

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

**The Influence of Socio- Demographic factors on the level of
Obesity and Health-Awareness among Physically Disabled in
Nablus Governorate**

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Dedication

First I dedicate this work to the Palestinian people who are struggling for their freedom, for Jerusalem the Capital of Arab Culture, and the Capital of our Palestinian Stat

For the Disabled in The World Disabled Day

For my wonderful parents who carried restlessness and fatigue with me to complete the master's thesis to be a beacon for generations to capitalize on heightened in learning and teaching and to equity disabled in our society on the basses of equal rights and duties for all members of the community.

To those who have dedicated their lives for our disabled children, to the anonymous soldiers who work in shade to heal, protect and help the disabled where ever are they.

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إقرار

أنا الموقع أدناه مقدم الرسالة التي تحمل العنوان:

The Influence of Socio- Demographic Factors on the level of Obesity and Health-Awareness among Physically Disabled in Nablus Governorate

أقر بأن ما اشتملت عليه هذه الرسالة إنما هي نتاج جهدي الخاص، باستثناء ما تمت الإشارة إليه حيثما ورد، وأن هذه الرسالة ككل، أو أي جزء منها لم يقدم من قبل لنيل أية درجة علمية أو بحث علمي أو بحثي لدى أية مؤسسة تعليمية أو بحثية أخرى.

Declaration

The work provided in this thesis, unless otherwise referenced, is the researcher's own work, and has not been submitted elsewhere for any other degree or qualification.

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التوقيع

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التاريخ

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Abbreviations list

BMI	Body Mass Index
ICIDH	International Classification of Impairments, Disabilities and Handicaps
NAASO	The North American Association for the Study of Obesity
WHO	World Health Organization

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Abstract

This study aimed to identify the influence of socio- demographic factors on the level of obesity and health awareness among the physically disabled in Nablus Governorate through measuring Body Mass Index and a questionnaire designed to measure the health awareness among the physically disabled in Nablus Governorate. The questionnaire was validated and its reliability was suitable for the study purposes. The questionnaire was distributed to a purposive sample with size (244) and the BMI was calculated for each subject of the study sample. After data collection, SPSS program was used to analyze it. The major results of the study that the researcher found were the following:

- The total score of the present status health awareness among physically disabled in Nablus Governorate is low.
- The total score of health awareness in managing stress and smoking domains was medium, while it was low in nutrition and medical care domains, and it was very low in exercises domain.
- Mean of Body Mass index (BMI) among physically disabled in Nablus Governorate, is (25.91) Kg/m².
- There are significant correlation between BMI and gender, age, place of residence, social status and education.

- There are significant differences in health awareness due to social status, education, daily watching TV and daily using computer.

Based on the findings of this study, the researcher recommended the following:

1. The need to disseminate health awareness concerning the handling of a balanced diet for all age groups, where the results of the study showed low awareness of the balanced health food.
2. Practicing aerobic exercises regularly, and follow a certain diet, to maintain physical fitness, and body mass index within the normal range.
3. The need to debrief tension through appropriate means, and not to use unhealthy ways to overcome the lack of care or the resulting effects.

Chapter One

Study Significance and Problem

1.1 Introduction

There can be little doubt that culture and knowledge play vital roles in developing one's status and lifestyle, which in turn is reflected on family and society, especially that we now live in an age of accelerating information flows. So, it is a must for every body to follow up changes of every days life related to health, body fitness and happiness...etc.¹ Empowering and raising the level of health education and awareness are very important and necessary measures for the interest of information, skills, and attitudes aiming at making changes in one's vision, and attitudes, by the process of converting health facts to behavioral patterns for individuals, families, societies and environments². Obesity is one of the most common health diseases in modern societies and is assuming epidemic proportions in both developed and developing countries⁴. Indeed, it is an ironic and rather sad reflection on prevailing reality that the two major nutritional problems that the world's people presently face are that - 600 million people face severe energy deficits and starvation while at the same time 310 million people face problems relating to chronic energy surplus and obesity³⁹.

To follow Champe and Pamela as well as Abdul-Rahim et al., obesity is defined as a disorder of body weight regulatory systems characterized by an accumulation of excess body fat^{5,35}; obesity, then, results from imbalance calorie intake and inadequate expenditure of energy, both of

which are affected, as pointed out by Speak man, Larry, and others, by environmental and genetic factors like low levels of physical activity or genetic predispositions to high fat storage^{39, 31, 28, 10, 37}. The rise in obesity among youth, for example, has been found to be due mainly to easier access to large portions of energy-dense foods coupled with reduced levels of physical activity.²⁶

The amount of body fat is difficult to measure directly, and is usually determined from an indirect measure—body mass index (BMI)—which is shown to correlate with the amount of body fat in most individuals⁴. As Ekelund et al. claim, BMI is widely considered a reasonably valid marker of overweightness and obesity in population-based epidemiologic studies²⁵.

The BMI is calculated in both men and women as:

$$\text{BMI} = (\text{weight in kg}) / (\text{height in meter})^2$$

The healthy range for BMI is considered to be between 19.5 and 25.0. So individuals, then, with a BMI between 25 and 29.9 are found to be overweight, and those BMI is greater than 30 are defined as obese⁵.

Health practitioners universally agree that too much body fat is a serious health risk for everyone, even healthy individuals. Problems such as hypertension, elevated blood lipids, diabetes mellitus, cardiovascular disease, respiratory dysfunction, osteoarthritis, sleep apnea, gallbladder disease, some joint diseases, certain types of cancer, and psychological problems have often been found to be related to obesity.^{46, 34} These conditions, then, often synergize to further limit the everyday functioning of the overweight and obese.²⁸

As the relationship between obesity and disability is the main concern of this study, the study aimed at measuring the effect of socio- demographic factors on obesity and health – awareness among physically disabled in Nablus Governorate. It is necessary here to address the definition of disability as well as its incidence rate and prevalence in the world and in Palestine. The definition of disability has largely been a discussion of where to locate the problem(s) of disability. In this discussion two opposing views or “pathologies,” can be distinguished in this context, as illustrated by Waddington and Rioux^{11, 12}. The first is the individual model of disability which is traditionally defined as an observable physical, mental, sensory or psychological deviation from normality caused by disease, trauma or another health condition. The individual (and medical) approach to disability underlies almost all medical taxonomies, including the International Classification of Impairments, Disabilities and Handicaps (ICIDH)¹³.

The second is the social model which approaches disability evolved out of dissatisfaction with the individual models, based upon able-bodied assumptions of normality. Social model centered on that disability can be seen as a social construct. Moreover, society creates disability by accepting an idealized norm. The “social constructionists” therefore reject the causal relationship between individual impairment and disabilities put forward by the individual models, and contend that disabilities are products of the failure of the physical and social environment to take into account the needs of particular individuals or groups, as argue Hendricks and Rebell^{14, 15}.

In the world there are about 600 million people living with disabilities of various types, and the number is increasing due to the rise of chronic diseases, injuries, car crashes, falls, violence and other causes such as age. According to the WHO, 80% of these disabled people live in low-income countries: most are poor and have limited or no access to basic services, including rehabilitation facilities ¹⁶.

1. 2: The statement problem of the study:

The considerable burden of chronic diseases and sedentary lifestyles has been associated with increasing medical consequences on human health in general and to physically disable particularly.

According to recent data compiled by the Palestinian Central Bureau of Statistics, the disabled rate in Palestine has reached 2.7%, with males being more vulnerable than females in this sense due to their being subject to violence while participating in political activities. During 2004 -2006 the rate was 1.7%, while in 2006 it rose to 2.7%. As for the West Bank, it reached 2.9%, and in Gaza 2.3% ¹⁷.

The researcher noticed that disabled people suffered from obesity as the researcher works in the field of disabled people rehabilitation. So, it might well be necessary to shed light on the situation especially in Nablus Governorate in the West Bank, in an effort to avoid the impairing consequences of degraded life quality for human beings.

1.3 Significance of the study:

Life quality is significant to humanity, and so this study will attempt to examine the physically disabled in Nablus Governorate, in particular with

results that may play an important role in helping preventing obesity-related diseases, especially given that the researcher works with various kinds of disabilities on daily base. Raising up and evaluating individuals' awareness may help to overcome negative life style and attitudes, pushing positively towards health status improvement.

This will be a gateway to investigate health for this vital sector in playing any role in life development, and decrease the burden of obesity expenditure on health especially in individuals' economically productive age.

1.4 The purposes of the study :

The study aims at achieving the following purposes:

1. To determine the present level of obesity and health awareness among the physically disabled in Nablus Governorate.
2. To determine the influence of socio-demographic factors on the level of obesity and health awareness among the physically disabled.

1.5 The questions of the study :

The study aims at answering the following questions:

1. What are the present levels of obesity and health awareness among physically disabled in Nablus Governorate?
2. Are there significant differences at the level ($\alpha = 0.05$) in the means of BMI and health awareness, according to Gender, Age, Place of residence,

Disability type, Social status, Education, Economic status, Monthly income, Daily TV watching and Daily computer using variables?

1.6 The hypotheses of the study:

The study aims at examining the following hypotheses:

- 1 There are no significant differences at the level ($\alpha = 0.05$) in the means of BMI, according to Gender, Age, Place of residence, disability type, Social status, Education, Economic status, Monthly income, Daily TV watching and Daily computer using variables.
- 2 There are no significant differences at the level ($\alpha = 0.05$) in the means of health awareness and it's domains, according to Gender, Age, Place of residence, disability type, Social status, Education, Economic status, Monthly income, Daily TV watching and Daily computer using variables

1.7 Definition of terms:

The study considers these definitions;

1. $BMI = (\text{weight in kg}) / (\text{height in meter})^2$
2. Obesity: Obesity is a condition of excessive fatness. Fatness is often expressed as a percentage of body weight. The average adult male is 20 percent fats, and the average adult female is 30 percent fats.
3. Health Awareness: Health awareness means being aware of how the body looks and feels and what is normal for the person and to notice any changes.

4. Physical disability: any disability which limits the physical function of limbs or fine or gross motor ability.

1.8 Limitations of the study

This study is limited to Nablus Governorate, and limited to disabled people.

The results of this study is limited and generalized upon the responses of its sample, validity and reliability of its instruments.

Chapter Two

Review of Related Literature

This chapter includes the related literature of obesity and health awareness. The researcher reviewed studies and articles searched in obesity and health awareness as follows:

McLaren, for one, has found an increasing proportion of positive associations and decreasing proportion of negative associations as one moved from countries with high levels of socioeconomic development to countries with medium and low levels of development.⁶ Ekelund et al. find several studies as consistently showing that the prevalence of overweight and obesity among the young is increasing dramatically.²⁶ As reviewed by Tucker and Bagwell, many observers have placed the dramatic rise in overweight and obesity rates around the world to increased television viewing, with the physical passivity that encourages as well as often-misleading nutritional messages communicated via such media.¹⁰ Indeed, ironically, the food abundance that originally allowed for victory over malnutrition is the very phenomenon which, coupled with increasing sedentariness over time, has brought about the high overweightness and obesity rates of the present day.³⁶

Obesity is dramatically on the rise in low and middle-income countries according to a Sept. 22, 2005 news release from the World Health Organization (WHO). Some contributing factors are said to include a global shift in diet towards increased calorie, fat, salt, and sugar intake, a trend towards decreased physical activity due to the sedentary nature of

modern work and transportation, and increasing urbanization. The WHO estimates that more than 75% of women older than 30 years now are overweight in countries as diverse as Barbados, Egypt, Malta, Mexico, South Africa, Turkey, and the United States. Estimates are similar for men, with over 75% now overweight in countries such as Argentina, Germany, Greece, Kuwait, New Zealand, Samoa, and the United Kingdom. The Western Pacific islands of Nauru and Tonga have the highest global prevalence of overweight individuals, with nine out of ten adults being overweight ⁷.

Kremer found that children with high awareness of personal behavior and high habit strength were reported to be more physically active. Furthermore, psychosocial factors were less associated with physical activity in children with low health awareness of their personal physical activity levels and in children for whom physical activity was strongly habitual than in children with high awareness or with low habit strength concerning physical activity.⁴⁷

In the past 20 years, rates of obesity have tripled in developing countries that have been adopting Western lifestyles that involve decreased physical activity and over consumption of cheap, high-calorie food. Such lifestyle changes are also affecting children in these countries, as the prevalence of overweight among them ranges from 10 to 25%, with the prevalence of obesity ranging from 2 to 10%. The Middle East, Pacific Islands, Southeast Asia, and China face the greatest threat in this sense, as Hossain et al. warn⁸. Indeed, surveys from many Arab-majority countries in the Middle East present an alarming picture of prevalent obesity rates, which, for

reasons explored above, could in turn serve as an indicator for a higher prevalence of other chronic diseases in the region, according to Abdul-Rahim et al.³⁵ Indeed, Stene et al. have found obesity rates to be higher in this region than in most others globally, and the problem is said to be particularly severe among women.³²

The severity of the problem posed by obesity should not be underestimated: In 2000, the World Health Organization declared it to be the greatest health threat facing the West. Indeed, the WHO predicts that during the next 10 years, cardiovascular disease-related deaths will increase by more than 25% in the Eastern Mediterranean and African regions and warns of the rising threat of heart disease and stroke as overweight and obesity rapidly increase⁷.

Obesity, then, seem to be the most dangerous threats of the century, related to 26 different and severe diseases such as diabetes, high blood pressureetc. Over the past five decades, the incidence rates of overweightness have increased 2-fold and that of obesity more than 3-fold, according to Nisha.⁹ in the United States, for example, these problems have taken on epidemic proportions: estimates made by Must et al. and Yancey et al^{46, 30}. claim that 1 out of 2 adults are either overweight or obese, with possibly two-thirds being overweight.^{46, 30} In fact, the US Surgeon General claimed that a failure to address overweightness and obesity in that country could “wipe out some of the gains we've made in areas such as heart disease , several forms of cancer, and other chronic health problems”.⁴³.

As McLaren argues, lower socioeconomic status is associated with a higher prevalence of obesity generally, and especially as observed among

women.⁶ Socioeconomic disadvantage has been associated with a wide range of risk behaviors that affect health adversely, claim Najman et al.: low socioeconomic status is often linked with lesser access to healthy food and ability to exercise safely²⁷.

The relationship between obesity and poverty is complex, being poor in one of the world's poorest countries is associated with underweightness and malnutrition, whereas being poor in a middle-income country is associated with an increased risk of obesity. The financial costs of obesity are mounting; a higher body-mass index has been shown to account for up to 16% of the global burden of disease, expressed as a percentage of disability-adjusted life-years. In the developed world, 2 to 7% of total health care costs are attributable to obesity. In the United States, the combined direct and indirect costs of obesity were estimated to be \$123 billion in 2001. According to Hossain et al., the economic consequences of non-communicable diseases, mainly obesity and diabetes, in the Pacific Islands amounted to \$1.95 million, comprising 60% of the health care budget of Tonga.⁸

Lifestyle and daily life activities are essential factors that affect and influence individuals' tendency to become overweight or obese through accumulation of excess body fat or inadequate expenditure of energy. According to all previous studies, health awareness is very important to predict and overcome factors as: a) nutrition b) exercise c) stress management d) smoking and medical care as examples, which play an important role in increasing obesity rates and related health problems for people in general and the physically disabled in particular.

As stated above, obesity is a major health problem in developed countries and increasingly in developing ones.^{31 33} Among other things, obesity causes serious medical complications and impairs quality of life in older persons and can exacerbate the age-related decline in physical function and lead to frailty, as mentioned in a study on obesity in older adults by the American Society for Nutrition and NAASO, The Obesity Society.¹⁸ Gutierrez-Fisac et al. in the European Journal of Public Health find obesity rates to be inversely proportional to levels of education, with less-educated individuals being more susceptible to being obese⁴¹.

Studies indicate that differences in body mass index between educational groups have even been increasing during the last few decades. Low socioeconomic status and economic constraints may restrict behavioral options such as access to healthy foods or safe exercise, while specific problems such as low income levels, unemployment and social isolation may increase the likelihood of weight changes, as claimed by Lahteenkorva and Lahelma, among others⁴⁰. Gutierrez-Fisac et al., however, have found obesity itself to influence or even determine one's socio-economic standing⁴¹

The overall pattern of results, for both men and women, was of an increasing proportion of positive associations and decreasing proportion of negative associations as one moved from countries with high levels of socioeconomic development to countries with medium and low levels of development is found in McLaren study⁶.

As reviewed by McLaren, most findings have found a consistently inverse association for women in developed societies, with a higher likelihood of

obesity among women in lower socioeconomic strata.⁶ Among men, however, Gutierrez-Fisac et al. find study results to be much less consistent when obesity rates are tracked against socioeconomic position, with findings that find both positive and negative relationships here.⁴¹ In developing societies, nonetheless, a strong direct relation has been seen to hold for obesity rates for men, women, and children when correlated with higher economic standing.⁶ For the latter situation, as argued by Drewnowski and Darmon, it may then well be that the economic correlation is explained by observations of cost.³⁸ Indeed, several studies suggest the prevalence of overweightness and obesity to be higher in cultures that do not find thinness the pinnacle of attractiveness³⁰

It is found that high body fatness is an independent predictor of mobility-related disability in older men and women, whereas high body fatness in old age should be avoided to decrease the risk of disability, which resulted in Visor study that pertaining the relation between body composition and self-reported, mobility-related disability (difficulty walking or stair climbing).²⁰ Many studies have lamented the widespread failure to meet even minimal recommendations for healthful levels of regular physical activity, despite the widespread acknowledgement of its necessity for health and overall quality of life, both physical and psychological.³⁰ Most studies on this question conclude that growing urbanization, and hence a lesser need to perform physical labor, together with television-watching are to blame in this sense.^{30 32, 30, 34} Predictably, then, as observed by Piechota et al., this problem is found to be much more acute among the disabled²⁸

The prevention of weight gain with increasing age is likely to reduce morbidity and disability among older men, as was mentioned in a study regarding The Relations of Body Composition and Adiposity Measures to Ill Health and Physical Disability in Elderly Men²¹. In Frank et.al study about television watching and other sedentary behaviors in relation to risk of obesity and Type 2 diabetes mellitus in Women, the independent factors of exercise levels, sedentary behaviors, especially TV watching, were associated with a significantly elevated risk of obesity, whereas even light to moderate activity was associated with a substantially lower risk²². Jean et al. had shown that increasing in television viewing is associated with increased caloric intake and less robust measures of physical fitness generally among youth.²³ This is so because, as claim Tucker and Friedman, when the TV is on, physical activity ceases, as the body's muscles are neither exercised nor strengthened, nor are calories expended during this time⁴⁴

Al-Arabi found that media means can contribute positively in health awareness especially in preventing from obesity or overweighting. Al-Arabi conducted a study in Suadia Arabia, to identify the effect of using media means over overweightness, sport and nutrition³

While in Jean study which was about children's food consumption during television viewing, a significant proportion of children's daily energy intake is consumed during television viewing, and the consumption of high fat foods on weekends may be associated with high BMI in younger children.²³

Klumblene, et.al⁴⁸ conducted a study aimed to analyze the pattern of sociodemographic variations in the prevalence of obesity in Estonia,

Finland and Lithuania. In addition, the association between obesity and selected health behaviours was examined. Cross-sectional surveys were conducted among representative national samples of adult populations in 1994, 1996 and 1998. The number of participants aged 20–64 was 3759 in Estonia, 9488 in Finland and 5635 in Lithuania. The data were obtained from mailed questionnaires (covering socio-demographic characteristics, health behavior indicators, and self-reported height and weight). Obesity was defined as $BMI \geq 30 \text{ kg/m}^2$. The results showed that the prevalence of obesity among men and women was 10% and 15% in Estonia, 11% and 10% in Finland, and 10% and 18% in Lithuania respectively. The prevalence of obesity increased only among Estonian men. Obesity was more prevalent among those aged over 50 in all three countries.

It was also more prevalent among the less educated women in all countries and among the less educated men in Finland. Obesity was less prevalent among daily smokers among Estonian men and women and Lithuanian men. Physically inactive Estonian women and Finnish men and women were more likely to be obese.

Conclusions: A significant association was found between low educational level and obesity in women in all the countries, but this association was found for men only in Finland. In Finland obesity was also more consistently associated with indicators of unhealthy behavior than in Estonia and Lithuania. Thus, even though the social gradient of obesity was broadly similar in all the countries studied, differences emerged with regard to the behavioral correlates of obesity.

Fontaine and et.al⁴⁹ estimate the expected number of years of life lost (YLL) due to overweight and obesity across the life span of an adult. . The data was from the US Life Tables (1999); Third National Health and Nutrition Examination Survey (NHANES III; 1988-1994); and First National Health and Nutrition Epidemiologic. Results showed that marked race and sex differences were observed in estimated YLL. Among whites, a J- or U-shaped association was found between overweight or obesity and YLL. The optimal BMI (associated with the least YLL or greatest longevity) is approximately 23 to 25 for whites and 23 to 30 for blacks. For any given degree of overweight, younger adults generally had greater YLL than did older adults. The maximum YLL for white men aged 20 to 30 years with a severe level of obesity (BMI \geq 45) is 13 and is 8 for white women. For men, this could represent a 22% reduction in expected remaining life span. Among black men and black women older than 60 years, overweight and moderate obesity were generally not associated with an increased YLL and only severe obesity resulted in YLL. However, blacks at younger ages with severe levels of obesity had a maximum YLL of 20 for men and 5 for women.

Andersen and et.al⁵⁰ studied the relationship of physical activity and television watching with body weight and level of fatness among children, to assess participation in vigorous activity and television watching habits and their relationship to body weight and fatness in US children. Study design was nationally representative cross-sectional survey with an in-person interview and medical examination. The study conducted between 1988 and 1994, (4063) children aged 8 through 16 years were examined as part of the National Health and Nutrition Examination. Results were 80%

of US children reported performing 3 or more bouts of vigorous activity each week. This rate was lower in non-Hispanic black and Mexican American girls (69% and 73%, respectively). 20% of US children participated in 2 or fewer bouts of vigorous activity per week, and the rate was higher in girls (26%) than in boys (17%). Overall, 26% of US children watched 4 or more hours of television per day and 67% watched at least 2 hours per day. Non-Hispanic black children had the highest rates of watching 4 or more hours of television per day (42%). Boys and girls who watch 4 or more hours of television each day had greater body fat ($P, .001$) and had a greater body mass index ($P, .001$) than those who watched less than 2 hours per day. Many US children watch a great deal of television and are inadequately vigorously active. Vigorous activity levels are lowest among girls, non-Hispanic blacks, and Mexican Americans. Intervention strategies to promote lifelong physical activity among US children are needed to stem the adverse health consequences of inactivity.

Drinkard and et.al⁵¹ investigated relationship between walk/run performance and cardiorespiratory fitness in adolescents who are overweight. Subjects were eight African-American adolescents (5 female, 3 male) and 10 Caucasian adolescents (5 female, 5 male) who were overweight (mean age 14.5 years, SD 2.0, range 12–17; mean body mass index [BMI] 42.9 kg/m², SD 11.5) participated in this study. Subjects performed a 12-minute walk/run test. The distances traveled at both 9 minutes (D9) and 12 minutes (D12) were recorded, and the distance traveled between 9 and 12 minutes (D9–12) was calculated. Subjects also completed a maximal cycle ergometry test, during which peak oxygen uptake ($\dot{V}O_{2peak}$), anaerobic threshold (AT), peak power (W_{peak}), and

power at the anaerobic threshold (W_{at}) were determined. Body composition was determined by air displacement plethysmography. Results showed that the mean percentage of body fat was 48.6% (SD 5.3%, range 40.3%–60.4%). Percentage of body fat and BMI were each inversely related to D9, D12, and $\dot{V}O_{2peak}$ (all $P < .005$). Peak oxygen uptake ($r = .72$, $P < .0001$), $\dot{V}O_{2peak}/kg$ lean body mass ($r = .60$, $P < .005$), W_{peak} ($r = .88$, $P < .0001$), and W_{at} ($r = .72$, $P < .0007$) were all related to D12, with greater r values than for D9. If D9–12 was included in regression analyses, D9 did not account for additional variance in any of the cycle ergometry variables.

Discussion and Conclusion.

These results suggest that an easily obtained measurement of physical performance (distance traveled during a 12-minute walk/run test) is related to cardiorespiratory fitness and to body composition in adolescents who are overweight. The 12-minute walk/run distance is more predictive of cycle ergometry test results than the 9-minute distance.

Jeffery and French⁵² examined the relationship between socioeconomic status (SES) and weight control practices in women. SES defined by family income, was examined in an economically diverse sample of 998 women in relation to dieting practices by means of multivariate regression analyses controlling for age, ethnicity, smoking, and body mass index. Results showed that SES was positively associated with healthy, but not unhealthy, weight control practices; inversely related to energy and fat intake; and positively associated with weight concern and perceived social support for healthy eating and exercise. SES gradients were particularly striking at the low end of the income distribution (i.e., family income $<$ or $=$ \$10,000 per

year). The SES gradient in body mass index persisted in analyses controlling for attitudes and behaviors. Economic deprivation may contribute to high rates of obesity among lower SES women. The reasons for this require further research.

Frank et.al⁵³ examined the relationship between various sedentary behaviors, especially prolonged television (TV) watching, and risk of obesity and type 2 diabetes in women. Prospective cohort study conducted from 1992 to 1998 among women from 11 states in the Nurses' Health Study. The obesity analysis included 50277 women who had a body mass index (BMI) of less than 30 and were free from diagnosed cardiovascular disease, diabetes, or cancer and completed questions on physical activity and sedentary behaviors at baseline. The diabetes analysis included 68497 women who at baseline were free from diagnosed diabetes mellitus, cardiovascular disease, or cancer. Results showed that during 6 years of follow-up, 3757 (7.5%) of 50277 women who had a BMI of less than 30 in 1992 became obese (BMI \geq 30). Overall, the researchers documented 1515 new cases of type 2 diabetes. Time spent watching TV was positively associated with risk of obesity and type 2 diabetes. In the multivariate analyses adjusting for age, smoking, exercise levels, dietary factors, and other covariates, each 2-h/d increment in TV watching was associated with a 23% (95% confidence interval [CI], 17%-30%) increase in obesity and a 14% (95% CI, 5%-23%) increase in risk of diabetes; each 2-h/d increment in sitting at work was associated with a 5% (95% CI, 0%-10%) increase in obesity and a 7% (95% CI, 0%-16%) increase in diabetes. In contrast, standing or walking around at home (2 h/d) was associated with a 9% (95% CI, 6%-12%) reduction in obesity and a 12% (95% CI, 7%-16%) reduction

in diabetes. Each 1 hour per day of brisk walking was associated with a 24% (95% CI, 19%-29%) reduction in obesity and a 34% (95% CI, 27%-41%) reduction in diabetes. The researchers estimated that in our cohort, 30% (95% CI, 24%-36%) of new cases of obesity and 43% (95% CI, 32%-52%) of new cases of diabetes could be prevented by adopting a relatively active lifestyle (\leq 10 h/wk of TV watching and \leq 30 min/d of brisk walking).

Moore and et.al⁵⁴ prospectively examined BMI based on technician measurements of weight and height from 10 years prior to start of follow-up in relation to subsequent mortality in a cohort of 50 186 women who were 40–93 years old at baseline in 1987–1989. Deaths were ascertained through the US National Death Index. Proportional hazards regression was used to estimate hazard ratios (HRs) of mortality, adjusted for age, education, race/ethnicity, income, menopausal hormone use, smoking and physical activity. During 10 years of follow-up through 1997, 5201 women died. Overall, we observed a J-shaped association between BMI and mortality, with increased risk for women who were underweight, overweight or obese. The HRs and 95% confidence intervals of mortality for BMI categories of <18.5, 18.5–20.9, 21.0–23.4 (reference), 23.5–24.9, 25.0–27.4, 27.5–29.9, 30.0–34.9 and 35.0+ kg m⁻² were 1.43 (1.19, 1.72), 1.07 (0.98, 1.17), 1.00 (reference), 1.10 (1.00, 1.20), 1.20 (1.11, 1.31), 1.23 (1.11, 1.37), 1.60 (1.44, 1.77) and 1.92 (1.64, 2.24). There was little evidence that pre-existing conditions (heart disease, diabetes and/or cancer) or smoking history modified the past BMI and mortality relation ($P=0.54$ and 0.76).

Summary:

The studies about obesity and health awareness showed different ratios of obesity among different population. Also the studies proofed the importance of examining obesity with various variables like gender, age, watching T.V and sport practicing. Despite obesity, the studies over health awareness were few.

This study differs from other studies as it examines obesity in physical disabled people and it examines obesity and health awareness.

Chapter Three

Methodology and Procedures

This chapter presents the study methodology, population, sample, instruments, procedures, variables and statistical analysis.

3.1 Methodology

A descriptive analysis survey method was used, as it suitable to the purposes of the study.

3.2 Population of the study:

The study population consisted of (2524) disabled from all types of disability, (753) of them physically disabled persons in Nablus Governorate.

3.3 Sample of the study:

The study sample consisted of (244) physically disabled selected from Nablus Governorate, after coordination with disabled Union and Community based rehabilitation program at Nablus Governorate for data collection about number of disabled. Ageing is between (20-40) years old from both genders, by a purposive sample. Tables (1) show the sample distribution according to the study independent variables.

Table (1)

Sample distribution according to the study independent variables (N=244)

Variables	Levels of Variables	Frequency	Percent (%)
Gender	Male	155	63.5
	Female	89	36.5
Place of residence	City	73	29.9
	Village	95	38.9
	Camp	76	31.2
Disability type	Physical disability	210	86.1
	Multiple	34	13.9
Social status	Single	146	59.8
	married	93	38.1
	divorced	4	1.6
	Widow	1	0.5
Education	university	47	19.3
	secondary	88	36.1
	basic	78	32.0
	Non- educated	31	12.7
Economic	work	100	41.0
	Not work	144	59.0
Monthly income	Less 1000NIS	114	46.7
	1000-1500 NIS	65	26.6
	1501-200 NIS	47	19.3
	More than 2000 NIS	18	7.4
TV watching	No watching	25	10.2
	1-less 2 h	67	27.5
	2- 3 h	66	27.0
	More 3 h	86	35.2
Computer using	No use	137	56.1
	1-less 2 h	38	15.6
	2- 3 h	26	10.7
	More 3 h	43	17.6

3.4 Instrumentation:

1. Body Mass Index (BMI) :

The researcher measured BMI by taking the (weight in kg)/ (height in meters) ² of all participants in the study. The weight was measured by a medical balance and the height was measured by a meter. All measurements of height were without shoes.

2. Health Awareness Questionnaire :

The researcher has adopted a questionnaire prepared by the American Red Cross (1994) and translated it into terms suitable for the purpose of the study and for Palestinian society (appendix A). The questionnaire was filled in by the participants themselves with support and help if needed. The researcher reworded some sentences in order to make the statements of the questionnaire more clearly for the participants. All the items of the questionnaire were written in a positive manner. The responses of the items were set according to Likert scale as follows:

(5) Very high

(4) High

(3) Medium

(2) Low

(1) Very Low

3.4.1: Validity:

To ensure that the content of the questionnaire was valid, the questionnaire was reviewed and accordingly edited by five experts in Public Health and Measurement and Evaluation at An-Najah National University. The specialists approved of the validity of the questionnaire in general but suggested some modifications. Each item reached (80%) and more of the agreement between experts, was an item of the final version of the questionnaire. (Appendix 1)

3.4.2: Reliability:

To determine the reliability of the Health Awareness Questionnaire, the researcher used Alpha Formula for reliability. Table (2) shows the reliability coefficients for Health Awareness Questionnaire domains and total score.

Table (2)
Reliability coefficients for Health Awareness Questionnaire domains
And total score

No.	Domain	No. of items	Reliability coefficient
1	Nutrition	15	0.746
2	Exercises	6	0.847
3	Managing Stress	11	0.707
4	Smoking	5	0.708
5	Medical Care	12	0.712
Total score		49	0.851

As seen from table (2), all reliability coefficients values are suitable for research purposes.

3.5 Procedures of the study:

The researcher conducted the following procedures:

- Collecting of data about disabled from Palestinian Central Bureau of Statistics.
- Put a list of disabled from all areas of Nablus Governorate by contacting Societies related as medical relief Union and community based rehabilitation programs.
- Contacting the target groups to explain the idea of the study.
- Those who agree to take part will be asked to sign a special consent form.
- Putting a program of each area to carry out the test.
- Making the test for the target group.

3.6: Study variables:

Independent variables, which consisted of:

- Gender : (Male, Female)
- Age : (20-25 years, 26-30 years, 31-35 years, 36- 40 years)
- Social status: (Single, Married, Divorced, Widow)
- Education:(University, Secondary school, Primary school, Literal)

- Place of residence: (City, Camp, Village)
- Disability type: (Physical, Multiple)
- Economic status, (Working, Unemployed, Other)
- Monthly income for family : (Less than 1000 NIS, 1000-1500 NIS, 1501-2000 NIS, More than 2000 NIS)
- Daily television watching: (Don't watch television, watch about 1-to less than 2 hours, watch about 2-3 hours, watch more than 3 hours)
- Daily computer using : (Don't use computer, use for 1- to less than 2 hours, use for 2-3 hours, use more than 3 hours)

Dependent variables:

- Health awareness (H A)
- Body mass index (BMI): ($< 30 \text{ kg/m}^2$, $\geq 30 \text{ kg/m}^2$)

3.7 Statistical Analysis:

The researcher used the following statistical analysis:

1. Frequency and percentage tables of dependent and independent variables.
2. Independent T- test
3. One- Way ANOVA tests.
4. Scheffes' Post Hoc test.

Chapter Four

Findings of the Study

This chapter presents the findings of the study in accordance with its questions and hypotheses. This study aimed at measuring the influence of socio- demographic factors on level of obesity and health – awareness among physically disabled in Nablus Governorate. Furthermore, the study aimed at determining the extent to which gender, age, place of residence, disability type, social status, education, economic status, monthly income, daily TV watching and daily computer using affect the level of obesity and health – awareness among physically disabled in Nablus Governorate. Thus, the findings of the study will be presented according to the sequence of the study questions and its hypotheses respectively.

Findings related to the questions of the study:

1-Study Question: What is the present level of health awareness among physically disabled in Nablus Governorate?

To answer this question, the researcher calculated means, percentages of the questionnaire items. The researcher used the following scale, which had five levels, to evaluate the degree of agreement of the respondents regarding the use of each item.

- 80 % - 100 %: very high.
- 70 – 79 %: high
- 60 -69 %: medium
- 50 -59 %: low
- Below 50 %: very low.

Tables (3 to 8) show the results of each domain and the total score

Table (3)

The Mean Scores, and Percentages of Nutrition Domain

No.	Statement	Mean	Percent %	Estimation level
1.	I eat a balanced diet.	2.96	59.2	Low
2.	I limit my intake of saturated fats and cholesterol.	2.69	53.8	Low
3.	I limit my intake of salt.	2.87	57.4	Low
4.	I bake, broil, or grill foods rather than frying them.	2.96	59.2	Low
5.	I eat fruits, vegetables, and low-fat yogurts when snacking rather than “junk” food.	3.62	72.4	High
6.	I read labels for information about the nutritional weight.	2.94	58.8	Low
7.	I maintain an appropriate weight.	3.05	71.0	High
8.	If I need to lose weight, I avoid fad, starvation, or miracle diets that are harmful to my health.	2.89	57.8	Low
9.	I eat meals on regular bases.	2.85	57.0	Low
10.	I go to the toilet regularly.	3.03	60.6	Medium
11.	I suffer from constipation.	2.18	43.6	Very low
12.	I eat pickles and other similar foods.	2.93	58.6	Low
13.	I avoid eating while listening to music or watching TV.	2.48	49.6	Very low
14.	I avoid drinking too much tea and coffee.	2.34	46.8	Very low
15.	I eat and drink more even when I’m not hungry in social situations.	2.96	59.2	Low
Total score of Nutrition domain		2.85	57.0	Low

* Maximum point of response (5) point

The result of table (3) show that the present status of health awareness in the Nutrition domain among physically disabled in Nablus Governorate are high on items (5, 7) where the percentages of responses are respectively (72.4%) and (71.0%), medium on item (10) where the percentage of responses is (60.6), low on items (1, 2, 3, 4, 6, 8, 9, 12, 15) where the percentages of responses are respectively (59.2%, 53.8%, 57.4%, 59.2%, 58.8% , 57.8% , 57.0% , 58.6%, 59.2%) and very low on items (11, 13, 14) where the percentages of responses are respectively (43.6%, 49.6%, 46.8%).The total score of the nutrition domain is low where the percentage of responses is (57%).

Table (4)

The Mean Scores, and Percentages of Exercises Domain

No.	Statement	Mean	Percent%	Estimation level
1.	I participate in continuous, vigorous physical activity for 20 to 30 minutes or more at least three times per week.	1.99	39.8	Very low
2.	I follow an exercise program appropriate for my level of fitness	2.03	40.6	Very low
3.	I warm up properly before vigorous activity and cool down afterwards.	1.82	36.4	Very low
4.	I use exercise equipment properly and safely.	1.84	36.8	Very low
5.	I swim only when others are present.	1.95	39.0	Very low
6.	I wear highly visible clothing when exercise outdoor such as walking, running, or biking.	1.73	34.6	Very low
Total score of Exercises domain		1.89	37.8	Very low

* Maximum point of response (5) point

The results of table (4) show that the present status of health awareness in the Exercises domain among physically disabled in Nablus Governorate, is very low, on items (1, 2, 3, 4, 5, 6) where the percentages of responses are respectively (39.8%, 40.6%, 36.4%, 36.8%, 36.8%, 39.0%, 34.6%). The total score of the exercises domain is very low where the percentage of responses is (37.8%).

Table (5)

The Mean Scores, and Percentages of Managing Stress Domain

No.	Statement	Mean	Percentage	Estimation level
1.	I schedule my day to allow time for leisure activity.	2.27	45.4	Very low
2.	I get an adequate amount of sleep.	3.41	68.2	Medium
3.	I express feeling of anger or worry openly and constructively.	3.63	72.6	High
4.	I say "no" without feeling guilty.	3.27	65.4	Medium
5.	I make decisions with a minimum of stress and worry.	3.02	60.4	Medium

No.	Statement	Mean	Percentage	Estimation level
6.	I set realistic goals for myself.	3.26	65.2	Medium
7.	I accept responsibility for my actions.	3.86	77.2	High
8.	I seek professional help when stress becomes too difficult to manage.	3.32	66.4	Medium
9.	I allow myself to cry.	3.11	62.2	Medium
10.	I manage stress so that it does not affect my physical well-being.	2.89	57.8	Low
11.	I discuss problems with friends or relatives.	3.09	61.8	Medium
Total score of Managing Stress domain		3.19	63.8	Medium

* Maximum point of response (5) point

The results of table (5) show that the present status of health awareness in the Managing Stress domain among physically disabled in Nablus Governorate, are high on items (3, 7) where the percentages of responses are respectively (72.6%, 77.25), medium on items (2, 4, 5, 6, 8, 9, 11) where the percentages of responses are respectively (68.2%, 65.4%, 60.4%, 65.2%, 66.4%, 62.2%, 61.8%), low on item (10) where the percentage of responses is (57.8) and very low on item (1) where the percentage of responses is (45.4%). The total score of the managing stress domain is medium where the percentage of responses is (63.8%).

Table (6)

The Mean Scores, and Percentages of Smoking Domain

No	Statement	Mean	Percent%	Estimation level
1.	I avoid smoking cigarettes, cigars, pipes, or using other forms of tobacco such as chewing tobacco or snuff.	2.90	58.0	Low
2.	I try to avoid inhaling the smoke of others.	2.75	55.0	Low
3.	I recommend others to refrain from smoking.	3.30	66.0	Medium
4.	I am trying to quit smoking.	3.64	72.8	High
5.	I am aware that smoking is very harmful to.	4.20	84.0	Very High
Total score of Smoking domain		3.36	67.2	Medium

* Maximum point of response (5) point

The results of table (6) show that the present status of health awareness in the Smoking domain among physically disabled in Nablus Governorate, are very high on item (5) where the percentage of responses is (84.0%), high on item (4) where the percentage of responses is (72.8%), medium on item (3) where the percentage of responses is (66.0%), low on item (1, 2) where the percentage of responses are respectively (58.0%, 55.0%). The total score of the smoking domain is medium where the percentage of responses is (67.2%).

Table (7)

The Mean Scores, and Percentages of Medical Care Domain

No.	Statement	Mean	Percent%	Estimation level
1.	I seek appropriate care or cut back on activities, as necessary, when I feel unwell or tired.	2.89	57.8	Low
2.	I maintain an accurate, written, current personal health history.	3.26	65.2	Medium
3.	I brush my teeth at least twice a day.	2.79	55.8	Low
4.	I floss my teeth at least once a day.	1.91	38.2	Very low
5.	I ask questions of health care providers.	2.99	59.8	Low
6.	I use a sunscreen with ultra-violet (UV) protection when spending time in the sun.	1.99	39.8	Very low
7.	I wear sunglasses with UV protection when out in the sun.	2.34	46.8	Very low
8.	I practice good personal hygiene by bathing daily and washing my hands frequently.	3.71	74.2	High
9.	I have regular medical checkups.	2.49	49.8	Very low
10.	I have regular dental checkups.	2.26	45.2	Very low
11.	I have regular eye examinations.	2.59	51.8	Low
12.	I maintain adequate health insurance coverage.	3.81	76.2	High
Total score of Medical Care domain		2.75	55.0	Low

* Maximum point of response (5) point

The results of table (7) show that the present status of health awareness in the Medical Care domain among physically disabled in Nablus

Governorate, are high on items (8, 12) where the percentage of responses are respectively (74.2%, 76.2%), medium on item (2) where the percentage of responses is (65.2%), low on items (1, 3, 5, 11) where the percentage of responses are respectively (57.8%, 55.8%, 59.8%, 51.8%) and very low on items (4, 6, 7, 9, 10) where the percentage of responses are respectively (38.2%, 39.8%, 46.8%, 49.8%, 45.2%). The total score of the medical care domain is low where the percentage of responses is (55.0%).

Table (8)

The Mean Scores, and Percentages of Health Awareness and total score

No.	Domain	Mean	Percent%	Rank order
1.	Nutrition	2.85	57.0	3
2.	Exercises	1.89	37.8	5
3.	Managing Stress	3.19	63.8	2
4.	Smoking	3.36	67.2	1
5.	Medical Care	2.75	55.0	4
Total score		2.81	56.2	Low

* Maximum point of response (5) point

The results of table (8) show that the total score of the present status of health awareness in the among physically disabled in Nablus Governorate, are medium on smoking and managing stress domains where the percentage of responses are respectively (67.2%, 63.8%), low on nutrition and medical care domains where the percentage of responses are respectively (57.0%, 55.0%) and very low on exercises domain where the percentage of responses is (37.8%). The total score of the present status of health awareness among physically disabled in Nablus Governorate is low where the percentage of responses is (56.2%). Figure (1) presents a bar graph for the domains of level of health awareness.

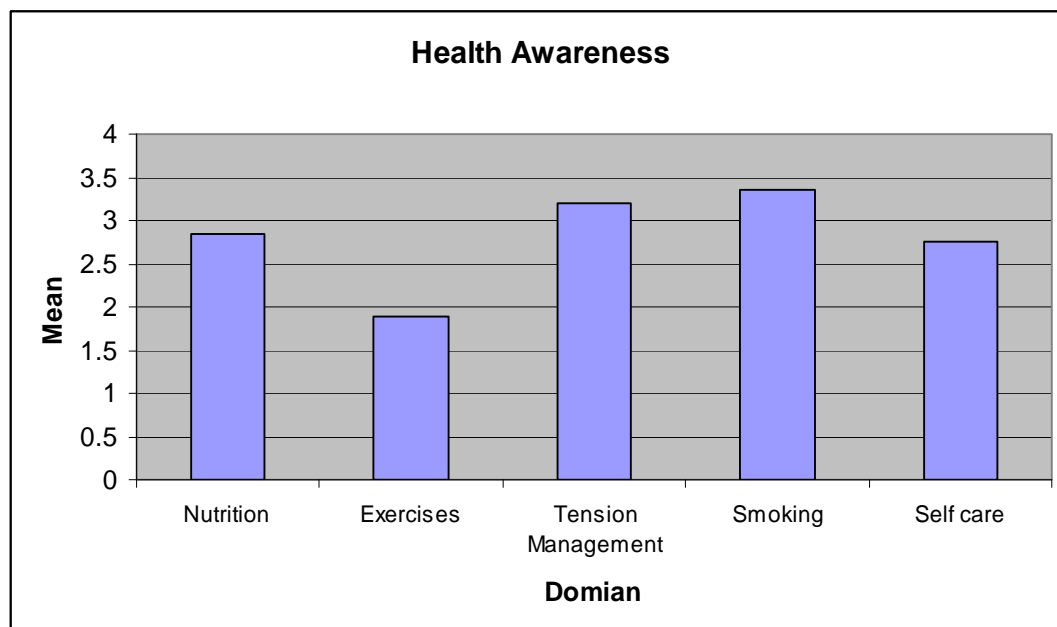


Figure (1)
The means of health awareness domains

Table (9)

The Mean Scores, Standard Deviations and Percentages of Sample weights, heights and BMI

No.	Domain	Mean	Standard Deviation
1.	Weight	69.84	14.11
2.	Height	1.64	0.127
4.	BMI	25.91	4.519

Table (9) shows the means of the sample weights, heights and BMI. Table (9) was used to clarify the calculation of BMI,

Results Related to the Hypotheses of the study:

Results related to hypothesis one:

Hypothesis one says: There are no significant differences at the level ($\alpha = 0.05$) in the means of BMI, according to Gender, Age, Place of residence, disability type, Social status, Education, Economic status, Monthly income, Daily TV watching and Daily computer using variables.

A-Gender

The researcher conducted independent t-test and the results of this analysis are shown in table (10).

Table (10)
Results of t-test for BMI according to gender variable

gender	Frequency	Mean	Standard Deviation	D.F	T value	Sig*
Male	155	25.42	4.34	242	2.220	0.027*
Female	89	26.75	4.72			

* Statically significant at ($\alpha = 0.05$).

Table (10) indicates that there are significant differences at the level ($\alpha = 0.05$) between the means of BMI, between males and females, in favor of females.

B- Age

The researcher conducted One Way ANOVA Test and the results of this analysis are shown in tables (11), (12).

Table (11)
Frequencies, means and standards deviations of BMI, according to Age variable

Age	Frequency	Mean	Standard deviation
20-25	78	25.11	4.28
26-30	57	24.99	3.63
31-35	44	26.29	5.60
36-40	65	27.39	5.09
Total	244	25.91	4.52

Table (12)
Results of One Way ANOVA Test for BMI according to Age variable

Source of Variation	Sum of Squares	Degrees of freedom	Mean Square	F value	Sig
Between Groups	246.873	3	82.291	4.187	0.007*
Within Group	4716.464	240	19.652		
Total	4963.337	243			

* Statically significant at ($\alpha = 0.05$)

Table (12) indicates that there are significant differences at the level ($\alpha = 0.05$) in the means of BMI, according to Age variable. To know in favor of whom the differences are related, Scheffes' Post Hoc Test was conducted. Table (13) shows the results of using Scheffe Post Hoc Test.

Table (13)

The results of using Scheffe Post Hoc, for comparing the means of BMI according to Age variable

Age	20-25	26-30	31-35	36-40
20-25		0.1210	-1.180	-2.279*
26-30			-1.301	-2.400*
31-35				-1.099
36-40				

- Statically significant at ($\alpha = 0.05$)

Table (13) shows that:

- There are significant differences at the level ($\alpha = 0.05$) in the means of BMI, according to Age variable, (20-25) and (36-40) in favor of (36-40).
- There are significant differences at the level ($\alpha = 0.05$) in the means of BMI, according to Age variable, (26-30) and (36-40) in favor of (36-40).

C- Place of residence:

The researcher conducted One Way ANOVA Test and the results of this analysis are shown in tables (14) and (15).

Table (14)

Frequencies, means and standards deviations of BMI, according to Place of residence variable

Place	Frequency	Mean	Standard deviation
City	73	26.91	4.66
Village	95	25.16	4.04
Camp	76	25.86	4.82
Total	244	25.91	4.52

Table (15)

Results of One Way ANOVA Test for BMI according to Place of residence variable

Source of Variation	Sum of Squares	Degrees of freedom	Mean Square	F value	Sig
Between Groups	126.778	2	63.389	3.159	0.044*
Within Group	4836.559	241	20.069		
Total	4963.337	243			

* Statically significant at ($\alpha = 0.05$).

Table (15) indicates that there are significant differences at the level ($\alpha = 0.05$) in the means of BMI, according to Place of residence variable. To know in favor of whom the differences are related, Scheffes' Post Hoc Test was conducted. Table (16) shows the results of using Scheffe Post Hoc Test.

Table (16)

The results of using Scheffe Post Hoc, for comparing the means of BMI, according to Place of residence variable

Place of residence	City	Village	Camp
City		1.751*	1.053
Village			-0.698
Camp			

* Statically significant at ($\alpha = 0.05$)

Table (16) shows that:

- There are significant differences at the level ($\alpha = 0.05$) in the means of BMI, according to Place of residence variable, between City and Village in favor of City.

D- Disability type:

The researcher conducted independent t-test and the results of this analysis are shown in table (17).

Table (17)

Results of t-test for BMI according to disability type variable

disability type	Frequency	Mean	Standard Deviation	D.F	T value	Sig*
Physical disability	210	26.02	4.52	242	0.962	0.337
Multiple	34	25.21	4.49			

* Statically significant at ($\alpha = 0.05$).

Table (17) indicates that there are no significant differences at the level ($\alpha = 0.05$) in the means of BMI, according to disability type variable.

E- Social status:

The researcher conducted independent t-test and the results of this analysis are shown in table (18).

Table (18)

Results of t-test for BMI according to social status variable

Social status	Frequency	Mean	Standard Deviation	D.F	T value	Sig*
Single	146	25.30	4.41	242	2.583	0.010*
Married	98	26.81	4.55			

* Statically significant at ($\alpha = 0.05$).

Table (18) indicates that there are significant differences at the level ($\alpha = 0.05$) in the means of BMI, according to social status variable, in favor of married.

F- Education:

The researcher conducted One Way ANOVA Test and the results of this analysis are shown in tables (19) and (20).

Table (19)

Frequencies, means and standards deviations of BMI, according to Education variable

Education	Frequency	Mean	Standard deviation
University	47	25.27	5.14
Secondary	88	24.63	3.89
Basic	78	27.35	4.13
Non-educated	31	26.86	5.06
Total	244	25.91	4.52

Table (20)

Results of One Way ANOVA Test for BMI according to Education variable

Source of Variation	Sum of Squares	Degrees of freedom	Mean Square	F value	Sig*
Between Groups	354.065	3	118.022	6.145	0.0001*
Within Group	4609.272	240	19.205		
Total	4963.337	243			

* Statically significant at ($\alpha = 0.05$).

Table (20) indicates that there are significant differences at the level ($\alpha = 0.05$) in the means of BMI according to Education variable. To know in favor of whom the differences are related, Scheffes' Post Hoc Test was conducted. Table (21) shows the results of using Scheffe Post Hoc Test.

Table (21)

The results of using Scheffe Post Hoc, for comparing the means of BMI, according to Education variable

Education	University	Secondary	Basic	Non-educated
University		0.644	-2.080	-1.592
Secondary			-2.724*	-2.236
Basic				0.488
Non-educated				

* Statically significant at ($\alpha = 0.05$)

Table (21) shows that:

- There are significant differences at the level ($\alpha = 0.05$) in the means of BMI, according to Education variable, between secondary and basic in favor of basic.

G- Economic status:

The researcher conducted independent T-Test and the results of this analysis are shown in table (22).

Table (22)
Results of t-test for BMI according to Economic status variable

Economic status	Frequency	Mean	Standard Deviation	D.F	t-test value	Sig*
Work	100	26.13	4.86	242	0.637	0.525
No work	144	25.57	4.28			

* Statically significant at ($\alpha = 0.05$).

Table (22) indicates that there are no significant differences at the level ($\alpha = 0.05$) in the means of BMI, according to economic status variable.

H- Monthly income:

The researcher conducted One Way ANOVA Test and the results of this analysis are shown in tables (23) and (24).

Table (23)
Frequencies, means and standards deviations of BMI, according to Monthly income variable

Monthly income	Frequency	Mean	Standard deviation
Less 1000 ns	114	25.69	4.39
1000-1500 ns	65	25.64	4.37
1501-2000 ns	47	27.01	4.99
More than 2000 ns	18	25.35	4.51
Total	244	25.91	4.52

Table (24)

Results of One Way ANOVA Test for BMI according to Monthly income variable

Source of Variation	Sum of Squares	Degrees of freedom	Mean Square	F value	Sig*
Between Groups	72.657	3	24.219	1.188	0.315
Within Group	4890.680	240	20.378		
Total	4963.337	243			

* Statically significant at ($\alpha = 0.05$).

Table (24) indicates that there are no significant differences at the level ($\alpha = 0.05$) in the means of BMI, according to monthly income variable.

I – Daily TV watching

The researcher conducted One Way ANOVA Test and the results of this analysis are shown in tables (25) and (26).

Table (25)

Frequencies, means and standards deviations of BMI, according to Daily TV watching variable

Daily TV watching	Frequency	Mean	Standard deviation
No viewing	25	26.04	4.81
1- less 2h	67	26.03	4.55
2-3 h	66	25.38	4.60
More 3 h	86	26.17	4.39
Total	244	25.91	4.52

Table (26)

Results of One Way ANOVA Test for BMI according to Daily TV watching variable

Source of Variation	Sum of Squares	Degrees of freedom	Mean Square	F value	Sig*
Between Groups	26.015	3	8.672	0.422	0.738
Within Group	4937.322	240	20.572		
Total	4963.337	243			

* Statically significant at ($\alpha = 0.05$).

Table (26) indicates that there are no significant differences at the level ($\alpha = 0.05$) in the means of BMI, according to Daily TV watching variable.

J - Daily computer using

The researcher conducted One Way ANOVA Test and the results of this analysis are shown in tables (27) and (28).

Table (27)

Frequencies, means and standards deviations of BMI, according to Daily computer using variable

Daily TV watching	Frequency	Mean	Standard deviation
No use	137	26.10	4.36
1- less 2h	38	26.10	4.73
2-3 h	26	26.50	5.11
More 3 h	43	24.75	4.42
Total	244	25.91	4.52

Table (28)

Results of One Way ANOVA Test for BMI according to Daily computer using variable

Source of Variation	Sum of Squares	Degrees of freedom	Mean Square	F value	Sig*
Between Groups	73.308	3	24.436	1.199	0.311
Within Group	4890.028	240	20.375		
Total	4963.337	243			

* Statically significant at ($\alpha = 0.05$).

Table (28) indicates that there are no significant differences at the level ($\alpha = 0.05$) in the means of BMI, according to Daily computer using variable.

Results related to hypothesis tow:

Hypothesis tow says: There are no significant differences at the level ($\alpha = 0.05$) in the means of health awareness and it's domains, according to Gender, Age, Place of residence, disability type, Social status, Education,

Economic status, Monthly income, Daily TV watching and Daily computer using variables

A- Gender:

The researcher conducted independent t-test and the results of this analysis are shown in table (29).

Table (29)

Results of t-test for health awareness and its domains according to gender variable

Domains	Male (n=155)		Female (n=89)		t-test value	Sig
	Mean	Standard deviation	Mean	Standard deviation		
Nutrition	2.78	0.605	2.97	0.696	2.252	0.025*
Exercises	2.07	1.042	1.59	0.751	3.820	0.0001*
Managing Stress	3.14	0.731	3.30	0.654	1.729	0.085
Smoking	3.18	1.064	3.67	1.116	3.444	0.001*
Medical Care	2.73	0.676	2.79	0.723	0.709	0.479
Total score	2.78	0.521	2.87	0.499	1.271	0.205

* Statically significant at ($\alpha = 0.05$). degree of freedom = 242

Table (29) indicates that there are significant differences at the level ($\alpha = 0.05$) in the means of Nutrition and Smoking domains, attributed to gender variable, in favor of females and there are significant differences at the level ($\alpha = 0.05$) in the means of Exercises domain, according to gender variable, in favor of males. Significant differences are not found in the means of Managing Stress, Medical Care and Total score, according to gender variable.

B- Age:

The researcher conducted One Way ANOVA Test and the results of this analysis are shown in tables (30) and (31).

Table (30)

Frequencies, means and standards deviations of health awareness and its domains, according to Age variable

Domains	Age	Frequency	Mean	Standard deviation
Nutrition	20-25	78	2.88	0.59
	26-30	57	2.91	0.68
	31-35	44	2.82	0.63
	36-40	65	2.78	0.69
	Total	244	2.85	0.65
Exercises	20-25	78	2.12	1.10
	26-30	57	1.86	0.83
	31-35	44	1.90	1.03
	36-40	65	1.65	0.83
	Total	244	1.89	0.97
Managing Stress	20-25	78	3.25	0.57
	26-30	57	3.26	0.73
	31-35	44	3.22	0.74
	36-40	65	3.06	0.80
	Total	244	3.19	0.71
Domains	Age	Frequency	Mean	Standard deviation
Smoking	20-25	78	3.45	0.96
	26-30	57	3.34	1.17
	31-35	44	3.17	1.05
	36-40	65	3.40	1.24
	Total	244	3.36	1.11
Medical Care	20-25	78	2.87	0.67
	26-30	57	2.86	0.61
	31-35	44	2.76	0.80
	36-40	65	2.52	0.68
	Total	244	2.75	0.69
Total score	20-25	78	2.91	0.49
	26-30	57	2.84	0.53
	31-35	44	2.77	0.51
	36-40	65	2.68	0.52
	Total	244	2.81	0.51

Table (31)
Results of One Way ANOVA Test for health awareness and its domains according to Age variable

Domains	Source of Variation	Sum of Squares	Degrees of freedom	Mean Square	F value	Sig*
Nutrition	Between Groups	0.580	3	0.193	0.461	0.709
	Within Group	100.534	240	0.419		
	Total	101.114	243			
Exercises	Between Groups	8.122	3	2.707	2.931	0.034*
	Within Group	221.663	240	0.924		
	Total	229.785	243			
Managing Stress	Between Groups	1.637	3	0.546	1.094	0.352
	Within Group	119.647	240	0.499		
	Total	121.283	243			
Smoking	Between Groups	2.324	3	0.775	0.629	0.597
	Within Group	295.426	240	1.231		
	Total	297.750	243			
Medical Care	Between Groups	4.982	3	1.661	3.572	0.015*
	Within Group	111.584	240	0.465		
	Total	116.567	243			
Total Score	Between Groups	1.972	3	0.657	2.533	0.058
	Within Group	62.281	240	0.260		
	Total	64.253	243			

- Statically significant at ($\alpha = 0.05$)

Table (31) indicates that there are no significant differences at the level ($\alpha = 0.05$) in the means of Nutrition, Managing Stress, smoking domains and total score, according to Age variable.

Also table (31) indicates that there are significant differences at the level ($\alpha = 0.05$) in the means of Exercises and Medical Care domains, according to Age variable. To know in favor of whom the differences are related, Scheffes' Post Hoc Test was conducted. Tables (32) and (33) show the results of using Scheffes' Post Hoc Test.

Table (32)

The results of using Scheffe Post Hoc, for comparing the means of Exercises domain, according to Age variable

Age	20-25	26-30	31-35	36-40
20-25		0.2651	0.2203	0.4756*
26-30			-0.045	0.2106
31-35				0.2554
36-40				

* Statically significant at ($\alpha = 0.05$)

Table (15) shows that:

- There are significant differences at the level ($\alpha = 0.05$) in the means of Exercises domain, attributed to Age variable, (20-25) and (36-40) in favor of (20-25).

Table (33)

The results of using Scheffe Post Hoc, for comparing the means of Medical Care domain, according to Age variable

Age	20-25	26-30	31-35	36-40
20-25		0.010	0.1040	0.3410*
26-30			0.094	0.3309
31-35				0.2370
36-40				

* Statically significant at ($\alpha = 0.05$)

Table (33) shows that:

- There are significant differences at the level ($\alpha = 0.05$) in the means of Medical Care domain, according to Age variable, (20-25) and (36-40) in favor of (20-25).

C- Place of residence:

The researcher conducted One Way ANOVA Test and the results of this analysis are shown in tables (34) and (35).

Table (34)

Frequencies, means and standards deviations of health awareness and its domains, according to Place of residence variable

Domain	Place of residence	Frequency	Mean	Standard deviation
Nutrition	City	73	2.70	0.77
	Village	95	2.98	0.62
	Camp	76	2.84	0.51
	Total	244	2.85	0.65
Exercises	City	73	2.10	1.15
	Village	95	1.80	0.84
	Camp	76	1.82	0.92
	Total	244	1.89	0.97
Managing Stress	City	73	3.16	0.71
	Village	95	3.13	0.69
	Camp	76	3.31	0.72
	Total	244	3.19	0.71
Smoking	City	73	3.17	1.18
	Village	95	3.66	0.99
	Camp	76	3.16	1.11
	Total	244	3.36	1.11
Medical Care	City	73	2.66	0.74
	Village	95	2.70	0.68
	Camp	76	2.91	0.65
	Total	244	2.75	0.69
Total score	City	73	2.76	0.63
	Village	95	2.85	0.49
	Camp	76	2.81	0.41
	Total	244	2.81	0.51

Table (35)

Results of One Way ANOVA Test for health awareness and its domains according to Place of residence variable

Domain	Source of Variation	Sum of Squares	Degrees of freedom	Mean Square	F value	Sig*
Nutrition	Between Groups	3.102	2	1.551	3.813	0.023*
	Within Group	98.013	241	0.407		
	Total	101.114	243			
Exercises	Between Groups	4.286	2	2.143	2.290	0.103
	Within Group	225.499	241	0.936		
	Total	229.785	243			
Managing Stress	Between Groups	1.369	2	0.684	1.375	0.255
	Within Group	119.915	241	0.498		
	Total	121.283	243			
Smoking	Between Groups	14.399	2	7.199	6.123	0.003*
	Within Group	283.352	241	1.176		
	Total	297.750	243			
Medical Care	Between Groups	2.735	2	1.367	2.895	0.057
	Within Group	113.832	241	0.472		
	Total	116.567	243			
Total Score	Between Groups	0.388	2	0.194	0.732	0.482
	Within Group	63.865	241	0.265		
	Total	64.253	243			

* Statically significant at ($\alpha = 0.05$)

Table (35) indicates that there are no significant differences at the level ($\alpha = 0.05$) in the means of Exercises , Managing Stress, Medical Care domains and total score, according to place of residence variable.

Also table (35) indicates that there are significant differences at the level ($\alpha = 0.05$) in the means of Nutrition Smoking domains, according to Place of residence variable. To know in favor of whom the differences are related, Scheffes' Post Hoc Test was conducted. Tables (36) and (37) show the results of using Scheffe Post Hoc Test.

Table (36)

The results of using Scheffe Post Hoc, for comparing the means of Nutrition domain, according to Place of residence variable

Place of residence	City	Village	Camp
City		- 0.273*	- 0.132
Village			0.141
Camp			

* Statically significant at ($\alpha = 0.05$)

Table (36) shows that:

- There are significant differences at the level ($\alpha = 0.05$) in the means of Nutrition domain, according to Place of residence variable, between City and Village in favor of Village.

Table (37)

The results of using Scheffe Post Hoc, for comparing the means of Smoking domain, according to Place of residence variable

Place of residence	City	Village	Camp
City		- 0.491*	0.015
Village			0.505*
Camp			

* Statically significant at ($\alpha = 0.05$)

Table (37) shows that:

- There are significant differences at the level ($\alpha = 0.05$) in the means of Smoking domain, according to Place of residence variable, between City and Village in favor of Village.

- There are significant differences at the level ($\alpha = 0.05$) in the means of Smoking domain, according to Place of residence variable, between Camp and Village in favor of Village.

D- Disability type:

The researcher conducted independent t-test and the results of this analysis are shown in table (38).

Table (38)
Results of t-test for health awareness and its domains according to disability type variable

Domains	Motion (n=210)		Multiple (n=34)		T- value	Sig*
	Mean	Standard deviation	Mean	Standard deviation		
Nutrition	2.85	0.64	2.86	0.68	0.061	0.951
Exercises	1.91	0.99	1.77	0.85	0.768	0.443
Managing Stress	3.22	0.70	3.07	0.76	1.136	0.257
Smoking	3.37	1.11	3.30	1.07	0.334	0.738
Medical Care	2.78	0.69	2.62	0.71	1.256	0.210
Total score	2.82	0.51	2.72	0.55	1.070	0.286

* Statically significant at ($\alpha = 0.05$). degree of freedom = 242

Table (38) indicates that there are no significant differences at the level ($\alpha = 0.05$) in the means of health awareness and its domains according to disability type variable.

E- Social status:

For testing hypothesis, the researcher conducted independent t-test and the results of this analysis are shown in table (39).

Table (39)

Results of t-test for health awareness and its domains according to social status variable

Domains	Single (n=146)		Married (n=98)		t- test value	Sig*
	Mean	Standard deviation	Mean	Standard deviation		
Nutrition	2.90	0.61	2.77	0.68	1.574	0.117
Exercises	1.89	0.99	1.89	0.95	0.008	0.994
Managing Stress	3.26	0.66	3.10	0.76	1.664	0.097
Smoking	3.55	1.08	3.08	1.09	3.346	0.001*
Medical Care	2.81	0.70	2.66	0.68	1.656	0.099
Total score	2.88	0.49	2.70	0.53	2.744	0.007*

* Statically significant at ($\alpha = 0.05$). degree of freedom = 242

Table (39) indicates that there are significant differences at the level ($\alpha = 0.05$) in the means of Smoking domain and total score, according to social status variable, in favor of single. Significant differences are not found in the means of Nutrition, Exercises, Managing Stress and Medical Care domains, according to social status variable.

F- Education:

The researcher conducted One Way ANOVA Test and the results of this analysis are shown in tables (40) and (41).

Table (40)

Frequencies, means and standards deviations of health awareness and its domains, according to Education variable

Domains	Education	Frequency	Mean	Standard deviation
Nutrition	University	47	3.12	0.70
	Secondary	88	2.87	0.59
	Basic	78	2.81	0.62
	Non-educated	31	2.49	0.60
	Total	244	2.85	0.65
Exercises	University	47	2.14	0.98
	Secondary	88	1.93	0.99
	Basic	78	1.82	0.96
	Non-educated	31	1.61	0.86

Domains	Education	Frequency	Mean	Standard deviation
	Total	244	1.89	0.97
Managing Stress	University	47	3.35	0.61
	Secondary	88	3.25	0.63
	Basic	78	3.15	0.77
	Non-educated	31	2.89	0.81
	Total	244	3.19	0.71
Smoking	University	47	3.58	1.14
	Secondary	88	3.39	1.09
	Basic	78	3.31	1.06
	Non-educated	31	3.08	1.19
	Total	244	3.36	1.11
Medical Care	University	47	2.99	0.66
	Secondary	88	2.84	0.63
	Basic	78	2.62	0.77
	Non-educated	31	2.48	0.54
	Total	244	2.75	0.69
Total score	University	47	3.04	0.53
	Secondary	88	2.85	0.44
	Basic	78	2.74	0.51
	Non-educated	31	2.51	0.54
	Total	244	2.81	0.51

Table (41)

Results of One Way ANOVA Test for health awareness and its domains according to Education variable

Domains	Source of Variation	Sum of Squares	Degrees of freedom	Mean Square	F value	Sig*
Nutrition	Between Groups	7.466	3	2.489	6.378	0.001*
	Within Group	93.648	240	0.390		
	Total	101.114	243			
Exercises	Between Groups	5.909	3	1.970	2.111	0.099
	Within Group	223.876	240	0.933		
	Total	229.785	243			
Managing Stress	Between Groups	4.433	3	1.478	3.035	0.030*
	Within Group	116.850	240	0.487		
	Total	121.283	243			

Domains	Source of Variation	Sum of Squares	Degrees of freedom	Mean Square	F value	Sig*
Smoking	Between Groups	5.108	3	1.703	1.396	0.245
	Within Group	292.642	240	1.219		
	Total	297.750	243			
Medical Care	Between Groups	6.819	3	2.273	4.970	0.002*
	Within Group	109.748	240	0.457		
	Total	116.567	243			
Total Score	Between Groups	5.719	3	1.906	7.816	0.001*
	Within Group	58.534	240	0.244		
	Total	64.253	243			

* Statically significant at ($\alpha = 0.05$)

Table (41) indicates that there are no significant differences at the level ($\alpha = 0.05$) in the means of Exercises and Smoking according to Education variable. Also table (41) indicates that there are significant differences at the level ($\alpha = 0.05$) in the means of Nutrition, Managing Stress and Medical Care domains and total score, according to Education variable. To know in favor of whom the differences are related, Scheffes' Post Hoc Test was conducted. Tables (42), (43), (44) and (45) show the results of using Scheffe Post Hoc Test.

Table (42)

The results of using Scheffe Post Hoc, for comparing the means of Nutrition domain, according to Education variable

Education	University	Secondary	Basic	Non-educated
University		0.250	0.305	0.625*
Secondary			0.055	0.375*
Basic				0.320
Non-educated				

* Statically significant at ($\alpha = 0.05$)

Table (42) shows that:

- There are significant differences at the level ($\alpha = 0.05$) in the means of Nutrition domain, according to Education variable, between university and non-educated in favor of university.

- There are significant differences at the level ($\alpha = 0.05$) in the means of Nutrition domain, according to Education variable, between secondary and non-educated in favor of secondary.

Table (43)

The results of using Scheffe Post Hoc, for comparing the means of Managing Stress domain, according to Education variable

Education	University	Secondary	Basic	Non-educated
University		0.100	0.203	0.460*
Secondary			0.102	0.359
Basic				0.257
Non-educated				

* Statically significant at ($\alpha = 0.05$)

Table (43) shows that:

- There are significant differences at the level ($\alpha = 0.05$) in the means of Managing Stress domain, according to Education variable, between university and non-educated in favor of university.

Table (44)

The results of using Scheffe Post Hoc, for comparing the means of Medical Care domain, according to Education variable

Education	University	Secondary	Basic	Non-educated
University		0.155	0.367*	0.507*
Secondary			0.212	0.352
Basic				0.140
Non-educated				

* Statically significant at ($\alpha = 0.05$)

Table (44) shows that:

- There are significant differences at the level ($\alpha = 0.05$) in the means of Medical Care domain, according to Education variable, between university and non-educated in favor of university.

Table (45)

The results of using Scheffe Post Hoc, for comparing the means of Total score, according to Education variable

Education	University	Secondary	Basic	Non-educated
University		0.182	0.294*	0.526*
Secondary			0.112	0.344*
Basic				0.231
Non-educated				

* Statically significant at ($\alpha = 0.05$)

Table (45) shows that:

- There are significant differences at the level ($\alpha = 0.05$) in the means of total score, according to Education variable, between university and non-educated in favor of university.
- There are significant differences at the level ($\alpha = 0.05$) in the means of total score, according to Education variable, between university and basic in favor of university.
- There are significant differences at the level ($\alpha = 0.05$) in the means of total score, according to Education variable, between secondary and non-educated in favor of secondary.

G- Economic status:

For testing hypothesis, the researcher conducted independent t-test and the results of this analysis are shown in table (46).

Table (46)

Results of t-test for health awareness and its domains according to Economic status variable

Domains	Work (n=100)		No work (n=144)		t- test value	Sig*
	Mean	Standard deviation	Mean	Standard deviation		
Nutrition	2.91	0.69	2.81	0.62	1.106	0.270
Exercises	1.94	0.97	1.86	0.98	0.622	0.534
Managing Stress	3.26	0.66	3.15	0.73	1.124	0.262
Smoking	3.14	1.11	3.51	1.08	2.606	0.010*
Medical Care	2.80	0.70	2.72	0.69	0.859	0.391
Total score	2.81	0.53	2.81	0.51	0.055	0.956

* Statically significant at ($\alpha = 0.05$). degree of freedom = 242

Table (46) indicates that there are significant differences at the level ($\alpha = 0.05$) in the means of Smoking domain and, according to economic status variable, in favor of no work. Significant differences are not found between the means of Nutrition, Exercises, Managing Stress and Medical Care domains and total score, according to economic status variable.

H- Monthly income

The researcher conducted One Way ANOVA Test and the results of this analysis are shown in tables (47) and (48).

Table (47)

Frequencies, means and standards deviations of health awareness and its domains, according to Monthly income variable

Domains	Monthly income	Frequency	Mean	Standard deviation
Nutrition	Less 1000 ns	114	2.72	0.61
	1000-1500 ns	65	2.86	0.60
	1501-2000 ns	47	3.02	0.68
	More than 2000 ns	18	3.21	0.72
	Total	244	2.85	0.65
Exercises	Less 1000 ns	114	1.86	0.99
	1000-1500 ns	65	1.84	0.88

Domains	Monthly income	Frequency	Mean	Standard deviation
	1501-2000 ns	47	1.96	1.00
	More than 2000 ns	18	2.11	1.11
	Total	244	1.89	0.97
Managing Stress	Less 1000 ns	114	3.20	0.73
	1000-1500 ns	65	3.14	0.69
	1501-2000 ns	47	3.25	0.64
	More than 2000 ns	18	3.18	0.77
	Total	244	3.19	0.71
Smoking	Less 1000 ns	114	3.33	1.15
	1000-1500 ns	65	3.38	1.09
	1501-2000 ns	47	3.30	1.11
	More than 2000 ns	18	3.59	0.87
	Total	244	3.36	1.11
Medical Care	Less 1000 ns	114	2.62	0.67
	1000-1500 ns	65	2.72	0.64
	1501-2000 ns	47	3.01	0.69
	More than 2000 ns	18	3.06	0.77
	Total	244	2.75	0.69
Total score	Less 1000 ns	114	2.75	0.52
	1000-1500 ns	65	2.79	0.47
	1501-2000 ns	47	2.91	0.51
	More than 2000 ns	18	3.03	0.59
	Total	244	2.81	0.51

Table (48)

Results of One Way ANOVA Test for health awareness and its domains according to Monthly income variable

Domain	Source of Variation	Sum of Squares	Degrees of freedom	Mean Square	F value	Sig*
Nutrition	Between Groups	5.806	3	1.935	4.873	0.003*
	Within Group	95.309	240	0.397		
	Total	101.114	243			
Exercises	Between Groups	1.333	3	0.444	0.467	0.706
	Within Group	228.452	240	0.952		
	Total	229.785	243			
Managing Stress	Between Groups	0.310	3	0.103	0.205	0.893
	Within Group	120.973	240	0.504		
	Total	121.283	243			
Smoking	Between Groups	1.211	3	0.404	0.327	0.806
	Within Group	296.539	240	1.236		
	Total	297.750	243			
Medical Care	Between Groups	7.083	3	2.361	5.176	0.002*
	Within Group	109.483	240	0.456		
	Total	116.567	243			
Total Score	Between Groups	1.836	3	0.612	2.353	0.073
	Within Group	62.417	240	0.260		
	Total	64.253	243			

* Statically significant at ($\alpha = 0.05$)

Table (48) indicates that there are no significant differences at the level ($\alpha = 0.05$) in the means of Exercises, Managing Stress and Smoking domains and total score according to monthly income variable.

Also table (48) indicates that there are significant differences at the level ($\alpha = 0.05$) in the means of Nutrition, and Medical Care, according to monthly income variable. To know in favor of whom the differences are related, Scheffes' Post Hoc Test was conducted. Tables (49) and (50) show the results of using Scheffe Post Hoc Test.

Table (49)

The results of using Scheffe Post Hoc, for comparing the means of Nutrition domain, according to monthly income variable

Monthly income	Less 1000 ns	1000-1500 ns	1501-2000 ns	More than 2000 ns
Less 1000 ns		-0.138	-0.306	-0.497*
1000-1500 ns			-0.168	-0.358
1501-2000 ns				-0.191
More than 2000 ns				

* Statically significant at ($\alpha = 0.05$)

Table (49) shows that:

- There are significant differences at the level ($\alpha = 0.05$) in the means of Nutrition domain, according to Monthly income variable, between (less 1000 ns) and (more than 2000 ns) in favor of (more than 2000 ns).

Table (50)

The results of using Scheffe Post Hoc, for comparing the means of Medical Care domain, according to monthly income variable

Monthly income	Less 1000 ns	1000-1500 ns	1501-2000 ns	More than 2000 ns
Less 1000 ns		-0.108	-0.395*	-0.449
1000-1500 ns			-0.288	-0.342
1501-2000 ns				-0.054
More than 2000 ns				

* Statically significant at ($\alpha = 0.05$)

Table (50) shows that:

- There are significant differences at the level ($\alpha = 0.05$) in the means of Medical Care domain, according to Monthly income variable, between (less 1000 ns) and (1501-2000 ns) in favor of (1501-2000 ns).

I- Daily TV watching

The researcher conducted One Way ANOVA Test and the results of this analysis are shown in tables (51) and (52).

Table (51)

Frequencies, means and standards deviations of health awareness and its domains, according to Daily TV watching variable

Domains	Daily TV watching	Frequency	Mean	Standard deviation
Nutrition	No viewing	25	2.52	0.64
	1- less 2h	67	2.89	0.67
	2-3 h	66	2.90	0.62
	More 3 h	86	2.87	0.63
	Total	244	2.85	0.65
Exercises	No viewing	25	1.91	1.10
	1- less 2h	67	1.85	0.96
	2-3 h	66	2.01	1.02
	More 3 h	86	1.84	0.92
	Total	244	1.89	0.97
Managing Stress	No viewing	25	2.81	0.77
	1- less 2h	67	3.28	0.71
	2-3 h	66	3.35	0.55
	More 3 h	86	3.13	0.75
	Total	244	3.19	0.71
Smoking	No viewing	25	2.74	1.16
	1- less 2h	67	3.27	1.07
	2-3 h	66	3.45	1.01
	More 3 h	86	3.54	1.14
	Total	244	3.36	1.11
Medical Care	No viewing	25	3.38	0.61
	1- less 2h	67	2.68	0.62
	2-3 h	66	3.05	0.68
	More 3 h	86	2.69	0.71
	Total	244	2.94	0.63

Domains	Daily TV watching	Frequency	Mean	Standard deviation
	Total	244	2.75	0.69
Total score	No viewing	25	2.47	0.51
	1- less 2h	67	2.80	0.52
	2-3 h	66	2.95	0.51
	More 3 h	86	2.81	0.47
	Total	244	2.81	0.51

Table (52)

Results of One Way ANOVA Test for health awareness and its domains according to Daily TV watching variable

Domains	Source of Variation	Sum of Squares	Degrees of freedom	Mean Square	F value	Sig*
Nutrition	Between Groups	3.132	3	1.044	2.557	0.056
	Within Group	97.983	240	0.408		
	Total	101.114	243			
Exercises	Between Groups	1.245	3	0.415	0.436	0.728
	Within Group	228.540	240	0.952		
	Total	229.785	243			
Managing Stress	Between Groups	5.964	3	1.988	4.137	0.007*
	Within Group	115.320	240	0.480		
	Total	121.283	243			
Smoking	Between Groups	13.440	3	4.480	3.782	0.011*
	Within Group	284.310	240	1.185		
	Total	297.750	243			
Medical Care	Between Groups	9.939	3	3.313	7.457	0.0001*
	Within Group	106.628	240	0.444		
	Total	116.567	243			
Total Score	Between Groups	4.165	3	1.388	5.545	0.001*
	Within Group	60.088	240	0.250		
	Total	64.253	243			

* Statically significant at ($\alpha = 0.05$)

Table (52) indicates that there are no significant differences at the level ($\alpha = 0.05$) in the means of Nutrition, Exercises domains, according to Daily TV watching variable.

Also table (52) indicates that there are significant differences at the level ($\alpha = 0.05$) in the means of Managing Stress, Smoking, Medical Care and total score, according to Daily TV watching variable. To know in favor of whom the differences are related, Scheffes' Post Hoc Test was conducted. Tables (53), (54), (55) and (56) show the results of using Scheffe Post Hoc Test.

Table (53)

The results of using Scheffe Post Hoc, for comparing the means of Managing Stress domain, according to Daily TV watching variable

Daily TV watching	No viewing	1- less 2h	2-3 h	More 3 h
No viewing		-0.461*	-0.531*	-0.311
1- less 2h			-0.073	0.149
2-3 h				0.220
More 3 h				

* Statically significant at ($\alpha = 0.05$)

Table (53) shows that:

- There are significant differences at the level ($\alpha = 0.05$) in the means of Managing Stress domain, according to Daily TV watching variable, between (No viewing) and (1- less 2h) in favor of (1- less 2h).
- There are significant differences at the level ($\alpha = 0.05$) in the means of Managing Stress domain, according to Daily TV watching variable, between (No viewing) and (2-3 h) in favor of (2-3 h).

Table (54)

The results of using Scheffe Post Hoc, for comparing the means of Smoking domain, according to Daily TV watching variable

Daily TV watching	No viewing	1- less 2h	2-3 h	More 3 h
No viewing		-0.539	-0.713	-0.801*
1- less 2h			-0.174	-0.263
2-3 h				0.088
More 3 h				

* Statically significant at ($\alpha = 0.05$)

Table (54) shows that:

- There are significant differences at the level ($\alpha = 0.05$) in the means of Smoking domain, according to Daily TV watching variable, between (No viewing) and (more 3 h) in favor of (more 3 h).

Table (55)

The results of using Scheffe Post Hoc, for comparing the means of Medical Care domain, according to Daily TV watching variable

Daily TV watching	No viewing	1- less 2h	2-3 h	More 3 h
No viewing		-0.304	-0.671*	-0.317
1- less 2h			-0.368*	-0.013
2-3 h				0.354*
More 3 h				

* Statically significant at ($\alpha = 0.05$)

Table (55) shows that:

- There are significant differences at the level ($\alpha = 0.05$) in the means of Medical Care domain, according to Daily TV watching variable, between (No viewing) and (2-3 h) in favor of (2- 3 h).
- There are significant differences at the level ($\alpha = 0.05$) in the means of Medical Care domain, according to Daily TV watching variable, between (1- less 2 h) and (2-3 h) in favor of (2- 3 h).
- There are significant differences at the level ($\alpha = 0.05$) in the means of Medical Care domain, according to Daily TV watching variable, between (more 3 h) and (2-3 h) in favor of (2- 3 h).

Table (56)

The results of using Scheffe Post Hoc, for comparing the means of Total score, according to Daily TV watching variable

Daily TV watching	No viewing	1- less 2h	2-3 h	More 3 h
No viewing		-0.324	-0.478*	-0.341*
1- less 2h			-0.154	-0.017
2-3 h				0.137
More 3 h				

* Statically significant at ($\alpha = 0.05$)

Table (56) shows that:

- There are significant differences at the level ($\alpha = 0.05$) in the means of Total score, according to Daily TV watching variable, between (No viewing) and (2-3 h) in favor of (2- 3 h).
- There are significant differences at the level ($\alpha = 0.05$) in the means of Total score, according to Daily TV watching variable, between (No viewing) and (more 3 h) in favor of (more 3 h).

J - Daily computer using

The researcher conducted One Way ANOVA Test and the results of this analysis are shown in tables (57) and (58).

Table (57)

Frequencies, means and standards deviations of health awareness and its domains, according to Daily computer using variable

Domains	Daily computer using	Frequency	Mean	Standard deviation
Nutrition	No use	137	2.72	0.61
	1- less 2h	38	2.86	0.72
	2-3 h	26	3.24	0.63
	More 3 h	43	3.03	0.58
	Total	244	2.85	0.65
Exercises	No use	137	1.74	0.89
	1- less 2h	38	2.09	1.07
	2-3 h	26	2.07	0.93
	More 3 h	43	2.09	1.10

Domains	Daily computer using	Frequency	Mean	Standard deviation
	Total	244	1.89	0.97
Managing Stress	No use	137	3.12	0.72
	1- less 2h	38	3.22	0.78
	2-3 h	26	3.53	0.51
	More 3 h	43	3.22	0.64
	Total	244	3.19	0.71
Smoking	No use	137	3.29	1.12
	1- less 2h	38	3.22	1.11
	2-3 h	26	3.61	1.07
	More 3 h	43	3.54	1.05
	Total	244	3.36	1.11
Medical Care	No use	137	2.61	0.64
	1- less 2h	38	2.86	0.73
	2-3 h	26	3.02	0.62
	More 3 h	43	2.96	0.76
	Total	244	2.75	0.69
Total score	No use	137	2.70	0.48
	1- less 2h	38	2.85	0.57
	2-3 h	26	3.09	0.51
	More 3 h	43	2.97	0.49
	Total	244	2.81	0.51

Table (58)

Results of One Way ANOVA Test for health awareness and its domains according to Daily computer using variable

Domain	Source of Variation	Sum of Squares	Degrees of freedom	Mean Square	F value	Sig*
Nutrition	Between Groups	7.678	3	2.559	6.574	0.0001*
	Within Group	93.436	240	0.389		
	Total	101.114	243			
Exercises	Between Groups	6.935	3	2.312	2.490	0.061
	Within Group	222.850	240	0.929		
	Total	229.785	243			
Managing Stress	Between Groups	3.768	3	1.256	2.565	0.055
	Within Group	117.516	240	0.490		
	Total	121.283	243			
Smoking	Between Groups	4.421	3	1.474	1.206	0.308
	Within Group	293.329	240	1.222		
	Total	297.750	243			
Medical Care	Between Groups	6.809	3	2.270	4.963	0.002*
	Within Group	109.758	240	0.457		
	Total	116.567	243			
Total Score	Between Groups	4.953	3	1.651	6.683	0.0001*
	Within Group	59.300	240	0.247		
	Total	64.253	243			

* Statically significant at ($\alpha = 0.05$)

Table (58) indicates that there are no significant differences at the level ($\alpha = 0.05$) in the means of Exercises, Managing Stress and Smoking domains, according to Daily computer using variable.

Also table (58) indicates that there are significant differences at the level ($\alpha = 0.05$) in the means of Nutrition, Medical Care domains and total score,

according to Daily computer using variable. To know in favor of whom the differences are related, Scheffes' Post Hoc Test was conducted. Tables (59), (60) and (61) show the results of using Scheffe Post Hoc Test.

Table (59)

The results of using Scheffe Post Hoc, for comparing the means of Nutrition domain, according to Daily computer using variable

Daily computer using	No use	1- less 2h	2-3 h	More 3 h
No use		-0.148	-0.519*	-0.312*
1- less 2h			-0.371	-0.165
2-3 h				0.206
More 3 h				

* Statically significant at ($\alpha = 0.05$)

Table (59) shows that:

- There are significant differences at the level ($\alpha = 0.05$) between the means of Nutrition, attributed to Daily computer using variable, between (No use) and (2- 3 h) in favor of (2- 3 h).
- There are significant differences at the level ($\alpha = 0.05$) between the means of Nutrition, attributed to Daily computer using variable, between (No use) and (more 3 h) in favor of (more 3 h).

Table (60)

The results of using Scheffe Post Hoc, for comparing the means of Medical Care domain, according to Daily computer using variable

Daily computer using	No use	1- less 2h	2-3 h	More 3 h
No use		-0.252	-0.406	-0.345*
1- less 2h			-0.154	-0.093
2-3 h				0.061
More 3 h				

* Statically significant at ($\alpha = 0.05$)

Table (60) shows that:

- There are significant differences at the level ($\alpha = 0.05$) in the means of Medical Care, according to Daily computer using variable, between (No use) and (more 3 h) in favor of (more 3 h).

Table (61)

The results of using Scheffe Post Hoc, for comparing the means of Total score, according to Daily computer using variable

Daily computer using	No use	1- less 2h	2-3 h	More 3 h
No use		-0.156	-0.396*	-0.270*
1- less 2h			-0.239	-0.114
2-3 h				0.126
More 3 h				

* Statically significant at ($\alpha = 0.05$)

Table (61) shows that:

- There are significant differences at the level ($\alpha = 0.05$) in the means of Total score, according to Daily computer using variable, between (No use) and (2- 3 h) in favor of (2-3 h).
- There are significant differences at the level ($\alpha = 0.05$) in the means of Total score, according to Daily computer using variable, between (No use) and (more 3 h) in favor of (more 3 h).

Chapter Five

Discussion and Recommendations

Discussion related to study question:

What is the present status of obesity and health awareness among physically disabled in Nablus Governorate?

Results showed that the level of health awareness is low among subjects of the sample, the researcher interprets this low level of the scarcity of media that increase the health education of the citizens in general and in the category of the disabled in particular, where most media outlets is the orientation towards politics, and rarely touched on topics such as health care, fitness and body building.

The researcher interpreted the subject of health, awareness is not common in the Palestinian street, which focused attention on the economy and politics in most cases, what is not common in the Palestinian street is periodic review of the doctor, but in particular persons with disabilities do not care about the rules of health, as a lack of knowledge, as their physical may not able them to exercise some sports activities, and that the practice was not available, the awareness of the health facilities have become out of personal interest.

Despite the low level of health awareness, some (20%) of respondents who are obese, a figure almost identical with what it has (Hossain) in that the rate of obesity is located between 10-25% of the members of any society, and are consistent with the results of Al-Arabi in the presence of a medium proportion of health awareness among the Saudi youth in the sports. also

the results of this study agree with the results of Kremers et.al that children who are showing more awareness of vital health, and the percentage of health awareness in nutrition. while this study results differ with (Yancey) that the proportion of obesity is (50%) among adults. The study results also agreed with the results of WHO study in the ratio of obesity in the Arab countries,

Discussion related to study hypotheses:

1. Gender:

The results showed that there were statistical differences in body mass index in favor of females over males, and the results also showed the presence of health awareness, nutrition and smoking in favor of females, and the results also showed that there were statistical differences in health awareness in the exercises domain in favor of males.

The researcher attributes this result to that of females in less movement from males by virtue of custom and traditions, which gives considerable freedom to males in the movement, and thus the movement helps in the disbursement of the amount of fat and makes males more sleeker than the female, and this is reflected also in the exercise and sport in general, as it is open to males more than females, but for the superiority of females in the field of nutrition, due to the female role in cooking as mothers, wives or girl in the family, and this makes them aware of food and it's types. The superiority of females in the area of smoking is to the fact that females smoke less than males. Girls especially mothers and pregnant women know about the dangers of smoking on family members. It is worth to mention

that smoking is one of the means of discharge, which male practicing at the moments of anger or excitement, while female's tears is in those moments. These results are consistent with the results of McLaren study in the presence of the relationship between gender and obesity. The results of this study are different from the study of WHO which shows that women are obese more than men.

2. Age:

The results showed superiority of the age group (20-25) in the areas of exercise and self-care, and results showed that there was a statistical difference in body mass index for the age group (36-40) over the ages of (20-25) and (26-30) .

The researcher interpreted these findings to the age group (20-25) are young people interested in the appearance and fitness seriously, and this stage represents the last stage of adolescence, which seeks to attract the attention of the young man to the other, so it is interested in body building, exercises, to maintain his/her weight without an increase or decrease as much as possible. While these things decrease or disappear at age group (36-40), which is often the head of the family, and he has interest's prior physique and fitness, so the body begins to acquire weight increase.

The results of this study are consistent with results of Fontaine et.al, Klumbkence et.al and Moore et.al in the positive between age and obesity; they found that people over (50) are suffered form obesity more than people under (50).

3. Place of residence:

The results showed that body mass index to the city's population are higher than the population of the village. The results also showed superiority of the village residents in nutrition over the city residents. The results also showed superiority of the village over the city and the camp residents in the area of smoking.

The researcher interpreted this result to the high normal body mass index in the city, to the provision of the city's population to the means of transport in all their movements, because of the wide streets and transportation available throughout the day, and this causes an increase in weight and, consequently, body mass index. While the superiority in the villages, in the area of nutrition, due to the nature of the people of the villages and their dependence essentially on agriculture and handmade products from local milk, cheese and bread, and this makes them more aware of and knowledge of food and nutrition. For the superiority of the population of the villages in the area of smoking, is perhaps due to the health education sessions held in the villages is widespread, especially in recent times.

The results of this matched the results of Stene et.al, which found that obesity ratio, differs between countries,

4. Disability type:

The results showed that there was no relationship between obesity and type of disability or health awareness, the researcher attributes this result to the habits of the categories of the disabled themselves, whether the mobility or multiple disabilities, the disabled tends to a lack of movement, so as not to

inconvenience others, and contribute to adaptation to his/her disability in certain behaviors on an almost daily basis, in addition all persons with disabilities have the same culture and the environment around them, so the degree of health awareness almost identical.

5. Social Status:

The results showed that the degree of awareness of the health of singles is more than the married. The researcher explains this to the concern of married to family issues, and to ensure a decent life to them. This makes married people - as a result of lack of time - less available for the culture of singles that have more leisure time and, therefore, have more readings and concerns.

The results of this study are consistent with the results of McLaren, who found a relation between obesity and socio-demographic as social status.

6. Education Level:

The results showed superiority of the educated class to the uneducated or less educated, in the degree of health awareness. The researcher explains this to the acquisition of scientific information literate health through the educated people study or their readings, which increase the health education, and increase awareness of their health, and make them more capable of the application of health information within their environment. This result of the study is supported by the results of Gutierrez & Fisac in the existence of a connection between obesity and educational level. The results of this study are consistent with results of Klumbence et.al who found that less educated people have a high rate of BMI and this means a state of obesity.

7. Economic level:

The results showed that the degrees of health awareness in the area of smoking among those who are not working are higher than those who are working. The researcher explains that those who do not work already rarely smoked because of the lack of work and reliable pocket money, so the reasons for their awareness in the area of smoking, resulting from low practice of smoking, and non-affected with its negative sides on personal health.

The results of this study match the results of Hossain et.al, Najman and Lahtehkorva & Lahelma in poverty and unemployment raise the obesity.

8. Monthly income:

The results showed that high-income (more than 2000 NIS) have more awareness of health in the areas of nutrition and self-care more than those have low income (less than 1000 NIS). The researcher interprets this result that higher-income, choose their own food according to a specific pattern, They have many options and the ability to purchase various kinds of food, and they were often the owners of offices, and those who have the ability to read, and own advanced information means as internet and elsewhere, they typically have the enough money to take care about themselves, and review the doctors or called them in the case of disturbing, even a simple sense, this is not available to low-income classes, which are barely engaged in the provision of food. These results are consistent with the results of the WHO in the presence of a relationship between monthly income and health awareness.

The results of this study differs from the results of Malaren and Najman et.al, as the found a strong relation between low social economic variables and obesity.

9. TV watching:

The results showed that those who watch television for longer periods have a greater awareness of health over those who watch TV for shorter periods. The researcher attributes this result to the possibility of access to health information, such as adequate food or the effects of smoking or exercise, increasing to increase the number of hours of watching television. Some do not even limited to watching TV, but more than that to work with the demands of television, shows clearly that those who engage in exercise with the TV. Some are influenced by what televisions present, like data from studies on the health or health habits that we practice. These results are different to a large extent with what Piechota and others, Jean et.al, Tucker, Larry and Friedman that watching television for long hours increased obesity.

The results also differ from the results of Frank et.al and Andersen et.al, in the relation between watching T.V and rising of BMI.

10. Computer using:

The results showed that those who use the computer for more hours have more awareness of health more than their counterparts who do not use it. The researcher interprets this result to those who use the computer, browse the web sites of information and studies on health or health habits, in addition to those who do not use computers, may be due to that they do not have computers, as a result of lack of money, or they have not used computers due to inability to read or lack of time.

Recommendations:

Based on the findings of this study, the researcher recommends the following:

1. Need to disseminate health awareness concerning the handling of a balanced diet for all age groups, where the results of the study showed low awareness of the health food balanced.
2. Practicing aerobic exercises, and follow a certain diet, to maintain physical fitness, and body mass index within the normal range.
3. The need to debrief tension through appropriate means, and not to use unhealthy ways to overcome the lack of care or the resulting effects.
4. Care to review physicians periodically, and not only when it is necessary.
5. The importance of the regulation of T.V watching and organizing the food schedule without watching T.V.
6. The necessity of activating the role of health institutions in guiding the people from the side effects of obesity and the ways to handle it.
7. Conduct future research, to examine the obesity in different population or in different professions.

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Health Awareness Questionnaire

Part One:

Please put (x) on the right place:

- 1) **Sex:** Male () Female ()
- 2) **Age:** 20-25 years() 26 -30 years()
3 -35 years() 36- 40 years()
- 3) **Marital status:** Single () Married ()
Divorced() Widowed()
- 4) **Education:** University() Secondary school()
Primary school() Literal()
- 5) **Place of residence:** City () Camps() Villages()
- 6) **Type of disability:**
Physical disability() Multiple (more than one disability)()
- 7) **Economic activity status:** Working() Unemployed() Other()
- 8) **Monthly income for family:**
Less than 1000 NIS() 1000-1500 NIS()
1501-2000 NIS() More than 2000 NIS()
- 9) **Daily television watching:**
Don't watch television() Watch about 1-2 hours()
Watch about 2-3 hours() Watch more than 3 hours()
- 10) **Daily computer using:**
Don't use computer() Use for 1-2 hours ()
Use for 2-3 hours () Use more than 3 hours()

Part Two

No.	Item				
Nutrition					
1.	I eat a balanced diet.				
2.	I limit my intake of saturated fats and cholesterol.				
3.	I limit my intake of salt.				
4.	I bake, broil, or grill foods rather than frying them.				
5.	I eat fruits, vegetables, and low-fat yogurts when snacking rather than “junk” food.				
6.	I read labels for information about the nutritional weight.				
7.	I maintain an appropriate weight.				
8.	If I need to lose weight, I avoid fad, starvation, or miracle diets that are harmful to my health.				
9.	I eat meals on regular bases.				
10.	I go to the toilet regularly.				
11.	I suffer from constipation.				
12.	I eat pickles and other similar foods.				
13.	I avoid eating while listening to music or watching TV.				
14.	I avoid drinking too much tea and coffee.				
15.	I eat and drink more even when I’m not hungry in social situations.				
Exercises					
16.	I participate in continuous, vigorous physical activity for 20 to 30 minutes or more at least three times per week.				
17.	I follow an exercise program appropriate for my level of fitness				
18.	I warm up properly before vigorous activity and cool down afterwards.				
19.	I use exercise equipment properly and safely.				
20.	I swim only when others are present.				
21.	I wear highly visible clothing when exercise outdoor such as walking, running, or biking.				
Stress management					
22.	I schedule my day to allow time for leisure activity.				

No.	Item				
Nutrition					
23.	I get an adequate amount of sleep.				
24.	I express feeling of anger or worry openly and constructively.				
25.	I say "no" without feeling guilty.				
26.	I make decisions with a minimum of stress and worry.				
27.	I set realistic goals for myself.				
28.	I accept responsibility for my actions.				
29.	I seek professional help when stress becomes too difficult to manage.				
30.	I allow myself to cry.				
31.	I manage stress so that it does not affect my physical well-being.				
32.	I discuss problems with friends or relatives.				
Smoking					
33.	I avoid smoking cigarettes, cigars, pipes, or using other forms of tobacco such as chewing tobacco or snuff.				
34.	I try to avoid inhaling the smoke of others.				
35.	I recommend others to refrain from smoking.				
36.	I am trying to quit smoking.				
37.	I am aware that smoking is very harmful to.				
Health care					
38.	I seek appropriate care or cut back on activities, as necessary, when I feel unwell or tired.				
39.	I maintain an accurate, written, current personal health history.				
40.	I brush my teeth at least twice a day.				
41.	I floss my teeth at least once a day.				
42.	I ask questions of health care providers.				
43.	I use a sunscreen with ultra-violet (UV) protection when spending time in the sun.				
44.	I wear sunglasses with UV protection when out in the sun.				
45.	I practice good personal hygiene by bathing daily and washing my hands frequently.				
46.	I have regular medical checkups.				
47.	I have regular dental checkups.				

No.	Item				
Nutrition					
48.	I have regular eye examinations.				
49.	I maintain adequate health insurance coverage.				

تأثير العوامل الديمغرافية الاجتماعية على مستوى السمنة والوعي الصحي لدى
المعوقين حركياً في محافظة نابلس

أخي \ أختي الفاضلة :-

تحية طيبة وبعد:

تقوم الباحثة بإجراء دراسة حول " تأثير العوامل الديمغرافية الاجتماعية على مستوى السمنة والوعي الصحي لدى المعوقين حركياً في محافظة نابلس" وذلك استكمالاً لمتطلبات الحصول على درجة الماجستير في الصحة العامة من جامعة النجاح الوطنية علماً بأن هذه الدراسة ستعود بالفائدة لكم ولمجتمعنا.

لذا نأمل منكم التكرم بالإجابة عن فقرات الاستبانة علماً أن هذه المعلومات سرية ولن تستخدم الا لأغراض البحث العلمي فقط.

شاكراً لكم حسن تعاونكم،،،

الباحثة: سماح مقبول

استبانة الوعي الصحي

الجزء الأول

يرجى وضع إشارة (×) فيما ينطبق عليك:

- (1) الجنس: ذكر () أنثى ()
 (2) العمر: 25-20 () 30-26 () 35-31 () 40-36 ()
 (3) مكان السكن: مدينة () قرية () مخيم ()
 (4) نوع الإعاقة: حركية () متعددة ()
 (5) الحالة الاجتماعية: أعزب () متزوج () مطلق () أرمل ()
 (6) المستوى التعليمي:

جامعي () ثانوي: ()
 أساسي: () أمي: ()

(7) الحالة الاقتصادية

يعمل () لا يعمل ()

(8) الدخل الشهري للأسرة بالشيكل:

أقل من 1000 شيكل () 1000-1500 شيكل ()
 1501-2000 شيكل () أكثر من 2000 شيكل ()

(9) مشاهدة التلفزيون يومياً:

لا أشاهد () أشاهد لمدة 1- أقل من ساعتين ()
 أشاهد 2-3 ساعات () أشاهد أكثر من 3 ساعات ()

(10) استخدم الحاسوب يومياً:

لا استخدم () استخدم من 1- أقل من ساعتين ()
 استخدم 2-3 ساعات () استخدم أكثر من 3 ساعات ()

الجزء الثاني

الرقم	الفقرة	درجة كبيرة جداً	درجة كبيرة	درجة متوسطة	درجة قليلة	درجة قليلة جداً
التغذية:						
1	أتناول غذاءً متوازناً.					
2	أضبط استهلاك الدهون المشبعة والكوليسترول.					
3	أضبط كمية الملح التي أتناولها.					
4	أتناول الأطعمة المسلوقة والمشوية أكثر من المقلية					
5	أتناول الخضروات والفواكه الطازجة أكثر من المعلبة.					
6	أقرأ التعليمات المتعلقة بالقيمة الغذائية الملصقة على الأغذية.					
7	أحافظ على وزن مناسب.					
8	إذا احتجت لإنقاص وزني أتجنب الحميات التي قد تضر بصحتي.					
9	أتناول الوجبات الغذائية في أوقاتها المحددة.					
10	أنظم عملية الإخراج في مواعيد ثابتة.					
11	أعاني من الإمساك والصعوبة في الإخراج.					
12	أتناول المخللات والتوابل والمحارشات بكميات قليلة.					
13	أتجنب تناول الطعام مع سماع الموسيقى، أو مشاهدة التلفاز.					
14	أتجنب شرب الشاي والقهوة بدرجة كبيرة.					
15	أجامل اجتماعياً في تناول المأكولات والمشروبات.					
التمارين:-						
16	أمارس أنشطة رياضية مختلفة لمدة 20-30 دقيقة 3 مرات أسبوعياً على الأقل.					

الرقم	الفقرة	درجة كبيرة جداً	درجة كبيرة	درجة متوسطة	درجة قليلة	درجة قليلة جداً
17	اتبع برنامج تمارين تتناسب مع مستوى اللياقة لدي.					
18	أبدأ بالحمية المناسبة قبل البدء بالتمارين الرياضية وأنهى بتمارين التهدئة عند الانتهاء.					
19	أستخدم الأجهزة الرياضية بطريقة آمنة ومناسبة.					
20	أسبح عندما أكون برفقة آخرين.					
21	أرتدي ملابس ذات ألوان فاتحة حين أتمرن خارجاً أثناء المشي والركض والجري.					
إدارة التوتر:						
22	أضع جدولاً يومياً يسمح لي بأنشطة ترفيهية.					
23	أنام ساعات كافية.					
24	أعبر عن مشاعر الغضب بشكل صريح وبناء.					
25	أقول لا دون أن أشعر بالذنب.					
26	اتخذ القرارات حين يكون التوتر والقلق لدي قليل.					
27	أضع أهدافاً واقعية لنفسي.					
28	أتحمل مسؤولية أفعالي.					
29	أطلب المساعدة المتخصصة حين يصعب علي إدارة القلق.					
30	اسمح لنفسي بالبكاء.					
31	أدير القلق بحيث لا يؤثر على شكلي الخارجي.					
32	أناقش مشكلاتي مع أصدقائي وأقاربي.					
التدخين:						
33	أتجنب التدخين بجميع أشكاله بما فيها السجائر والرجيلة.					
34	أتجنب استنشاق دخان الآخرين.					
35	أنصح الآخرين بالإقلاع عن التدخين.					
36	أحاول الإقلاع عن التدخين.					

الرقم	الفقرة	درجة كبيرة جداً	درجة كبيرة	درجة متوسطة	درجة قليلة	درجة قليلة جداً
37	أدرك أن التدخين مضر جداً.					
	العناية الذاتية (الطبية) :					
38	ألجأ إلى الطبيب والتوقف عن الأنشطة حين أشعر بالتعب.					
39	احتفظ بالسجل الطبي الخاص بي.					
40	أنظف أسناني مرتين باليوم على الأقل.					
41	استخدم الخيط الطبي لتنظيف أسناني مرة واحدة باليوم على الأقل.					
42	استفسر حول أمور صحية من ذوي العلاقة.					
43	استخدم واقي للجسم حين التعرض للشمس.					
44	استخدم نظارات شمسية للوقاية من الأشعة فوق بنفسجية.					
45	أمارس عادات صحية مثل الاستحمام اليومي وغسل الأيدي باستمرار.					
46	أجري فحوصاً طبية دورية باستمرار.					
47	أفحص أسناني بشكل دوري.					
48	أجري فحص عيون بشكل دوري.					
49	لدي تأمين صحي ساري المفعول.					

جامعة النجاح الوطنية
كلية الدراسات العليا

تأثير العوامل الديمغرافية الاجتماعية على مستوى السمنة والوعي الصحي لدى المعوقين
حركياً في محافظة نابلس

إعداد
سماح واصف مقبول

إشراف
الدكتور محمد جواد مسمار

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

2009

ب

تأثير العوامل الديمغرافية الاجتماعية على مستوى السمنة والوعي الصحي لدى المعوقين حركياً في محافظة نابلس

إعداد

سماح واصف مقبول

إشراف

الدكتور محمد جواد مسمار

الملخص

هدفت هذه الدراسة إلى التعرف إلى تأثير العوامل الديمغرافية الاجتماعية على مستوى السمنة، والوعي الصحي لدى المعوقين حركياً في محافظة نابلس، وذلك من خلال قياس مؤشر كتلة الجسم، واستبانة صُممت لقياس درجة الوعي الصحي لدى المعاقين حركياً في محافظة نابلس، وبعد التأكد من صدق الاستبانة وثباتها، تم توزيعها على عينة قصدية قوامها (244) معاقاً، وحُسب مؤشر كتلة الجسم لكل فرد من أفراد العينة، وبعد معالجة البيانات إحصائياً باستخدام الرزمة الإحصائية للعلوم الاجتماعية، تم التوصل إلى النتائج الآتية :

- إن الدرجة الكلية للوعي الصحي بشكل عام، والتغذية والاهتمام بالذات بين المعاقين حركياً في محافظة نابلس هي درجة منخفضة، وتنخفض جداً في مجال التمرينات، وتكون متوسطة في مجال إدارة التوتر، والتدخين.

- إن متوسط مؤشر كتلة الجسم لدى أفراد العينة يساوي (25.91) كجم/م².

- هناك علاقة دالة إحصائياً بين مؤشر كتلة الجسم، والجنس، والعمر، ومكان السكن، والحالة الاجتماعية، ومستوى التعليم.

- هناك فروق دالة إحصائياً في درجة الوعي الصحي، وفق متغيرات الحالة الاجتماعية، ومستوى التعليم، وعدد الساعات اليومية لمشاهدة التلفزيون، وعدد الساعات اليومية لاستخدام الحاسوب.

ت

وفي ضوء ما توصلت إليه الدراسة من نتائج، فقد أوصت الباحثة بعدة توصيات منها :

1. ضرورة نشر الوعي الصحي المتعلق بتناول غذاء متوازن لدى جميع الفئات العمرية، حيث أظهرت نتائج الدراسة انخفاض الوعي الصحي بالغذاء المتوازن.
2. ممارسة الرياضة بانتظام من خلال أنشطة وتمارين، وإتباع نظام حمية معين، للحفاظ على لياقة بدنية، ومؤشر كتلة جسم ثابتة تقريباً.
3. ضرورة تفريغ التوتر بوسائل مناسبة، وعدم استخدام طرق غير صحية في تجاوزه أو عدم الاهتمام بالآثار الناتج عنه.