effective measures to save maternal and newborn lives. Making motherhood safer is critical to saving newborns. Research shows that a significant number of stillbirths and neonatal deaths could be prevented if all women were adequately nourished and received good quality care during pregnancy, delivery, and the postpartum period (Anne, 1997).

The early postnatal period is a vulnerable time for both women and newborns. Sixty-one percent of maternal deaths occur during the first six weeks after birth, and nearly half of those deaths take place during the first day after delivery (X.F. Li et al., 1996)

Two-thirds of neonatal deaths occur in the first week of life, and two-thirds of those die within the first 24 hours (Joy, et al., 2001).

Palestine has made significant progress in a number of health indicators. Infant Mortality Rate (IMR) was one of the indicators didn't show dramatic changes. In 2000 IMR (per 1000 live births) was 25.5, and in 2006: 25.3 (PCBS, 2006).

Beliefs and practices surrounding the postpartum period and early childhood are culturally patterned (Brettell, et al., 1997). A lack of cultural knowledge on the part of registered nurses can make appropriate care difficult to deliver (Lauderdale, (1999).

Traditional practices cannot be ignored when trying to achieve better neonatal care in developing countries because most deliveries occur at home and health services may not be available. Even babies delivered in hospitals may be affected by traditional practices after discharge. These practices have a major impact on neonatal morbidity and mortality patterns. Traditional and cultural practices must identify and the extent of their impact on newborn health evaluated before global standard guidelines are adapted to the local situation (WHO, 2004).

Family practices and behaviors play a fundamental role in the care of newborn infants. Inappropriate feeding and other practices predispose neonates to risk of complications and delayed recognition of illness, and delayed health seeking may lead to a potentially preventable death. Hence it is of immense value to understand community perceptions about newborn health in order and explore practices towards newborn care. With this objective this study was conducted to explore knowledge of newborn care and attitudes among mothers in Jenin district mainly in a camp and a village, and in the city.

1.2. Problem statement

The most frequent causes of neonatal deaths worldwide are birth asphyxia and injuries, complications of prematurity, and infections-tetanus, sepsis, pneumonia, and diarrhea. Most causes of early neonatal death can be identified and many problems can be treated easily if recognized in time. It has been estimated that as many as 70% of newborn deaths could be prevented with simple and appropriate care of the mother during pregnancy and childbirth, and of the newborn in the first week of life.

Official estimates of the infant mortality rate in Palestine range from 23 per 1000 live births to 15.3 per 1000 live births (Palestine Ministry of Health, 2004). Unpublished reports indicate that approximately 75% of neonatal deaths occur within 0-6 days of birth and about 25 % occur between 7 and 28 days of birth. Low birth weight, congenital malformations and respiratory infection are by far the leading causes of infant mortality (MoH, 2004).

Many studies had focused on postnatal care and newborn care, focusing on what women should practice but not on why she is practicing them and what are the barriers to correct them.

Traditional practices in Palestine may introduce child and mother to serious problems that may affect his health. From where it mandate the need to focus on these practices and address them. Exploring traditional practices can give a clue to the barriers from healthy practices that were addressesd in Palestinian Ministry of Health protocols and Guidelines.

The postpartum period is a critical period that mandate attention from multidimensional prospective. The objective of the study is to explore common neonatal home-based practices with emphasis on harmful practices and behaviors that can affect the well-being of newborn. This period is critical because at least 25% of infant death occur during this period where health of women and newborn babies is at a vulnerable stage.

The study aimed to explore knowledge of newborn care and attitudes among mothers in Jenin district to identify their range of practices and main influences and source of mother's information. The results of this study may help the policymakers to evaluate the effectiveness of current health promotion services, which allows better planning to promote healthy and safe practices among caregivers.

1.3. Study justification

Traditional practices cannot be ignored when trying to achieve better neonatal care because still some deliveries may occur at home and health services may not be available. Even babies delivered in hospital may be affected by traditional practices after discharge. These practices have a major impact on neonatal morbidity and mortality patterns. Traditional and cultural practices must be identified and the extent of their impact on newborn health evaluated before global standard guidelines are adapted to the local situation. Practices related to antenatal, resuscitation, thermal control, feeding and infections for example, should be classified as follows:

1. Good practices worth promoting.
2. Harmful practices that should be discontinued.

3. Neutral practices which may be ignored for the time being.
4. Practices that need further research before a decision can be taken as to their beneficial or harmful effects.

Some modern practices are also harmful. Bottle-feeding, pacifiers, and separation of the mother from her baby should be discouraged.

Once beneficial and harmful practices are identified, suitable communication strategies should be developed for individual and community education.

1.4. Study aim and Objectives

The purpose is to explore major useful and harmful practices performed at home by mothers of children age 0-6 month in Jenin area.

Study Objectives

1. To capture patterns of mothers positive and negative newborn care practices
2. To identify factors affecting these practices among mothers of newborns.
3. To describe the patterns of newborn care by area of mother's residence by mothers of children age 0-6 months.

1.5. Study Limitation

Practices are part of the behavior and it is hard to predict or change behavior. The cultural issues must be paid attention because we are dealing with conservative culture. To have informative sample to give us insight to explore practices we have to be concerned about points of entry to the community we are dealing with.

In addition, the study methodology as a qualitative research has strengths and weaknesses that are diametrically opposite. The strength of the qualitative research lies in its flexibility and potential to yield insights into the true nature of a complex phenomenon through a wealth of in-depth information. However, such insights are not gratuitous, because qualitative research is almost always based on small unrepresentative samples and is engaged in by solitary researcher using data collection and analytic procedures that rely on subjective judgments, qualitative research may suffer in terms of reliability and generalizability. Accordingly, the study findings can't be generalized from the sample studied to the population (Denise, et al., 1999).

In particular, focus groups have disadvantages: The researcher has less control over a group than a one-on-one interview, and thus time can be lost on issues irrelevant to the topic; the data is tough to analyze because the talking is in reaction to the comments of other group members; observers/ moderators need to be highly trained, and groups are quite variable and can be tough to get together (Nachmais, et al., 2008).

Focus groups are "One shot case studies" especially if they are measuring a property-disposition relationship within the social sciences, unless they are repeated. Focus groups can create severe issues of external validity, especially the reactive effects of the testing arrangement. A fundamental difficulty with focus groups (and other forms of qualitative research) is the issue of observer dependency: the results obtained are influenced by the researcher, raising questions of validity. The issue evokes associations with Heisenberg's famous Uncertainty Principle. When said, "What we observe is not nature itself, but nature exposed to our method of questioning." Indeed, the design of the focus group study (e.g. respondent selection, the questions asked, how they are phrased, how they are posed, in what setting, by whom, and so on) affects the answers obtained from respondents (Nachmais, et al., 2008).

Another issue is with the setting itself. If the focus groups are held in a laboratory setting with a moderator who is a professor and the recording instrument is obtrusive, the participants may either hold back on their responses and/or try to answer the moderator's questions with answers the participants feel that the moderator wants to hear. Another issue with the focus group setting is the lack of anonymity. With all of the other participants, there cannot be any guarantee of confidentiality. Accordingly we have to deal with the issues of the reactive effects of the testing arrangement (Campbell, et al.: 2006).

1.6. Thesis chapters description

The thesis will consist of 6 chapters. In chapter one, I discussed the aim, problem statement, study justification, and objectives. Also, I included the study hypothesis and its limitations. Chapter two presented the literature review of previous studies that are related to research topic while in chapter three the theoretical and conceptual frame work for the study are discussed. In chapter four study methodology, study population, study design, data collection tool, study questions, data analysis, and operational definitions are presented, in chapter five, the study results are presented and demonstrated in form of tables and narrative. At last; in chapter six, the study results and findings are discussed and recommendations are presented.

CHAPTER 2: LITERATURE REVIEW

2.1. Introduction

The literature review in this chapter focused on dependant and independent variables related to the study focusing on qualitative studies. Literature review included the concepts of women health and child health in Palestine, regionally and internationally, child health services, breastfeeding, childhood illnesses, socio-economic status, grandmother's influence on child care, and traditional newborn care practices and their relevant effect. The literature review surveyed articles, books, studies, and relevant websites to the area of the research.

2.2. Qualitative Research

The Nature of qualitative research and why it was chosen as the methodology for this research:

Qualitative research is concerned with developing explanations of social phenomena. That is to say, it aims to help us to understand the world in which we live and why things are the way they are. It is concerned with the social aspects of our world and seeks to answer questions about: Why people behave the way they do, how opinions and attitudes are formed, how people are affected by the events that go on around them, how and why cultures have developed in the way they have, and the differences between social groups (Beverley Hancock, 2002).

Qualitative research is concerned with finding the answers to questions which begin with: why? How? In what way? Quantitative research, on the other hand, is more concerned with questions about: how much? How many? How often? To what extent?

Qualitative research is concerned with the opinions, experiences and feelings of individuals producing subjective data. Qualitative research describes social phenomena as they occur naturally. No attempt is made to manipulate the situation under study as is the case with experimental quantitative research. Understanding of a situation is gained through a holistic perspective. Quantitative research depends on the ability to identify a set of variables. Data are used to develop concepts and theories that help us to understand the social world. This is an inductive approach to the development of theory. Quantitative

research is deductive in that it tests theories which have already been proposed (Beverley Hancock, 2002).

Qualitative data are collected through direct encounters with individuals, through one to one interviews or group interviews or by observation. Data collection is time consuming. The intensive and time consuming nature of data collection necessitates the use of small samples. Different sampling techniques are used. In quantitative research, sampling seeks to demonstrate representativeness of findings through random selection of subjects. Qualitative sampling techniques are concerned with seeking information from specific groups and subgroups in the population (Beverley Hancock, 2002).

Literature review in qualitative research and approach used in this research:

The function of a literature review in research studies is to provide an objective account of what has been written on a given subject. This in turn should reflect prominent emerging themes and inform the conceptual framework of the study.

Qualitative research follows the naturalistic paradigm based on the assumption that multiple realities exist and such realities are constructed by the research participants. It aims to explore the phenomenon in question by focusing on the individuals who experience it (Vishnevsky, et al., 2004). Qualitative methods are concerned with experiences, feelings and attitudes, as opposed to precise measurement and statistical analysis. Qualitative methodologies vary regarding the inclusion of a literature review before the data collection period. Similarly, there is debate over whether the conceptual framework should precede the period of data collection and data analysis.

In qualitative studies, the researcher has to rationalize his/her chosen approach. A major premise of grounded theory, for example, is that data are collected in isolation from any predetermined theory or conceptual framework. The literature review is therefore carried out after the data have been collected. The aim of this approach is to explore concepts embedded in the data, thereby allowing theory to be generated from the data rather than vice versa (Robinson, 2002). Similarly, in phenomenological investigations the literature review may be delayed until the data analysis is complete.

This ensures that the findings reflect participants' experiences and are truly grounded in the data. This is congruent with the philosophical orientation of phenomenology, which views

the subjective experience of participants as central to the methodology (Burns, et al., 2001). The conceptual frameworks or themes that emerge from the study may then be supported by evidence gleaned from a subsequent examination of the literature. The ethnographic approach attempts to examine the experiences of the person in the context of his/her natural world and explores the topic of study through the perceptions of the subjects of study. The literature review in ethnographic studies is used to demonstrate knowledge of previous work in the area, as well as frameworks used in the analysis of data. According to Meadows (2003), existing literature provides both the basis for research and the context for interpreting findings. In this study literature review was carried out before data collection and analysis, to provide a comprehensive and balanced account of previous work, identifying, where appropriate, the relevant themes, conceptual models and theoretical frameworks that provide a sound background to the research.

In qualitative research, a research question that reflects the identified phenomenon of interest is used to direct the course of the research. A research hypothesis is never used in qualitative research, unlike quantitative research (Connell Meehan, 1999).

2.3. Women's Health in Palestine

The percentage of women at childbearing age from total population is 48.8%, and the maternal mortality ratio per 100,000 live births among women aged 15-49 years is 83. The total fertility rate is still one of the highest rates, calculated at 4.6 (5.4 in Gaza strip and 4.2 in West Bank). About 98.9% of births took place in health institutions. The governmental hospitals have the highest contribution of the total deliveries with a percentage of 56%. The number of visits for antenatal care was 99,510 visits to MoH primary health care clinics in 2009. And the number of registered pregnant women in 2009 showed to be 24,543. Moreover antenatal care coverage was 38.9%. The number of visits paid per pregnant women in Ministry of Health was 4.1. Anemia prevalence among pregnant mothers registered in Ministry of Health showed to be 28.6% (MoH, 2010).

Private hospitals are more likely to be used by women living in urban areas, women with more education, and women who have more antenatal visits. Similarly, doctors are more likely to assist births for urban women who are more educated, living in wealthy areas or

households, and who receive more care that is antenatal According to a Mother Child Health program of USAID/WB&G MARAM (2004).

The level of postnatal care (PNC) remains at an unacceptable level in spite of progress made over the last 10 years. MoH 2009 annual report showed that number of visits for postnatal care paid by mothers was 11,124 visits , which is about 17,6% of the total love births (MoH, 2010).

Only a very small percentage of women and newborns make a postnatal visit in the first three days after birth, which is the most crucial time for prevention of maternal and neonatal complications and for the promotion and support of exclusive breastfeeding. According to MARAM (2004) household survey, among women who delivered babies in the 6 months preceding the survey, less than 5% received postnatal care, and less than 2% made the recommended two visits, one within 72 hours after delivery and one 40 days after delivery

In the same study, the facility level data collection also included exit interviews of 1,624 women who were asked questions about postnatal care and counseling. Only 18.2% of the women interviewed received postnatal care. This is paralleled by a low utilization of postnatal care for the newborn.

Further, the same survey indicated women from Tubas (65%) received postnatal care more often than other districts and governorates, particularly Gaza, Khan Younis, and Deir El Balah, where fewer than 5% of women received postnatal care. The report did not mention the reasons behind this range. Postnatal care is more frequently received at UNRWA facilities than governmental ones in both Gaza and West Bank (MARAM, 2004).

In comparison, UNRWA's postnatal care services coverage rate was 80.6% in West Bank and 95.6% in Gaza (UNRWA, 2002).

The 2004 MARAM baseline health survey showed variations among the different governorates responsible for various aspects of postnatal care; hemoglobin assessment, blood pressure measurement, nutrition, and breastfeeding counseling were the most frequently received interventions (more than 75%). They were more often received in Gaza than in the West Bank. Around 50% of clients (more in WB than in Gaza) received care regarding uterine involution, insertion of IUD, as well as counseling on initiation and continuation of breastfeeding, breast self-examination, and episiotomy care. The prenatal

study demonstrates that almost 70% of women were never told how to identify danger signs in both their infants and themselves, nor were they told where to seek advice in case of danger signs. Only 33.4% of the women reported that they were told how to recognize signs of a dangerous illness of their infant or where to go for the medical care. In response to the problem of low postnatal coverage, the Ministry of Health has been emphasizing postnatal care in the first week following birth to detect anemia, infections, and bleeding warranting further referral. This initiative has started in Hebron, Ramallah, and Jenin. This pilot project is funded by the UNFPA and it is in the initial stage of implementation.

2.4. Child Health in Palestine

The infant mortality rate IMR, which is one of the best indicators of overall well being of a society, has been significantly reduced in the last years. Evidence exists that IMR has declined over the past two decades from levels estimated to be 28.3/1,000 in WB/G 1999-2003 to about 24.2/1,000 in 2006 (PSBC, 2006).

Reduction in the IMR is a result of the cumulative effects of such factors as: controlling the major childhood infectious diseases, successful immunization and oral rehydration solution (ORS) program, reduced morbidity from diarrhea, increased number of hospital beds, Primary Health Centers and delivery centers and rising educational, socioeconomic and nutritional standards.

The Ministry of Health (MoH) has adopted the Gaza figure for the national IMR, due to recognized underreporting in WB (MoH, 2004). Two additional surveys (Barghouti, et al.: 2003) confirm this estimate and the under-reporting in remote villages of the WB.

The major leading causes of infant deaths in the WB/G are prematurity and low birth weight (41.1%), congenital malformation (14.3%), pneumonia and other respiratory diseases (13.1%), infectious diseases (6.6%), and sudden infant death syndrome (5.8%) (MoH 2004).

2.5. Child Health Services

260 health clinics in Ministry of health are providing service for children including preventive and curative care. 31,706 visits of children under three years to Mother Child

Health clinics were reported in the west bank. In 2004 , the percentage of children has had breast feeding was 95.6%, 25.4% of children aged 0-6 months were exclusively breast fed, and 38.1% were mixed fed (MoH 2006).

Child health services are provided jointly with the maternal health services in the context of primary health care. In addition to the MoH as main provider of the mother child health services along with other PHC service, the service is provided also by UNRWA, NGOs, and private sector. However, there is no clear coordination between the major health providers including MoH, UNRWA, NGOs and private sector. Even published studies reported variations among provider-practices are great and client "shopping-around" among providers is a common practice (MARAM, 2004).

Child health service includes growth monitoring, immunization, and child health nutrition counseling.

Growth monitoring, is provided included with postnatal and nutrition services which are less likely to be provided (provided in only 50% of Primary Health Centers facilities) (MARAM, 2004). Growth monitoring in PHC facilities is not consistent, not always systematic and is often linked poorly to growth promotion. According to the MARAM Baseline Report (2004), child growth monitoring is mainly provided at UNRWA and MoH immunization providing facilities. As a result, growth-monitoring assessments, including assessments of compliance with measurement of weight, height and hemoglobin, are typically conducted when children receive immunizations. After the children, finish their immunizations they are unlikely to receive growth monitoring. In addition, various providers use different growth monitoring charts and different growth monitoring measurements.

Immunization is provided by MoH and UNRWA for refugees. Both providers had unified their immunization schedule. Children receiving all vaccines imply those who had 3rd dose of DTP and Polio and received Measles and BCG. Immunization coverage for 12-23 Months is 96.4%. There is only slight variation in immunization uptake among males and females, and by locality and mother's education (PCBS, 2006).

Child health nutrition counseling services are weak (MARAM, 2004). A wide gap was revealed between providers' perspectives and clients' perspectives about counseling (only 21% of women reported that they had received immunization related counseling, while

70% of providers reported providing counseling services). Although child health nutrition relevant protocols and clinical practice guidelines (for child care - diarrhea management, ARI, growth monitoring, IMCI, infection control, essential drugs and immunization) are present at all MoH PHC clinics, but, as previously reported, adherence levels are low (Awwadallh, et al.: 2004).

In addition, Fattouh (2004) indicated that PHC physicians' compliance with the PHC Palestinian Essential Drugs List is generally low. Following the recommended generic prescription was the most problematic area in Gaza; it was also the lowest in the reviewed countries of the region (5.47%). Despite dissemination of the Palestinian National Formulary, the availability of the list inside facilities was low (28.3%). There was a shortage in key drugs (82.6%) which must be available 100% of the time. (Fattoh, 2004).

2.6. Traditional Newborn care practices

Context obviously influences home-care practices; however, practices and decision-making behind the practices usually differ depending on whether women, men or babies are healthy or sick (Marge Koblinsky, 2006). Papers that describe practices for women and babies most often begin with the practices of healthy persons (Barnett, et al.: 2003).

For example, most newborn care practices are the preventive behaviors that improve the health of the baby (Darmstadt GL, et al.: 2006).For people who are ill and for pregnant women, overcoming barriers to the use of care deemed appropriate by formal medical reviews, should lead to reduction of mortality. However, care-seeking from skilled providers can be low even when women are about to deliver a baby, for various well-known reasons—sociocultural differences, high cost, value women place on delivery by traditional birth attendants, and chronic under-staffing of health centers (Cotter, et al.: 2006).

Exploring specific barriers, such as cost (Borghi, et al.: 2006), or barriers for a specific population, such as the poorest, enriches our understanding of the barriers and provides insight into means of overcoming them contrast the decision-making for use of facilities for care (Parkhurst, et al.: 2006).

The early postnatal period is a vulnerable time for both women and newborns. Sixty-one percent of maternal deaths occur during the first six weeks after birth, and nearly half of those deaths take place during the first day after delivery (X.F., et al., 1996)

Two-thirds of neonatal deaths occur in the first week of life, and two-thirds of those die within the first 24 hours (Joy, et al.: 2001).

Some traditional practices, such as giving newborns cold baths and breast-milk substitutes soon after birth, are harmful. Education for families and communities about how to care for newborns and how to recognize health problems among women and newborns that require immediate attention is essential to improving maternal and newborn health (Patricia, et al: 2002)

Studies reveal that there are many commonly practiced behaviors pertaining to neonates that are harmful, in particular those having to do with covering the umbilicus with gauze (practiced by 40% of Palestinian families) in contravention of clean cord care, and giving *sukar fadi* (21% of families) which contradicts the practice of exclusive breastfeeding and makes the neonate vulnerable to bacteria from unclean water and other contaminants (MARAM, 2004).

Research studies show that women in the West Bank and Gaza are often discharged from hospital within 2-4 hours after delivery. While this is often due to a lack of available bed space, it is just as likely that the mother and her family are anxious to leave the hospital for the comfort of their homes. This is far from the ideal as medical expert's state that it is critical for the mother and infant to be monitored in the hospital for 24 hours after delivery (MARAM, 2004).

Studies conducted during the postnatal period have revealed that women and their newborns are subject to a variety of customs that serve no purpose in caring for either and can actually prove to be harmful. The custom of preventing the recently delivered mother from leaving the house or being exposed to sun serves no useful purpose and to the extent that it does not allow her early access to postnatal services at a clinic, within six days after delivery, can actually prove harmful to her health and possibly survival. While postpartum women in the West Bank and Gaza are not encouraged – and are instead, actively discouraged by their families - from accessing care during this period, they are

also themselves complicit in that they do not go for a checkup within 6 days if they are feeling healthy (MARAM, 2004).

2.7. Breastfeeding

Early childhood feeding practices and patterns are important determinants of the nutritional status of children, which influence their health status. A mother's nutritional well-being before and during pregnancy influences the health of her baby at birth, her ability to breastfeed successfully, and her own general health. The health benefits of breastfeeding for both mother and child, which are undisputed, are influenced by both the duration and intensity of breastfeeding and by the age at which the child receives supplementary foods and other liquids (ANON, 1991).

While breastfeeding remains prevalent (96%) (PCBS), the practice of early supplementation with other liquids and foods diminishes the optimal nutrition and protective factors, a priority in this context of poverty and restricted access to clean water, adequate sanitation and health facilities. Exclusive breastfeeding for the first six months has increased from 17% in 2000 to 25% in 2004, but a continuing large gap in best practices, despite almost universal prevalence, indicates a critical need for better advice, management and breastfeeding support. In the West Bank, the decline in continued breastfeeding rate (9-12 months) between 2000 and 2004, from 67.4% to 58.6% warrants attention (PCBS, 2004).

Immediate breastfeeding, which helps women by stimulating the contractions of the uterus that protect against severe bleeding, also protects infants by providing nutrients and essential immunities from disease. Exclusive breastfeeding, not supplemented with other foods or liquids, is particularly effective at preventing infection in newborns, yet rates are extremely low in developing countries (Patricia, et al.: 2002).

A newborn baby needs to remain in skin-to-skin contact with the mother as much as possible, and it is best for the mother and baby to stay together in the same room or bed. Early skin-to-skin contact and early suckling is associated with more affectionate behavior of mothers towards their infants, and mothers who start breastfeeding early have fewer

problems with breastfeeding in general. Many new mothers need encouragement and help to begin breastfeeding. They also need to be reassured that they can feed their young babies properly with breast milk alone. Mothers who have themselves had babies are not always the best teachers in proper breastfeeding techniques as often they have not been taught the correct techniques for breastfeeding nor told why breastfeeding correctly is important. It is therefore imperative that all nursing mothers learn quickly the importance of proper positioning, attachment, and effective feeding (MARAM, 2004).

Breast milk should be the baby's first taste and the only taste during the first 6 months of its life. There should be no prelacteal feeds such as water, other liquids, or ritual foods. This is the meaning of exclusive breastfeeding. Breast milk completely satisfies an infant's nutritional and fluid needs for about 6 months. Infants do not need water or other liquids such as herbal teas to maintain good hydration even in hot climates. The potential dangers of water supplementation include the introduction of contaminants and reduced nutrient intake. Moreover, breast milk is the baby's "first immunization". Babies who are breastfed have fewer illnesses and they are protected against diarrhea, chest and ear infections and other health problems. No other drinks or foods can provide this protection. If all babies were fed only breast milk for the first six months of life, the lives of a large number of infants would be saved every year and the health and development of several thousand others would be greatly improved. The protection is greatest when only breast milk is given for the first six months and breastfeeding is continued in combination with other foods and liquids for well into the second year. Exclusive breastfeeding for the first six months is a complex behavior involving multiple points of intervention. Mothers must decide initially to breastfeed and learn the correct techniques. They need to persevere when difficulties arise, and sometimes they must counter cultural norms and advice from people they respect regarding supplemental feeding. Information and counseling throughout this sequence of behaviors can keep mothers on track to exclusive breastfeeding (MARAM, 2004).

In another household baseline health survey conducted in 2003 in the West Bank and Gaza Strip supported by MARAM project targeting mother of children under five, addressed questions on different aspects of feeding practices. Mothers were asked about changes in their feeding practices to children under the age of one year. The results indicated that

introduction of supplementary foods begins early in child's life; the proportion of children receiving fluid at first month of age was 19 percent. It was clear that 84% and 60% of children were given fluids and food respectively before the child reaches the age of 7 months. This means only 16% are exclusively breastfed until the child reaches 7 months of age, which is considered very low in relation to the recommendation of continuing exclusively breastfeeding until the age of six months.

A review of feeding guidelines promoted by various national and international organizations has shown that there are inconsistencies in the specific recommendations for feeding infants and young children. Some of the feeding guidelines are based more on tradition and speculation than on scientific evidence, or are far more prescriptive than is necessary regarding issues such as the order of foods introduced and the amounts of specific foods to be given (American Academy of Pediatrics, 2004).

2.8. Childhood illnesses

Dehydration: Several factors place infants and children at a greater risk of dehydration. They have a larger body surface area relative to body weight and a higher body water percentage (Brockenkamp, et al.:2003). Indeed, 80% of neonatal body weight is comprised of water, with the proportion dropping to between 50% and 60% in adult women and men, respectively (Brockenkamp, et al.:2003). However, maintaining this balance is more problematic in infants and children, compared with adults, because children's metabolic pathways are immature and they have a decreased capacity to detoxify and excrete hazardous substances. Children's kidneys have a limited capacity for handling the solute load from high-protein intakes required for growth. In infants, decreased concentrating and diluting capacity of the kidneys can lead to abnormal water balance; this may explain the rapidity with which infants dehydrate. The ability to concentrate urine is achieved between 3 and 6 months of age (Brockenkamp, et al.:2003). Yet, another factor that makes infants especially susceptible to dehydration is that they are unable to express thirst (Kleiner 1999). Osmoregulation is almost completely mediated by osmoreceptors in the hypothalamus. Normally, the hypothalamus responds to changes in extracellular tonicity by altering both thirst and secretion of antidiuretic hormone. However, this delicate balance may malfunction in an ill child leading to either fluid retention or excessive fluid

loss. Various illnesses can cause disruption in fluid and electrolyte balance, be it acutely or chronically (Popkin, et al.:2006). This may produce serious, and sometimes irreversible, neurological consequences because of rapid shifts of water to and from the brain (Brockenkamp, et al.:2003). Clinical signs of dehydration occur when there is a significant loss of body water. Early symptoms of dehydration are fatigue, loss of appetite, headache, light-headedness, dry mouth and eyes (Kibel, et al.:2005), a burning sensation in the stomach, and dark urine with a strong odour (Kleiner 1999) 'straw-colored' urine is associated with a state of normal hydration (Popkin et al. 2006). Signs of advanced dehydration are clumsiness, shriveled skin, sunken eyes (and fontanels in children), difficulty in swallowing, dim vision, numb skin, delirium, muscled spasms and painful urination (Kleiner 1999). Dehydration is considered to be severe if the child shows signs of shock or lethargy or loss of consciousness. Thirst is the primary determinant of hydration status, although thirst sets in only after the commencement of dehydration, when total body water loss reaches 1–2% of body mass (Kleiner 1999; Popkin et al. 2006). Practical issues concerning the detection of dehydration (Kleiner 1999), such as urine color, can be taught in communities settings. Diarrhea is associated with mortality in young children, and Integrated Management of Childhood Illness (IMCI) categorizes the main types of diarrhea. IMCI emphasizes determining the duration of the diarrhea, assessing the severity of dehydration and the presence of blood in the stools in order to categorize the type of diarrhea and propose appropriate treatment (WHO, 2005).

All children with acute watery diarrhea may to some degree be dehydrated (World Health Organization 2005). Diarrhea inevitably brings about a state of electrolyte and fluid imbalance, and a degree of dehydration (Kibel, et al.: 2005). Indeed, the majority of diarrheal deaths are caused by dehydration. Diarrhea has multiple causes and can occur at any age (Kibel, et al.: 2005). Its incidence can more often be traced to socio-economic conditions and poverty than to climate and location (Kibel, et al.: 2005). Children are more susceptible to pathogens than adults as they engage in much exploratory play; they can therefore be exposed to excreta (fingers to faeces to food). Furthermore, their immune systems are not yet fully developed (Curtis, et al.:2004). Diseases are more easily transmitted where groups of children are together and where inadequate toilets or hand washing facilities make it easy for transmission from child to child and thence through the community (Bartlett, et al.:2003).

Respiratory tract infections are the neonatal infection most commonly diagnosed after nursery discharge. Respiratory tract infections affect the nose, throat, and airways and may be caused by any of several different viruses. Common respiratory tract infections include the common cold and influenza. (Thingvoll, et al.: 2008).

Children develop on average six viral respiratory tract infections each year. Viral respiratory tract infections include the common cold and influenza. Doctors often refer to these as upper respiratory infections, because they produce symptoms mainly in the nose and throat. In small children, viruses also commonly cause infections of the lower respiratory tract, airways, and lungs. These infections include croup, bronchiolitis, and pneumonia. Children sometimes have infections involving both the upper and lower respiratory tracts.

In children, rhinoviruses, influenza viruses (during annual winter epidemics), parainfluenza viruses, respiratory syncytial virus, enteroviruses, and certain strains of adenovirus are the main causes of viral respiratory infections.

Most often, viral respiratory tract infections spread when children's hands come into contact with nasal secretions from an infected person. These secretions contain viruses. When the children touch their mouth, nose, or eyes, the viruses gain entry and produce a new infection. Less often, infections spread when children breathe air containing droplets that were coughed or sneezed out by an infected person. For various reasons, nasal or respiratory secretions from children with viral respiratory tract infections contain more viruses than those from infected adults. This increased output of viruses, along with typically lesser attention to hygiene, makes children more likely to spread their infection to others. The possibility of transmission is further enhanced when many children are gathered together, such as in child care centers and schools. Contrary to what people may think, other factors, such as becoming chilled, wet, or tired, do not cause colds or increase a child's susceptibility to infection.

When viruses invade cells of the respiratory tract, they trigger inflammation and production of mucus. This situation leads to nasal congestion, a runny nose, scratchy throat, and cough, which may last up to 14 days. Fever, with a temperature as high as 101 to 102° F (about 38.3 to 38.9° C), is common. The child's temperature may even rise to 104° F (40° C). Other typical symptoms in children include decreased appetite, lethargy, and a general feeling of illness (malaise). Headaches and body aches develop, particularly

with influenza. Infants and young children are usually not able to communicate their specific symptoms and just appear cranky and uncomfortable.

Because newborns and young infants prefer to breathe through their nose, even moderate nasal congestion can create difficulty breathing. Nasal congestion leads to feeding problems as well, because infants cannot breathe while suckling from the breast or bottle. Because infants are unable to spit out mucus that they cough up, they often gag and choke.

The small airways of young children can be significantly narrowed by inflammation and mucus, making breathing difficult. Children breathe rapidly and may develop a high-pitched noise heard on breathing out (wheezing) or a similar noise heard on breathing in (stridor). Severe airway narrowing may cause children to gasp for breath and turn blue (cyanosis). Such airway problems are most common with infection caused by parainfluenza viruses and RSV. Affected children need to be seen urgently by a doctor.

Some children with a viral respiratory tract infection also develop an infection of the middle ear (otitis media) or the lung tissue (pneumonia). Otitis media and pneumonia may be caused by the virus itself or by a bacterial infection that develops because the inflammation caused by the virus makes tissue more susceptible to invasion by other germs. In children with asthma, respiratory tract infections often lead to an asthma attack.

Doctors and parents recognize respiratory tract infections by their typical symptoms. Generally, otherwise healthy children with mild upper respiratory tract symptoms do not need to see a doctor unless they have trouble breathing, are not drinking, or have a fever for more than a day or two. X-rays of the neck and chest may be taken in children who have difficulty breathing, stridor, wheezing, or audible lung congestion. Blood tests and tests of respiratory secretions are rarely helpful.

The best preventive measure is practicing good hygiene. A sick child and the people in the household should wash their hands frequently. In general, the more intimate physical contact (such as hugging, snuggling, or bed sharing) that takes place with an ill child, the greater the risk of spreading the infection to other family members.

Antibiotics are not necessary to treat viral respiratory tract infections. Children with respiratory tract infections need additional rest and should maintain normal fluid intake. In infants and young children, congestion may be relieved somewhat by using a cool-mist

vaporizer to humidify the air and by suctioning the mucus from the nose with a rubber suction bulb (Thingvoll, et al., 2008).

Jaundice is a yellow discoloration of the skin and the white part (the sclera) of the eyes. It results from having too much of a substance called bilirubin in the blood. Bilirubin is formed when the body breaks down old red blood cells. The liver usually processes and removes the bilirubin from the blood. Jaundice in babies usually occurs because their immature livers are not efficient at removing bilirubin from the bloodstream. Jaundice in newborns most commonly occurs because their livers are not mature enough to remove bilirubin from the blood. Jaundice may also be caused by a number of other medical conditions (Colby, 2005).

Physiologic jaundice is the most common form of newborn jaundice. The baby's liver plays the most important part in bilirubin breakdown. The type of bilirubin that causes the yellow discoloration of jaundice is called unconjugated bilirubin. This form of bilirubin is not easily removed from the baby's body. The baby's liver changes this unconjugated bilirubin into conjugated bilirubin, which is easier for the baby's body to remove. The livers of newborn babies are immature. They are not able to perform this job very efficiently at first. The combination of these two problems causes an elevation of bilirubin, and this is seen as the yellow discoloration of the baby's skin. As the breakdown of red blood cells slows down, and the baby's liver matures, the jaundice rapidly disappears. When jaundice is due to these factors alone, it is termed physiologic jaundice.

- Neonatal jaundice will be seen in cases of maternal-fetal blood type incompatibility. The mother's body will actually produce antibodies that attack the fetus's blood cells. This causes a breakdown of the red blood cells and thus an increased release of bilirubin from the red cells.

- Healthy red blood cells can be destroyed in a condition called hemolysis.

- Polycythemia is a condition in which a child is born with an excess of red blood cells.

- A large scalp bruise called a cephalohematoma can occur during the birthing process. Such a bruise is really a collection of clotted blood just beneath the skin surface. As the body naturally breaks down this clotted blood, a large amount of bilirubin is

released at once. This sudden excess in serum bilirubin may be too much for the baby's liver to handle, and jaundice will develop.

- Sometimes a baby swallows blood during birth. This swallowed blood is broken down in the baby's intestines and absorbed into the bloodstream. Just as the excess blood from a blood clot will cause a rise in serum bilirubin, so will this.
- A mother who has diabetes may cause a baby to develop neonatal jaundice.
- Crigler-Najjar syndrome and Lucey-Driscoll syndrome are also conditions that can cause jaundice.

As a baby's bilirubin levels rise, jaundice moves from the head to include the arms, trunk, and finally the legs. If the bilirubin levels are very high, a baby will appear jaundiced below the knees and on the palms of his or her hands. Newborn babies will begin to appear jaundiced when they have more than 5 mg/dL of bilirubin in their blood. It is important to recognize and treat neonatal jaundice because high levels of bilirubin can cause permanent damage to a baby's brain. This brain damage is called kernicterus.

Jaundice is most often treated with phototherapy. This involves placing the baby on a warmer beneath special lights. Physiologic jaundice (the most common form) almost never requires treatment beyond phototherapy. When all other treatments have failed to reduce the bilirubin level enough, the last resort is an exchange transfusion. In this treatment, the baby's blood is exchanged with donated blood. This is a very specialized procedure and is done only in facilities capable of caring for critically ill children (Colby, 2005).

2.9. Socioeconomic state and Traditional Newborn Care Practices

Traditional newborn care practices revealed from traditional healers and other key persons in the community are more prevalent in low socioeconomic settings. Although breastfeeding was relatively common in this setting, the predominance of other risky traditional newborn care practices stresses the need for promoting health education programs on improving newborn care practices (Fikree, et al., 2005).

A number of economic and social strategies have been proposed for improving child health in the developing world (Caldwell, et al., 1986). These include economic development, reduction of poverty and the provision of educational, health and social welfare programs. Many of these strategies are interdependent and their effects subject to national forces operating within host countries. It is important to disentangle the unique impact of each strategy and estimate to what extent this impact is modified by country specific circumstances. This would help policy makers understand both the leverage available and the context required for these strategies to achieve their child health objectives. Economic development level, household wealth and maternal education have substantial and distinctive influences on child health. Level of economic development is an important factor underlying between-country differences in child health. This underscores its potential for improving levels of population health and agrees with ecological studies in developing countries looking at child mortality and malnutrition (Filmer, et al., 2003).

2.10. Grandmothers influence on child care

Family support to the mother in the form of help provided in childcare, household work, emotional support or informational support is an important resource facilitating improved childcare by the mother. Older women, or grandmothers, traditionally have considerable influence on decisions related to maternal and child health at the household level. The influence of beliefs and practices of grandmother on various aspects of childcare by mothers is highly recognized and can't be missed. Grandmothers appear to play an important role in supporting desirable child-feeding and child care practices, and increasing the child caloric intake from complementary feeding. They however could also be a negative influence in terms of encouraging some undesirable child feeding and child care practices. Grandmother's participation in interventions to improve maternal and child survival, health and nutrition status needs to be encouraged, as including only mothers in behavior change interventions may have limited impact (Sharma, et al.: April 2006).

2.11. The influence and relevant effect of traditional newborn care practices; Cord care

A wide variety of traditional practices and beliefs are associated with care of the umbilical cord. Traditional beliefs must be taken into account when introducing clean cord care programs in a community since these beliefs may conflict with program recommendations. Some traditional practices such as applying unclean substances to the cord are dangerous and should be discouraged or replaced with safer alternatives. Practices will not change unless people are convinced that the new practice is indeed better. Some traditional practices are beneficial and should be promoted, while others may be ignored (Obuekwe, et al.: 2003).

The following are examples of traditional cord care practices (Obuekwe, et al.: 2003):

In many cultures, people believe that all life from the placenta must be transferred to the newborn for otherwise the baby may die. Therefore, the cord is usually cut after cord pulsations stop or after the delivery of the placenta. This practice is harmless and may even be beneficial to the baby. In some areas the cord is milked, especially if the baby is not breathing, in order to bring the baby's soul back from the mother.

Materials used to tie the cord include strings, threads and strips of cloth. In Nepal, the custom is to use home-made cord ties of raw cotton in accordance with the saying, "a new thread for the new baby". Sometimes blades of grass, bark fibres, reeds or fine roots are used: this is harmful because such materials often harbour tetanus spores from the soil and thus increase the risk of neonatal tetanus. In some areas, no tie is used or the cord is tied only if bleeding occurs. This practice increases the risk of bleeding from the stump. In traditional societies in India, the practice of waiting for placental expulsion and using a blunt instrument to cut the cord, which results in more vessel spasm than using a sharp one, ensures that cord bleeding is uncommon even if the cord is not tied very tightly. A variety of tools are used to cut the cord. They are usually items that are available in the house, or that relate to the father's trade, such as scissors, knives, broken glass, stones, sickles, or used razor blades. These are rarely cleaned or boiled before use and are dangerous sources of infection. Some cultures have more beneficial customs such as heating the knife over a fire or candle before cutting the cord. The umbilical cord is left long in most traditional cultures. Exceptionally, it is cut very short, as in some communities in Uganda (this

practice is associated with the danger of umbilical bleeding as it makes the cord hard to tie). In Ecuador, the cord is left 12-15 cm long in girls because it is believed that anything shorter than that would cause a girl to have a small uterus and narrow hips later in life and therefore have difficulty in childbirth. The effect of leaving the cord long on cord infections has not been studied. It is, however, harder to keep the cord dry and clean if it is long, and it could more easily come into contact with urine and faeces (though this would not happen where the cord is tied loosely around the neck or arm, as is the custom in some African countries) (Obuekwe, et al.: 2003).

In most cultures, some kind of substance is applied to the cord stump. Ash, oil, butter, spice pastes, herbs and mud are substances that are commonly used. These substances are often contaminated with bacteria and spores and thus increase the risk of infection. One of the most dangerous practices is the application of cow, chicken or rat dung to the stump; this is associated with a high risk of neonatal tetanus. Ghee application has also been found to be a risk factor for tetanus. The most common reasons given for applying a substance to the cord are to prevent bleeding from the stump, to promote separation of the stump, and to keep spirits away. The effect of these practices on bleeding and separation has not been studied. Some Latin American cultures have beneficial customs regarding treatment of the cord, such as cauterizing the stump with a candle flame, hot coal or burning stick. In KwaZulu-Natal and in some communities in Kenya, some mothers apply expressed breast milk (colostrum) to the cord stump (this could in fact be beneficial in view of the antibacterial factors present in breast milk). In many cultures, it is common to bind the newborn's abdomen with cloth or bandages. This practice keeps the stump moist, thus delaying healing and increasing the risk of infection, especially if the material used is unclean. Various reasons are given for the custom of binding, such as to prevent the umbilicus from bulging or protruding from the body, to secure the newborn's internal organs, or to protect the stump from "bad air" which is considered in some cultures to be a cause of illness (Obuekwe, et al., 2003, WHO 1998).

2.12. Summary

Palestine has made significant progress in number of health indicators. Infant Mortality Rate (IMR) was one of the indicators didn't show dramatic changes. In 2000 IMR (per 1000 live births) was 25.5, and in 2006: 25.3 (PCBS, 2006). To sustain previous health gains and meet the United Nations Millennium Development Goals, policymakers need to place much greater emphasis on proven, cost-effective measures to save maternal and newborn lives. Making motherhood safer is critical to saving newborns. Research shows that a significant number of stillbirths and neonatal deaths could be prevented if all women were adequately nourished and received good quality care during pregnancy, delivery, and the postpartum period (Anne Tinker 1997). Beliefs and practices surrounding the postpartum period and early childhood are culturally patterned (Brettell, et al.:1997). A lack of cultural knowledge on the part of health providers can make appropriate care difficult to deliver (Lauderdale, 1999). These practices have a major impact on neonatal morbidity and mortality patterns. Traditional and cultural practices must identify and the extent of their impact on newborn health evaluated before global standard guidelines are adapted to the local situation (WHO, 2004). Studies conducted during the postnatal period have revealed that women and their newborns are subject to a variety of customs that serve no purpose in caring for either and can actually prove to be harmful. The custom of preventing the recently delivered mother from leaving the house or being exposed to sun serves no useful purpose and to the extent that it does not allow her early access to postnatal services at a clinic, within six days after delivery, can actually prove harmful to her health and possibly survival. While postpartum women in the West Bank and Gaza are not encouraged – and are instead, actively discouraged by their families - from accessing care during this period, they are also themselves complicit in that they do not go for a checkup within 6 days if they are feeling healthy. (MARAM, 2004).To explore different range of practices the study employed qualitative research design which is concerned with developing explanations of social phenomena. It is concerned with the social aspects of our world and seeks to answer questions about: Why people behave the way they do, how opinions and attitudes are formed, how people are affected by the events that go on around them, how and why cultures have developed in the way they have, and the differences between social groups (Beverley Hancock, 2002).

CHAPTER 3: THEORETICAL AND CONCEPTUAL FRAMEWORK

3.1. Introduction

In this chapter we will discuss issues related to newborn care practices definition, study area and study population. In addition, an overview of the study conceptual model used will be also presented.

3.2. Study Area

Jenin is a Palestinian city located in the northern West Bank. It serves as the administrative center of the Jenin Governorate and is a major agricultural center for the surrounding towns. In 2007 the city has population of 256,600. The adjacent refugee camp (also named Jenin) had a population of over 20,300. Jenin is designated under the administration of the Palestinian Authority (PCBS, 2007).

Geography: Jenin overlooks both the Jordan Valley to the east and the Jazreel Valley (known by the Palestinians as "Marj Ibn Amer" to the north.

Etymology: Jenin was known in ancient times as the Canaanite village of "Ein-Ganim" or Tel Jenin. Tel Jenin, its name in Arabic, is located at the center of what is today Jenin's business center. The city of Ein-Ganim is mentioned in the Hebrew bible as the city of the Levites of the Tribe of Issachar. After some years, the city's name was changed to "Giant". In the book of Judith, the settlement is mentioned as "Gini". The Jewish historian Josephus also mentioned Ganim as a city in northern Samaria. The Arabic name "Jenin" ultimately derives from this ancient name (Shaheen, 2005).

The PCBS defines a locality as agglomeration of population regardless the number of inhabitants and classify it into three types:

Urban: Any locality whose population amounts to 10,000 persons or more. This applies to all governorate/districts centers regardless of their size. Besides it refers to all localities whose population varies from 4,000 to 9,999 persons provided they have at least four of the following elements: public electricity network, public water network, post office,

health center with a full-time physician and a school offering a general secondary education certificate.

Rural: Any locality whose population is less than 4.000 persons or whose population varies from 4.000 to 9,999 persons but lacking four of the aforementioned elements.

Refugee camps: it refers to any locality referred to as refugee camp and administered by the United Nation Refugees and Work Agency in the Near East UNRWA (PCBS)

3.3. Study Population

Mothers resident in Jenin city, village and camps were targeted through main women community centers. The centers where identified as the entry point to the community, as centers workers are well-known to mothers and aware of study target sample. Mothers are defined as young women who are married and have had recent deliveries in the last 6 months and age between 15-35 years. The aim of the study was to explore newborn care practices carried by mothers, however the study population was not limited to mothers who gave birth in the last month only, and expanded to include mothers gave birth in the last 6 months, to give the chance for more mothers to participate, as the number of mothers who gave birth in the last month was little and those mothers were not in favor to go out in this critical period to participate in a survey.

The selection of mothers utilized the operational definition above and the criteria as follows:

- Have had delivery in the last 6 months including recent deliveries (Mother that delivered 0-6 month before starting the study
- Willing to participate in the study
- Mothers age (Number of years she lived)
- Range of educational levels (between 6-12 years, and university)
- Range of socio-economic levels (range of income for the family)
- Residency (City, village or camp)

- Main health provider (MOH, UNRWA, NGO's, Private)

3.4. Study Theoretical Framework

According to the study aim and objectives, exploration of the literature and identification of the main theme and concept, we developed this study conceptual framework; framing the study. Identification of themes has guided and used to focus data collection and/or data analysis and presentation of findings. Main themes and concepts explored in the research are identified below.

The postnatal period begins after delivery of the placenta and lasts until six weeks after delivery. Postpartum care includes prevention/early detection and treatment of complications and disease, and provision of advice/services in breastfeeding, birth spacing, immunization and maternal nutrition.

An important element of routine postpartum care is monitoring of the mother and the newborn. To support the mother and her family in the transition to a new family constellation, and response to their needs, to prevent, diagnose early and treat complications of mother and infant, to refer mother and infant for specialized care when necessary, to counsel on baby care, to support breastfeeding, to counsel on maternal nutrition, and supplementation if necessary, to counsel and provide service for contraception, the resumption of sexual activity, and immunization.

The newborn period is defined as beginning at birth and lasting through the 28th day following birth. Newborn Care is defined as care provided to newborn after delivery as per Palestinian National Authority Ministry Of health Protocol and guidelines that was developed with technical support from MARAM project (2004). Mainly Newborn care and resuscitation protocol and Postnatal care protocol, and, as per the National Unified Reproductive Health Guidelines and Protocol by the Palestinian Ministry of health with Financial and technical support of the UNFPA. The basic elements of newborn care should include: recognition of danger signs, reduction of neonatal hyperthermia, umbilical cord care, and immediate and exclusive breastfeeding.

The importance of mothers and family members practicing essential newborn care needs to be stressed in terms of what must be done and why, in the following areas:

Warming baby: (drying, wrap baby including head, and skin to skin contact to maintain warmth), Bathing: (delay bathing for 24 hours), and Clean cord care: (secure cord tie with clean ties, clean cord cut, keep cord dry, and put nothing on it).

Breastfeeding: refers to the method of feeding infants and children, and is defined as a child having been fed breast milk directly from the breast or expressed.

Exclusive breastfeeding: children aged 0-6 months who are being breastfed and have not received any other food or drink, except for vitamins and medications.

Breastfeeding Practices: World Health Organization (WHO) in its global recommendations report for appropriate feeding of infants and young children spelled out the following guidelines:

1. Breastfeeding should start early, within one hour after birth.
2. Breastfeeding should be exclusive for six months.
3. Appropriate complementary feeding should start from the age of six months with continued breastfeeding up to two years or beyond.

Childhood illnesses: worldwide, diarrhea and respiratory infections are a major cause of death in children, especially young ones. In Palestine according to the MoH, respiratory disease is the second cause of death after prematurity and low birth weight for 2006.

Diarrhea: the passage of loose or liquid stools at least 3 times in 24-hours period or more frequently than is normal of individual. Diarrhea may be defined as understood by mothers as they consider the consistency of stool rather than number. The discussion used the mother's definition in this study.

Respiratory infection: mothers were asked if the child had fever or cough, fast breathing, or nose block during the bout. Respiratory infection defined as understood by mothers as newborn complaining acutely of any of the above mentioned symptoms. The discussion used the mother's definition.

Physiologic Jaundice is a yellow discoloration of the skin and the white part (the sclera) of the eyes that appears after 24 hours of life. Jaundice defined as understood by mothers as

yellowish discoloration of skin that appears after newborn discharge. The discussion used the mother's definition.

Health providers: MoH is considered the major provider of primary health care services as it operates 413 PHC facilities out of 651 representing 63.4% of total PHC facilities, where as local NGO's operates 28.4%, followed by UNRWA that operates 8.2% of the facilities (National Strategic Health Plan, 2008).

3.5. Summary

According to the study aim and objectives, exploration of the literature and identification of the main theme and concept, we developed this study conceptual framework; framing the study. This means that the purpose of the study is exploratory/descriptive and not to test a theory. In addition, the study area and study population were defined. The above definitions, review for guidelines, factors affecting mothers carried practices during newborn care and main practices highlighted have been discussed. Each factor will be discussed later in terms of influence on newborn care practices carried by mothers in the study area.

CHAPTER 4: STUDY METHODOLOGY

4.1. Introduction

This study aims to explore useful and harmful newborn care practices carried by mothers of children age 0-6 month. In this chapter the research methodology will be presented. The study design, data collection tools, research key question, and data analysis are described.

4.2. Study area; socio-demographic and geographic description

Jenin governorate lies in the northern part of the West Bank, in the central part of Palestine. It is a regional center due to its proximity to the Israeli, Jordanian, Lebanese and Syrian borders. It is also well-known stop-over for pilgrims to Nazareth and Jerusalem. (Ministry of Interior 2008)

Demographic trends in Jenin district, as is the case of other districts in the West Bank, have been close related to the political situation. According to the population statistics estimated by the Palestinian Center Bureau of Statistics (PCBS), the end total population of 2007 was around 256,619 individuals, which includes one refugee camp population. Sex ratio male per 100 female) was 103.2. Jenin district has very young population with 40.0% of the population under 14 years of age (PCBS 2007). The Jenin governorate is an agricultural are with over 580,000 dunums of fertile, high quality soil that produce considerable harvests. The agricultural sector of the Jenin governorate contributes 30% of the Palestinian National Income, and supplies work for 25% of the Palestinian population as farmers (Ministry of Interior 2008)

4.3. Study design

Qualitative research methodology was be used to answer the study questions. Qualitative research defined as research whose findings are not arrived at by statistical or other quantitative procedures. Qualitative research is often said to be naturalistic (Hutchins 1995). That is, its goal is to understand behavior in a natural setting. Two other goals attributed to qualitative research are understanding the phenomenon from the perspective of the research participant and understanding the meanings people give to their experience.

It attempts to do this by using so-called naturalistic methods—interviewing, observation, ethnography, participant observation and focus groups. Each of these methods seeks to understand the perspective of the research participant within the context of their everyday life. This means that the researcher is concerned with asking broad questions that allow the respondent to answer in their own words. These methods allow the researcher to try to qualify their understanding during the research process through further probing questions. In addition, a method such as observation allows the researcher to observe people within natural settings—particularly those in public places. This has resulted in greater understanding of people's behaviors.

A focus group is a form of qualitative research in which a group of people are asked about their perceptions, opinions, beliefs and attitudes towards a product, service, concept, advertisement, idea, or packaging. Questions are asked in an interactive group setting where participants are free to talk with other group members. (Hutchins 1995)

4.4. Feasibility of the study

Qualitative research is most appropriate for the purpose of this research because it allows in-depth understanding of the practices and factors influencing these practices given that this is associated with traditions, values and attitudes of mothers that are difficult to address in quantitative techniques. The qualitative design will allow better validation of responses, addresses the why and how questions and allows synergy and group dynamics to play effectively in generating responses that may not be generated by soliciting data from structured individual questionnaires or interviews.

With the qualitative method of focus groups, we can experience the mother practices and have their stories. In a focus group, it is much easier to get people to talk about their feelings, perceptions, attitudes and value systems than with a highly structured questionnaire.

The main characteristics of the focus group are:

- Interaction between the participants of the focus group stimulates the development of new ideas.

- Reactions and responses in the group offer a possibility of observing a group process.
- The group offers ideas, dynamics of attitudes and opinions.
- Discussion often 'provokes' greater spontaneity and honesty than could be expected with individual interviews.
- Cooperation in the group can be emotionally provocative, which is not the case with the individual interview.

4.5. Data Collection

Focus groups discussion with 24 focus groups: (8 in city, 8 in village, and 8 in Jenin camp) were conducted. Each group was composed of 10-12 mothers. The interviews were arranged and organized through the help and support of key figures in the community and a consent form was signed. Main women center were an entry point to recruit the mothers. The interviews were carried out in an independent and acceptable place that they feel safe (emotionally and socially) and comfortable in the selected city, village and camp.

Table 1: Focus groups conducted at City, village and camp.

Methods	**City**	**Camp**	**Village**	**Total focus groups**
Focus groups with mothers	8 focus groups in for newly delivered mothers	8 focus groups in for newly delivered mothers	8 focus groups in for newly delivered mothers	24 focus groups

4.6. Ethical consideration

The title and the research method were approved by the professional public health research committee and Higher Studies Council agreement, which allowed passing the first part of the interview. Ethically, the research by no means would harm any participant either physically or psychologically. Mothers were identified by the women's community centers at their localities, who invited them to participate after explaining the aim and objective of the study. Mothers participated upon their willing and after clear explanation of the study and reviewing the consent form. (Annex 3).

4.7. Study tools and equipment

A standard qualitative research methodology was utilized to gain an in-depth understanding of traditional newborn care practices in Jenin and of the factors influencing these practices for of mothers of infants 0-6 months. The qualitative design allowed exploration of mothers' responses and facilitated group dynamics, which played effectively in generating answers that may not be solicited using structured individual questionnaires or interviews.

Key question

1. Identify main traditional newborn care practices :

- Postpartum care
- Feeding practices
- Home remedies
- Cleaning practices & warming practices

11. Identify reasons & rational for Practices

111. Identify Key people influencing mother's home care practices during neonatal period.

4.7.1 Data Collection Sheet:

Key questions of mothers with children age 0-6 months detailed in Annex A. The form used for documenting responses of mothers during focus group discussion is detailed in Annex B. The data collection sheet including the key questions was used by the researcher. The data collection sheet was developed in reference to previously validated questionnaires. The key questions were designed guided by the study conceptual framework of pre defined factors influencing newborn care practices. After developing the data collection sheet, it was shard with experts in the field of newborn care and qualitative research. The questions were piloted before using them in the field.

4.7.2 Study Variables:

1 .Dependant variable:

- Mother's newborn care practices

2. Independent variable:

- Mothers area of residence in Jenin area (city, camp or village)
- Mothers education
- Mothers occupation

4.8. Data analysis

All data from all focus groups were tape-recorded, transcribed where common categories and trends were identified. The analysis process of information (textual or numbers) was guided by the following analysis plan:

1. A profile of the research sample under research methods (focus groups and individual was profiled in terms of sampling characteristics)

- City, village or camp

-Age of mother

-Type of service provider

2. Analysis of mother's responses that covered research key questions to identify their trends/directions was tabulated by regional background.

Data analysis depended mainly on the manual text analysis of basic trends of responses by the different independent variables such as rural, urban areas; mothers age 15-35 and MoH, NGOs and UNRWA health care providers and others. Analysis of the interviews included manual coding of the transcripts, extended discussions, and summarizing the results of findings.

4.9. Summary

The study employed qualitative design in exploring the traditional home newborn care practices of mothers of children age 0-6 months. 24 focus group discussions with mothers of children 0-6 months were conducted (8 focus groups with mother's inhabitant in Jenin City, 8 focus groups with mother's inhabitant in Selit-Al Harthia which is a village that present rural Jenin, and 8 focus groups with mother's inhabitant in Jenin camp). Data was analyzed and categorized utilizing content analysis of responses obtained in each key question.

CHAPTER 5: RESULTS

5.1. Introduction

This chapter will present and discuss the results obtained from focus group discussion. The study aim is to explore major useful and harmful practices performed at home by mothers of children age 0-6 month in Jenin area.

Data analysis involves the transformation of raw data into a final description, narrative, or themes and categories. Analysis is presented for the most part in a narrative form, in addition to the inclusion of some quantitative measures and numerical expression is used for example presenting percentages. The analysis of information (textual or numbers) was guided by presenting participants profile and analysis of responses of participants to research key questions.

5.2. Participant's Profile

24 focus groups were conducted with a total participant of 240.

Table 2: Demographic characteristics of the participants in the focus groups

Characteristic	**Number**
Mother's age	
≤18	48 (20%)
19–29	96 (42.5%)
≥30	90 (37.5%)
Mother's educational level	
Elementary school	24 (10%)
Preparatory school	43 (17.9%)
Secondary school	118 (49.1%)
University and above	55 (22.9%)
Mother's work status	
House wife	209 (87.1%)
Working	19 (7.9%)
Student	12 (5%)

Average monthly family expenditure Less than 600 NI From 600 to 1199 NIS From 1200 to 2000 NIS More than 2000 NIS	 50 (20.8%) 67 (27.9%) 83 (34.6%) 40 (16.6%)
Residency area City Village Camp	 79 (32.9%) 83 (34.5%) 78 (32.5%)
Service Provider MoH clinic UNRWA clinic NGO clinic Private clinic	 92 (38.3%) 73 (30.4%) 24 (10%) 51 (21.2%)

5.3. Description of the main findings

5.3.1. Postpartum Care

While all mothers reported that they were not told about postpartum care during the antenatal visits, those registered at the UNRWA said they received routine postpartum care after delivery. Mothers who received antenatal care in the MOH clinics did not report any mechanism for postpartum follow-up.

All mothers reported giving birth at hospitals, mainly at Jenin governmental hospital. Some mothers reported giving birth at nongovernmental hospital in Jenin and few reported giving birth at a private hospital in Jenin.

More typically doctors make the discharge decision – usually 24 hours after delivery (a little longer in private hospital or nongovernmental hospital in Jenin); however, mothers are generally happy to leave the government hospital due to lack of care and the unacceptable conditions in the facility. For mothers who gave birth at private or nongovernmental hospital they preferred to leave earlier to save money as they pay out of their pocket.

While mothers who delivered in the private hospital received no information regarding postpartum care and postpartum care importance, some of those who delivered at the governmental hospital claimed that they were provided information by the nurses – prior to

discharge – on breast feeding, care of the baby and mother, and these were supported by leaflets.

Across all groups in Jenin City and camp, mothers explained that, during the postpartum period, their focus – and the focus of the family - was on the baby, that no health worker visited them, and while their families "do not prevent them from receiving such care, they do not encourage it too." One mother said "mothers are careless about their own health but do care about the health of their babies." However, in the city, most mothers did not know what "besides bathing and breast feeding" was required to take care of a baby; they also reported that typically babies are taken to the government clinic for Phenylketonuria (PKU) test and weighing in the 1st month and then the mother is told to return again for vaccinations and growth monitoring at six months.

At the UNRWA clinic, mothers are expected to bring their babies for the first vaccination within five days of birth at same time they receive postpartum care. One mother said that when her husband went to the UNRWA clinic to register the birth, he was given an appointment for both the baby and the mother (UNRWA clinics do not see the baby without the mother); during the appointment she was given information on nutrition and family planning. Another mother mentioned that the UNRWA nurse told her how to do a self breast exam (for cancer), and to "watch for her periods."

Across village groups, mothers registered at the Palestinian Medical Relief Society clinics received postpartum care during the home visit – the health worker knows the due date and visits the home shortly thereafter. The health worker weighs the baby and also checks the mother's blood pressure, advices her on a number of issues including: breast feeding and the importance of breastfeeding in the first three days so that the baby receives the "liba," cleaning the nipple, showering the baby and herself daily, taking care of the umbilical cord, and spacing births. One mother mentioned that she was constipated after delivery because she had not prepared herself adequately with fluids such as soups, because her mother-in-law lives out of the country, as does her mother.

There was no post delivery home visit by health care provider in the Jenin city groups. Instead, mothers reportedly followed the advice of their mothers-in-law who told them to stay warm and cover with sheets because they have "open pores" after delivery. In case of

complaints of abdominal cramps due to "feeling cold," breastfeeding, or "khawalef" (hemorrhaging) their mothers-in-law give them herbal fluids, soups, a daily teaspoon of oil to prevent constipation. Mothers-in-law also bathe the baby, take them for vaccinations and help out in other ways.

Most mothers in the Jenin City group who were married early said that family pressure, especially from their mothers-in-law, would prevent them from receiving postpartum care and they are reluctant to "cross" their mothers-in-law. These mothers were also generally dissatisfied with the services at the government clinics and reported several incidents of receiving poor care – stitches breaking resulting in an abscess, and being stitched without anesthesia. One mother's mother-in-law told her "why do you want to go for follow-up, what will they do for you, nothing, so stay at home." Not only is there little support and encouragement from mothers-in-law for preventive postpartum care, most mothers said that they are actively discouraged by care providers - one mother said that the MOH doctor asked her why she came to the clinic since she "has not been stabbed".

Given the poor quality of care, mothers in the city agreed that if they have no complaints they will not pay 50 NIS for a postpartum exam (implying that they would access such care only at a private clinic) – if they felt fine after delivery they would not go to a clinic "even if we had money" but that they would go to a clinic if they didn't feel fine (e.g., excessive bleeding) even if they had little money.

In Jenin city, camp and village some mothers mentioned that their families, and especially their mothers-in-law, are barriers to receiving postpartum care. However, most mothers in the city mentioned other reasons such being busy, having too many kids, not having anyone to look after the kids, not knowing where to go to receive such care, living a fair distance from the clinic. However, similar to mothers in the city, the mothers in the village said that if care was deemed necessary they would definitely go to the clinic.

While some mothers in the city said that "mostly no one bothers to take care of the mother after the baby is born," generally across all groups they said they were cared for at home by their mothers-in-law, who allowed them to rest, and fed them high protein diets (e.g., meat, liver, chicken). Some mothers in the village said that postnatal care only meant good nutrition ("it's good they brought me 7 kilos of meat post delivery"). Mothers also reported that the type of care they receive from their mothers-in-law depends on whether the baby is a boy or a girl – if it's a boy they are cared for well, otherwise not; sometimes the baby is cared for by the husband's family and the mother is cared for by her mother.

Mothers-in-law typically care for their daughters-in-law in the early days/weeks after delivery, preparing a variety of foods, allowing them to rest, and making sure that they are regaining their strength. Mothers across all groups were well aware of the danger signs and knew that they should seek care immediately if there are complications. Danger signs mentioned across groups were excessive bleeding, fever, severe headache and severe abdominal pain.

5.3.2. Feeding practices

Almost all mothers reported breastfeeding their babies either immediately or within a couple hours after delivery. Those who started breastfeeding 2 or more days after delivery had delivered by C-Section.

Most mothers know the importance of breast feeding for the baby (develops immunity to germs and sickness, develops a bond with the mother) and for the mother (helps the uterus get back to normal, delays menstruation and is a natural way to delay pregnancy, develops a bond with the baby).

Mothers gave several other reasons why breast milk is good:

- Cheap, clean, available, and of the right temperature in both summer and winter
- A child on artificial milk is "like a balloon with no health"
- Good for developing baby's intelligence
- Develops strong bones and teeth for baby

- Prevents diseases such cancer (for the mother)
- Relaxes the mother
- One cup of breast milk is better than a whole bottle of artificial milk
- Helps uterus “return to its place”
- Prevents cancer
- Protects babies from diseases like diarrhea because it has natural immunity
- Contains all essential ingredients needed for baby’s growth and development
- Clean
- Temperature is “suitable, neither hot nor cold”
- Best for baby because “God created it”
- Helps baby’s teeth grow faster

In addition, mothers in the camp mentioned that breastfeeding prevents pregnancy, is cheap, helps the mother to lose body fat, and saves the mother time as she does not have to prepare the baby’s bottles.

Table 3 summarizes mother’s response in terms of their total number in each locality and their preserved advantages of breastfeeding, disaggregated by locality. The percentage indicates mother’s positive responses. It was calculated by dividing the number of mothers who gave positive response regarding the studied parameter in reference to the total participant’s number in the same locality.

Table 3: Perceived advantages of breastfeeding

Perceived advantages	**City**	**Village**	**Camp**
Number of participants	79	83	78
1. Increases child immunity	50%	60%	70%
2. Boosts child intelligence	30%	20%	100%
3. Contains Calcium and vitamins	20%	Not mentioned	30%
4. Considered rich in all nutrients needed for the child	40%	40%	Not mentioned

5. Saves money	Not mentioned	60%	30%
6. Protects mothers from breast cancer	Not mentioned	Not mentioned	50%
7. Available and easily accessible	Not mentioned	Not mentioned	20%
8. Decreases incidence of diarrhea	20%	20%	50%
9. Increases bonding between child and mother.	20%	Not mentioned	50%

There are many sources from which mothers have heard about the importance of breastfeeding including their mothers-in-law and own mothers, school, television, doctors and nurses during antenatal visits, doctors at the hospital. However, mothers acknowledged that there are circumstances when it is difficult for a mother to breast feed, e.g., when she has a cracked or retracted nipple, due to breast engorgement and hardness, if the mother's milk is insufficient.

As with all groups, what is referred to as "exclusive" is not strictly so across all groups. While a few mothers in the city and village said they breast fed "exclusively" for 7, 8, and 10 months on one extreme and for 2 months on the other, the most frequently mentioned duration for breast feeding "exclusively" across all groups was 4-6 months. In fact, no one actually breast feeds exclusively, the reasons for which vary as followed:

- mother cannot produce enough milk
- mother's milk is "light" and "not of good quality"
- baby is hungry even after being breast fed
- if the mother does not have good health or does not/cannot eat well
- baby must be given herbs (cumin, maramia) for "gas" and colds
- herbal fluids are important as breast milk may cause baby abdominal distension from the foods eaten by the mother

- C-Section babies are bottle-fed as mothers do not see them the first 2-3 days
- mothers who get pregnant while breastfeeding stop immediately
- mothers-in-law put pressure to introduce solids early
- babies need food early – by the 4th month - to grow, and be able to teeth and walk

In addition table below summarizes mothers response regarding reasons that prevent from exclusive breastfeeding their babies disaggregated by locality.

Table 4: Reasons that prevent mothers from exclusive breastfeeding

Type of factors	City	Village	Camp
Number of participants	79	83	78
1. Abdominal colic	100%	100%	100%
2. Child is not satisfied with mother's breast milk (stays hungry) and insufficient mother's milk/ Low child weight	50%	40%	30%
3. Lack of mother's time	70%	20%	Not mentioned
². Working mother	50%	20%	30%
5. Mother's pregnancy	10%	30%	10%
6. Mother's sickness or breast pain	10%	20%	10%
7. Mother's enrollment in education	20%	30%	Not mentioned
8. Lack of mother's experience (married at very young age)	5%	10%	Not mentioned
9. To orient the child to home made food	10%	50%	10%
10. To offer the child a different taste to increase his appetite	10%	50%	10%
11. large Number of children in the family	Not mentioned	5%	10%

Type of factors	City	Village	Camp
12. Baby born prematurely	Not mentioned	5%	10%
14. lack of mother interest to breastfeed	5%	Not mentioned	Not mentioned

While several mothers, particularly in the Jenin camp groups, knew that exclusive breastfeeding is recommended for six months, most said that it would be difficult and impractical for mothers to practice this given the prevalence of feeding babies herbs (in liquid form) early as a remedy for "gas," marrakoh (clear soup prepared for the mother) the day after delivery, and giving them a "taste" (of a variety of solid foods) after 40 days (feeding of marrakoh and "tasting" were mentioned by mothers across Jenin camp groups).

Most of the mothers in one village group said that they encourage by their mothers-in-law to breast feed exclusively (by which they meant giving only breast milk and no other liquids or solids) for up to 6 months. As for duration of breastfeeding, all except two mothers said that her mother-in-law encouraged her to breastfeed (with additional food) for up to 1½-2 years.

In contrast, some mothers in a village group said they are introducing solids early. These mothers put samen baladi, halqoom and other traditional sweets in a gauze and give it to newborns for the first few days (starting within a few hours of the child's birth) "until the breast milk production is established." It is not uncommon for babies to be given sweets, sugar water, and molasses grapes from the time they are born. Most mothers said they listen to their mother's and mothers-in-law about breastfeeding practices yet some of the mothers preferred to introduce artificial milk earlier than recommend, even against the wish of their mother's and mothers-in-law.

In the city group mothers consider 4-6 months best for "exclusive" breastfeeding. However, not all mothers continue breastfeeding if they cannot produce enough milk, baby is hungry after breastfeeding, or if they work outside the house. Working mothers in the city groups said that feeding start "as soon as possible so that the baby does not depend on breast milk when the mother is out of the house." Typical foods given around the 4-6

month period are: boiled carrots, helba, mohalabia, rice mixed with milk and honey, mixed fruits, cooked potato, shumenit, cereals; meat is introduced around the first birthday as then it will be "easier to metabolize." Some mothers mentioned giving babies "a taste" from the 40th day onwards.

Mothers in the camp recommend "exclusive" breastfeeding for 3-6 months, though they give the baby herbs such as karawia and anise. There was some controversy about the wisdom of giving babies marrakah (clear soup of meat/chicken) – this is a soup prepared for the mother after delivery. One mother said that she gives the baby a spoon of the marrakah the day after delivery; other mothers said that this is not good for the baby as the soup is very strong. Some mothers said that they recommend solid food after 6 months but to start giving them a "taste after 40 days." Typically the foods babies start with after 3-6 months are cereals; vegetable soup (carrots, zucchini, and mashed potato); cocktail of fruits such as apples and bananas; biscuits with milk; yogurt; rice soup. Some mothers also mentioned giving canned baby food purchased at the pharmacy "as it is right for the baby's age."

More mothers in the camp group were aware that exclusive breastfeeding for 6 months is recommended, but very few practice this. The reasons given for why it would be "impossible" to convince mothers to adopt this practice were:

- you rarely find a mother who doesn't give herbs
- ladies don't have time to keep breast feeding
- nothing will convince mothers
- babies must be given food to gain weight

While the duration for breastfeeding (with complementary liquids and solids) was frequently reported lasting until the 6th month, several mothers mentioned breastfeeding for anywhere from 13-18 months. Several mothers reported their mother in laws wanted them to breastfeed for 1½ - 2 years (as recommended in the Qoran); it was more likely that the daughters-in-law preferred weaning their babies earlier.

In the village and camp groups mothers said that their children were given "calcium drops" – they knew it was calcium and should be given for one year but most of them did not know much more about it. One mother said that it "strengthens blood" and in reference to hemoglobin level said that it "prevents the blood from being 7 and raises it to 11." The mothers in a village group said that their children were given the "brown drink" for strengthening bones as well as "iron drops" for hemoglobin but not in the first 3 months.

In the city, mention was made of giving babies "Adol" (vitamins A and D) for bone strengthening. Mothers are aware of importance of supplements prescribed by health providers. However they may not give it to their babies as recommended because they keep forgetting. In addition some mothers pointed that they may not give their babies supplements because they are well breastfeeding their babies.

Almost all mothers across the groups said that they feed on demand during the day and at night. Some mothers in the village said that they do not breast feed when they are angry as it will "make the child grow up in an angry mood;" they also said that mothers should not feed when they are afraid of something as it will "stop the milk supply." Of the few who said that they do not breast feed on demand, mothers in the village were the most vocal – "if I am not busy I will feed her" or "if I am busy I will not give the child enough time during the feed."

Mothers in Jenin city said that they breastfeed babies on demand but the duration varies – from 45 minutes (on each breast) on the first day of delivery to 30 minutes on each breast, and finally 15 minutes on each breast after one month.

Most of the mothers in the camp said that they breast feed the babies on demand, but said they cannot leave it to baby's demand. For example, when the baby is very young and sleeps for 4 to 5 hours, they wake up the baby to feed him/her. One mother in the camp group said that when she has spare time she feeds her daughter even though the daughter doesn't ask.

Most of the mothers said that during the day they breastfeed for 15-20 minutes per breast, sometimes less if they are busy. Although some mothers remarked that first time mothers the most difficulties with breast feeding, the moderators observed several mothers applying

finger pressure on the breast or improperly positioning the baby while breastfeeding them during the focus group sessions.

Night feeding was considered good for the baby – "for intelligence," "psychologically," and for the baby's "growth and development." No mention to importance of night feeding towards increasing milk supply. Very few mothers said that they are seated while breast feeding at night; most reported feeding the baby lying down, "giving a little from both breasts" and frequently falling asleep while the baby is still sucking – "we wake up to find the baby asleep and my breast exposed." Some mothers in the camp group said they give one breast at night as the baby "doesn't ask for much milk" and goes to sleep quickly; others in the city group gave babies artificial milk at night because they believed it was "richer" so the baby will sleep through the night.

Mothers across groups said that they know that their baby is well fed and satisfied if he is not crying, and gaining weight. Few mothers mentioned that frequent passage of stool is an indication that their babies are satisfied.

5.3.3. Home remedies

The mothers defined diarrhea as frequent passage of watery stool. Mothers were well aware of the danger signs of diarrhea and follow newborn treatment as per health provider advice. They made their own diagnoses of the causes of diarrhea, and determined the most appropriate home remedy based on this; remedies included, among others, liquids such as salt/sugar solution, starch with lemon and water, as well as "casts" made of mint or egg yolk that was applied to the child's abdomen. Other practices included warding off the evil eye by reading from the Quran, and wrapping a comb in a sheet and tying it around the navel. If the child does not recover within the timeframe considered appropriate, s/he is taken to a doctor.

The mothers defined acute respiratory infection as common childhood illness in the winter, baby show runny nose, fever, cough or difficulty in breathing. A mother said" all my children had respiratory infections, and most of the time it goes without treatment."

The mothers mentioned that the most important thing is to protect the baby, keep baby warm and avoid changes in weather. Few mothers mentioned that good hygiene practices

are essential to protect the baby not only from respiratory infection but also other diseases. A mother said “if anyone in the family is sick or someone who came to visit us is sick, I immediately keep my baby away to protect him from catching the infection.”

The mothers mentioned using home remedies as recommended by their mother’s and mother’s in law. A mother said “when my baby have cold first I give him baboneg (Chamomile), as my mother in law advised me, if my baby don’t get better in two days, I take him to the doctor.”

In general mothers use home remedies as the first line of treatment for childhood illnesses, and they follow the recommendations of their mothers and mothers in law.

The mothers defined jaundice as yellowish discoloration of the skin. They pointed that the main symptom is the change of baby skin color to be yellowish. Most mothers said that they follow their doctor advice about how to take care of the jaundiced baby. The mothers mentioned doctor advice to continue breast feeding frequently.

5.3.4. Bathing and cleaning practices

Mothers across all groups care a lot about bathing and cleaning their children, which they perform it daily.

Some mothers mentioned bathing the baby within the first two days after birth. Most mothers reported bathing the baby soon after delivery, with most babies bathed just after the cutting of the umbilical cord. Delivery fluids and blood are regarded and hence the baby is not perceived to be clean or pure until it is bathed.

As all births took place at hospitals, all mothers mentioned that the first baby bath was at the hospital by their mothers or mothers in law. A mother who watched her baby’s bath said “After delivery and cutting the cord the baby was wiped off with a piece of cloth and kept on the bed. Then water was put in a bowl and the baby was bathed with soap. The baby was put in the bowl and slowly water was poured on the body.”

Mothers mentioned that rigorous efforts made to remove the vernix during the first bath and afterwards. The vernix was generally perceived as "filthy"; a product from the mother's womb that needed to be removed as soon as possible after birth. A mother in the village

group said “Those [vernix] are the filthy things the baby gets from the mother's womb. It looks ugly if that [vernix] is not removed, the skin looks dry.”

Another said “my mother rubbed off those [vernix] after birth. She rubbed properly with a piece of cloth. It was winter so she did not bathe my baby. She was afraid of cold so she wipe off the body. After three days she bathed the baby.”

Mothers reported regular bathing of their babies during the first week of life, usually between two to seven times. If the baby was sick, the number of baths was less frequent.

The first bath was given with slightly warm water, and many mothers reported including dettol and/or soap. Mothers perceived dettol as having more antiseptic 'power' than normal bath soaps. Some mothers reported including other materials in the bath water such as salt.

A mother said “I bathed the baby daily. There is a variation between persons in terms of the practice of bathing the baby. There are some mothers who get the baby cold during the bathing. They don't understand how to bathe [a newborn baby] properly. I bathe my baby in a way so that it does not get cold. The water is warm and I add salt to the water.” Adding salt was not mentioned by other mothers. Some mothers mentioned that they think it is harmful and they think it makes baby’s skin dryer.

The risk of cold was the main factor in determining the time of the bath. Mothers mentioned some measures to prevent their newborn babies from cold wrapping the baby after the bath.

Care of umbilical stump varied from area to area (Table 5), some can be harmful to the newborn. Mothers talked about their experience and how they were concerned about umbilical area care until the stump fell.

Mothers across groups mentioned that cord care is provided as part of daily care of the baby skin; during bathing the baby they make sure it is clean and apply different substances they think as good to the baby.

Traditional practices of cord care included use of olive oil mainly in village and camp groups, use of baby powder across groups but were rigorously mentioned by city groups.

Mothers in village group mentioned using breast milk as recommended by their mother’s in law. Few mothers in the village mentioned they use ash.

Mothers in the city group mentioned that they care more about the female, in terms of providing more attention to cord care compared to male babies, because they care more about baby girl beauty.

Table 5: Care for umbilical area:

Type of care for umbilical area	City	Village	Camp
Put olive oil	Not mentioned	40%	25%
Put baby powder	70%	20%	30%
Apply medicine	30%	Not mentioned	Not mentioned
Put breast milk	Not mentioned	10%	Not mentioned
Apply ashes from the stove	Not mentioned	5%	Not mentioned

5.3.5. Health provider

Most mothers said that they seek medical service from MoH clinics (38.3%), and mothers resident in the camp said that they prefer to go to UNRWA clinics (30%) as they have UNRWA health insurance card. Mothers in the village said that they go to the nongovernment clinic of the Palestinian medical relief society mainly, but some said that they prefer to go to MOH clinic (10%).

Mothers at village group prefer to go to the PMRS clinic even that they have to pay charge, compared to MoH service which is provided with no cost. A mother said "I have to pay a symbolic charge when I take my baby to Aligatheh (Relief) clinic, but I prefer to go to them as they are so nice and they take care of me and my baby."

Mothers at the village group mentioned that the PMRS doctor is professional and skilled, and nurses provide them with counseling. Mothers said that nurses at PMRS clinic answer their questions and pay attention to their concerns. In addition, mothers at the village group acknowledge the visits they received by PMRS community health workers. Who followed them after delivery and came to their home to check them and their babies.

There was a general agreement in Jenin city that MOH clinics do not provide counseling regarding newborn care unless a mother is experiencing “problems;” if the mother do have any problem seek advice, they typically visit a private provider. In contrast, mothers registered at UNRWA clinic receive counseling service regarding newborn care. “Defaulters” at the UNRWA clinics are closely monitored.

Mothers expressed dissatisfaction with MOH clinics, due to the rude staff, prevalence of male doctors, cursory examination, and inadequate information about breastfeeding, newborn bathing, and home remedies.

Mothers in the city groups mentioned that they prefer to seek health service from private doctors, who are recommended by their sisters and sisters in law. A mother said “each time my baby gets sick I go to a private doctor, as I don’t have to wait, once I arrive the clinic the doctor examines my baby, and gives me time to ask questions and answers them clearly.” Other mother said “my baby private doctor keeps calling to check on my baby, and my doctor is the doctor of my friends and relatives.”

5.3.6. Main source of information

Mothers for the first time are more likely to seek advice and particularly if they are experiencing “problems.” Most commonly, advice is sought from mothers-in-law, but also from their mother’s.

Women who get married early (in their early/mid teens) are least prepared on what to expect through newborn care and most reliant on their mothers-in-law for information, as experienced by one Jenin City group.

The main sources of information that mothers received about newborn care include "community health workers", "medical relief organizations", " mothers' own experience" and " experience of the mother in law", while in few groups they have the combination of both which includes "clinic nurses",” mothers' own experience",” mothers in their neighborhoods" ,” and in one group a mother pointed to workshop and lectures". There are different sources of information that influenced mothers' responses.

There was some difference between group's responses regarding the source of newborn care information. It is apparent that mothers in Jenin camp receive information about breast feeding and newborn care from different professional sources while in Jenin City and village groups they rely on both the traditional care givers, professional sources and personal experience.

Mothers who have experienced giving birth before tend not to consult with anyone as they know what to do, while mothers who gave birth before or who faced problems, they usually consult their mothers-in-law, others consulted – though infrequently mentioned - older sisters, sisters in law and husbands. Several mothers said that it is important to get advice from "experienced mothers in law" however, participants from city and camp groups mentioned that they seek advice also from doctors and nurses when they experience problems with their newborns.

In general, community health workers, TV spots and educational material are main sources of information on newborn care. Most of the responses mentioned that they get such information from medical and health providers e.g. clinic, nurse, health educator). This reflects the key role the health providers can play in disseminating information and influencing practices if they are equipped with the necessary policies, protocols and skills. In addition, these responses may be influenced by the traditional methods used by health care providers, which proved in any instances not very effective in changing mothers' behaviors. The professional model that put the blame of their practices on mothers proved to be ineffective and unethical given that we are blaming the victims of the social system where women are not the sole decision makers.

Given the rise on depending on health care providers to obtain health information bring about positive and negative concerns. The positive as addressed previously need to be equipped to disseminate this information properly in a way that can address all influencing figures and factors in the community. While at the same time it can negatively confuse, mothers with so many different messages and information that can be subject to misinterpretation and negative implications for mothers' breastfeeding practices.

5.3.7. Health topics of interest

While mothers in all groups mentioned a range of topics on which they would like to be educated, the more frequently mentioned were on nutrition for the baby and pregnant woman, how to breastfeed and appropriate weaning practices, care of the newborn, common childhood diseases and how to care for the baby, care during pregnancy especially complicated pregnancies, and birth spacing.

The most preferred mode of receiving information across all groups was health workers and through group meetings that combined “lectures” with the opportunity to ask questions and encouraged discussion.

CHAPTER 6: DISCUSSION AND CONCLUSIONS

6.1. Summary of main findings

The key findings of the focus group discussions revealed that the situations are much more favorable for promotion of appropriate newborn care practices. Along a continuum of best practices to harmful practices, households in the Jenin urban and camp area are much closer to best practices than are households in Jenin rural area, although there is still room for improvement on a large range in Jenin urban and camp areas. Routine newborn care practices are similar across study areas including bathing pattern, caring of sick child and feeding practices. Mothers were well aware of the danger signs of diarrhea and respiratory infections. They made their own diagnoses of diarrhea, and determined the most appropriate home remedy based on this; remedies included, among others, liquids such as salt/sugar solution, starch with lemon and water, as well as "casts" made of mint or egg yolk that was applied to the child's abdomen. Other practices included warding off the evil eye by reading from the Quran, and wrapping a comb in a sheet and tying it around the navel. If the child does not recover within the timeframe considered appropriate, s/he is taken to a doctor.

Mothers have no previous knowledge of the proper definition of exclusive breastfeeding. Herbal remedies are seen as essential in caring for the baby's health, and consequently liquids are given almost immediately after birth. Therefore, even though babies were being given liquids and a taste of some solids, most mothers reported breastfeeding "exclusively" for approximately 4 months. Most mothers reported starting their babies on solids by the 4th month that included mashed fruits, rice with milk, egg yolk with milk, fruit juices, soups, cereals, liver, and bread. Mothers expressed strong desire for knowing how to feed their children properly and complained that they do not have trustworthy sources of information that help them follow the proper feeding practices. It is a common belief that introducing herbs, cerelac and formula milk are common practices and they are not aware that such practices do not contradict with proper way of feeding and breastfeeding the child.

The main source of care varies between areas, mothers resident in the city consider private doctors as the main source of care, while the camp resident seeks care at UNRWA's clinic and the village resident seek care at the NGO care provider.

Mothers for the first time are more likely to seek advice and particularly if they are experiencing "problems." Most commonly, advice is sought from mothers-in-law, but also from their own mothers.

While mothers in all groups mentioned a range of topics on which they would like to be educated, the more frequently mentioned were on nutrition for the baby and pregnant woman, how to breastfeed and appropriate weaning practices, common childhood diseases and how to care for the baby, care during pregnancy especially complicated pregnancies, and birth spacing. The most preferred mode of receiving information across all groups was through group meetings that combined "lectures" with the opportunity to ask questions and encouraged discussion.

6.2. Difference in newborn care between Jenin city, village and camp

Most of newborn care practices are similar across study areas. Significant differences highlighted in Table 6.

Table 6: Differences in newborn care between Jenin city, village and camp:

	City	**Village**	**Camp**
Breastfeeding	Early introduction of milk formulas and early weaning	Give the baby cow milk and introduce food early in addition to breast milk	If baby does not get sufficient breast milk then they add milk formula but no extra food.
Bathing the baby	Bath baby daily using trade mark baby shampoo	Avoid bathing if the baby is sick or weather is cold. Use to wipe the baby with piece of cloths	Bath baby daily, using available soap.
Skin care	Massage the baby	Massage the baby with	Massage the baby with

	City	Village	Camp
	body with baby oil to smooth the skin	olive oil, or holy water (old person read Holy Quran over the water). Massage the baby girl with "Watwat' blood to give her smooth skin	olive oil but not protect from cold, to smooth the skin
Wrapping	Make sure to cover the body of the baby head, body and legs to protect from cold.	For the first months they warp the baby tight with "Kofalyeh" to keep baby back straight	Cover baby body with heavy cloths pieces (more than 3 pieces) to protect from cold.
Home remedies	Baby suffers more from Acute Respiratory infections. Seek care at private health providers	Babies suffer from Diarrhea and ARI. Depend on home remedies and herbal for treatment. If baby seriously ill seek care at PMRS clinic or governmental hospital.	Babies suffer more from Diarrhea. Treat baby with home remedies for one day and if baby still sick seek care at UNRWA clinic

6.2. Postpartum care

Clinics across the board do not provide information on postpartum care during the antenatal visit. However, UNRWA, and Palestinian Medical Relief Society (PMRS) closely monitor their antenatal clients and have mechanisms to follow-up - post-delivery - to provide early postpartum care and newborn care.

Mothers are reluctant to visit an MOH clinic for postpartum care unless they are experiencing excessive bleeding or other danger signs. Also, there appears to be no mechanism for early, routine postpartum follow-up and care in these clinics; instead,

mothers in Jenin city mentioned that they are actively discouraged from accessing such care by providers.

Mothers care about their babies, and consider them as priority. Accordingly they don't appreciate the importance of seeking postpartum care unless if they are experiencing problems or they are seeking care for their newborn, for instance seeking vaccination service or to do the PKU test.

In addition to mothers believe that postpartum care is not a priority, for the ones who are interested to go their mother in law or their husbands are not supportive of such visit. Mothers in law inset on keeping their daughters at rest, and may consider that any visit outside their homes may be a source of threat on their daughters in law health.

Mothers across all groups said that the postpartum period lasts 40 days, a period when they and their babies should be well looked after. Mothers in village group said that during this time there mother's and mother-in-law do all the housework to be giving rest and they are offering them meals such as "shorabah" (soup). However, mothers do not get a physical exam or "check themselves" during the postpartum period instead they rely on the mothers-in-law, for their care and comfort. Most of the mothers complained of abdominal cramps, vaginal secretions, breast problems, "khawalef" (blood clots, discharges). None of the mothers in the city were visited by a health care worker - if they went to the clinic it was for the child's health.

The mothers also said that their mother-in-law prepare food for them: soups, qerfa, merameya and mint fluids to help avoid constipation, meat, liver, young pigeon. They prepare kezha and halawa to "increase milk production."

Mothers-in-law care of their daughters-in-law by ensuring that they get rest and are undisturbed by noise; taking care of the new born baby and the other children in the house for one week; and, preparing soups, warm drinks, meat, chicken.

In a village group a mother said that her mother-in-law take care of her by ensuring she wears warm clothes, and by giving her good food such as soups, eggs, milk, and pigeon.

Only refugee mothers and those registered at UNRWA clinics receive early postpartum care (by the 7th day after delivery); early after delivery they go to the UNRWA clinic and

latter they are visited by health worker. In all other cases mentioned, in the camp groups, only the "high risk" cases go to the government clinic after delivery, as well as mothers with "negative blood" to "take the injection."

Mothers do not favor MoH clinics for postpartum care, compared to mothers who are seeking care from PMRS clinics who are followed by health workers and receive the service at home.

MoH clinics provide the postpartum care service free of charge; however there is low uptake of the service. This may be related to the mother's lack of knowledge about the service as the clinics do not provide relative information during antenatal care. In addition the clinics are experiencing overload, and this may negatively affect the quality of service provided, which may be reflected in mothers omen reporting unwelcoming health provider behavior for mothers seeking postnatal care, if she is not experiencing a health problem.

Barriers to postnatal care in addition to mothers lack of knowledge about the service, family members who are not supportive toward the visit, and health care provider attitude.

The service is provided free of charge at MoH and UNRWA clinics, accordingly service fees is not consider as a barrier regardless of the mother's family income.

6.3. Feeding practices

Almost all mothers have not heard of exclusive breastfeeding as spelled out in the language used by WHO or MoH breastfeeding protocol and guidelines. Most mothers in village group defined exclusive breastfeeding as giving the child only breast milk without adding fluids or foods for up to 6 months of the child age. While probing further, this group admitted that they learned about this optimal breastfeeding practice from the Palestinian medical relief committee society (PMRS) community health workers and nurses in the area but they did not realize that this practice is called "exclusive breastfeeding."

The other groups from city and camp defined it as feeding from breast with no introduction of other foods or fluids but without specifying the duration of exclusive breastfeeding. Some participants from rest of the groups tried to come up with different meanings. one of them defined it as "keeping the milk inside the mother's breast for a while on purpose in

order to be full of milk at the time she gives her breast to her child." others indicated that the term might mean that the mother should continue breastfeeding her child for certain duration, e.g. 40 days, 4, 8, 12, 14, and 24 months. However, the majority could not come up with any meaning that corresponds to the WHO definition of exclusive breastfeeding.

Afterwards, when mothers were informed by the field interviewers of the "proper" meaning of exclusive breastfeeding "giving the baby breast milk only up to 6 months without adding fluids or foods," almost all of them, responded that they had not heard about this term before. Only few indicated that they practice exclusive breastfeeding after they were informed of the proper definition of exclusive breastfeeding. The local terminology used by few mothers who heard or practice exclusive breastfeeding and corresponds with the who definition of exclusive breastfeeding ; "complete breastfeeding" or "absolute breastfeeding" or "pure breastfeeding." in other words, the term exclusive breastfeeding is not present in the local dictionary of majority of mothers interviewed, which indicates that there is little awareness or education about the meaning and importance of exclusive breastfeeding to mothers, and their children. Moreover, having no defined local terminology makes it more difficult to be remembered by mothers who are exposed to different terminology used by different health care providers.

After mothers were introduced to the definition of exclusive breastfeeding, they were asked whether exclusive breastfeeding could be useful to their children. Generally speaking, mothers seem to appreciate the potential benefits of exclusive breastfeeding for their children and themselves.

When mothers were asked about the potential benefits of exclusive breastfeeding after defining it by the moderator, most mothers were aware of the benefits of breastfeeding and could not see the difference between breastfeeding and exclusive breastfeeding. Therefore, mothers responses reflected good understanding of the benefits of breastfeeding in general. The mothers who considered exclusive breastfeeding useful were asked to explain why exclusive breastfeeding is beneficial to children, majority seem to be aware of these benefits to them and their children. Examples of benefits as expressed by mothers include; "increases child immunity against diseases e.g. diarrhea" and "increases child intelligence". One of the very few mothers who practiced exclusive breastfeeding from a village group said "my son whom I breastfed exclusively is so special among my children, he is the smartest and he rarely got sick ". The general understanding of the benefits of exclusive

breastfeeding by the majority of mothers was confused with breastfeeding without taking notice that giving fluids such as herbal drinks or other types of fluids is different from what is considered proper exclusive breastfeeding.

Overall, most mothers were able to mention the benefits of breastfeeding in general but without specifying in particular the benefits of exclusive breastfeeding which could be expected since the majority have not heard about it before.

Almost all mothers recognized the importance and benefits of breastfeeding to them and their children despite the slight variation in the nature and type of these benefits. Upon asking the mothers about the advantages of breastfeeding for them and their children, they mentioned many advantages such as; it protects from breast cancer; helps uterus to get back to its original size and can be used as a natural family planning method and others.

The main factors that contribute to motivating mothers to breastfeed their children as expressed by majority of them; are their knowledge of breast milk advantages on their baby health and development.

In addition, the majority of mothers motioned that breastfeeding strengthens bonds between mothers and their children. One participant from Jenin city said" I have very strong bond with my child who I breastfed for long period of time, he is so attached to me and to be honest I love him the most among his brothers".

Other mothers mentioned the preventive benefits of breastfeeding as many stated that it prevents diseases such as preventing cold and diarrhea and strengthens the immunity of children. A mother from mentioned an interesting story and she said, "I use my breast milk to relief my child nasal congestion, when he develops flue or cold during winter, I put some drops of my milk in his nose to help him breath and eat better".

Another mother said, "breast milk is a gift from God and a natural thing that we have which can help our children to grow stronger and healthier". Another mother said "breastfeeding is a blessing from God and always available with us as mothers".

The same observation can be applied to other advantages of breastfeeding, where mothers focused on the protection from breast cancer but no one mentioned the importance of breastfeeding in reducing post-delivery bleeding, chances of anemia, and helps the mother regain her normal figure. In addition, mothers had not mention any other health benefits

during adulthood years for children who are breastfed such as they become less prone to develop diabetes, heart diseases, eczema, asthma and other allergic disorders.

In addition, most of the mothers mentioned that breastfeeding boosts child's intelligence. This is an interesting finding especially with this high level of responses. Although studies have not until now shown any significant link between breast fed children and their level of intelligence and concluded that breast feeding does increase children's intelligence when compared to those who are not breastfed. However, these studies found out those more intelligent mothers to breast feed their children more than mothers of lower intelligence or intelligence level (Hardy SC. Et al.: 1994).

In general these findings reaffirm the fact that mothers are generally aware of the importance of breastfeeding. On the other hand, it was important to explore the reasons for not practicing exclusive breastfeeding by mothers who indicated so. They expressed their conviction that breast milk would not be enough to fulfill their children hunger and there is always a need to add extra fluids and foods to help children grow, gain weight and become healthier. A mother said "providing breastfeeding only and especially for long duration would not be enough for my daughter therefore, I need to give her herbal drinks to make sure that she is getting enough". another mother said "my sister in law gives her son who is 4 months old breast milk only but he looks pale and his general health is not good, he needs to eat food especially that his mother leaves him for long period when she goes to work , in addition her diet is so poor".

There are many reasons that affect mothers' choice or decision to exclusively breastfeed their children. Although the results of the focus groups indicated that mothers believe, breastfeeding is important until 2 years and beyond of the child's age, almost all mothers acknowledged that children cannot depend on breast milk only in feeding their children without adding other types of fluids or food. Factors that prevent mothers from exclusively breast feed their children included " abdominal pain or distention", " child does not get enough milk from his mother ", "to increase the weight of the child as mothers' milk is not sufficient for the child to achieve comparable weight with other children of same age in the neighborhood" and " the child feels hungry after giving only breast milk".

Other reasons were s mentioned specific to mothers themselves such as "mothers' being ill", "mothers being busy either at home or at work outside the house", "too many children to care for in the family", and " lack of mothers' experience in breastfeeding specially

those who are married young" or “becoming pregnant". "breast problems" such as cracked or infected nipples were also mentioned as factors affect mothers’ ability to breastfeed their children exclusively.

An example stated by mothers for introducing fluids in the first months of the child life is that they believed that there is a need to give herbal drinks to “alleviate abdominal colic” as the most important factor behind not being able to breastfeed exclusively. One mother said " when my child suffers from abdominal pain, I have to give mixed herbal solution (called sqieh) which consists of sweet cumin, shomer, "sukkar feddi" (means silver colored sugar), yansoun (anisum), mehlab (cherry) all wrapped in a cloth and soaked in water, after retaining it for some time, I give it to my child to suck to relieve his abdominal pain". Another mother said, “I use sweet cumin in boiled water and after it gets cooled, I give it to my child in order to keep him sleep for hours".

Mothers also mentioned that their mothers and mothers in law insist on giving herbal drink like “yansoun (anisu), helbah (fenugreek), sukar fadi (silver colored sugar), kammon (cumin), mahlab (cherry), babonij (chamomile), shomer (fennel,), za’ter (origanum) and merameieh (sage) “to treat abdominal colic and distension and to keep children calm or sleepy even if they disagree with them. This came as a follow up on the question if mothers are convinced of giving the child these types of herbal drinks.

Since all mothers consider this issue as the most important hindering factor of exclusive breastfeeding, it is worth explaining to mothers in more details the fact that there is no treatment recipe for children abdominal colic. In addition, it is important to explain that breast milk is easier on the baby's and digestive tract than packaged formulas; therefore breastfed babies are also less likely to be colicky than those who are not breastfed or exclusively breastfed.

Occasionally, "colic,” "gassiness" and child crying can be improved by changing breastfeeding techniques. The reasons behind that if the mother switches the baby from one breast to the other during the feed, before the baby finishes on the first side, the baby may get relatively low amount of fat during the feeding. If the baby takes in a lot of milk (to make up for the reduced concentration of calories and because of the relatively low fat content of the milk), the stomach empties quickly, and a large load of milk sugar (lactose) arrives in the intestine all at once which is difficult to digest and the baby may develop abdominal colic.

Therefore, mothers should be advised to feed the baby on one breast, as long as the baby actually gets milk from the breast until the baby comes off himself, or is asleep at the breast. If, after "finishing" on the first side, the baby still wants to feed, the mother should offer the other side but the next feeding, the mother should start the baby on the other breast in the same way (Skinner JD., at al.:1997).

Nevertheless, mothers should be informed that most herbal treatments have not been thoroughly researched, particularly concerning lactation. "Natural" substances are not automatically safe and herbs are drugs, so it is necessary to use caution when using them and that applies for her and her baby. For example, the compounds coumarin and nicotinic acid found in fenugreek (helbah) can have very potent effects on heart rate, blood pressure, blood sugar, and other bodily functions. If a mother consumes fenugreek regularly in large amounts, her baby can experience these symptoms as well through breast-milk.

In addition, mother's belief of having insufficient milk to feed the child came up as an important issue that shakes her confidence of her ability to satisfy the baby's hunger. A mother said, "my womb is rich in nutrients and food much more than my breast milk". another mother from said," my milk is too thin and clear, my mother in law told me it can't satisfy my daughter so I started adding formula milk to grow up properly this concern seems to be one of the most common believes about breast milk among mothers in all districts, meaning that breast milk is important but not sufficient for children to gain weight as demanded by society.

This emphasize the importance of filling this gap in mothers' knowledge through educating mothers and those influencing their feeding practices such as mothers in laws, husbands and others. The health messages should demonstrate how the nutritional composition of breast milk could match the needs of the fast growing baby, goes through different stages of lactation: colostrum, transitional milk and mature milk. In addition, mothers need to know that mature milk changes during the length of a single feed to suit the needs of a baby. Mature milk looks thinner and more watery than cow's milk, which might be sometimes confusing to mothers. In addition, the milk that flows at the beginning of a feed is called foremilk, which is low in fat and high in lactose, sugar, protein, vitamin, minerals, and water. As the feed goes on, the milk changes to hind milk, which is richer in fat.

Although the differences between foremilk and hind milk might appear as an academic matter, it really affects the baby's fulfillment and satisfaction (Breastfeeding Promotion and support Module 2005).

Stating the above-mentioned message might not convince all mothers, where some of them might still be concerned about "not having enough milk for her child." although in most cases this fear is unnecessary. Mothers need to be assured and supported by clear and convincing information and successful experiences that are sensitive to mothers' concerns. For instance, mothers should be educated to watch for the signs that indicate her baby is getting enough milks such as wet diapers, bowel movements, swallowing sound, growing well …etc. at this point, the importance of promoting educational messages comes to play a crucial role by providing hints to mothers to help them avoid and manage breastfeeding problems and support successful breastfeeding practices.

This would also necessitate targeting mothers who experience having too little milk to feed their children especially with young and newly married women. In this case, educational messages should tackle these women's needs and to consult with lactation specialists or experienced mothers to increase milk supply. In addition, there should be provision of useful and practical tips to increase milk production such as telling the mother about the fact the more milk is drained from breasts the more milk will be produced as well as the importance of well positioned and correctly latched-on baby. .

Few mothers reported that they believe that exclusive breastfeeding affects child's liking to food and it is important to prepare the child to accept homemade food. Consequently, this can be as one of the limiting factors that prevent mothers from breastfeeding exclusively. Many mothers indicated that introducing fluids and foods in the early months of the child's life receives strong support, encouragement, and pressure by experienced grandmothers and mothers in law in order for the child to get used to homemade food. This gives an indication about the importance of providing mothers with proper information about effective feeding practices and providing her with suitable tips on how to introduce foods to the child at appropriate age without being concerned about his rejection to food.

In addition, some of mothers stated another factor that can prevent from exclusively breastfeed their children such as "the enrollment of mother in higher education that forces her to bottle-feed her child". This was more prevalent in Jenin city groups as mothers have higher percentage of enrollment in higher education compared to other groups. This can

imply that health messages should provide mothers in such category (working mother) with alternative solutions to provide her child with his/her needs while she is away like manual expression of milk, proper storage of milk and spoon-feeding. A mother from Jenin city said, “when I go to the university, I am obligated to switch my child to bottle feeding that can be given by my family".

Interestingly, few mothers in different groups mentioned mothers’ lack of interest to breastfeed their children as well as their concerns and anxiety about their weight and figures are among the hindering factors to practicing exclusive breastfeeding. A mother in Jenin city said, “exclusive breastfeeding requires vast commitment and time from the mother which is in a way very constraining and demanding and to be honest I do not have interest and time to do so” again, mothers workload should be considered as part of any effort to attract them to follow proper exclusive breastfeeding practices which requires different types of interventions such as help women to better plan their pregnancies.

Yet, in almost all groups mothers said that if proper reasons are given – emphasizing benefits to the child – mothers would listen: “if you give us advice and we find it good for our children we don’t mind following that advice.” Mothers in Jenin city mentioned that they would welcome information through discussions supported by leaflets.

6.4. Home remedies

The most common health problems experienced by children across all groups were: fever, diarrhea, vomiting, abdominal pain, cough, tonsillitis, common cold, nasal congestion, laryngitis, chest infection, and difficulty breathing. In addition, jaundice was mentioned but not as a problem, as mothers considers it to happen to all children. A mother said “All my children had jaundice after birth and it goes by itself, I never worried.”

More mothers mentioned diarrhea in the camp group, and in the city group respiratory tract infections were mentioned more frequently. Diarrhea and RTI were mentioned equally in the village groups.

Mothers were able to define common childhood illnesses, and danger signs. Mothers mentioned that they get concerned and harry to the doctor if their baby is sleeping

excessively, or a sudden change in feeding behavior (has to be repeatedly awakened to nurse or can't stay awake for feedings), showing inability to sustain sucking or nursing, showed decreased movements, or change in color (pale, or bluish), or unusually crying.

The main concern of all mothers was when their baby's develop fever. They define fever as increase in temperature. They know that their baby has fever by putting their hands over the baby forehead. Some mothers said that they don't only depend on touching the baby to compare his skin temperature with her; they only depend on thermometer at home.

Herbal remedies are seen as essential in caring for the baby's health, and consequently liquids are given almost immediately after birth.

In general mothers use herbal remedies, even that they don't know it is consequences on their baby's health. This area worth further studies, mainly study the long term effect of herbs widely used in Palestine (Abed Y, 1993).

Mothers are giving their baby's herbs as advised by their mother's and mother's in law. Mothers claimed that this was one of the main reasons behind excessive use of herbs.

Interestingly even mothers who have university education, mentioned that they use herbs as home remedies. No differences among group's responses were noticed in reference to either mother education or equitation.

6.4.1. Diarrhea

Mothers across groups said that signs which alert them to the fact that their child has diarrhea are: fever, type of stool: consistency, smell, presence of mucous, frequency of stool (more than five times a day), persistent vomiting, smell of vomit, dehydration, sunken eyes, yellow skin, wrinkling of abdominal skin. Frequent demand for water was also mentioned in the camp groups.

In such situations, the mother is the primary caregiver and the sick child is first treated in the home. The common traditional remedies practiced in the village homes consist of giving the child boiled oats, "cast" made of egg yolk applied to the abdomen, tea without sugar, and boiled ja'ada. Some common remedies between the village and the camp communities included starch with lemon and water, salt and sugar to "compensate for what they have lost," soup with mashed potato, boiled mint, "cast" made of mint, and boiled rice

water (starch). Mention was made in the camp groups that if they have the "solution" (ORS) at home they prepare that for the baby.

Mothers in the village groups mentioned a variety of other home remedies such as: boiled mint with rice water, boiled mint and maramia with rice, boiled pomegranate skin, boiled maramia and cumin with rice water, a cup of 7 Up, "cast" made of cumin and mint spread on baby's belly. One mother in a village group also mentioned making a mixture of basil, mint, onion and vinegar, which she then spread on the baby's body. She also gave the child coffee with lemon; yogurt; suggested continuous breastfeeding and immediately discontinuing formula; and discontinuing all kinds of "zaffar" (e.g., meats).

In the village mothers mentioned that two treatments - the "cast" made of egg yolk, and boiled ja'ada - are used to determine if the diarrhea is weather related (from cold) or from a micro-organism; both remedies are believed to "help stop the diarrhea" and the cast also helps to support the child's abdomen. If the diarrhea does not stop after using the cast or boiled ja'ada they immediately take the child to the doctor. In the case of the other remedies, when these fail to cure the child or the signs and symptoms are particularly severe, s/he is taken to the hospital; it could be anywhere from 1 day to 7 days later, but typically the family waits for 2-3 days. The doctor usually asks if the child is being breastfed; if the answer is yes, then the doctor says there is nothing to worry about, and that s/he will recover.

In the village groups most mothers believe that these remedies are effective if the diarrhea is due to a cold, but that if the baby doesn't recover they wait until the second day (maximum) and then take the baby to the hospital; they also believe that if the diarrhea is a result of other factors, they don't wait "too long" and take the child for a consultation to the doctor.

Most mothers said they learnt of these home remedies from experience ("we've used it before and it was effective"); their mother's, mothers-in-law ("they used it before and we use it now), and other older ladies who are neighbors; and, doctors. NGOs also play an important role in providing information – mothers in the village mentioned PMRS, training received (on diarrhea treatment and nutrition); in the camp, mention was made of UNRWA clinic.

Most of the mothers across the groups mentioned that they treat girls and boys the same when it comes to treatment of diarrhea; this point was emphasized by the mothers in the city group. One mother in the village said that though "in her heart she loves the boy more" she still treats them the same because "it's a sin to mistreat girls." Another mother in the camp said that when girls are sick they should be treated better "as boys can live anywhere in the streets" but they cannot leave girls anywhere, suggesting that girls are "weaker."

After first saying that "there is no difference between boys and girls" one mother in the village said "do you want me to lie, I swear there is a difference;" another agreed that "while we look after both our hearts shift more towards boys more than the girls." The explanation given for doing this was "girls are stronger" and that "God takes care of them – they recover faster."

6.4.2. Acute Respiratory Infection

Mothers across groups mentioned that their children suffer from respiratory tract infections due to: sudden weather changes (from warm to cold when bathing or waking from sleep) and the carelessness performed by the mother. Some mothers in the city also mentioned weak defenses if very small child, "hereditary" (for conditions such as asthma), and catching infection from other children.

In the camp, other reasons mentioned were: children exposed to fans and cool air when sweaty (e.g., upon waking up); milk bottles that have not been cleaned properly and have germs; mothers are careless and do not dress children sufficiently well for the weather.

Mothers are aware of danger signs and were able to name different signs. Signs that alerted mothers in all groups to the fact that their child has a respiratory tract infection were: fever of 39-40 C; cough; tearing eyes; pale face; vomiting; runny nose; constant coughing resulting in vomiting and/or fainting; cannot suck; "crackles" (i.e. congested breathing). Some mothers in the camp group also mentioned that the child's face turns "blue," the child is uncomfortable while being breastfed, and becomes lethargic/has no energy.

The mothers said that once they notice any of the danger signs they rush immediately to the doctor, seeking medical care for their baby.

The mothers said if the baby only have common cold- defined by mothers as mild symptoms of little cough or runny nose- they don't take the baby to health provider, they treat baby at home. Mothers across all groups said that parents ask for help from mothers-in-law after they have first tried their own remedies like giving cold pads to decrease the temperature.

The mothers make herbal fluids by boiling maramiya (sage), babonage (chamomile), ge'da al subian (crinkle herbs), or guava leaves for the children to drink as well as to inhale. They'd learned of these remedies from their own mother's and mothers-in-law. Other common practices across the groups included massaging the baby's chest with simsim (sesame) oil, and dipping a piece of wool or cotton in oil and leaving it, overnight, on the child's chest.

Practices that were different in the village included wrapping a small comb in a sheet around the navel to "prevent envy," reading from the Quran on the baby's head to ward off envy different, putting a piece of dough with mint on the navel with an opening in the middle "to allow for breathing," and putting coffee on the child's mouth in case of sore throat. In camp they stopped giving the child formula. Mothers claimed that these practices are highly advised by their mother's and mother in law. They believe that they are good for their babies, as their mother's and mother in law practiced the same while caring of them. A mother said "I am doing the same things my mother did caring of me while I was a baby, as I am enjoying being healthy, and I want to do the same for my baby."

Mothers across all the groups said that these traditional remedies have proved successful.

The family decides to take the child to the hospital if the fever remains at 39-40 C and the other symptoms do not go away. Mothers across groups mentioned that they prefer to go to the hospital emergency room if their husbands are around to take them, if not they go to the nearest doctor, mainly private health providers.

Most of the mothers said that their babies are prescribed medication (they were not able to recall the name of prescribed medicine) by private doctors, and they give their baby's the treatment as recommended.

All mothers insisted that there is no discrimination in favor of boys; on the contrary, they were more sympathetic to girls "because girls are weak in our Arab culture."

6.4.3. Jaundice

Mothers in all groups defined jaundice as yellowish discoloration of skin. A mother said "One easy way to check for jaundice is to press a finger against baby's skin, for a while. Normal skin will turn white when you do this, but jaundiced skin will stay yellow."

Some mothers said that they also notice that in addition to yellow skin their babies showed to have fever and not feeding well.

Mothers were not able to name danger signs of jaundice or when it is necessary to take jaundiced child to the doctor. Mothers didn't mention if the jaundice spreads to the arms or legs or if it lasts beyond 1 week, child appears ill to you (if he or she is refusing to eat, seems excessively sleepy, or has floppy arms and legs) or has a fever as signs that necessitate contacting the doctor.

Mothers are aware of home care of jaundiced child as recommended by their doctor. They pointed to the importance of increasing breastfeeding. A mother mentioned that she places her child in a place where he can be indirectly exposed to sunlight, as placing him close to a window.

Mothers said that they experienced hospitalization of their children when doctor told them that jaundice test showed high level, and their babies place under special type of light.

A mother said "my baby's bilirubin level was very high and appeared ill, and he was admitted to the hospital for treatment.

6.5. Bathing, warming and skin care

Mothers across groups recognize that coldness is a problem in newborn, and take action to prevent it. Practices to keep baby worm include wrapping the baby with several pieces of soft cotton cloths, and covering the baby with blankets.

Mothers recognize that bathing can make the baby cold, accordingly mothers in village group said that they avoid bathing the baby if the weather is cold or if the baby is sick.

The table (Table 7) below shows bathing patterns, most babies is bathed on the day of birth and on daily basis using warm water and soap.

Table 7: Bathing practices:

Bathing practices	City	Village	Camp
Baby bathed on day of birth	100%	80%	100%
Mother bath the baby	90%	50%	80%
Mothers of mothers or mothers-in-law bath the baby	20%	70%	30%
Bath baby daily	80%	90%	70%
Wipe baby in bath	Not mentioned	30%	Not mentioned
After bath massage baby oil on skin	50%	Not mentioned	Not mentioned
After bath massage olive oil on skin	Not mentioned	60%	20%

Some mothers avoid bathing the baby on the day of birth as they had the fear that the baby was vulnerable to cold if bathed earlier. Other said that they avoid bathing the bay because baby was sick and the weather was cold.

Mothers across the city and camp groups confirmed bathing the baby on the day of birth.

Mothers across groups said that they bath their babies daily, more than 5 times a week.

Mothers didn't know that infant doesn't need much bathing if they wash the diaper area thoroughly during diaper changes. Three times a week during babies first year may be enough. Bathing more frequently may dry out baby's skin, particularly if soaps are used or moisture is allowed to evaporate from the skin.

During her first week or two, until the stump of the umbilical cord falls off, newborn should have only sponge baths.

Mothers mentioned that they bath their babies in a warm room, laying the baby anywhere that's flat and comfortable, bed, floor, or counter next to the sink. In addition they prepare all what they need for the baby bath in advance. A mother mentioned that she used to use her baby soft clothes to wash her hair and rub her skin.

Differences between group was obvious regards practices performed after bathing the baby, in the city group some mothers massage the baby with baby oil to smooth skin, while in the village and camp they massage the baby with olive oil, to smooth skin. In village group some mothers said that they massage baby with holy water to protect from devil eye.

Good cord care practices reduce the incidence of neonatal morbidity and mortality from neonatal infections and tetanus. While cord care practices vary from place to place, some of can be harmful to the new born. To identify the practice of cord care, mothers where asked about the traditional practices of cord care performed.

Some mothers in village group reported putting applying ash to accelerate the separation of the stump. This practice is often harmful, because these substances are often contaminated with bacteria and spores, thus increasing the risk of infection.

Traditional cord dressings may include the use of cow milk, ash and herbal preparations. These are practices that promote neonatal infections instead of preventing it, thus should be discouraged.

Mothers in the city group said that they apply medicine that was recommended by the doctor or a friend to prevent infection and accelerate separation.

Interestingly, mothers in city group said that they care more about their female baby's cord more compared to male babies. A mother said "we care more about our daughter umbilicus because umbilicus look is important for female as it is part of her belly, and adding to her beauty. Compared to male, where it is not a matter for him or his surrounding if his umbilicus didn't look pretty." This is the only topic where mothers mentioned difference in treating males compared to females.

All mothers are aware and knowledgeable in regard to signs of infection, naming redness and discharge. All said that they seek medical advice from doctors; mothers at Jenin city group said that they seek private doctor advice, compared to village mothers group who said that they go to MoH clinic and camp group who mainly seek medical service at

UNRWA clinic. Mothers across groups do not perform any special care for the umbilical area after the stump fell off; care is provided as part of the whole skin care.

A mother mentioned that she didn't have a problem during the period of cord care, she said "if it is not infected why to worry, it will fall spontaneously at the age of one week."

Few mothers mentioned applying alcohol as part of cord care. There have been various reports on the use of alcohol as a cleansing agent (WHO 1998). However recent reports revealed that the use of alcohol has more adverse effect than being beneficial, because it causes the cord to dry up quickly. It also prolongs the period of separation of the cord (Janssen P., et al.:2003).

Mothers should allow it to dry naturally, which is now being advocated in some reports (Weathers L. et al.:2007). Regardless of the current umbilical cord care practices in use, it is important to educate mothers and health providers on the proper topical application and care of the umbilical stump, as well as the risks and benefits of any cleansing agent used and symptoms of adverse toxic effects associated with the cleansing agent.

Teaching should also include education regarding the normal appearance of the umbilical stump especially if a drying agent is not utilized, the local and general signs of infection and the expected length of time for the cord separation to occur; this will either prevent or reduce the morbidity and mortality associated with this preventable condition. The community workers should have special role during conducting home visits, as they can have important role educating about neonatal infections and care of the cord. Health education should target mothers and mothers in law who has high influence on mother's practices.

Mothers also discussed different wrapping practices (Table 8), as part of their newborn care practices. Emphasizing the role of mothers in law in the wrapping the baby.

Mothers who use to wrap their babies with "Koflayeh" said that it protects baby's back and help them to hold their baby. Mothers from city group said that they don't recommend using it as they believe it limits the baby ability to move freely and move his/her hands. In addition they said that free movement of the baby is important for baby's development, as it important for baby to watch his/her hands.

Table 8: Wrapping practices

	City	Village	Camp
Wrap the baby tight with "Koflayeh"	10%	60%	15%
Mothers -in-law wrap the baby	10%	50%	10%
Mothers wash the baby each time they change diapers	80%	100%	100%
Mother use wit tissue rather than washing the baby when change their diapers	10%	Not mentioned	Not mentioned

6.6. Sources that influence newborn care practices

Almost half of mothers from all regions indicated that the main influence that affects mothers' newborn care practices is the power of the mother in law; as she is considered experienced, and an authority figure that mothers especially young ones cannot avoid as a sign of respect (see table 9). Moreover, listening to mothers in law helps mothers to avoid blame in case something goes wrong with the health of their children. In addition, husbands were considered by mothers as one source of influence on how mothers breast feed their children especially in exclusive breastfeeding. This is explained by the desire of husbands to have more children and to become pregnant while dealing with large responsibility in providing huge household work and serving large size families. These factors are linked with also the ability of mothers to have the time, energy and awareness to breast her child exclusively for six months.

Table 9: type of people who influence mothers' newborn care practices

Influential	Jenin City	Village	Camp
Number of participants	79	83	78
1. Mother in law	30%	44%	50%
2. Mothers' experience	29%	21%	19%
3. Husbands and his mother	Not mentioned	12%	8%
4. Sister in law and sisters	13%	5%	20%
5. Health professionals	23%	Not mentioned	3%
6. Child condition	Not mentioned	9%	Not mentioned
7. Religious people	5%	9%	Not mentioned

Some mothers mentioned that mothers in law demand that their daughters in law introduce herbals for sick children. One mother said, "my mother in law and my husband forced me to give my child chamomile (babonej) when he was one months old so as he was complaining of cough". In another case, one of the mothers said, "my husband forced me to give my baby medication who is prescribed to one of our relatives, as my baby was complaining of diarrhea, without taking my baby to a doctor".

Other sources of influence were sisters in law. In Jenin city and camp mainly as mothers indicated that their sisters in law play a role in influencing their newborn care practices as they can demonstrate the child is not looking healthy enough through comparing weights and looking of children and thus convince mothers of introducing fluids, remedies, and food that make children gain more weight so as to be comparable with others.

Moreover, a mother in law who had successfully convinced of the importance of exclusive breastfeeding and other positive traditional newborn care practices can play a tremendous role by convincing their immediate married son, and relatives, demonstrating how healthy practices can be of benefit for the child and his family. A mother said " I would like to take care and feed my baby the food I think is right for him especially continuing breastfeeding without additions, but my mother in law give my child other food or remedies if sick while

I am not at home or busy doing stuff at home". This story gives an indication that mothers are not the only one that should be targeted in promoting exclusive breastfeeding, and positive newborn care practices; other influencers should be involved to cover the different dimensions of such practices.

Social and cultural beliefs mixed with religious practices can also influence mothers newborn care practices. Religious motivation can have some influence one of the mothers said " I breast feed my son but he was very colicky and irritable child and always crying, people advised me to take him to a traditional healer who is also religious, he told me that my child is crying and acts abnormally because of my breast milk influences with what I eat, so he asked me to watch what I am eating, and I did".

6.7. Health topics of interest

Mothers across all groups mentioned a range of topics on which they would like information; the most common topic was postpartum care (how to keep the mother safe and healthy after delivery). In one Jenin city group mothers said they wanted information on exercise and diet after delivery so they could “get back in shape.”

Other topics included:

- care of woman during pregnancy, particularly high risk pregnancies
- stages of fetus development
- how to assist in emergency deliveries
- nutrition for baby: when and what to feed
- how to breast feed
- weaning practices
- how to space between deliveries
- care of the new born
- monitoring growth and health of child
- common childhood diseases and how to care for the baby
- topics on mother’s health mainly related to breast related problems (pain or discharge)
- information on first aid, e.g., fractures, shocks, burns

Typically mothers receive information from other mothers, particularly from mothers-in-law and their own mother's; in the city groups several mothers mentioned women's magazines and the local television station, Farah.

Across all groups mothers said they liked the discussion format of the focus groups (also referred to as "debates" by some groups in the camp groups), but rather than give information they would like to receive information from experts, i.e. doctors. They would also like to view audiovisual films, and receive pamphlets/brochures but only in the context of a discussion.

6.8. Conclusion

Mothers are not aware of postnatal care service and it is importance. Regardless that the service is provided at no cost at MoH and UNRWA clinics, there is low uptake of the service, which is not only caused by the mothers limited knowledge but also to service provider attitude in addition to other barrier which is simplified by the dominant role of mothers in law and husbands who are not supportive of such visits unless the mother is experiencing a problem.

Mothers value their babies from the moment of conception which justify the high uptake of antenatal care. They seek medical service during pregnancy but after birth they seek medical service only if they experience a problem, or to take their baby to the doctor seeking medical service, vaccination of to perform the PKU test.

Mothers are knowledgeable about breastfeeding advantages however they are not committed to exclusive breastfeeding.

There several challenge facing the adoption of exclusive breastfeeding by mothers as in many other cultures and contexts. Exclusive breastfeeding is not known, understood, appreciated or relevant given the different cultural, traditional, economic and health system factors that shape such practices. Promoting exclusive breast feeding has also another challenge similar to challenges of changing health behaviors that people can't realize their benefits to the individuals and societies. In addition, there is not yet an easy answer to many cultural and social queries surrounding best practices in terms of what food, what age and how much should be given to children under the age of one year. This would necessitates that health care providers and policy makers need to incorporate these understanding in their health promotion and mobilization programs and to take into consideration the complexity of the issue at hand.

Therefore, most of barriers and misconceptions are influenced by previous experiences and traditional practices used by mothers over generations. The positive aspect of such practices is the fact that most mothers are concerned over the health and well-being of their children more than other factors. This positive motivation if used constructively by health workers can in the long run be used to change the negative practices to positive ones given

that mothers are convinced that such change can lead to improvement in the health of their children.

Nevertheless, mothers should be informed that most herbal treatments have not been thoroughly researched, particularly concerning lactation. "Natural" substances are not automatically safe and herbs are drugs, so it is necessary to use caution when using them and that applies for her and her baby. For example, the compounds coumarin and nicotinic acid found in fenugreek (helbah) can have very potent effects on heart rate, blood pressure, blood sugar, and other bodily functions. If a mother consumes fenugreek regularly in large amounts, her baby can experience these symptoms as well through breast milk.

This emphasize the importance of filling the gap in mother's knowledge through educating mothers and those influencing their feeding and newborn care practices such as mothers in laws, husbands and others. The health messages should demonstrate up to date information's along with adopted protocols and guidelines.

Stating health messages might not convince all women, they need to be assured and supported by clear and convincing information and successful experiences that are sensitive to mothers concerns. For instance, mothers should be educated to watch for the signs that indicate her baby is getting enough milks such as wet diapers , bowel movements, swallowing sound, growing well …etc. At this point, the importance of promoting educational messages comes to play a crucial role by providing hints to mothers to help them avoid and manage breastfeeding problems and support successful breastfeeding practices.

Interestingly, mothers in camps showed to have better knowledge and reported healthy practices, in contrast to village mothers who rely more on traditional remedies.

Social and cultural beliefs mixed with religious practices can also influence mother's newborn care practices. Religious motivation can have some influence One of the mothers from a village group said " I breast feed my son but he was very colicky and irritable child and always crying, people advised me to take him to a traditional healer who is also religious, he told me that my child is crying and acts abnormally because of my breast milk, so he asked me to stop breastfeeding, and I did".

It is apparent that mothers react differently to child's illness. Mother's reaction and behaviors are dictated by the local culture, social system, traditional practices, mother's

role in society, socioeconomic factors including access to health and social services. Therefore, health behaviors and feeding practices should be dealt with carefully while addressing the general conditions while appreciating the uniqueness and peculiarity of each family and child.

The focus groups discussion managed to explore somewhat good and bad newborn care practices, factors influencing such practices and possible ways to improve them. In addition, it is observed that the interviewed mothers knowledge, attitudes and practices about newborn care practices are influenced by their mother's and mothers-in-law who are utilizing their social, religious and traditional authorities. However, in spite of the satisfactory level of knowledge among the interviewed groups, it was obvious that most of them lack the proper knowledge and information to enable them to provide accurate newborn care practices. In many ways, they base their experience on the cumulative knowledge they received from different sources including their own personal experience and the surrounding influence.

Recognizing the role and contribution of influential people can help in improving health practices aimed at improving the health of women and children. Unfortunately, there is a tendency to marginalize or antagonize the role of traditional health care providers (conventional health care providers) and in many ways create a negative environment which decreases the trust and cooperation among the different types of key informants. Consequently, this can leave mothers with conflicting messages and opinions on the different aspects of feeding and raising their children.

6.9. Recommendation

Research Methodology:

- Qualitative research is essential to address public health issues and it underling factors; providing a human face for undergoing circumstances.
- Qualitative research is a mean of empowering study population not only to be involved in explaining an issue of concern but also in providing suggested solutions to overcome these issues from their perspectives.

Health providers and policy maker:

- Postpartum care is as importance of antenatal care; accordingly special emphasis should be given by policy makers and health providers to promote postpartum care.
- Health providers may need special training regarding delivery of postnatal care according to postpartum protocols and guidelines adopted by the MoH.
- Families seeks different health providers, accordingly there is a need to have an integrated comprehensive health care services across health providers to provide consistent service according to the National adopted protocols and guidelines.
- Women should be supported through comprehensive community-based and outreach program to help mothers prevent and manage common newborn problems, feeding difficulties, illnesses, and weaning practices.
- Scaling up of the PMRS postpartum service provided by community health workers for clinic's beneficiary. As this service is not only providing follow up to mothers at home but also highly recommended by mothers who received the service.
- Most of barriers to exclusive breastfeeding and misconceptions are influenced by previous experiences and traditional practices used by mothers over generations. The positive aspect of such practices is the fact that most mothers are concerned over the health and well-being of their children more than other factors. In addition, to their knowledge of breast milk advantages on their baby health and development. These positive motivations if used constructively by health workers can in the long run be used to change the negative practices to positive ones given that mothers are convinced that such change can lead to improvement in the health of their children.

- Health providers when trying to change mothers feeding practices need to appreciate and recognize mothers believes and logic behind providing herbal mixture is useful to alleviate or reduce the abdominal colic that occurs with children especially in the first months of the child's life.

Health Education/Promotion:

- Health educational materials should contain accurate and culturally sensitive and consistent messages about exclusive breastfeeding, optimal breastfeeding practices and newborn care practices that focus on context-specific aspect of behaviors.

- Identification of appropriate channels for messages should take in to consideration the characteristic of the target groups is a key factor for spreading information. In some communities verbal communication and discussion is more effective than written material. Given that mothers prefer and trust their private and personalized counseling during home visits. It is recommended to promote the role of community health workers and community nurses in the promotion of importance of positive practices.

- Tailored education programs and health messages should target mothers and mothers-in-law, in reference their level of education and role in society. Mothers cannot escape the influence of their mother’s or mothers in law especially that many of young mothers resort to them for helping them in feeding their children. In addition to being influencer promoting positive practices mothers and mothers in law may promote negative practices, as inherited from older generation.

- Health education programs should be tailored to address mother’s occupation. As for working mother, health messages should provide with alternative solutions to provide her child with his/her needs while she is away like manual expression of milk, proper storage of milk and spoon-feeding.

- Mothers require more specific information on the signs of growth and healthy development including the need to advocate and request that government and nongovernmental health care providers continue to provide growth monitoring. This needs to be coupled with educational programs and policies that encourage and educate mothers to monitor children growth.

Areas to be explored:

- As mothers are extremely concerned about their children intelligence, as most of the mothers mentioned that breastfeeding boosts child's intelligence. Conducting further studding directly correlating relation of exclusive breastfeeding to children intelligence comparing breastfed to those who are not breastfed. Using evidence based practices, will highly motivate mothers to exclusively breastfeed.
- Further research should take place to study the effect of wide used home remedies and herbs, as they are popular in the Palestinian community.

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Appendix (1): Key questions targeting mothers of children 0-6 months old

Suggested Key Questions	More probing questions	Guidelines
Postpartum care: Do you seek postpartum care (care after delivery)	Where do you seek postpartum care? When do you seek care? Who support of prevent you from seeking care? Who are the main influencers on you to seek care?	This question should be used as a warm up to the topic discussion. A quick around the circle response should be elicited from each mother.
Feeding practices: Exclusive breastfeeding **Have you heard of the term "exclusive breastfeeding" and if so what do you think this means? Where did you learn about exclusive breastfeeding?**		This question should be used as a warm up to the topic discussion. A quick around the circle response should be elicited from each mother. At the end of this quick exercise, the moderator share the WHO protocol for exclusive breastfeeding (breast milk only – no other fluids, water, food or herbs – for the first six months), without stating this definition in an authoritative way – but more just to present the idea.
Do you think that breastfeeding is important for your child and if so, why? If not, why not?	How might your child benefit from breastfeeding?	
What influences would affect your ability to breastfeed your	What kind of difficulties would exclusive	

Suggested Key Questions	More probing questions	Guidelines
child exclusively and why?	breastfeeding pose for you and why?	
Home remedies **How do you know that your child is ill?**	How do you define diarrhea, acute respiratory infection and jaundice?	This question should be used as a warm up to the topic discussion. A quick around the circle response should be elicited from each mother.
	What are the most common symptoms?	
	How do you deal with your ill child?	
	Who or what influence you about caring of ill child?	
Who is the main health provider you seek service from?	Why you chose this health provider?	
Bathing, care of umbilical stump, thermal and skin care: **How do you give your baby a bath, warm and care of skin?**	How often you? Pattern of care?	
Are there any differences male and female children in how you treat them and if so why?	Why are girls and boys treated differently?	
What type of information do you need that would help you improve your newborn care practices? **In what way should this information be provided and made available that can be useful to you?**		

Appendix (2): General Form for documenting responses of mothers during focus group discussions

الأسئلة الرئيسية (key questions)	الإجابات ملخص (main group responses)	التوافق في مدى الاجابات (level of consensus on responses)	حول وخبرات قصص ممارسات الامهات 'important and relevant mothers stories)

Annex (3): informed consent

كلية الصحة العامة – جامعة القدس
بحث كمتطلب لماجستير الصحة العامة
اسم الطالبة: تسنيم غالب خضر عطاطرة

الممارسات الأسرية والسلوكيات تلعب دورا أساسيا في رعاية الأطفال حديثي الولادة. فالتغذية غير السليمة وغيرها من الممارسات الخاطئة قد تعرض الأطفال لخطر حدوث مضاعفات وأمراض في المقدور تجنبها. وبالتالي فإنه من الأهمية فهم تصورات المجتمع حول صحة أطفالهم و استكشاف الممارسات المختلفة في رعاية الأطفال.

الهدف الرئيسي من هذه الدراسة هو استكشاف الممارسات الإيجابية والسلبية في رعاية الأطفال حديثي الولادة بين أمهات أطفالهم في سن 0-6 أشهر. تستهدف الدراسة ثلاثة مواقع في محافظة جنين في الضفة الغربية.

نرجو منكم المشاركة في اثراء النقاش من خلال مشاركتم في مجموعات النقاش. ونأمل منكم المشاركة بموضوعية تامة. ان المعلومات الواردة في النقاش ستستعمل لأغراض البحث العلمي فقط.

شاكرين لكم حسن تعاونكم

الباحثة: تسنيم عطاطرة

تقييم العادات والسلوكيات المتبعة في رعاية الأطفال حديثي الولادة في محافظة جنين

تسنيم غالب خضر عطاطرة

ملخص الدراسة:

تناولت هذه الدراسة الممارسات والسلوكيات الأسرية دورا أساسيا في رعاية حديثي الولادة. فالتغذية غير السليمة وغيرها من الممارسات الخاطئة قد تعرض حديثي الولادة لخطر حدوث مضاعفات وأمراض كان من الممكن تجنبها باتباع العادات السليمة. ومن هنا برزت أهمية فهم تصورات المجتمع حول صحة أطفالهم و استكشاف الممارسات المختلفة في رعاية حديثي الولادة.

وكان الهدف الرئيسي من هذه الدراسة هو استكشاف الممارسات التقليدية الإيجابية والسلبية منها لرعاية حديثي الولادة وأنماطها والعوامل الرئيسية وراءها بين أمهات أطفالهن في سن 0-6 أشهر. واستهدفت الدراسة ثلاثة مواقع في مناطق جنين في الضفة الغربية.

أما منهجية الدراسة، فكانت دراسة نوعية من خلال اجراء 24 مناقشات جماعية مركزة مع أمهات الأطفال أعمارهم 0-6 أشهر موزعة بين ثلاثة تجمعات سكنية (8 مجموعات في مدينة جنين ، 8 مجموعات في قرية السيلة الحارثية في محافظة جنين ، و8 مجموعات في مخيم جنين). وتم تحليل البيانات وتصنيفها باستخدام تحليل مضمون الردود التي تم الحصول عليها حول مسألة أساسية.

وأظهرت النتائج الرئيسية للمناقشات الجماعية المركزة أن ممارسات الأمهات أكثر تشجيعا للممارسات المثلى في رعاية حديثي الولادة. وأظهرت المنافشات أن الأسر المقيمه في المدينة ومخيم جنين مقارنة بالأسر المقيمة في المناطق الريفية في جنين أقرب الى المثالية، على الرغم من ذلك ما زال هناك حاجة ماسة للتحسين وتثقيف الأمهات في المدينة ومخيم جنين. شملت الدراسة الممارسات الروتينية المطبقة لرعاية حديثي الولادة بما في ذلك الاستحمام وتنظيف الطفل ، رعاية الطفل أثناء المرض وممارسات التغذية. الأمهات يدركون جيدا علامات الخطر من الإسهال والتهابات الجهاز التنفسي. فبإمكانهم تشخيص الإسهال، وتحديد وسيلة العلاج المنزلية الأكثر ملاءمة استناداً إلى ذلك؛ وتشمل العلاجات المنزلية، بين أمور أخرى، السوائل مثل الملح/السكر أو حل النشا مع الليمون والمياه، أو البيض الذي يتم وضعه كعجينة على بطن الطفل. وتشمل الممارسات الأخرى درء العين بقراءة آيات من القرآن

الكريم، والتفاف آيات مكتوبة في ورقة وربطها حول السرة. إذا لم يسترد الطفل عافيته خلال الإطار الزمني الذي يعتبر مناسباً من منظور الأم، يأخذ الطفل إلى الطبيب.

وقد أظهرت الأمهات عدم معرفتهم المسبقة بالتعريف الصحيح للرضاعة الطبيعية الخالصة. حيث أجمعت معظم الأمهات أن الأعشاب تعتبر عنصرا أساسيا في العناية بصحة الطفل، وبناء على ذلك يتم إعطاء السوائل على الفور تقريبا بعد الولادة. بالإضافة لإعطاء الرضيع بعض المواد الصلبة والسوائل على سبيل التذوق. أفادت معظم الأمهات أنهن يرضعن أطفالهن رضاعة طبيعية خالصة لمدة 4 أشهر تقريبا. وأفادت معظم الأمهات بدؤهم باعطاء أطفالهن المواد الصلبة بالشهر الرابع وتضمن الفواكه المهروسة ، الأرز باللبن، صفار البيض مع الحليب ،عصير الفاكهة، الحساء، الحبوب، الكبد، والخبز. أعربت الأمهات عن رغبتهن في معرفة كيفية إرضاع أطفالهن بشكل صحيح، واشتكين شح أو قلة وجود مصادر جديرة بالثقة للمعلومات التي تساعدهم على اتباع ممارسات التغذية السليمة. الاعتقاد السائد بأن إدخال الأعشاب، سيريلاك واللبن من الممارسات الشائعة وهم لا يدركون أن هذه الممارسات تتعارض مع الطريقة الصحيحة للتغذية، والرضاعة الطبيعية للطفل.

المصدر الرئيسي للرعاية الصحية يتباين بين المناطق، فالنساء المقيمات في المدينة تعتبر أطباء القطاع الخاص المصدر الرئيسي للرعاية الصحية، بينما تسعى الأمهات المقيمات في المخيم الى عيادة الأونروا أما المقيمات في القرية يسعين الى مقدمي الرعاية من الجمعيات غير الحكومية.

الأمهات للمرة الأولى يلتمسن المشورة في معظم الأحيان من حمواتهن أو من أمهاتهن، وخاصة إذا كانوا يعانون من مشاكل.

في حين أن الأمهات من جميع الفئات المذكورة أعربن عن رغبتهن بالمزيد من المواضيع حول رعاية أطفالهن ، وكانت المواضيع الأكثر طلباً تتعلق بتغذية الطفل والمرأة الحامل، كيفية الرضاعة الطبيعية وممارسات الفطام المناسبة، أمراض الأطفال الشائعة وكيفية رعاية الطفل المريض، الرعاية أثناء الحمل ولا سيما الحمل الخطر، والمباعدة بين الولادات. وتفضل الأمهات الحصول على المعلومات من خلال المشاركة بمحاضرات حيث تتاح الفرصة لهن بطرح الأسئلة والإشتراك بالنقاش .

ومن أهم مميزات هذه الدراسة أنها دراسة نوعية من خلال نتائجها تم استيحاء عدة توصيات. إن الترويج لممارسات سليمة في رعاية حديثي الولادة بين أمهات الأطفال أعمارهم 0-6 أشهر، يتطلب وضع استراتيجية شاملة لتعبئة المجتمع وتبني سياسة موحدة بشأن رعاية حديثي الولادة، واستهداف المؤثرين الإيجابيين على الأمهات والتشجيع على الممارسات السليمة ، وتصميم رسائل صحية تهدف الى تعزيز الممارسات السليمة وضحض الخاطئة منها ، وتوفير برامج مشورة وإرشاد تستهدف الأمهات ومن حولهم من المؤثرين الفعالين في السلوكيات المتبعة، ومعالجة العوامل والمسببات التي تمنع الأمهات من اتباع الممارسات السليمة واستهداف العوامل الاجتماعية والثقافية المؤثرة بشكل خاص على سلوكيات الأمهات المتبعة خلال رعاية أطفالهن. من المهم اشراك واستهداف الحموات، ومقدمي خدمات الرعاية الصحية، والقابلات و المعالجين بالأعشاب في البرامج الرامية إلى تعزيز الممارسات السليمة لرعاية الأطفال حديثي الولادة بين الأمهات.