Knowledge of Palestinian Girls & Women about HIV/AIDS: Behavioural Policy-Oriented Approach for Health Promotion

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1 Introduction

Over the past two decades, HIV/AIDS has emerged as one of the worst infectious diseases in modern history. The epidemic spread with devastating effects in Africa and is now sweeping with similar force in Eastern Europe, India, China, Thailand and many other transition economies around the world.

HIV/AIDS typically hits people of working age, as well as those of child-bearing and child-rearing age. Consequently, the spread of disease leads to the loss of skilled and unskilled workers, the main breadwinners, and caretakers of the family. The high morbidity and mortality rates among these groups can seriously undermine the social and economic foundations of a nation (The World Bank, 2005).

The Millennium Development Goals (MDGs) as stated in the global development framework adopted by the United Nations in 2000 for improving people's lives and combating poverty in a sustained and sustainable way by 2015 makes the clear statement of combating HIV/AIDS as a prime goal on the global agenda (United Nations Statistics Division, 2005).

One year later, at the close of the United Nations General Assembly Special Session (UNGASS) on HIV/AIDS in June 2001, 189 Member States adopted the Declaration of Commitment on HIV/AIDS. The Declaration of Commitment reflects global consensus on a comprehensive framework to achieve the Millennium Development Goal of HIV/AIDS epidemic by 2015. Recognizing the need for multisectoral action on a range of fronts, the Declaration of Commitment addresses global, regional and country-level responses to prevent new HIV infections, expand health-care access and mitigate the epidemic’s impact.

2 Background & Significance

From a global perspective, there were serious limitations to the data submitted in 2003 for the UNAIDS Progress Report on the Global Response to the HIV/AIDS Epidemic (Global Progress Report). For example, while almost all of the countries completed the National Composite Policy Index questionnaire, only 40% of the countries that submitted reports supplied information related to other national indicators. In addition, less than 20% of the national-level data submitted was disaggregated by gender, age, location, etc., which further complicated the ability to draw valid conclusions from the data. There was also an uneven level of reporting between regions, with the highest proportion of responding countries per region coming from sub-Saharan Africa and the lowest level of reporting from countries in the Middle East and North Africa-MENA region (UNAIDS, 2005).

Although it was governments that initially endorsed the Declaration of Commitment, the declaration document's vision extends far beyond the governmental sector--to private industry and labour groups, faith-based organizations, nongovernmental organizations and other civil-society entities.

As released, the Declaration of Commitment on HIV/AIDS comprised a number of global and national indicators. The national indicators are especially important for two reasons. First, they can help individual countries evaluate the effectiveness of their national response, which reinforces the value of including these indicators in national monitoring and evaluation frameworks. Second, when data from multiple countries is analyzed collectively, the indicators can provide critical information on the effectiveness of the response at regional and global levels while simultaneously supplying countries with insights into the efforts of other national-level responses.

The core national-level indicators are divided into three categories (UNAIDS, 2005);

A. *National commitment and action.* These indicators focus on policy and the strategic and financial inputs for the prevention of the spread of HIV infection, the provision of care and support for people who are infected and the mitigation of the social and economic consequences of high levels of morbidity and mortality due to AIDS. They also capture programme outputs, coverage and outcomes; for example, the

prevention of mother-to-child transmission and treatment with antiretroviral combination therapy.

B. *National knowledge and behaviour.* These indicators cover a range of specific knowledge and behaviour outcomes, including accurate knowledge of HIV transmission, age at first sex, and sexual behaviours, to say a few.

C. *National-level programme impact.* These indicators focus on the extent to which the other national programme activities have succeeded in reducing rates of HIV infection and its impact on adults and children receiving antiretroviral therapy

Successful HIV prevention depends on changing risk behaviours to which knowledge is a precondition. This includes increasing condom use and limiting the number of sex partners among sexually active people, reducing needle-sharing behaviour among injecting drug users, and delaying the onset of first intercourse among young people by rising legal age of marriage as in the Palestinian case, for example.

To get to desirable behaviours, relevant knowledge must be investigated and most importantly among vulnerable groups of whom girls and women are prime ones. Many countries with low-level epidemics such as Palestine have not felt the need to invest resources in collecting behavioural data, assuming that if the virus is largely absent, risk behaviour must be limited. However, it is exactly at this point of the epidemic that behavioural data can act most effectively as a warning system. Where behavioural data and other indicators such as STDs or hepatitis B prevalence show that people are having unprotected sex with multiple partners such as the case is in polygamous marriages for example- or are sharing injecting equipment, it may simply be a matter of time before HIV follows. Almost inevitably in these situations, if HIV surfaces it will do so first in those groups whose behaviour carries a high risk of exposure to the virus.

Feeding into this argument, in a study of women from over ten countries undertaken by the International Centre for Research on Women (ICRW) it was observed that "though many women expressed concern about the infidelities of their partners, they were submissive to their lack of control over the situation. Women from India, Jamaica, Papua New Guinea, Zimbabwe and Brazil report that raising the issue of their partners' infidelity can jeopardise their physical safety and family stability" (Gupta and Weiss, 1993).

Unequal power in sexual relations leads to the sexual double standard which has alarming implications for both men and women's ability to prevent the sexual transmission of HIV (Wilton, 1997). This is when men appear to pass on HIV more efficiently than women during unprotected vaginal intercourse. Furthermore, the denial, blame and stigma surrounding HIV has silenced open discussions, delayed effective responses, and added to the burden of those living with HIV and AIDS. Indeed, women's sexuality is particularly subject to stigma and control in this regard (Tallis, 2002).

Collecting information on behaviour with knowledge as one of its drivers spotlights potential flash points for HIV infection. It can raise awareness among the public and among policymakers of the dangers posed by not doing anything to keep the virus confined at low levels, and it can help suggest what must be done, and for whom. It is the intention of this study to go back to basics and uncover the knowledge that guides the AIDS-related behaviour of Palestinian girls and women.
In terms of policy, this serves the second core national-level indicator "national knowledge and behaviour" as specified in the international Declaration of Commitment on HIV/AIDS (UNAIDS, 2005).

3 Context in Palestine

Up until the end of 1997 there was no comprehensive action plan for the sexually transmitted diseases among Palestinians. Starting at the end of that same year the Ministry of Health endorsed a decision to establish STDs unit in the Primary Health Care Department. The STDs unit commenced with two major clinics; one for AIDS/HIV, and another for other sexually transmitted diseases. However; reporting of STDs in Palestine is based on aetiology and syndromic diagnosis. Based on the specified guidelines, information and data from the Palestinian Annual Report (2002) new cases of STDs dropped from 13,342 in the year 2001 to 4116 new cases in the year 2002.
Consequently, the incidence rate of the STDs, based on syndromic diagnosis, was 118,8 per 100,000 in Palestine in 2002; 24.5 per 100,000 in males versus 220,4 per 100,000 in females. The incidence rate in the West bank was 145.9 per 100,000, compared to 71.6 per 100,000 in Gaza Strip (MOH, 2003).

On the other hand, based on the etiological causes, about 2910 new cases of sexually transmitted diseases were reported, with an incidence rate of 84 per 100,000. Of these, 1658 cases were reported in the West Bank and

the remaining 1252 cases were registered in Gaza Strip with an incidence rate of 99.2 per 100,000 population (MOH, 2003).

Data from the Palestinian Annual Health report (2003) show that in females the most important reported cases of sexually transmitted diseases were 984 cases of candidiasis, 587 cases of pelvic inflammatory disease, 317 cases of bacterial vaginosis, 103 cases of trichomnoiasis, and 49 cases of non – gonococcal urethritis. There were also 43 cases of neonatal conjunctivitis and about nine cases of genital wart. Infections with gonorrhoea and herpes simplex were low with only 5 cases of gonorrhoea and 4 cases of herpes simplex virus being reported registering the low incidence rate of less than 1 per 100,000 population (MOH, 2003).

Ramlawi (2005) conducted a study to investigate the infection rate of trichomonas and candidiasis among women attending reproductive health clinics. A total of 2003 women participated in this survey. Results show that 10.6% of the target population was infected with trichomonas vaginalis and 12.5% with candidiais. However; the infection rate of trichomonas vaginalis and candida albicans was the highest among women of reproductive age, with 22.7% having trichomonus vaginalis and 18.2% having candida albicans.
Notably, no significant statistical differences were found in the infection rate with trichomonus vaginalis and candida albicans in relation to; occupation, educational level, economic status or marital status.

With respect to AIDS/HIV profile in particular, according to MOH annual reports low incidence rate of cases and carriers were registered. Since 1986 up to 2003 the cumulative number of cases was 55 cases, out of which 40 were AIDS cases and 15 were asymptomatic HIV. The cumulative prevalence rate per 100,000 of AIDS/HIV was 1.75. By sex, 44 were males, 9 were females and 2 did not declare sex. In 2003, out of the total, 31 people were still alive. In 2006, per 100,000 persons, incidence rate of AIDS cases was 0.06 compared to 0.03 of HIV infection.
The predominant mode of transmission was heterosexual (54.5%) followed by blood and blood products (18.2%), drugs (5.5%) and bisexual (3.6%). To date, a total of 79 cases of AIDS/HIV have been documented in the MOH registry.

Between April and July, 2002 the Palestinian Central Bureau of Statistics conducted a needs assessment to find out about the users needs of health services with respect to information, education and communication in the area of reproductive health. The household questionnaire consisted of three main parts. The second part aimed to collect information about

peoples' knowledge about selected reproductive health issues including sexually transmitted diseases and modes of transmission. A sample of 140 households was drawn from 14 localities in the West Bank and Gaza Strip wherein a MOH clinic operates. From each locality an equal number of men and women within the age group 18 – 49 years were interviewed. The study reported that the majority of the respondents know about STDs, especially AIDS, gonorrhoea and syphilis (PCBS, MOH & UNFPA, 2002).

4 Aim of the study

This study aims to examine the core national-level indicators of; national commitment and action and national knowledge and behaviour as articulated in the International Declaration of Commitment on HIV/AIDS and applied in Palestine within the framework of the national policy.

5 Objectives of the study.

This aim will be achieved by meeting the following objectives;

- Find out about the knowledge respondents have about STDs including HIV/AIDS
- Explore respondents' understanding of the risky behaviour related to HIV/AIDS
- Understand the extent of stigmatization and discrimination the respondents hold against people with HIV/AIDS, if any.
- Learn about the normative practices shaping the attitudes of the study respondents towards HIV/AIDS and its victims.
- Examine the national commitment and action taken toward combating HIV/AIDS within the policy framework.
- Identify government initiatives for informing the public and influencing its HIV/AIDS related behaviour.

6. Methodology

6.1 Phase one: the quantitative part.

A cross sectional household survey design was adopted in this phase. Data collection for the whole study started with this part. All married and unmarried females within the age group 15-49 years were targeted.

Sampling frame was an electronic file that was constructed in light of the Palestinian Central Bureau of Statistics population census data. The listing

inside the file encompasses an enumeration of all localities, their defining variables and the categorical variables that were used in clusters formulation.
Conventional clusters were used in a multi-stage sampling design.
In the first stage, the two regions of Palestine were considered as the first level stratification comprising two strata within which the 16 directorates; 11 in the West Bank and 5 in Gaza strip are the clusters. Inside these clusters a total of 77 statistical areas as enumerated in the PCBS maps represented the primary sampling units that accomplished the study sample size.
In the second stage, within each cluster (directorate), number of the secondary sampling units (SSU) which are the population blocks in this case was relative to weight of the cluster in the overall population targeted. Thus probability proportional to size sampling was employed here.
In the third stage, elementary sampling units which are individual households within each SSU were selected using a systematic-random sampling method. Tertiary sampling units within households, one individual female was invited to participate in the study. In cases where there was more than one potential participant selection was made using Kish tables[1] wherein only one eligible female was invited to participate.
Sample size: For an accepted error of 3% and confidence level of 97% based on the size of our target population and bearing in mind over sampling to compensate for anticipated non-response we targeted a total of 1100 single and married females. With 22 females refusing to participate (response rate = 98%) and 31 questionnaires dropped during the data cleaning phase we ended up with a 1047 valid questionnaires of which the data was analyzed and utilized in this study.

Data Collection Instrument: Recognizing that HIV surveillance does not, by itself, meet the information needs of HIV prevention, UNAIDS, WHO, and FHI have developed a new framework for HIV surveillance. This framework, known as Second Generation HIV Surveillance, stresses the need to design a surveillance system that is appropriate to the epidemic state of the country. It particularly advocates for the more extensive use of behavioural data in planning and evaluating an appropriate response to HIV.
Furthermore, It identifies several important roles for information that reliably tracks changes in the behaviours-largely guided by knowledge of individuals and groups at the first place- that spread HIV on the grounds that; behaviour is an early warning system, tracking behaviour helps evaluate programs, and changes in behaviour help explain changes in HIV

[1] Kish tables provide a random sampling method for selecting one individual only from each household.

prevalence. Behavioural surveillance surveys (BSS) is a core part of a second generation surveillance system for HIV. Standardized indicators have been defined for several sub-populations likely to be included in BSS including youth of both sexes and women. A modified version of the BSS, particularly questionnaires that target women and youth (females only in this case) subgroups were employed.

6.2 Phase two: the qualitative part.

This part of the study followed the completion of the field work, data management, entry and analysis from the first part. It comprised two components.

Focus groups discussions were completed with women and girls with characteristics similar to those targeted in the first phase. A total of 8 focus groups were done; 4 with married women and 4 with adolescent girls; 5 in the WB and 3 in GS. Those conducted in the West Bank took place in; Jenin, Toulkarem, Jerusalem, Jericho and Hebron, while the ones in Gaza were held in East Gaza, Ashate' camp and Gaza mid zone. An average of 14 females participated in each focus group discussion totalling 124 married and singles, altogether.

Interviews with key informants followed. These were carried out with policy and/or upper management level government officials, key funding agencies, key local and international NGOs. A pre-used UNAIDS developed questionnaire titled "the national composite policy index" (NCPI) and designed to assess development and implementation of national level HIV/AIDS policies and strategies was employed here (UNAIDS, 2005). The NCPI is divided into two parts. Part A was administered to governments' officials covering the five broad areas of; strategic plan, political support, prevention, care and support, and monitoring and evaluation.
Part B administered to representatives from the governments' primary partners including nongovernmental organizations, international agencies, and UN-system organizations. This part covered the four broad areas of; human rights, civil society involvement, prevention and care and support. Professionals most knowledgeable about the intended areas were targeted with the Composite Policy Index totalling 6 altogether; two from the government policy officials, two policy makers from NGOs active in the field and two from key international UN and bilateral agencies.

7 Discussion of Major Findings

In this study a household survey, focus groups discussions and national policy index analysis depicted the image of HIV/AIDS in Palestine. Putting behavioural and policy data adjacent to one another envisions policy as a deliberative project of contextual orientation and normative constituent. Besides, it also concords with Principle 5 of the ICPD document that underscored the bearing of the context on the question of reproductive health and therefore makes of this study a benchmark in the area of HIV/AIDS research in Palestine.

A total of 1047 females participated in the first part of the study. Of these, 63.9% were from the WB and 36.1% were from GS. By directorates within regions, percentages of participants were relative to weight of each in the overall population. In the second part, 8 focus groups discussions were completed; 5 in the WB and 3 in GS with an average of 14 females participants in each totalling 124 married and singles, altogether. The third, however, was confined to policymakers only totalling 6 professional experts equally distributed between government sector, NGOs and international agencies.

Around 63% of the first part respondents were ever married. Of these, 44.6% got married at 18 years of age or less, with particular notice of 18.6% who were married between 13-16 years of age. During the last 12 months 5.4% of the married women had forced sex with the husband when 4.2% are part of polygamous marriages. These figures bring into questioning the decision making and negotiation power these women can exercise within marriage including matters in connection with their sexual and reproductive well being, most critical of which are those in pertinence with STDs including AIDS.

7.1 Knowledge about STDs

A considerable percentage of the never married participants (89.4%) have heard of STDs, compared with a higher percent (92.5%) of the ever married women.
Despite clear discrepancy in the expected sexual and reproduction experiences of the two population groups, the concluded gap as narrow as 3.1% suggests a wide spread of women centred awareness programmes in this respect. However, the question that remains is what information quality and depth are offered to women in these programmes.

By region, most of those who reported not having heard about STDs are from the West Bank. Within regions by locality, the highest percentage was in WB north (2.8%) followed by Gaza Strip north also (2.3%). This gives us reason to conclude that future awareness programmes addressing STDs should place special emphasis on WB never married women particularly in the northern directorates.

Around 51% of the sampled females either do not think that an unmarried adolescent can catch an STD without prior sexual activity (38.7%) or do not know if this could happen at all (12.2%). Misconceptions inherent in these responses mirror obvious lack of basic factual information amongst the study respondents in addition to an attitudinal element as well. By marital status these comprised 19% of never married and 32% of the ever married women and by region 17.8% of them were from GS and 33.2% were from WB.

On the link between infertility and delayed or no treatment of an STD, a total of 40% responded negatively of whom 17% were singles, which is indicative of their serious ignorance about long term consequences in this case. Women in the WB were more aware of the link between infertility and late treatment or completely untreated STDs. More than 34% of them responded positively to the question addressing this link compared to around a quarter (25%) of their counterparts in GS. Therefore, universal commitment to this matter in awareness programmes is worthy, especially as it pertains to the unmarried and Gazan women.

In all cases ever married women scored higher than never married ones in their identification of STDs signs in both sexes. At best, however, percentages of those who could identify a sign of an STD did not exceed 55% of the total concerning the sign "burning pain on urination" in men followed by 52.3% for the sign "genital discharge" in women.
These findings present evidence on the dire need for extensive education of women both ever and never married but with more emphasis on the later so as to enlighten them about various aspects of STDs in both sexes.

The question the presence of a relationship between AIDS and prior less critical STDs revealed a considerable information gap. A total of 60.6% either do not think there is such a relationship or do not know of it altogether. Of these two thirds were ever married women.

Out of eleven treatment measures respondents may take up for curing genital discharge or ulcer, the measure taken most in 56.7% of the cases was that women tell the husband about the problem, followed by; seeking

advice/medicine from a gynaecologist in a private clinic (50.5%), abstinence from sex while the symptoms were there (34.4%) and seeking advice/medicine from a government. clinic or hospital (23.9). Use of condom upon having sex during which time the woman had the symptoms was a choice in 5.2% cases only. Nevertheless, there were married women who would do nothing about it (2%).
On the other hand, the never married respondents' prime action was to seek advice/medicine from a gynaecologist in a private clinic (8.7%) which was also confirmed in the focus group discussions. Do nothing about it and let it heal by itself (4.8%); a measure that is particularly alarming due to its short and long term impact on the sexual and reproductive well being of girls and women. To this end, awareness campaigns addressing such issues are instrumental in bringing to sight the detrimental consequences of this and correcting the adopted measures.

7.2 Knowledge about HIV/AIDS.

Almost all respondents (99.1%) reported having heard of AIDS. Prime information sources were TV as was stated by 94.4% followed by radio (40.9%) and friends and relatives (37%), sequentially. This raises concern as to the resourcefulness of these popular sources and the accuracy of information shared between friends and relatives, in particular, and passed on to others.

Health professionals were the declared information source on AIDS for no more than 12.3% respondents of which 93 were married women who are often regular clients at clinics and centres, be it for themselves or for other family members. While single women limited access known to be caused by socio-cultural barriers is one conclusion to be made here, other potential explanations deserve being considered here.

A total of 13.8% either do not think that something can be done to avoid HIV/AIDS or simply do not know if it can be avoided or not. Further to this, 2.7% know someone who is infected with HIV or who has died of AIDS. Of these, 1.8% is from the WB and 0.9% is from GS. In addition, 1.7% either has a relative (0.5%) or a close friend (1.2%) who is infected with HIV or has died of AIDS. Of these, 1.4% is from the WB and 0.4% is from GS.

In the absence of a national surveillance system for HIV/AIDS authentication of these numbers cannot be attained, especially when coupled with the concomitant socio-cultural taboos.

No more than 40% of the respondents recognize the protective role of accurately used condom against HIV/AIDS infection. Of these, around three fourth were ever married and only a fourth was single women. This means that ignorance is most amongst population groups with optimal sexual activity putting them at higher risk of catching the disease. Regional differences indicate that only 14.9% of GS participants responded positively to the proposed question.

About misconceptions the study clearly demonstrates how uninformed Palestinian women are in issues that are central to their intimate sphere of life. Nevertheless, it also shows aspects of relative strength which are crucial to identify for planning cost-effective programs and interventions such as respondents information on injecting oneself with a pre-used contaminated needle and an HIV positive pregnant passing the disease to her unborn infant. Here minor effort is recommended to boost already fruitful ones as can be concluded from pertinent responses.
An examination of prevalent misconception revealed substantial information gaps and knowledge disparity among participants. While 95% of the respondents were aware that injecting oneself with a pre-used contaminated needle is one means of HIV transmission more than a third believes that a mosquito bite is one route of transmission too and another third either did not think or did not have a clue about the fact that a healthy looking person could be HIV positive.

Such responses clearly demonstrate that a universal IEC package is not in place in Palestine; a conclusion that is well maintained by reported information sources, for example. This is a serious deficit on the side of health care providers particularly those concerned with public health, health education and promotion, and primary health care.

Knowledge of available community resources proved to be severely limited. Only 5.2% know about a place in the community where one may undergo a confidential HIV test. Of these; 3.8% were from the WB and 1.3% were from GS, 3.5% were ever married and 1.6% were single. Numbers clearly speak for themselves here and call for serious work in this regard.

No single woman of the study population has ever volunteered to do an HIV test. But, 1.6% (n=17) were asked to do it. Of these; 1.2% was from GS and 0.4% was from the WB; 2 did not and 15 actually did the test; 3 did not fetch their results and 12 did. Of these, 10 were from GS and only 2 were from the WB.

Despite this apparent lack of interest or perhaps fear or shame of the test and its results when asked about if they would do HIV test on voluntary bases as a precautionary step 57.5% (n= 587: 381 WB & 206 GS) responded positively to this question.
These findings hold implications for the prevention aspect of the strategic plan at the policy level especially that these are all issues integrated in the NPI as endorsed by UNAIDS and globally in the strategic plan particularly the action framework for addressing AIDS issues among national uniformed services.

7.3 Stigma and Negative Discrimination Against AIDS

Both qualitative and quantitative data on stigma and discrimination against AIDS was rather consistent with international literature. On the one hand, HIV/AIDS-related stigma and discrimination seem to be interacting with pre-existing ones associated with sexuality at the first place and with pre-existing fears about contagion and disease on the other. AIDS metaphors- as death, as horror, as punishment, as guilt, as shame, as otherness- have all exacerbated these fears, reinforcing and legitimizing stigmatization and discrimination.

Overall, responses to the scenario questions examining stigma and discrimination as well as in focus groups discussions indicated strong HIV/AIDS related stigma among Palestinian women. It further mirrored most of the existing metaphors. For example, a majority (67.3%) were reluctant to share a meal with an HIV/AIDS infected person despite the awareness of 75% that sharing a meal with an infected person is not a means for HIV transmission. Also data showed that higher percentage of the Gazan women (74.6%) held this negative stand compared to their WB counterparts (63.2%).
This image together with negative responses coming primarily from ever married women reiterated in almost all stigma questions and focus groups discussions.
By conclusion then, social stigma associated with HIV/AIDS is a major barrier to HIV prevention efforts that are to be rather strategic both at the programmatic and policy level.

7.4 Gender and AIDS

The study revealed wide agreement about the role of gender inequality and power dynamics within marriage on the one side and the STDs/HIV/AIDS profile of Palestinian women on the other. This was illustrated in responses indicating recognition of more than three quarters

of the study respondents of the link between multiple sex partners and STDs incidence, for example.

In settings where heterosexual transmission is significant, as the case is in the Eastern Mediterranean Region according to WHO (2004) sources, the spread of HIV infection has been associated with female sexual behaviour that is not consistent with gender norms. For example, prostitution is widely perceived as non-normative female behaviour, and female sex workers are often identified as “vectors” of infection that put at risk their clients and their clients’ wives. Equally, in many settings, men are blamed for heterosexual transmission, because of assumptions about male sexual behaviour, such as men’s preference or need for multiple sexual partners as legitimised via polygamous marriage, or subtly purchased from sex workers with both issues being brought up in this study.

7.5 HIV/AIDS Policy

This analysis investigated national commitment and action in light of the Declaration of Commitment on HIV/AIDS. Indicators focus is on policy and the strategic and financial inputs for the prevention of the spread of HIV infection, and the provision of care and support for people who are infected. They also capture programme outputs, coverage and outcomes.

It was found out that, similar to other low-level epidemic countries Palestine did not feel the need to invest in collecting behavioural data until recently. A National HIV/AIDS/STDs Prevention and Control Committee were founded in 1995 with sole ministerial membership except for few NGOs involved within their capacity as observers only. The committee operates with limited political support and endorsement of some stakeholders.
Key areas of intervention are; the strategic plan itself with women and girls, youth and at-risk population at the core, prevention, and care and support. Within prevention, emphasis is placed on programmes to ensure universal precautions in health care settings, school-based AIDS education for youth, and blood safety.

A strategy to promote information, education and communication and other preventive health interventions for most-at-risk populations is also in place. Emphasis is located on injecting drug users including; risk reduction information, education and counselling, needle and syringe programmes, treatment services and drug substitution treatment. Additionally, the two most-at-risk groups of men who have sex with men and sex workers are addressed in the adopted strategy.

Monitoring and Evaluation as a key policy area that is still in progress and is developed utterly by government policy makers at the Ministry of Health using top down approach with no involvement of civil society or people living with HIV; a major drawback that can hinder collective ownership and therefore adoption of and commitment to the policy, nationally.
Human right dimension and pertinent laws and legislations are completely absent, too

8 Overall Commentary.

Following from the discussion and conclusions are broad two-fold interconnected recommendations. One is programmatic while the second is on policy.

- *At the programmatic level.*

  There is evidence in literature that HIV/AIDS education and awareness from media sources, reactive classroom instruction, family communication, and knowing someone with HIV/AIDS are negatively related to sexual-behaviour risk for HIV/AIDS. This means that successful HIV prevention depends on changing risk behaviours to which knowledge is a prerequisite. Therefore, it is imperative to develop universal awareness campaigns incorporating carefully-studies audience-tailored IEC on AIDS and other STDs for Palestinian girls and women with particular emphasis on *ever married West Bank women and all females (married and single) in the northern directorates in the two regions of the WB and Gaza.* For these were areas of peaking misconceptions and misinformation, bearing in mind that knowledge of other female populations was only relatively better, but still unsatisfactory in most topics of relevance.

- *At the level of policy.*

  One definition of policy is that it is multidisciplinary, multi-layered dynamic process that is ideologically informed and culturally determined; occurring over time in arenas of conflict which implies that it is contextual. This is where this definition intersects with Fishbein's integrated theory of health behaviours wherein the socio economic variables constitute the context influencing both the adoption of health practices and success of intervention strategies.

Lasswell in applied social sciences argues for long term public policy making. In his pragmatist view policy is a dialogue between expert opinion and the opinions of a larger public, in a community united by the quest for answers to shared problems (Al-Rifai, 2004).

In light of the fact that they frame conditions for discourse (dialogue), introducing attitudes change is innate to any viable and progressive policy, which is that of HIV/AIDS/STDs in this case. This not only in relation to policy formulators and decision makers, but also to all other stakeholder categories in their broadest scope and definition in terms of: age, sex and position in society. This can be done by working on the cognitive component of an attitude wherein investment should be made in the socialisation and social learning as a major source of attitudes derivation. This can only be achieved by changing the substance and contents of what is taught socially, both in the formal and informal establishments in society. These are basic values that are acquired 'taught' from family, peers at school and work later in life (Al-Rifai, 2004).

Following from this, it is proposed to optimise education on AIDS and other STDs by ensuring the broadest dissemination of relevant information that is geared strategically, employing appropriate manoeuvres and tactics for influencing the mindset of the people within their capacities as policy makers as well as lay individuals.

As such women's agency fostered by education and stimulated by social norms that are challenged through awareness campaigns and public policy is the immediate objectives of a health promotion approach to AIDS prevention. Alongside, active involvement of human right organizations and endorsement of protective legislations are key supporting instruments in this.

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