

# Beliefs and Attitudes Regarding Determinants of Health in Turkey and Palestine

Menawi WA\*

Department of NBU, An-Najah National University

## Abstract

Health is a result of the cultural pigment of the individual and community beliefs and attitudes which in turn is affected by the environmental, social and political conditions. A comparative survey study on the beliefs and attitudes of citizens in both Palestine and Turkey regarding determinants of health and health promotion factors has been conducted. For a representative sample, stratified random sampling has been distributed on (4100) citizens as a total 1,500 in (Nablus) Palestine and 2,600 in (Ankara) Turkey between July 2013 and March 2014. Then data has been entered into SPSS 18.0 programs, to get frequency distributions and descriptive analysis. The result of analysis pointed out attitudes and beliefs of citizens regarding factors affect health and health promotion with statistically significant differences ( $p < 0.05$ ) between Palestinian and Turkish Citizens. As Turkish citizens believe that smoking with a rate of (83.2%), stress (78.8%), health care services (65.7%), nutrition and exercise (64%) frame the most influential factors on their health. In the same study, Turkish participants believe that reducing poverty, unemployment, cigarette consumption, air pollution and improving the sheltering quality will improve their health. In the other location of the study, Palestinians believe that reducing the rate of poverty, unemployment, pollution, cigarette consumption, and violence play a role in improving the health of the public. In conclusion, the participants' answers revealed factors that affect health among the citizens which in turn reflect the social and political circumstances they live under. Therefore, this study pictures the effect of political and socio-economic factors in shaping beliefs and attitudes of the individuals and communities. Thus, the related health behaviour necessarily reflects the importance of an integration of political, social and economic systems. As a result, these systems are considered to be a primary pillar in setting up our country's health agenda to improve health and limit the inequality in providing health services to citizens.

**Keywords:** Health determinants; Belief; Attitude; Health services; Socio-economic factors; Political views; Health promotion

## Introduction

Health is a human right regardless of religion, politics, belief, attitudes and socioeconomic status [1]. WHO declares that health is the interactive relationship between human beings and their surrounding environment to maintain the physical, mental and psychological wellness of the individuals and their communities [2]. This means that health consists of complex and multidimensional factors [3-5]. Where the socioeconomic and cultural components and their outputs like religion, behaviour, beliefs, attitudes, and the political framework affect the health of the individual [6-24]. And so, it is necessary to work on improving the environment which incubates these factors to improve health [25]. Therefore, WHO established a commission for the social determinants of health in 2005 and have released a report in 2008 declaring that socioeconomic factors besides the health systems and policies play a role in shaping the health status of the public at local and global levels [26,27].

Moreover, many studies have supported that the childhood phase will affect the health of the individual and society in advanced age [28-31]. For example, in the USA, if people who have a low education level has graduated from universities, mortality rates would have been reduced with an annual saving of \$1.007 trillion [32]. In the same field, the integral role of family, school, workplace and government will help in improving and qualifying health [33]. On the global space, WHO mutually is reinforced by member countries in various fields to improve the health of the public [34] as the aim of health systems chiefly is restoring, saving and developing health [35]. As proof of that, the wealth of any state in the world is related to educational level, experiment, qualified energy, health and the political options of the state [36]. Besides health care accessibility for the citizens [37]. From this point, WHO pays a tremendous effort to offer health for all [38] by

focusing policies and programs on the causes of health inequalities in and among the countries [32]. Health inequalities constitute from multi-dimensional factors [39] which widen the gap between advantaged and disadvantaged groups [40,41] but it is unnecessary and can be avoided [42,43] by developing life conditions [32,44] and socioeconomic policy guidance toward health [45], in other words, health in all policies [46].

Many countries, such as (United States of America [43,47,48], United Nations [27], Canada [49], Norway [46], Finland [50], Brazil [51], European Union [52] and Turkey [53]) strive to improve the health of their own people and reduce health disparities. For example, one of the basic principles of public health in Turkey is the holistic approach to health [53]. The health status of people in Turkey was promoted significantly in recent years. This can be connected to the success of health care reform under the title "People are First" Health Transformation Program. Turkey's government works on improving the efficiency and quality of the healthcare sector by restructuring the Ministry of Health and strengthening the Health system policies, planning and control [54]. As a result, the gap between per capita health expenditures for different occupational groups has been narrowed over the time due to the equalization of the benefits package for all [55]. As well as health outcomes, responsiveness and fair pricing issues have achieved important results at the level of European Union

\*Corresponding author: Menawi WA, Department of NBU, An-Najah National University, Turkey, Tel: 009568279063; E-mail: [w.menawi@najah.edu](mailto:w.menawi@najah.edu)

Received June 27, 2017; Accepted August 14, 2017; Published August 17, 2017

Citation: Menawi WA (2017) Beliefs and Attitudes Regarding Determinants of Health in Turkey and Palestine. J Community Med Health Educ 5: 546. doi:10.4172/21610711.1000546

Copyright: © 2017 Menawi WA. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

member states and European Economic Cooperation and Development Organization countries [56].

While in Palestine, the other side of this study, one of the key determinants of health is the political situation which affects human rights and justice. There are deep inequalities of power and wealth between the Palestinians and Israelis, the latter, imposes control on many aspects of daily life. Palestinians have lower socioeconomic conditions corresponding to a lower quality of life [57]. Thus, it creates gaps in health outcomes among Palestinians themselves [58]. Israel exerts a stress on Palestinians by imposing restrictions, which interfere in their daily lives and increasing economic difficulties. As a result, Palestinians suffer from social stress and pain [59]. So, the Palestinians have to work on unifying the efforts of civil society, the Ministry of Health and Social Affairs to eliminate these negative outcomes [60]. In addition to a Palestinian health care system which has passed a critical “transition” period. As, when the system fails to find sufficient financial resources to carry out social and economic reforms, how can this system spend more on health care? [61].

The studies appear to be of growing interest in the social determinants of health [62]. In Turkey, significant improvements have been made in the field of health, but the researchers have not revealed what are the individual beliefs and attitudes regarding the social determinants of health. In Palestine, there is little control over the social determinants of health [57]. In this study, the researchers will discuss the same religious and similar cultural elements, but with different socioeconomic and political structures in both countries, as issues concerning Palestine’s development in socio-cultural and religious terms begin to become apparent in the modern world once the Turkish Empire had moved into the region [63]. As the Palestinian question occupies a central place in the Turkish policy towards the Middle East, the recently adopted Turkish attitude typifies Turkey’s new policy agenda in the region [64]. Turkey believes that the daily life of the Palestinians has to be improved as an ethical and humanitarian mission for the whole international community [65].

For geographical and cultural rapprochement which the researchers have discussed earlier between Turkey and Palestine, many attitudes, beliefs and behaviours related to health, may be considered similar. Beliefs are the experiences that daily life makes us gain, and shape our way of existence [66]. Beliefs can also be defined as “a web of continuous feelings composed of individuals’ perceptions and descriptions of their own inner worlds” [67]. Therefore, the changes in the environment may affect on long-held traditional beliefs and as a result, health outcomes. Attitudes, are the tendencies which cannot be observed, but which is assumed to lead to certain behaviours [68]. According to Alport, an attitude is “the state of an individual being ready to display angry or rational behaviour which forms a leading or active power on responses to all objects” [69]. According to Dougless et al. (1995), attitudes similar as well as to beliefs cannot be assumed to be static as both can be affected by the environment [24].

A comparative study on beliefs and attitudes of the citizens has been surveyed in both countries: Palestine and Turkey regarding determinants of health to examine the social factors that affect the health of citizens in both countries. In other words, the aim of this study is to know; Turkish and Palestinian citizens’ beliefs and attitudes towards the factors affecting health. And if these beliefs and attitudes differ according to the; gender, age, educational level, income, health status, BMI (Body Mass Index) and political views. The researchers aimed to test whether there is a difference between beliefs and attitudes of Turkish society and Palestinian society about the social determinant of health or not.

## Sample and Method

This research was conducted by the descriptive survey model. Because the Likert-type scale technique is most commonly used in applied social science research [70], a questionnaire form was distributed as a public opinion survey earlier in Wisconsin and the United States [71] and adjusted for the study in Turkey and Palestine.

The questionnaire developed by the leading authors was composed of three parts. Part one contained questions about the participants’ demographic structure (gender, age, place of residence, level of education, income, health status and political views). Part two contained 23 statements which helped to identify the determinants of health. The participants responded to the questions according to their beliefs and attitudes and graded the situations described in the statements according to how much these factors affected the participants’ health (grading was between 0 and 10). Part three included 13 statements about improving health, and the participants were asked to grade them according to their influence on improving health. The participants answered them according to their beliefs and attitudes (grading was between 0 and 10) 0 (no response or feeling), 10 (high response).

To represent both areas for more accurate comparison, two cities were selected. One represented Turkey (Ankara) and the other Palestine (Nablus). In the two cities where the research was conducted, the residential census of Ankara was 5,045,083 in 2013; whereas, of Nablus was 336,380. The total number of questionnaires distributed in both geographic regions was 4,100 questionnaires. Based on population ratios, the biggest portion of the sample was from Ankara 2,600 questionnaires, and 1,500 questionnaires were in Nablus. The researchers had received 60.4% from Ankara (1570 survey) and 78% from Nablus (1171 survey). Populations of both cities were classified according to gender, age, education, health and income. To make it easier, the researchers received help from the Turkish and Palestinian Statistical Institute. Surveys were distributed between July 2013 and March 2014 with assistance from the Justice and Development Party, municipalities, private and public company directors, the Palestinian Embassy in Ankara, Gazi University professors, the Labor and Social Security Ministry, the Ministry of Health and public institutions. The obtained data were entered into SPSS 18.0. During the analysis of data, frequency distributions and descriptive analysis were made for sociodemographic characteristics, chi-square test for the comparison groups according to their scores. To further examine the results, a t-test, as well as a two-way variance analysis were used by the two independent groups. To measure the reliability of the developed instrument, a reliability analysis revealed an alpha value for the statements concerning the participants’ views on the most important factors affecting the health, resulting in a strong reliability calculated value of 0.966.

## Demographic description of the study sample

The distribution of the socio-demographic characteristics of the respondents in the study was 42.7% of the individuals lived in Palestine, while 57.3% lived in Turkey. 50.7% of respondents were females and 49.3% were males. 41.3% of respondents were of secondary education level, those who had diploma were 14.6% and those who had a bachelor and higher education level respondents were 44.1%. The study respondents who were aged  $\leq 35$  years old were 54.8%, while 45.2% were  $\geq 36$  years. According to the income level of the respondents, it was 50.9% as between 320.51-960.57 US dollars, whereas, 23.7% were  $\leq 320.19$  US dollars. The Job description of the participants; 24.6% of respondents were officers, 15.3% housewives, 16.1% workers, 15.1% students and 4.5% were unemployed. The respondents’ political views were; 27.6% moderate, 25.8% conservative, social democrat 12.7% and

8.6% of the respondents were nationalists and the political views of 3.3% of the respondents were liberal. While talking about the value of BMI of the study respondents, 48.8% were having normal BMI value, 33.6% were overweight, 13.9% were obese. Finally, the health status descriptions, 69.1% of the participants were in a good health condition, while 25.1% declared that they have a very good health.

There was a census conducted by the Turkish Statistical Institute from 29. 01. 2014, the number of people living in Turkey on December 31<sup>st</sup>, 2013 was 76,667,864. The proportion of the male and female population was 50%: 50% [72]. Gross domestic products per person increased more than 3 times in 2013 compared to 2002 and climbed up to \$10.782 from \$3.492. The rate of unemployment in May 2014 was 8.8%, while the rate of seasonally adjusted unemployment was about 9.5%. According to data coming from the World Bank (2012), Turkey was the country with the fifth biggest workforce after Russia, Germany, England and France [73]. On the other side, according to the statements made by Ula Awad, the President of Statistical Institute on December 2013, 5.9 million Palestinians lived in Palestinian lands at the end of the year 2013. According to the data, there were 103.3 men per 100 women [74]. The report announced by the Palestinian Statistics Bureau, gross domestic product was 6.8 billion dollars and the workforce was 1.1 million people in 2013. The rate of unemployment was 23.4% [75].

The median age in Turkey was 30.4 in 2013. While the proportion of the population in the working age group between 15-64 age was 67.7%, besides, the ratio of the population aged 65 and over has also increased to 7.7% [72]. The distribution of the population, according to educational level in Turkey over 15 years old was; 5% illiterate, 7% could read and write but did not finish school, 28% were primary school graduates, primary education diploma was 21% and 5% secondary school or balanced school graduates, 22% high school or balanced school graduates. The ratio of college or faculty, graduates was 11%, a high graduate degree was 1%, and doctorate degrees numbered 122.619 [76]. On the other side, in Palestine, the ratio of those who were undergraduate and above education was 12.1% and those who did not complete any education stages was 9.4% [77]. Life expectancy for men per women in Palestine was 71.5:74.4 [78]. In Turkey was 75.3 for men and 80.7 years for women [79].

The Turkish Nutrition and Health Research 2010 data showed that 34.6% were overweight and 30.3% obese, according to the BMI of individuals aged 19 years and over [80]. While the distribution of general health status of individuals in 2012 was found to be between very good/good 70.7% [81]. And here the researchers may note similar interest of the two communities in education and health depending on the statistics mentioned above, despite the different situation of the Turkish State and its prestigious situation in the world versus the critical economic and political conditions of Palestine. This marks the serious interest of the Palestinians in education. Thus, it raised the level of health and related social determinants.

## Results

Tables 1 and 2 show the participants' beliefs and attitudes scoring about 23 factors which were presented to have a potential effect on their health status. Respondents were asked to make ratings from (0 to 10) whereas 0 is for "no impact" and 10 "has a very strong influence" on health. While 8-10 values were considered to have a strong impact, and the results were summarized accordingly. To reduce the effects of bias, factors were randomly selected. The results were assessed as full samples and sub-samples according to gender, education level, income, health status, body mass index, and political opinion.

Table 1 shows beliefs and attitudes of the Turkish respondents regarding factors affecting health. In the beliefs and attitudes of the Turkish participants that the most powerful five influencing factors on their health were; smoking (83.2%), stress (78.8%), access to proper health care services (65.7%), environmental conditions like healthy food and exercise (64%) and the genetic makeup of the parents (60%), respectively.

Even upon the sub-groups; gender, age, income, health status, body mass index and the political views, beliefs and attitudes had the same arrangement in the top five ranking factors that affect health strongly. In this table, the square analysis according to the gender distribution showed statistically significant differences in smoking, access to appropriate health care, stress, health information, healthy food and environmental conditions, physical environment, health, insurance, level of social support, genetic structure of parents, personal health practices, community safety, housing quality, race/ethnicity and ego satisfying in the beliefs and attitudes of Turkish respondents regarding factors influencing their health.

By chi-square analysis of the age distributions, there was a statistically significant difference in the community safety, education, job description and freedom in beliefs and attitudes of Turkish citizens about factors affecting health. In the same table, the political opinion of the individuals from Turkey sharing in the analysis conducted on beliefs and attitudes on the impact of the social factors on health showed statistically significant differences in smoking, personal physical environment, health insurance, income, education, type of the job, religious belief/spirituality, political stability, freedom, and the ego to satisfy.

Secondary educated level Turkish respondents believed that the social factors have higher scores in affecting health rather than directly health related factors. For example, religious belief/spirituality, race/ethnicity, political stability and community safety were affecting the health of the secondary educated level of Turkish respondents with a rate of 49.7%, 26.3%, 31.1% and 46.8%, respectively, while in the beliefs and attitudes of the highly educated Turkish respondents these factors were affecting their health with a rate of 35.5%, 18.7%, 23% and 42.4% respectively.

Turkish respondents who have an income level  $\geq$  963.33 US dollars believed that smoking and stress affect their health with a rate of 83.4% and 81.5%, respectively, while those whose have 320.19 US or less dollars income level respondents believed that these factors affect their health with a rate of 79.9% and 74.3% respectively. In addition, there was a statistically significant difference when the chi-square test of the income level of Turkish respondents was analysed within environmental conditions for healthy food and exercise, social support, genetic structure of parents, religious belief or spirituality, political stability and ego satisfying in the beliefs and attitudes of the respondents regarding factors affecting health.

Again, Turkish respondents who self-reported very good health status had believed that the amount of social support affects their health with a rate of 46.1% and working 47.4%, while bad health, self-reported respondents believed that social support and work affect their health with a rate of 63.3% and 71.2% respectively. According to BMI value, Turkish respondents who have BMI value  $<$ 18.5 believed that personal health practices affect their health with a rate of 38.2%, whereas the respondents with 18.5-24 BMI value believed that personal health practices affect their health with a rate of 56.1% and there was a statistically significant difference between BMI value and personal health practices, social support, the genetic makeup, political stability

Factors Affected Health	Full Sample (%)	Gender (%)		Age (%)		Education (%)			Income (US Dollar)			Health Status (%)			BMI Value (%)				Politics View (%)				
		Women	Men	< 35	≥ 36	Secondary Education	College	Graduate & Post graduate	< 320,19	320,51-960,57	> 960,89	Bad	Good	Very Good	<18,50	18,5-24,9	25-29,9	> 30	Conservative	Moderate	Liberal	Social Democrats	Nationalist
Smoking	83.2	85.5*	80.8	84.1	82	80.6*	90.4	82.7	79.9	84.1	83.4	83.9	83.1	76.8	83.9	83.3	86.4	84.0*	85.5	81.7	91	77	81
Personal health practices	53.3	56.6*	50	53.3	53.2	52.5	54.5	53.5	55.7	50.6	56.3	62.3	52	38.2*	56.1	49.2	55.1	51.8	55.9	51.4	60.5	51	51.8
Accessibility to Appropriate health care	65.7	72.3*	59	65.6	65.7	63.4	67.1	66.7	64.4	66.2	65.4	65.5	65.5	63.6	68.3	61.6	66.7	66.7	70.1	62	67.2	63.6	63.1
Stress	78.8	83.8*	73.7	79.4	78	73.3*	80.8	81.6	74.3	78.6	81.5	80.3	79.9	76.8	78	78.9	84.7	78.4	80.8	82.4	85.1	77.9	75.3
Knowledge about health	54.7	59.1*	50.3	53.6	56.1	56.1*	62.2	51.8	56.9	53.4	55.6	70.5*	53.7	50	56.1	53.1	55.4	53.7	55.6	49.3	54.9	58.2	54.5
physical environment	56.7	60.5*	52.8	56	57.5	54.6	60.5	56.9	57.9	54.5	59.5	75.0*	56.6	49.1	57.9	55.6	56.2	52.5*	58.7	57.7	67.4	59.8	53.9
Environmental conditions for healthy food and exercise	64	68.3	59.8	62.8	65.6	58.0*	63.8	67.9	56.3*	65.6	66	80.3*	63.4	46.3	64.5	64	68.0	61	67.1	63.4	68.2	66.2	63
Having health insurance	50.8	56.5*	45	50.5	51.2	52.9*	57.2	47.7	52.1	50.8	50.1	68.9*	50	54.5	52.2	47.9	52.7	49.8*	56.8	34.8	52.3	53.8	49.3
Having a work	50.5	53.8*	47.2	47.4*	54.3	48.4	53.8	50.9	51.5	48.5	53.1	71.2*	50.3	35.7*	48.9	47.9	65.3	48.4	53.8	47.9	52	55.3	48.5
The amount of social support	47.5	50.9*	44.2	47.6	47.5	46.2*	59	45.2	53.2*	44.8	48.7	63.3*	47.1	44.4*	47.8	41.7	55.9	43.6	51.1	49.3	50.9	54.7	44.8
The genetic make-up inherited from parents	60.7	64.7*	56.6	62.7	58.2	54.6*	61.9	64.1	55.8*	59.6	65.2	57.4	61	56.4*	64.5	56.4	58.8	58.1	64.3	70	61.7	61.6	59
Income	53.4	56.3*	50.6	52.8	54.2	53.5	57.5	52.3	56.5	52.9	52.6	67.2	52.7	50	54.6	52.1	53.1	48.7*	60.6	47.1	61.6	60.8	48.8
Community safety	45.2	49.5*	40.9	42.8*	48.2	46.8*	51.8	42.4	47.8	44.1	45.5	55.7	44.1	37.5	45.6	42.6	46.6	42.1	50	42.9	49.2	51	42.1
Housing quality	54.1	57.7*	50.5	53.2	55.2	53.3	60	53	53.3	54.4	54	62.3	52.7	52.8	56	50.1	52.7	51.9	59	48.6	58.4	57.9	51.2
Education	49	51.2	46.8	46.6*	52	49.4	52.9	47.7	52	49.5	46.6	56.5	48.3	35.7	51.1	45	48.1	46.1*	48.2	44.3	58.4	54.8	46.7
Type of a job	52	51.2	52.8	49.5*	55.2	50.1	55.4	52.3	49.8	51.7	53.8	60.7	51.4	36.4	52.6	50	55.7	49.7*	51.8	56.3	60.5	59.9	46.7
Where a person lives	53.4	54.7	52.1	52.4	54.7	56.1	54.7	51.4	55.6	54.6	50.3	75.0*	52.6	41.1	54.6	50.7	56.5	50	50.9	57.7	56.8	56.4	54.8
Religious belief/spirituality	42.7	44.5	41	40.2*	45.9	49.7*	53.1	35.5	46.7*	44.6	37.5	51.6	41.3	30.9	42.2	42.4	47.0	48.0*	44.3	26.8	35.6	40.6	43.1
Race/ethnicity	22.8	25.8*	19.8	22.6	23.1	26.3*	59.5	18.7	25.3	22.7	21.5	28.8*	21.3	16.1	24.1	18.9	19.8	20.7	25.6	19.7	23.9	27.9	21.3
Political stability	26.9	28	25.8	25.6	28.5	31.1*	31.7	23	30.9*	28.2	22.6	35.5	25.7	14.5*	28	22.6	27.5	24.3*	29.7	20	32.4	32.7	24.2
Freedom	43.8	43.6	44.1	41.2*	47.1	45.3	49.8	41.3	43.5	44.6	42.7	59.3*	42.9	32.1	44.1	44.5	45.0	41.3*	41.8	34.8	51.7	53.8	41
Ego satisfying	25.4	28.3*	22.5	25.5	25.2	27.8	28.6	23	33.3*	24.1	23	26.7	24.8	17.5*	27.6	20.4	21.1	19.7*	22.9	22.5	34.3	34.5	25.1

Table 1: Beliefs and Attitudes of Turkish citizens about the factors that affect their health strongly. \*P<0.05



Factors Affecting Health	Full Sample (%)	Gender (%)		Age (%)		Education (%)			Income (US Dollar) (%)			Health Status (%)			BMI Value (%)				Politics View (%)						
		Women	Men	≥ 35	≥ 36	Secondary Education	College	Graduated & Post	≥ 320.19	320.51-960.57	≥ 960.89	Bad	Good	Very Good	<18.50	18.5-24.9	25-29.9	>30	Conservative	Moderate	Liberal	Social Democrats	Nationalist	No Idea	
Smoking	68.0	71.1	64.6	67.1	69.0	66.9	64.3	71.2	67.9	66.3	72.3	69.1	66.7	70.0	60.0	68.3	67.9	66.0	67.6	70.9	60.0	70.1	60.0	60.0	59.6
Personal health practices	63.7	70.0*	57.0	61.8	66.0	57.7*	58.9	75.1	59.0*	64.1	69.7	62.9	62.7	65.8	57.1	63.3	63.9	64.6	63.6*	67.7	70.0	65.9	62.9	62.9	48.2
Accessibility to Appropriate health care	64.7	73.0*	56.0	64.3	65.2	61.0*	58.3	73.3	61.8	64.1	70.6	64.9	63.4	67.1	68.6	65.6	67.2	58.9	61.7*	70.8	70.0	64.1	54.3	54.3	52.4
Stress	65.4	71.0*	59.5	63.4	67.9	60.7*	66.1	72.5	65.6	68.8	72.2	72.2	64.0	66.3	68.6	65.2	65.9	65.1	63.6*	70.9	75.0	68.3	60.0	60.0	47.6
Knowledge about health	60.4	66.2*	52.3	60.2	60.7	55.3*	63.6	66.6	61.7	58.8	62.7	57.8	60.4	61.1	50.0	58.8	61.6	60.5	54.9	64.6	63.2	62.1	59.4	59.4	53.3
physical environment	62.8	69.5*	55.7	62.2	63.5	61.0	62.2	65.8	66.6	61.9	59.4	65.2	62.4	62.9	54.5	64.4	59.3	64.6	60.3	66.1	76.5	62.3	51.5	51.5	57.1
Environmental conditions for healthy food and exercise	60.4	66.0*	54.5	59.4	61.6	58.5	59.2	63.8	61.4	57.7	67.0	67.0	60.5	58.6	57.6	59.6	59.3	60.9	58.7	62.8	66.7	63.3	51.5	51.5	53.2
Having health insurance	58.8	62.7*	54.7	55.8	62.4	61.1	56.0	56.4	64.1	56.8	56.1	69.9	57.8	57.7	51.5	55.6	57.6	66.3	53.6*	65.1	63.2	53.2	48.5	48.5	54.0
Having a work	65.6	70.7*	60.1	63.5	68.2	63.9	66.0	68.1	68.7	62.6	68.6	69.6	64.0	67.4	70.6	66.6	62.1	68.5	63.0*	70.1	78.9	60.3	67.6	67.6	58.3
The amount of social support	53.5	58.9*	47.7	49.5*	58.4	54.2	49.7	54.0	60.8*	50.3	51.1	65.9*	52.6	52.2	52.9	50.5	52.0	56.4	50.0	56.8	60.0	54.0	51.5	51.5	47.2
The genetic make-up inherited from parents	53.3	58.5*	47.7	51.2	55.8	52.8	51.2	55.0	55.5	51.9	53.7	66.0*	52.9	50.8	45.7	51.8	53.4	55.0	45.1*	60.6	45.0	54.5	42.9	42.9	44.6
Income	68.1	72.5*	63.5	66.3	70.4	63.7*	70.4	73.9	71.3	65.1	71.1	71.4	67.5	68.5	76.5	69.3	63.5	71.1	58.8*	77.0	55.0	67.7	57.6	57.6	58.1
Community safety	64.8	71.3*	57.9	62.3	67.9	64.3	65.2	65.5	70.0	63.2	61.5	69.9	65.6	62.2	66.7	64.3	63.4	65.2	57.9*	69.5	52.6	66.0	64.7	64.7	60.1
Housing quality	69.3	75.6*	62.6	66.4*	72.8	65.5*	73.8	73.3	71.0	67.9	70.5	65.6	69.4	70.2	64.7	68.7	67.7	70.4	65.1*	75.6	58.8	66.2	58.8	61.9	61.9
Education	66.9	72.1*	61.4	65.8	68.3	61.1*	77.0	71.5	70.2	66.0	64.4	65.6	66.7	67.7	65.7	64.2	66.9	67.7	62.0*	72.8	70.0	65.2	53.1	53.1	59.7
Type of a job	59.8	63.0*	56.5	59.3	60.5	55.9*	61.8	64.8	61.9	59.4	58.0	58.5	61.4	57.4	60.0	60.2	55.4	62.4	52.9*	65.5	63.2	60.5	48.4	48.4	53.8
Where a person lives	57.5	64.6*	49.9	56.3	59.0	56.2	63.8	56.8	65.0*	53.3	57.3	63.7	57.6	55.7	60.0	55.5	54.7	60.8	52.7*	62.8	50.0	55.8	54.5	54.5	51.3
Religious belief/spirituality	53.3	55.5	51.0	52.8	54.0	51.6	53.7	55.8	59.4*	50.5	51.8	53.2	52.3	55.3	57.6	53.6	51.1	53.2	52.3	56.9	52.6	50.6	37.9	37.9	49.4
Race/ethnicity	28.8	30.7	26.9	28.6	29.1	29.3	31.74	26.9	34.8*	28.0	22.1	40.0*	28.2	27.2	32.4	27.3	26.8	26.4	23.8	30.7	33.3	29.0	18.2	18.2	31.9
Political stability	56.4	60.0*	52.5	50.4*	63.5	55.7	58.3	56.5	60.7	53.9	56.3	63.9	55.2	56.6	51.4	53.6	55.5	59.8	59.7	56.8	55.0	57.5	60.0	60.0	48.2
Freedom	65.4	68.4*	62.3	59.9*	72.2	64.8	64.2	66.8	67.8	64.2	64.9	68.5	64.8	65.7	68.6	63.5	63.6	69.6	68.2*	67.2	77.8	63.5	70.6	70.6	54.9
Ego satisfying	59.9	63.9*	55.7	57.6	62.6	58.7	57.2	62.9	63.2	58.8	57.6	61.1	59.9	59.5	65.7	59.5	58.4	58.4	55.1	62.5	76.5	60.8	51.4	51.4	57.9

\*P <0.05

Table 2: Beliefs and Attitudes of Palestinian citizens about the factors that affect their health strongly.

Measures for Health Promotion	Full Sample (%)	Gender (%)		Age (%)		Education (%)			Income (US Dollar) (%)			Health Status (%)			Politics View (%)					
		Female	Male	< 35	> 36	Secondary Education	College	Graduated & Post graduated	< 320.19	320.51-960.57	≥ 960.89	Bad	Good	Very Good	Conservative	Moderate	Liberal	Social Democrats	Nationalist	No Idea
Smoking reduction	80.6	84.2*	76.9	81.6	79.3	75.4*	86.2	82.3	75.3*	80.8	83.2	69.4*	82.2	76.5	82.8	83.2	84.5	83.8	75.6	77.1
More peoples' health insured	52.8	59.1*	46.5	53.6	51.9	59.5*	60.2	46.6	63.6*	50.9	49.8	61.3	51.8	55.2	54.1	55.8	38.0	55.3	53.6	51.1
Programs to encourage people to develop individual health practices	53.6	59.2*	47.9	54.9	51.9	55.1	58.0	51.4	54.8	54.5	51.3	59.0	52.3	57.4	52.6	56.3	47.1	59.2	57.7	50.0
Pollution reduction	68.7	74.6*	62.9	68.9	68.5	67.1	73.2	68.5	65.0	70.6	67.8	70.5	68.7	68.5	66.4	72.6	71.4	76.0	65.1	67.3
Poverty reduction	63.8	68.7*	59.0	62.1	66.0	61.0*	73.4	62.9	62.6	63.6	64.8	72.9	64.0	61.4	57.9*	63.8	57.7	77.7	68.1	63.3
Increase access to early childhood development programs	53.5	57.8*	49.2	54.6	52.0	52.7	58.9	52.4	55.7	53.4	52.3	63.3	53.0	53.3	48.2*	53.6	53.5	66.1	59.3	50.9
Violence reduction	58.6	65.5*	51.8	58.7	58.6	59.8*	68.8	55.1	58.0	60.1	56.5	67.7	58.2	58.4	54.6	63.4	60.6	65.9	60.6	56.1
Unemployment reduction	61.3	66.8*	55.8	59.0*	64.1	63.1*	70.3	57.7	63.7	60.7	60.8	75.4*	61.6	57.2	59.2	60.5	62.0	70.2	65.0	58.3
Increase the number of people who are studying in college	47.0	50.3*	43.7	44.7	49.8	51.8*	51.3	42.8	52.9	45.3	46.5	61.3*	45.7	49.0	40.0*	50.0	43.7	58.8	58.1	43.3
Develop social support and social networks	54.4	59.2*	49.6	54.2	54.7	58.4*	59.3	50.6	56.8	55.4	51.5	58.1	53.4	57.6	49.4*	59.5	48.6	66.5	54.8	52.7
To increase the quality of living areas (accommodation)	65.7	69.8*	61.6	64.6	67.1	67.7	64.0	64.0	66.2	66.4	64.4	70.0	65.2	66.9	60.4*	68.6	60.6	73.2	69.4	65.8
Ego satisfaction	36.2	41.4*	31.0	34.5	38.2	44.5*	40.3	29.8	42.8*	37.5	30.2	49.2*	34.6	39.7	29.6*	41.1	37.7	46.6	43.1	32.6
Prepare urgent plans for the least damage to political and intellectual conflicts	36.5	41.9*	31.1	35.8	37.4	44.5*	40.8	30.3	44.4*	38.5	28.8	53.2*	35.7	36.6	32.6*	39.6	28.6	46.1	42.4	33.7

\*p<0.05

Table 3: Beliefs and Attitudes of Turkish citizens about the factors that affect the health promotion.

and ego satisfying according to the attitudes of Turkish respondents regarding factors affecting health.

As shown in Table 2, the strongest of the five factors that Palestinian participants believed to have a powerful influence on their health status were; quality housing (69.3%), income (68.1%), smoking (68%), education (66.9%), stress (65.6%) and freedom (65.4%). And it is interesting to note here, that ranking the top five most important factors was affecting powerfully the health of the Palestinian participants in all subgroups like gender, education, income, health status, BMI, and political views in the same order as full samples, excluding age determinants, as the Palestinians live under the same political conditions while those who are at an age 35 are more vulnerable to repression by Israeli soldiers. As a result of the chi-square test, there was a statistically significant difference between ages distribution and socially supported, housing quality, political stability and ego-satisfying factors which affect health ( $p < 0.05$ ).

The Palestinians study participants' beliefs and attitudes about the health determinant factors showed that the amount of social support, housing quality, political stability, status and ego satisfying according to the age factor was statistically significant ( $p < 0.05$ ) by the distribution of chi-square analysis test.

According to the educational attainment; the personal health practices, access to health care, stress, health information, income, housing quality, type of job and genetics statistically significant differences were recorded ( $p < 0.05$ ). For example, graduated and post graduated Palestinian citizens believed that housing quality affects health with a rate of 73.3%, but citizens with the secondary education level believed this factor affect their health with a rate of 65.5%. Low and high-income level citizens believed that housing quality affects their health strongly without a statistically significant difference between the two levels. In the same line, highly educated citizens believed that income level affects the health at a higher rate more than secondary educated people with a statistically significant difference, while the low and high-income level Palestinian respondents believed that income influences their health at the same level due to the political situation which affects everyone in Palestine.

When reading the findings related to the income variable; the personal health practices, the social support, where a person lives, religious belief and spirituality factor were found to be statistically significant ( $p < 0.05$ ) with the income variable as social determinants of health. For example, Palestinian participants who have income  $> 963.33$  US dollars believed that their health status was affected by the personal health practices with a rate of 69.7%, whereas the ones who have the income level  $\leq 321.11$  US dollars recorded a rate of 59%. For the income variable, Palestinian participants who have an income of  $\geq 963.33$  US dollars believed that their health status is affected by the social support with a rate of 51.1%, while the ones who have an income level of  $\leq 321.11$  US dollars with a rate of 60.8%.

When it comes to the Palestinian participants' beliefs and attitudes, there was a statistically significant difference at ( $P < 0.05$ ) between self-reported health status and the social support, the genetic structure and the race/ethnicity. For instance, Palestinian participants who have very good health believed that the genetic structure and race/ethnicity were affecting their health with a rate of 50.8% & 27.2%, respectively, unlike those who have bad health status and believed that the same factors affect their health with a rate of 66.0%, 40% respectively. Very good and bad health citizens believed that religion affects their health with a rate of 55.3% and 53.2%, respectively, which is explained by the concept of destiny, punishment and reward from God.

When analyzing gender, the Palestinian women believed that directly and indirectly, health-related factors affect their health higher than the men's rating. For example, Palestinian women believed that smoking and housing quality affect their health with a rate of 71.1%, 75.6%, respectively, but men's believed about these factors with a rate of 64.6% and 62.6% respectively.

Finally, Political views play an important role as a social determinant of health. the personal health practices, access to appropriate health care, stress, health insurance coverage, the genetic structure, income, social security, housing quality, education, occupation type, place of residence and freedom factors according to the Palestinian participants' political views showed a statistically significant difference ( $p < 0.05$ ).

Tables 3 and 4 showed Participants beliefs and attitudes scoring about 13 factors which were presented to have a potential effect on their health promotion. In this part of the study respondents were asked to make ratings from (0 to 10) has "no impact" and 10 "has a very strong influence" on health promotion. While 8-10 values were considered to have a strong impact and results were summarized accordingly. To reduce the effects of bias, factors were randomly selected. Then the results were assessed as full samples and sub-samples to gender, education level, income, health status, and political opinion.

Table 3 reviewed the Turkish participant's beliefs and attitudes towards the measures that played an important role in their health promotion. The respondents indicated that 80.6% cigarette use reduction, 68.7% pollution reduction, 65.7% the house quality improvement, and 63.8% poverty reduction were the strongest measurements of health promotion. When the distribution of square analysis according to sex respondents was examined, a statistically significant difference ( $p < 0.05$ ) in favour of women was revealed.

In the same table, the distribution of square analysis according to the age of respondents' views on measures to improve their health indicated that there was a statistically significant difference in unemployment reduction measures with age ( $p < 0.05$ ). Moreover, the distribution of square analysis according to respondent's education status, Turkish participants believed that smoking reduction, more people's health insured, reduction of poverty, violence and unemployment, increasing the level of education, developing networks, ego satisfaction and crisis management were a statistically significant difference ( $P < 0.05$ ) in their responses.

As shown in Table 3 again a, statistically significant difference between the participants' views about the measures that improve their health like smoking reduction, making more people health insured, ego satisfaction and crisis management with income determinants. For example, participants who have an income level  $\geq 960.8$  US dollars believed that smoking reduction improves their health with a rate of 83.2% and ego satisfaction with a rate of 30.2%, while the participants who have an income level  $\leq 320.2$  US dollars recorded with a rate of 75.3%, 42.8% respectively for the same measures.

Again, the same research indicated that the Turkish participants whose age  $\leq 35$ , believed that the unemployment reduction will improve health with a rate of 59.0%, but the respondents whose age  $\geq 35$  with a rate of 64.1%.

Statistically significant differences were shown according to participants' health status determinants with the reducing smoking, unemployment, increasing the number of college-educated people, ego satisfaction, talent orientation programs and minimizing political and ideological conflict ( $p < 0.05$ ). For instance, the participants who declared that their health status is bad believed that the reduction of

Measures for Health Promotion	Full Sample (%)	Gender (%)		Age (%)		Education (%)			Income (US Dollar ) (%)			Health Status (%)			Politics View (%)					
		Female	Male	< 35	≥ 36	Secondary Education	College	Graduated & Post graduated	<320.19	320.51-960.57	≥960.89	Bad	Good	Very Good	Conservative	Moderate	Liberal	Social Democrats	Nationalist	No Idea
Smoking reduction	72.9	74.5	71.3	73.7	72.0	69.3*	76.8	76.8	74.6	70.7	76.2	77.3	70.47	75.8	74.7	73.6	65.0	77.8	62.9	66.3
More peoples' health insured	64.9	66.2	63.6	64.8	65.0	64.3	65.9	65.9	66.8	62.5	68.4	69.1	65.6	62.6	60.5	66.6	70.0	68.3	65.7	62.0
Programs to encourage people to develop individual health practices	65.2	69.7*	60.4	63.2	67.5	62.1	69.0	69.0	65.3	63.3	69.7	64.9	63.1	68.9	66.4	64.0	70.0	68.9	62.9	63.3
Pollution reduction	73.2	76.8*	69.4	71.4	75.4	71.8	74.3	74.3	70.5	72.9	77.9	69.1	71.6	77.1	71.1	74.9	65.0	78.4	65.7	68.1
Poverty reduction	77.1	82.0*	71.9	74.6*	80.1	74.3	80.9	80.9	77.5	76.0	79.0	78.7	76.5	77.7	72.1*	80.5	83.3	81.5	80.0	67.9
Increase access to early childhood development programs	63.6	68.6*	58.4	61.5	66.2	61.8	64.9	64.9	63.4	62.8	66.1	73.1	61.2	65.6	60.8	66.0	72.2	63.6	55.9	61.1
Violence reduction	70.3	77.6*	62.6	70.3	70.4	68.9	73.0	73.0	75.4*	69.4	65.2	75.8	70.6	68.4	65.2*	73.9	75.0	74.5	57.6	64.6
Unemployment reduction	75.6	80.8*	70.0	74.2	77.3	74.0	76.0	76.0	77.6	75.7	72.3	77.1	75.3	75.7	70.8	77.7	80.0	80.1	79.4	70.5
Increase the number of people who are studying in college	69.0	75.1*	62.5	67.0	71.4	69.1	68.2	68.2	72.6	68.4	65.2	68.8	69.5	68.1	67.9*	72.3	65.0	72.1	57.1	59.7
Develop social support and social networks	61.8	66.7*	56.4	58.5*	65.6	59.0	65.9	65.9	64.5	59.9	62.6	68.4	60.5	62.3	62.0	63.1	66.7	63.3	71.4	52.6
To increase the quality of living areas (accommodation)	65.0	71.6*	57.9	62.4*	68.0	63.1	67.2	67.2	67.1	63.3	66.2	69.1	64.1	65.5	63.6	67.2	60.0	67.7	60.0	59.0
Ego satisfaction	60.4	66.0*	54.4	57.3*	64.1	59.8	59.7	59.7	64.9	59.0	57.1	71.9	58.8	60.3	57.9	61.9	70.0	63.2	50.0	57.2
Prepare urgent plans for the least damage to political and intellectual conflicts	61.0	66.1*	55.6	59.8	62.5	61.8	60.1	60.2	68.5*	56.9	60.4	67.7	60.0	61.0	59.7	62.2	72.2	67.1	62.9	51.3

\*P<0.05

Table 4: Beliefs and Attitudes of Palestinian citizens about the factors that affect the health promotion.



unemployment and increasing the level of education will improve their health with a rate of 75.4% and 61.3%, respectively, but the participants with very good health status believed that the same measures will improve their health by 57.2% and 49.0%, respectively.

Finally, before ending the discussion on the output of this table, the researchers wanted to highlight the political views of participants' beliefs and attitudes about the measures which play an important role in health promotion. The study pointed out statistically significant differences between the participants' political views within programs aimed at reducing poverty, increasing access to early childhood development programs, increasing the number of college-educated people, improving social assistance and social networks, increasing the quality of living spaces, ego satisfaction and talent orientation, and minimizing political and ideological conflicts ( $p < 0.05$ ). Whereas, conservative participants believed that the reduction of poverty improved their health with a rate of 57.9%, the Moderate, Liberal, Social Democrats and Nationalist views that the reduction of poverty played an important role in the health promotion with a rate of, 63.8, 57.7, 77.7 and 68.1%, respectively, and those who have no idea with a rate of 63.3%.

Table 4 indicates that Palestinians believed that the reduction of poverty, unemployment, pollution and smoking, scored rates of 77.1%, 75.6%, 73.2% and 72.9%, respectively, and these measures were the strongest ones that play a role in improving health in the Palestinians belief and attitude.

When the distributions of square analysis were tested, the Palestinian respondents belief and attitudes according to their gender determinants showed statistically significant differences in increasing access to early childhood development programs, reduction of violence and unemployment, increasing the number of people receiving tertiary education, social support and social networks, improving the quality of life (shelter), ego satisfaction and talent orientation and crisis management measures ( $p < 0.05$ ). Again, in Palestine, the respondents' views showed statistically significant differences in answers according to age determinants with the measures including; poverty reduction, social support and the quality of life improvement and ego satisfaction ( $p < 0.05$ ). For instance, the respondents whose age were  $\leq 35$  believed that poverty and unemployment reduction play a crucial role in improving their health with a rate of 74.6%, 74.2% respectively. While the respondents whose ages are  $\geq 36$  recorded a rate of 80.1%, 77.3%, respectively, which in return reflects the awareness of Palestinian people whose ages were  $\geq 36$  years about social safety. Whereas, the distribution of square analysis according to educational level, the views of the Palestinians participants showed statistically significant differences in decreasing cigarette use as a measure to improve health ( $p < 0.05$ ).

Again, in Table 4, a distribution of square analysis according to the participants' income level and views on health promotion measures showed a statistically significant difference in the measure of preparing

	Country	n	Average	Standard Deviation	T	P
Factors affecting health	Turkey	1569	1.5061	27028	-8.377	0.000*
	Palestine	1171	1.5970	29413		
Measures to improve health	Turkey	1558	1.5624	32871	-8.949	0.000*
	Palestine	1171	1.6752	32262		

\* $p < 0.05$

**Table 5:** Beliefs and attitudes of citizens towards the factors affecting health and measures for improving the health according to the living place in Turkey or Palestine.

urgent plans to minimize the political and intellectual conflicts and reduction of violence ( $p < 0.05$ ) and their scores according to their income level that  $\leq 320.19$  US dollars were (75.4%, 68.5%) vs. those whose income level  $\geq 960.89$  US dollars (65.2%, 60.4%) respectively. In the same Table, Palestinians respondents who have bad health status gave the rate of 71.9% for the ego satisfaction as a measure to improve their health, while participants who have very good health recorded a rate of 60.0% for the same measure.

Finally, when the views of the Palestinian on measures to improve the health were taken into consideration, the square analysis distribution according to political opinion was tested, differences in political views were found to be statistically significant in decreasing poverty, increasing access to early childhood development programs, reducing violence, and increasing the number of people receiving tertiary education measures ( $P < 0.05$ ). After highlighting the Tables 1-4 precisely, the researchers have to answer the focal study question by showing the results of hypothesis which was tested in the study on the "Beliefs and Attitudes towards Health Determinants between Two Communities", whereas the hypothesis was addressed as:

H: There are differences in beliefs and attitudes towards health affecting factors and measures to improve health between the Turkish people and Palestinians.

As it is clear from Table 5, statistically significant differences were found between participants living in Turkey and those who are living in Palestine in terms of beliefs and attitudes towards factors affecting the health and measures needed to improve health ( $p < 0.05$ ).

In this case, a hypothesis was accepted. It can be said that socioeconomic differences opportunities, the experience of financial problems financial problems and diseases are associated with attitudes towards health rather than with religious beliefs and shared historical culture as it is pointed out by Wardle and Steptoe (2003) [20] and this has been confirmed by this study.

## Discussion and Recommendation

The beliefs and attitudes of Palestinian and Turkish citizens who have the same common religion and similar cultures, but differ in an economic and political position necessarily reveal the role of biological, behavioural, psychological and well-being factors in determining the health status of the individual and the community in both countries.

In terms of Turkey, it is a country in the Middle East that has an independent and prestigious position in the economic and political arena and has begun negotiations to join the European Union. It is not easy to compare it with Palestine, which is still under occupation for more than 66 years. However, the concept of a human being does not change according to its geographical position but may change according to the economic and political situation of the country and the needs and priorities of the human. Because of differences in the socioeconomic and political position of both countries, social health determinants should be studied.

According to this research, both samples of the two communities, regardless of gender, age, education, family income, health status and political opinion, showed the most important factors that were believed to have very strong effects on health. Turkish citizens believed that smoking (83.2%), stress (78.8%), having access to the appropriate services (65.7%), exercise and healthy food (64%), and genetic (60.7%) from related medical factors that affect their health more than socioeconomic factors.

Though, when analyzing Palestinian participants' statements

on health determinants, it was found that the high frequencies were respectively: High-quality housing (69.3%), income (68.1%), smoking (68%), education (66.9%), stress (65.6%), and freedom (65.4%). The results showed that failure to meet housing (dwelling), education needs and freedom which were an essential need were included in health determinants in Palestine besides smoking and stress, this indicated that the most vulnerable people every time believe that the socioeconomic factors play an important role in affecting their health, and this result is pointed out by Robert and Booske [8]. Whereas, the measures that have a strong effect on improving health, according to Turks participants were 80.6%, reducing smoking, 68.7%, reducing pollution, 65.7% raising the quality of living quarters and 63.8% reducing poverty, on the other side, Palestinians participants said that: 77.1% reducing poverty, 75.6% reducing unemployment, 73.2% reducing pollution, and 72.9% reducing smoking had strong effects on improving health.

The responses of the participants to the factors influencing health and health promotion clearly reflect the social and political reality that participants are experiencing. According to Turkish citizens, social solidarity, social security, education, religion, race, political stability, freedom, ego factor and the reduction of conflict were affecting their health with a rate less than 50%. Whereas these measures affected the health of Palestinians with a rate more than 50%, excluding race. This study meets the WHO (2010) discussion paper on gender and health, [82] as the scores on factors influencing health and measures to improve health were clearly seen higher for women compared to male participants in considering the gender, age, education, family income, health status, body mass index and political opinion factors of participants, regardless of the country where the participants lived. The researchers thought that this is because of the fact that women regard psychological status, social, and political security as a building block for their life and these necessarily reflects their health. Regarding the 2010 World Health Organization study, gender is the most important health determinant as gender inequality exposes women to health hazards. The physical and performance differences between women and men have been reflected in their behaviour and as a result, have affected health outcomes.

According to the results related to age and the factors affect the health of the population, statistically significant differences were found between age and work, social security, education, work type, religion and freedom of Turkish citizens. According to Palestinians from different age groups, statistically significant differences were found in scores related to social solidarity, quality of the house, political stability and freedom in affecting their health. The difference in responses between different ages with unemployment reduction, according to Turkish citizens, and the age with personal development, according to Palestinian respondents were statistically significant as a measure to improve health. These study results assure that the age is the important determinant of health because lifetime exposure to various risks and hazards will have a major influence on health in older ages. Although seniors are no longer in employment, their exposure to hazards at the workplace in earlier life has been shown to affect health and socioeconomic status in old age as they retire [83].

Turkish citizens who are middle educated believed that the rate of health insurance, social security, place of residence, religion, race, freedom, political stability affect their health with a rate higher than those highly educated believed. Palestinian respondents who have a middle education level believed that the health insurance and the race or ethnicity affect their health with a rate higher than that affecting those with higher education. From the point of view of Turkish citizens who have middle education level, reducing the violence and unemployment

was an important factor in improving the health, but those with a low education level viewed the social and political security as a solution in the improvement of health. These days, the level of education is considered to be an essential social determinant of health as it is playing an important role in framing the well-being of physical and mental health and offering the opportunities of prestigious employment [84].

In this study, Turkish respondents whose level income was  $\leq$  320.19 US dollars believe that making a plan to deal with emergency political conflict and ego satisfaction will improve their health with a rate which is more than those who have an income level of  $\geq$  960.89 US dollars. In the other side of this research, Palestinian respondents whose level income was  $\leq$  320.19 US dollars sharing the beliefs and attitude of Turkish respondents whose level income was  $\leq$  320.19 US dollars that the violence reduction and dealing with political conflict will improve their health with a rate of more than those who have an income level  $\geq$  960.89 US dollars.

In general, the controlling the life conditions will affect the health positively. as the shortage of resources, social support and communication cycle can lead to lessening health skills and behaviours such as unhealthy eating habits, smoking and alcohol abuse [85]. And this is not incompatible with the findings of WHO, that's a very low income can impact negatively on health. As well as, facing financial and life stress over time may lead to health consequences such as immune and circulatory complications [86]. On the other side, those who have an adequate income and employment are likely to experience health outcomes that are less dependent on material needs and they have the control ability to take the decision which is suitable for facing their home and work problems [86,87]. The cultural pigments of society, the equal distribution of resources, social support, social networking and positive or negative childhood history can play an important role in framing the health of the individual and communities [87].

The respondents' views on the factors that affect their health indicated that health status, psychological, social, political and economic challenges, were important in shaping their beliefs. When the researchers put the responses on the table for discussion, the effect of religion on the health of Turkish participants who expressed their health status as poor versus very well was 51.6%, versus 46.6%. While Palestinians who described their health as poor versus very good were declaring that the religion affects their health with a rate of 65.9% vs. 52.6%, where Palestinians find consolation always in the religion because of the critical situation they live in. According to the results of the study, there were statistically significant differences between the body mass index for Turkish participants with; personal health behaviour, job presence, social solidarity, genetic factors, political stability and ego as health affecting factors. For Palestinians, those who have a body mass index equal to 30 believed that the personal behaviour, social security, financial security and political stability have more effect on their health than the rate of those who have a body mass index of 18.5 to 24.9.

While the BMI correlates with body fat and a higher level of body fat may increase the risk of developing diseases. As BMI increases, the risk for some diseases increases [88,89]. According to political views, regardless of their gender, age, education, family income and health status, the nationalist participants in Turkey believed that health insurance, health experience, job, social solidarity, social security, race, political stability, freedom and ego affect their health with a rate more than the rate of those who have other political views. While Social Democrats are more concerned with the smoking, personal behaviour, stress, physical conditions, sports fields, healthy food, income, quality of residence, education, type of residence and acceptance of the other.

Conservatives' beliefs and attitudes have shown that religion has a greater impact on health with a rate more than the rate of other political views toward the same factor. On the other hand, those with moderate political views believed that smoking, access to health care facilities, healthy experience, social security, genetic factors, income, quality residence, education, work type and religion have an important role in affecting their health.

According to the Palestinians Social Democratic, reduction of smoking, air pollution and unemployment were improving their health with a rate of 77.8%, 78.4% and 80.1%, respectively. Liberal Palestinians believed that organizing incentive program was the most important factor that improves their health. These results are underpinned that the health policies should be matched with social policies to improve the health of citizens. In this research, the researchers asked the participants to determine their political opinion, which raised a question mark about the relationship between politics and health? But when the answers were analyzed, the cubes were built and the picture was completed, and finally, the actual road map was determined. Social policies are saving boats for preserving the health of the public. These policies, which are created by the government and the private sectors, must be in the same line with the decision makers in the state to build and protect the health agenda.

This research, besides other studies, indicates that, in addition to medical services, social, political and economic factors are affecting health to a large extent. Studies illustrate the evidence that people's health behaviour (e.g., exercise, diet, smoking, etc.), psychological influences and their sources, and also the socioeconomic factors; (education level, income level, job prestige, etc.) besides, the environmental and political conditions in which people live, work and play are highly influential on health and health promotion [89-91]. In the welfare states, Social Democratic ensures the prerequisites of health, liberal; strong commitment to the economic and social security of the citizens, Conservative and less developed Latin welfare states emphasizes social security schemes that reduce the economic and social risks of salaried areas [92].

In this study, as there are differences between the political views of the respondents according to the factors affecting health and the measures to improve health, let the researchers take a look at the intersection points of this study with other studies. Starting from the family, educational institutions, social institutions, employers, industrialists, the government and society, 33 each factor of them can build political management skills through complementary work and research findings [93]. In addition, it is a fruitful work to recruit the media as a social policy to highlight the factors affecting the health and health promotion [94]. For those who have health problems in any area in the world let us give them Leonardo project butter; strong "partnership" between Physicians, care managers, and patients show a positive impact on patient health and self-management, and readiness to make changes in health behaviours [94].

This study illustrates the necessity for health and social policy makers and asks them to take into account the studies that measure the society's perceptions, opinions, beliefs and attitudes so that they can create strategies that are appropriate to the health agenda in both countries. In conclusion, although the religious and cultural structure is similar, significant differences have been found in the beliefs and attitudes towards the factors that affect respondents' health and the factors improving their health between the two countries whose ethnic and political structure is different. Finally, it is thought that the perception, beliefs and attitudes of the different ethnic groups under the

same political conditions towards health determinants in Turkey and Palestine will be important to be present in future studies.

## Limitations

The researchers acknowledge a number of limitations to this study. The results may not be generalizable to the general public as the questionnaires restricted to Ankara residents in Turkey and Nablus residents in Palestine. While the researchers have taken into account the real demographic composition of both communities and accordingly the samples were distributed after receiving the oral informed consent of the participants in the study besides the approval of the health care management department at the Gazi University on this study. So these research results should be reliable.

## Contributors

Menawi. W participated in planning the study, collecting the data, conducting the analyses and writing the article .

## References

1. Kelly MP, Bonnefoy J, Morgan A, Bergman V (2007) The social determinants of health: Developing an evidence base for political action. *Meas Evide Know* 10-23.
2. Soysal A (2010) What is health impact assessment? What is not? *TAF Preventive Medicine Bulletin* 9: 689.
3. Halfon N, Hochstein M (2002) Life course health development: An integrated framework for developing health, policy, and research. *Milbank Q* 80: 433-441.
4. House J, Landis K, Umberson D (1988) Social relationships and health. *Science* 241: 540-545.
5. Mahamoud A, Rochea B, Homerb J (2013) Modelling the social determinants of health and simulating short-term and long-term intervention impacts for the city of Toronto, Canada. *Soc Sci Med* 93: 247-259.
6. Smith GD, Shaw M (2004) Cultures of health, cultures of illness. *British Medical Bulletin* 69: 1.
7. Adler NE, Newman K (2002) Socioeconomic disparities in health: Pathways and policies inequality in education, income, and occupation exacerbates the gaps between the Health "Haves" and "Have-Nots." *Health Affairs* 21: 60-70.
8. Robert S, Booske B (2011) US opinions on health determinants and social policy as health policy. *Am J Public Health* 101: 1655-1663.
9. Jackson E (2010) The influence of cultural beliefs and attitudes on the perceptions of health, body size, and health behaviours among over-weight and obese African American Women. *Woman's University* 1-32.
10. Raphael D (2003a) Addressing the social determinants of health in Canada: Bridging the gap between research findings and public policy. *Policy Options* 35-40.
11. Cannon R (2008) The social determinants of health: South Australian council of social service (SACOSS). *South Australian health* 5-12.
12. Sorensen G, Emmons K, Hunt M, Barbeau E, Goldman R, et al. (2003) Model for incorporating social context in health behaviour interventions: Applications for cancer prevention for working-class, multiethnic populations. *Prev Med* 37: 188-197.
13. Murray DT (2011) The multiple determinants of religious behaviours and spiritual beliefs on well-being. *J Spiri Ment Health* 13: 182-185.
14. Mikkonen J, Raphael D (2010) Social determinants of health: the Canadian facts. *School of health policy and management. York University, Toronto* 3-47.
15. Raphael D (2008) Social determinants of health, (2<sup>nd</sup> Edn). *Canadian Perspectives, Canadian Scholar's Press* 3-6.
16. Beytut D, Muslu G, Başbakkal Z, Ve Yılmaz H (2009) Traditional beliefs and practices of pediatric nurses about pain 2: 13.
17. Tekin A (2007) Health-illness fact and its social roots (burdur study), Süleyman Demirel Üniversitesi, Isparta 93-95.
18. Abel T (2008) Cultural capital and social inequality in health. *J Epidemiol*



- Community Health 62: 13.
19. Adak N (2002) Health sociology women and urbanization. Individual publications. Istanbul 9: 78-79.
  20. Wardle J, Steptoe A (2003) Socioeconomic differences in attitudes and beliefs about healthy lifestyles. *J Epid Comm Health* 57: 440-443.
  21. Wilkinson R, Marmot M (2003) Social determinants of health: The Solid Facts (2<sup>nd</sup> Edn). WHO. Denmark 10-31.
  22. Marmot M (2010) Fair society, healthy lives: Strategic review of health inequalities in England, Post 2010. Department of Health, London, UK 10-20.
  23. Cambois E, Jusot F (2011) The contribution of lifelong adverse experiences to social health inequalities: Findings from a population survey in France. *Eur J Public Health* 21: 667-668.
  24. Murray C (2009) Beliefs and attitudes regarding health-enhancing behaviours in African American and Caucasian women. Walden University 1-15.
  25. Dannenberg AL, Jackson RJ, Frumkin H, Schieber R, Pratt M, et al. (2003) The impact of community design and land-use choices on public health: A scientific research agenda. *Ame J Public Health* 93: 1500-1508.
  26. Commission on Social Determinants of Health (2008) Closing the gap in a generation: Health equity through action on the social determinants of health. WHO, Geneva 3-177.
  27. Solar O, Irwin A (2010) A conceptual framework for action on the social determinants of health. Social determinants of health discussion paper 2. WHO, Geneva.
  28. Haney MO, Erdoğan S (2013) Health behaviour interaction model: A guide to determine children's dietary habits. *Dokuz Eylül University School of Nursing Elect J* 6: 218.
  29. Blane D (1995) Social determinants of health socioeconomic status, social class, and ethnicity. *Ame J Pub Health* 85: 903-905.
  30. Cutler D, Muney AL (2006) Education and health: Evaluating theories and evidence. national poverty center.
  31. Report to the Commission to Build A Healthier America (2008) Overcoming obstacles to health. Robert Wood Johnson Foundation 'RWJF' 4- 68.
  32. Lundell H, Niederdeppe J, Clarke C (2013) Public views about health causation, attributions of responsibility, and inequality. *J Health Commun* 18: 1116-1130.
  33. Varas A, Fortin C (2012) International cooperation to reduce inequality. The Norwegian Peacebuilding Resource Centre Report.
  34. WHO (2007) Everybody's business: Strengthening health systems to improve health outcomes. WHO's Framework for Action 1-8.
  35. Jamison T, Mosley W (1991) Disease control priorities in developing countries: Health policy responses to epidemiological change. *Ame J Public Health* 81: 20.
  36. Schneider M, Eide AH, Amin M, MacLachlan M, Mannan H (2013) Inclusion of vulnerable groups in health policies: Regional policies on health priorities in Africa. *Afr J Disabil* 2: 1-2.
  37. Pan American Health Organization (2007) Renewing primary health care in the Americas: A position paper of the pan American health organization/world health organization.
  38. Exworthy M, Bindman A, Davies H, Washington AE (2006) Evidence into policy and practice? Measuring the progress of U.S. and U.K. policies to tackle disparities and inequalities in U.S. and U.K. health and health care. *Milbank Q* 84: 77-81.
  39. Sheiham A, Alexander D, Cohen L, Marinho V, Moysés S, et al. (2011) Global oral health inequalities: Task group implementation and delivery of oral health strategies. *Adv Dent Res* 23: 259-267.
  40. Poval S, Haigh F, Abrahams D, Scott-Samuel A (2010) Health equity impact assessment 'Project Report'. Liverpool health inequalities research institute, Liverpool 1-56.
  41. Braveman P (2006) Health disparities and health equity: Concepts and measurement. *Annual Reviews Public Health* 27: 168-183.
  42. Brennan Ramirez LK, Baker EA, Metzler M (2008) Promoting health equity: A resource to help communities address social determinants of health. Centers for Disease Control and Prevention.
  43. Collins PA, Hayes MV (2007) Twenty years since Ottawa and epp: Researchers reflections on challenges, gains and future prospects for reducing health inequalities in Canada. *Health Promot Int* 2: 337-345.
  44. McCartney G, Leyland AH, Fischbacher CM, Whyte B, Walsh D, et al. (2013) Commentary: Long-term monitoring of health inequalities in Scotland a response to Frank and Haw. *Milbank Q* 91: 186-191.
  45. Lavin T, Metcalfe O (2008) Policies and actions addressing the socio-economic determinants of health inequalities: Examples of activity in Europe. *Determine Working* 4-25.
  46. Rütten A, Abu-Omar K, Gelius P, Schow D (2013) Physical inactivity as a policy problem: Applying a concept from policy analysis to a public health issue. *Health Resea Policy Sys* 11: 1-2.
  47. Centers for Disease Control and Prevention (2011) Health disparities and inequalities in the United States, *Morbidity and Mortality Weekly Report* 60: 3-4.
  48. PHAC (2011) What determines health? Health promotion.
  49. Melkas T (2013) Health in all policies as a priority in Finnish health policy: A case study on national health policy development. *Scand J Public Health* 41: 3-6.
  50. Beheshtian M, Manesh AO, Bonakdar SH, Afzali HM, Larjani B, et al. (2013) Intersectoral collaboration to develop health equity indicators in Iran. *Iran J Public Health* 42: 31-32.
  51. Stahl T, Wismar M, Ollila E, Lahtinen E, Leppo K (2006) Health in all policies: Prospects and potentials. Ministry of Social Affairs and Health 4-107.
  52. Şimşek Z (2013) The history and strategies based on the samples of health promotion. *TAF Prev Med Bull* 12: 343-355.
  53. WHO (2013) Country cooperation strategy and briefs.
  54. Yılmaz V (2013) Changing origins of inequalities in access to health care services in Turkey: From occupational status to income. *New Perspectives on Turkey* 48: 55-65.
  55. Barış E, Mollahaliloglu S, Aydın S (2011) Healthcare in Turkey: From laggard to leader. *BMJ* 342: 456.
  56. PNAM (2013) Palestinian national health strategy 2011-2013: Setting direction-getting results, PNAM 7-25.
  57. Mahmoud A (2013) Health challenges in Palestine, *Science & Diplomacy* 2: 2-6.
  58. Tawil S (2013) No end in sight: Moving towards a social justice framework for mental health in continuous conflict settings. *Intervention* 11: 25-28.
  59. Shaar A, Larenas J (2006) Social determinants of health: Palestine country paper. WHO 8- 15.
  60. Matariaa A, Donaldson C, Luchini S, Paul Moatti J (2004) A stated preference approach to assessing health care-quality improvements in Palestine: From theoretical validity to policy implications. *J Health Econ* 23: 1286.
  61. Phillips S (2005) Defining and measuring gender: A social determinant of health whose time has come. *Int J Equity in Health* 4: 4-1.
  62. Williams S (2004) Religious, social, and cultural theories on the Israeli-Palestinian conflict.
  63. Aras B (2009) Turkey and the Palestinian question. Foundation for political economic and social research. Policy Brief 27: 4.
  64. [http://www.mfa.gov.tr/turkey\\_s-political-relations-with-the-palestinian-national-authority.en.mfa](http://www.mfa.gov.tr/turkey_s-political-relations-with-the-palestinian-national-authority.en.mfa)
  65. Erdal B, ve Ok Ü (2012) The role of faith: Worldview styles in music preference. *Int J Social Science* 5: 60-66.
  66. Yalcin H, Kocak N (2012) Validity and reliability study of the nonfunctional beliefs and practices attitude scale. *Int J Soc Econ Scis* 2: 157-163.
  67. Kagıtcıbası C (2006) New man and people, social psychology series (10<sup>th</sup> edn) Evrim Publications.
  68. Inceoglu M (2010) Attitude perception communication (5<sup>th</sup> edn), Beykent University Publishing House, Istanbul 8-21.
  69. Bayat B (2014) Measurement, scales and "likert" scale establishment technique in applied social science research. *Journal of Gazi University Faculty of Economics and Administrative Sciences* 16: 23.
  70. Robert SA, Booske BC, Rigby E, Rohan AM (2008) Public views on determinants



- of health, interventions to improve health, and priorities for government. *WMJ* 107: 124-130.
71. Kurumu TI (2014) What are the numbers ? Turkish statistical institute press, Ankara.
  72. Ministry of Foreign Affairs of the Republic of Turkey (2014) General view of Turkish economy.
  73. Ajansı M (2014) Census: The number of palestinians in the world's 11.8 million, says statistics bureau. IMEMC News.
  74. Karagöl ET (2014) An economy under blockade: The Palestinian economy. *Seta* 59: 1-5.
  75. Turkey Statistical Institute (2013) 'TURKSTAT'. Literacy Report.
  76. PCBS (2014b) Living conditions of the palestinian population in palestine 2014. Ramallah, Palestine 32-36.
  77. PHIC (2014) Health annual report 2013. Ministry of Health, Palestine 20- 52.
  78. Sayı (2016) Hayat tabloları, 2013-2015. Turkey stastic institutation.
  79. Sağlık Bakanlığı TC (2012) Health statistics yearbook 2011. Ministry of Health. Ankara.
  80. Başara B, Güler C, Yentür GK (2014) General directorate of health research, Ministry of Health, Sentez Printing and Publishing, Ankara 30-36.
  81. WHO (2010) Gender, women and primary health care renewal. Discussion Paper. Geneva: WHO.
  82. NPHSW (2004) A profile of the health of older people in wales. A report by the national public health service for wales.
  83. Shankar J, Ip E, Khalema E, Couture J, Tan S, et al. (2013) Education as a social determinant of health: Issues facing indigenous and visible minority students in postsecondary education in Western Canada. *Int J Environ Res Public Health* 10: 3908-3929.
  84. Maemot M (2007) Achieving health equity: From root causes to fair outcomes. *Lancet* 370: 1153-1163.
  85. World Health Organization (2003) Social determinants of health: The Solid Facts.
  86. Irwin L, Siddiqi A, Hertzman C (2007) Early child development: A powerful equalizer. WHO.
  87. Zhang L, Fos P, Johnson W, Kamali V, Cox R, et al. (2008) Body mass index and health related quality of life in elementary school children: a pilot study. *Health Qual Life Outcomes* 6:77.
  88. Madden D (2006) Body mass index and the measurement of obesity. *HEDG* 6-11.
  89. Lantz PM, Lichtenstein RL, Pollack HA (2007) Health policy approaches to Population Health : The limits of medicalization. *Health Affairs* 26: 1253-1257.
  90. Woolf SH (2009) Social policy as health policy. *JAMA* 301: 1166-1169.
  91. Raphael D (2011) The political economy of health promotion: Part 1, national commitments to provision of the prerequisites of health. *Health Promotion International* 28: 2.
  92. Koh HK, Oppenheimer SC, Massin-Short SB, Emmons KM, Geller AC, et al. (2010) Translating research evidence into practice to reduce health disparities: A social determinants approach. *Ame J Public Health* 100: 72-80.
  93. Niederdeppe J, Bu QL, Borah P, Kindig DA, Robert SA (2008) Message design strategies to raise public awareness of social determinants of health and population health disparities. *Milbank Q* 86: 481-486.
  94. Ciccone MM, Aquilino A, Cortese F, Scicchitano P, Sassara M, et al. (2010) Feasibility and effectiveness of a disease and care management model in the primary health care system for patients with heart failure and diabetes (Project Leonardo). *Vasc Health Risk Manag* 6: 297-305.

Citation: Menawi WA (2017) Beliefs and Attitudes Regarding Determinants of Health in Turkey and Palestine. J Community Med Health Educ 5: 546. doi:10.4172/21610711.1000546

### OMICS International: Open Access Publication Benefits & Features

#### Unique features:

- Increased global visibility of articles through worldwide distribution and indexing
- Showcasing recent research output in a timely and updated manner
- Special issues on the current trends of scientific research

#### Special features:

- 700+ Open Access Journals
- 50,000+ Editorial team
- Rapid review process
- Quality and quick editorial, review and publication processing
- Indexing at major indexing services
- Sharing Option: Social Networking Enabled
- Authors, Reviewers and Editors rewarded with online Scientific Credits
- Better discount for your subsequent articles

Submit your manuscript at: [www.omicsonline.org/submission/](http://www.omicsonline.org/submission/)