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The Quality of Postpartum care at Governmental Hospitals in Gaza Strip: Challenges and Implications

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The Quality of Postpartum care at Governmental Hospitals in Gaza Strip: Challenges and Implications

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Dedication

I would like to dedicate this thesis to

My lovely mother **Sobhia** and lovely Father **Mahmoud**

Who always give their endless love, support, motivation and many things for success, I do love you very much.

****

Secondly,

For my husband, **Dr. Salem** and my siblings.

No one can make me happier and stronger than them.

****

Thirdly,

To my beloved **brothers** and **sisters**

Thanks a lot for your great love in my life.

Declaration

This is to certify that this thesis is for Al-Quds University to achieve the master's degree and it is a result of my special research except what the researcher pointed to what occurred. This paper was not offered to any other Universities to achieve any other degree .

Signature :

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Date17/04/2019

Acknowledgment

In the Name of Allah, the Most Merciful, the Most Compassionate, all praise be to Allah, the Lord of the worlds; and prayers and peace be upon Mohamed his servant and messenger.

First and foremost, I must acknowledge my limitless thanks to Allah, the ever-magnificent; the ever-thankful, for his help and bless. I am totally sure that this work would have never become truth, without his guidance. I owe a deep debt of gratitude to our university for giving us an opportunity to complete this work. I am grateful to great people, who worked hard with me from the beginning till the completion of the present research particularly my supervisor:

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Abstract

Health services provided to mothers after delivery constitute an essential component of the maternal and child health services in any population. According to Palestinian Ministry of Health (MOH) maternal mortality rate (MMR) in the Gaza-Strip was 30/100,000 live births in 2014, and 25 in 2015 ,which differed from that in the West Bank with 20/100, 000 in 2014 (Bottcher , et ,el .2018).

The aim of the study was to assess the quality of postpartum care provided at governmental hospitals in Gaza Strip and to identify mothers' satisfaction with postpartum care.

The study commenced from May 2018 to March 2019, the researcher used descriptive, analytical, cross sectional design. The sample of the study consisted of 115 nurses and midwives who are working in postpartum departments (NVD units and CS units) at governmental hospitals (Al Shifa hospital, Nasser hospital, Shohada Al Aqsa hospital, and Al Emaratey hospital), and 428 postpartum mothers from the same hospitals, the researcher chose this sample according the mean number of 2016 and 2017 cases. For data collection, the researcher developed three instruments: Quality of postpartum care(A nursing perspective), Mothers' Satisfaction from Postpartum Care, and observational checklist for nursing care, five trained nurses helped her in collecting data . Reliability of the questionnaire was tested and Cronbache alpha coefficient was 0.965 for satisfaction scale, and 0.852 for quality of postpartum care. For data analysis, SPSS (version 22) was used, and statistical analysis included frequencies, percentage, means, standard deviation, (t) test, and One way ANOVA.

The results showed that the mean age of mothers was 26.32±5.86 years, (75.2%) had normal vaginal delivery, 30.1% primiparous, (95.8%)delivered single baby. in addition, mean age of nurses was 30.96±6.007 years, (60.9%) had Bachelor degree, (71.3%) had low income, and (77.4%) were married. The results showed that 18.9% of mothers were highly satisfied and 53% were satisfied, and the mothers expressed above moderate satisfaction with mean score 3.78 and weighted percentage (75.6%). There were statistically significant higher satisfaction with postpartum care among mothers who delivered in Al Emaratey hospitals, and among those who live in nuclear family, but there were no significant differences in mothers' satisfaction related to age, level of education, work, income, number of pregnancies, number of deliveries, mode of delivery, and birth outcome. In addition, the results indicated high quality postpartum care (90%) in governmental hospitals in Gaza Strip. There were statistically significant differences in

quality of postpartum care and the lowest was in Kamal Odwan hospital, and nurses with 1 - 5 years of experience have the lowest mean score in providing quality of care, but there were no significant differences in quality of postpartum care related to nurses' age, qualification, marital status, and income. Furthermore, in observational checklists results the highest score was in communication with mean score 2.56 and weighted percentage 85.3%, and the lowest score was in efficient care of the baby with mean score 1.95 and weighted percentage 65%. The overall score of observed performance was above moderate with mean score 2.02 and weighted percentage 67.3 %. Also the researcher presented the challenges to improve mothers' satisfaction with PPC and the implications to improve the quality of PPC . In conclusion, according to the weakest points of postpartum care (A nursing perspective) the study raised the need to apply Palestinian unified, written protocols and guidelines that specify and describes nurses' interventions during the postpartum period for the mother and her baby.

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List of Abbreviation

ACIA: American Central Intelligence Agency

ANC : Antenatal Care.

BMI : Body Mass Index

CS: Cesarean Section

DHS: Demographic and Health Surveys.

ED: Early Discharge

EENC: Early Essential Neonatal Care

ICI: International Childbirth Initiative

IMBCO: International Mother Baby Childbirth Organization

GDG : Guidelines Development Group**.**

GDP: Gross Domestic Product

GS: Gaza Strip

LMICs : Low- and Middle-Income Countries.

MCHN: Mother Child Health Nursing.

MM :Maternal Mortality.

MOH : Ministry of health.

NGOS: Non-Governmental Organizations

NICE: National Institute for Health and Care Excellence

NMC: Naser Medical Complex.

NORWAC: Norwegian Aid Committee

NVD: Normal Vaginal Delivery .

PP: PostPartum .

PCBS: Palestinian Central Bureau of Statistics.

PHC: Primary Health Care

PPC: PostPartum Care.

PPH: PostPartum Hemorrhage

RTI: Respiratory Tract Infection

SDC: Socio-Demographic Characteristics.

SDM: Self Developed Model.

SIDS : Sudden Infant Death Syndrome

SMC: Shifa Medical Complex

SPSS: Statistical Package of Social Science.

UNRWA: United Nations Relief and Works Agency.

WB: West Bank

WHO: World Health Organization.

Chapter One

Introduction

1.1 Research Background

Taking home a new baby is one of the happiest times in a woman's life, but it also presents both physical and emotional challenges. Despite major policy in the united kingdom initiatives to enhance women's experiences of maternity care, improving in-patient postpartum care (PPC) remains a low priority, although it is an aspect of care consistently rated as poor by women (Bick et al., 2011).

Health services provided to mothers after delivery constitute an essential component of the maternal and child health (MCH) services in any population. The postpartum period (PP) is a critical time in the lives of mothers and newborn babies as most maternal and infant mortality and morbidity occur during this time. Therefore, The World Health Organization (WHO) initiated a review of the guidelines related to PPC supported by best practices and evidence-based studies (WHO, 2014) .

Every day, approximately 830 women die from preventable causes related to pregnancy and childbirth, and 99% of all maternal deaths occur in developing countries. Skilled care before, during and after childbirth can save the lives of women and newborn babies (WHO, 2018).

The number of women and girls who died each year from complications of pregnancy and childbirth declined from 532,000 in 1990 to 303,000 in 2015. These improvements are particularly remarkable in light of rapid population growth in many of the countries where maternal deaths are highest. Still, two regions, sub-Saharan Africa and South Asia, account for 88 per cent of maternal deaths worldwide. Sub-Saharan Africans suffer from the highest maternal mortality ratio – 546 maternal deaths per 100,000 live births, or

201,000 maternal deaths a year. This is two thirds (66 per cent) of all maternal deaths per year worldwide. South Asia follows, with a maternal mortality ratio of 182, or 66,000 maternal deaths a year, accounting for 22 per cent of the global total (UNICIEF 2015).

According to the Palestinian Ministry of Health (MOH), the Maternal Mortality Rate (MMR) in the Gaza-Strip was 30/100,000 live births in 2014, and 25 in 2015 ,which differed from that in the West Bank with 20/100, 000 in 2014 .

On the other hand, MMR was 7 in Israel, 58 in Jordan and 33 in Egypt (Bottcher , et ,el .2018)

In industrialized countries, postpartum hemorrhage PPH usually ranks in the top three causes of maternal mortality, along with embolism and hypertension. In the developing world, several countries have maternal mortality rates in excess of 1000 women per 100,000 live births, and WHO statistics suggest that 60% of maternal deaths in developing countries are due to PPH, accounting for more than 100,000 maternal deaths per year (Smith ,et. el.2018).

It has been noted that many women who give birth at health facilities in the developing world are discharged within hours after childbirth without any indication where they can obtain further care or support (Titaley et al. 2009). Reports from WHO indicated that up to two-thirds of maternal deaths occur after delivery. Therefore, the WHO suggested that health care should be provided at 6 hours, 6 days, 6 weeks, and 6 months post-delivery, in order to ensure women's physical and mental health and well-being (WHO, 2008).

One indicator of health care quality is patient’s satisfaction, which is the ultimate consumer or client satisfaction. Therefore, satisfaction is a key element in obtaining desirable patient’s outcome and preventing disease consequences. In addition, it is one of the main goals of management activities and a significant indicator of quality of care. Patient satisfaction leads to several benefits, such as improving the interaction between

nurses and patient, providing the required information to enhance health care programs, obtaining feedbacks from patients about the performance of nursing staff, increasing patient referrals and enhancing the financial status of health organizations (Al-Batttawi and Hafiz, 2017).

Research has demonstrated that a positive childbirth experience helps a woman develop a positive attitude towards motherhood, which facilitates the transition into the maternal role. The positive experience can also establish rich and successful family relations, encourage self-esteem, improve self-confidence and ensure positive development of the woman (Chwinui, 2010). Therefore, in this study, the researcher will identify quality of PPC provided at governmental hospitals in Gaza Strip (GS) and to assess mothers' satisfaction with PPC, in order to gain insight of the current situation of PPC and suggest recommendations to improve mothers' satisfaction and quality of PPC at governmental maternity hospitals in GS.

1.2 Research problem

Postpartum care is one of the most important maternal health-care services for prevention of complications and reduction of maternal mortality.

According to the Palestinian Ministry of Health (MOH), the Maternal Mortality Rate (MMR) in the Gaza-Strip was 30/100,000 live births in 2014, and 25 in 2015 ,which differed from that in the West Bank with 20/100, 000 in 2014 .

A total of 18 maternal mortalities occurred in Gaza between 1st July 2014 and June 30th 2015. Age at time of death ranged from 18 to 44 years, with 44.4% occurring before the age of 35 years. About 22.2% were primiparous, while 55.6% were grand multiparous women. The most common causes of death were sepsis, postpartum haemorrhage, and pulmonary embolism (Bottcher .2018).

Given the exceptional extent to which the deaths of mothers and babies occur in the first days after birth, the early identification of post-natal complications for both mother and baby can reduce maternal and newborn morbidity and mortality (Najoka, 2015). The ultimate goal is to improve the quality of postnatal care and health outcomes for mothers and newborns (WHO, 2013).

Knowledge and understanding of health services usage are necessary for health resource allocation and planning. In Palestine, the Ministry of Health (MOH) focuses its policy on facilitating access to maternal healthcare.

1.3 Justification of the study

While the researcher was working in the European Gaza hospital, her colleague's wife died after delivering a female baby in a private hospital, she felt very sad for that young woman and thought of how to prevent any complication which may lead to maternal death. This study conducted to assess the quality of PPC provided at governmental hospitals in GS, and to know the strong points and weak points through giving this care. When the researcher read about PPC, she found that studies have shown that women were more dissatisfied with PPC than other areas of maternity care (Brown et al., 2002; Waldenstrom et al., 2006), Therefore, it is important to evaluate different models of PPC to enable evaluation and development of postnatal care. Most maternal and infant deaths occur during this time. Yet, this is the most neglected period for the provision of quality care (WHO, 2013).

Results show that about half of all births in these countries continue to occur outside health institutions, and in seven out of ten birthing mothers do not receive any postpartum care (DHS, 2004). Every day, approximately 830 women die from preventable causes related to pregnancy and childbirth, and 99% of all maternal deaths occur in developing countries (WHO, 2018).

New mothers' lack of baby-care skills, they feel a loss of control in their lives and lack of time and space for themselves. Child-care responsibilities and lack of knowledge and preparation are sources of frustration and fatigue for new mothers (Cheng ,Fowles and Walker 2006). In Palestine specially in West Bank and Gaza, (Dhaher et al,2008) conducted studies between 2003 and 2005 reported that only 23 to 34% of women received PPC, The most frequent reason for not obtaining postnatal care was that women did not feel sick and therefore did not need postnatal care (85%), followed by not having been told by their doctor to come back for postnatal care (15.5%). Based on a multivariable analysis, use of postnatal care was higher among women who had experienced problems during their delivery, had a caesarean section, or had an instrumental vaginal delivery than among women who had a spontaneous vaginal delivery . As health professionals who practice in a wide range of health-care settings, nurses are in a pivotal position to contribute to health-care policies and practices that may improve care for postpartum women. This study is to draw attention of policy maker to take appropriate action in order to increase awareness about the benefit of PPC.

1.4 General objective

The general objective of the study is to assess the quality of postpartum care provided at governmental hospitals in Gaza Strip .

1.5 Specific objectives

- To assess the qubality of postpartum care provided by nurses to the mothers at governmental hospitals in Gaza Strip.
- To identify the quality of postpartum care provided by nurses to the newborns at governmental hospitals in Gaza Strip.
- To determine mothers' level of satisfaction with postpartum care they received at -governmental hospitals in Gaza Strip.

- To determine the association between mothers' level of satisfaction and sociodemographic variables.
- To assess the differences in quality of postpartum care provided by nurses in relation to sociodemographic variables.
- To provide recommendations that could improve the quality of postpartum care for the mothers and newborns at governmental hospitals in Gaza Strip.

1.6 Research questions

- What is the level of quality of postpartum care provided by nurses to the mothers at governmental hospitals in Gaza Strip?
- What is the level of mothers' satisfaction with postpartum care they received at governmental hospitals in Gaza Strip?
- What is the level of quality of postpartum care provided by nurses to the newborns at governmental hospitals in Gaza Strip?
- Is there an association between mothers' level of satisfaction and socio demographic variables?
- Are there statistically significant differences in quality of postpartum care provided by nurses in relation to socio demographic variables?
- What are the recommendations that could improve the quality of postpartum care for the mothers and newborns at governmental hospitals in Gaza Strip?

1.7 Context of study

1.7.1 Socio demographic context

Palestine lies within an area of 27,000 Km^2, expanding from Ras Al-Nakoura in the north to Rafah in the south. Due to Israeli occupation, Palestinian territory is divided into three areas separated geographically; the West Bank (WB) 5.655 Km^2, GS 365 Km^2 and East Jerusalem. The population density (capita/km^2) is considered very high 794 in

Palestine (510 capita/km2 in WB and 5204 capita/km2 in GS). The total population of 4.78 million in WB and GS (2.88 in WB and 1.943 in GS), and Palestinian sex ratio stood at 103.3, which means that there are 103 males for every 100 females. (Palestinian Central Bureau of Statistics - PCBS, 2018).

1.7.2 Economic context

The Palestinian economy is very fragile and unable to create decent and productive jobs, unable to reduce poverty and provide economic security for all social groups due to long-term siege imposed by Israeli occupation against GS. Economic status in the Palestinian territories is very low. Gross Domestic Product (GDP) is estimated about 9.3%, and the workforce participation 43.6, unemployment is very high and reached a rate of 26.9% for males (15.5% in WB and 34.4% in GS) and for females unemployment rate is 44.7% (29.8% in WB and 65.2% in GS) (PCBS, 2017). Due to blockade of the GS and restriction of movement and trade, a significant increase in poverty rates occurred in GS which reached up to 53% by the end of 2017 (United Nations Office for the Coordination of Humanitarian Affairs - OCHA, 2018).

1.7.3 Health care system

Palestinian health system is a complex mix of different sectors. The five major groups of health providers are the MOH, Palestinian NGOS, United Nations Relief and Works Agency for Palestinian Refugees in the Near East (UNRWA), the military health service, and the private sector. The total number of hospitals in Palestine is 81 hospitals, 30 of them in GS. The total number of hospital beds is 6146 beds with rate of 784 populations per bed (784 in GS and 783 in WB). The number of hospitals owned by MOH is 27 hospitals with a capacity of 3325 beds that accounts for 54.1% of total beds in Palestine, of these hospitals, there are 13 governmental

hospitals in GS with a capacity of 1664 beds. The number of beds allocated for children is 19.3% of the total number of beds in MOH hospitals (260 beds in WB and 381 beds in GS). The number of physicians working in different health facilities of MOH is 2529 physicians, with 5.3 physicians per 10,000 population (4.1 physician per 10,000 populations in WB and 7.0 physician per 10,000 populations in GS). The number of nurses and midwives working in MOH is 4142 nurses and midwives, of which, 2715 (65.5%) in WB and 1427 (34.5%) in GS distributed according to specialization to 3,745 nurses with 7.8 per 10,000 populations and 397 midwives with 0.8 per 10,000 inhabitants.

(MOH, 2017).

1.7.4 Maternal and Child Health

Primary health care facilities provide antenatal care, which usually consists of testing blood pressure and anemia and the provision of tetanus toxoid vaccinations. PHC staff normally provide these services while high-risk cases referred to hospitals or specialty clinics. According to the World Bank, 80 percent of pregnant women receive antenatal care at least once. PCBS estimates are higher at around 96 percent(PCBS.2018).

Health seeking behavior for PPC is much lower. Although hospitals recommend between 8 and 48 hours of post-partum admission, most women tend to discharge a few hours after delivery. Only 20% are estimated to receive postnatal check-ups.

Roughly 94% of all deliveries occur in health institutions and are attended by trained medical professionals in public and private hospitals. About 50 percent of home deliveries are attended by traditional birth attendants, relatives or friends. The majority of home deliveries occur in the West Bank (8.2%). An estimated 96 percent of babies are breastfed and seven percent are weaned within the first three months (Michaela P 2001).

1.8 Theoretical and operational definition of terms

Quality of care for women and newborn:

Quality of care for women and newborns is the degree to which maternal and newborn health services increase the likelihood of timely, appropriate care for the purpose of achieving desired outcomes that are both consistent with current professional knowledge and take into account the preferences and aspirations of individual women and their families (WHO, 2019).

The researcher defines quality of care for women and newborn operationally as the extent to which nurses respond to mothers and newborn needs in the following aspects: communication, comfort and safety, specific postpartum care, efficient care of the baby, organizational context and orientation, and specific care for women underwent cesarean section.

Nursing:

Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. It includes the promotion of health, the prevention of illness, and the care of ill, disabled and dying people (ICN,2002).

The researcher defines nursing care operationally as the care provided to the mother and her newborn after delivery, during her stay in the postpartum department.

Postpartum period:

Postpartum period is commonly used to refer to the first 6 weeks following childbirth (Romano et al., 2010).

The researcher defines postpartum period operationally as the period starting from the first minute of delivery until 42 days but concentrated on the period of stay in the postpartum department starting from the time of admission to the time of discharge from the

department, which usually range between 4 – 6 hours after delivery for normal vaginal deliveries.

Maternal Satisfaction:

Patient's satisfaction is defined as patient's subjective evaluation of their cognitive and emotional reaction as a result of interaction between their expectation regarding ideal nursing care and their perceptions of actual nursing care (Yarnold,et,al.2006).

Patient satisfaction has been defined as the degree of concordance between patients' expectations of the desired nursing care and their perception of the received care(Erikson.2003 , Tsuboi. et. al .2014)

The researcher defines maternal satisfaction operationally the overall satisfaction of mothers was measured based on the answer which they give for questions related to sex domains (communication, comfort and safety ,specific postpartum care, efficient care of the baby , organizational context and orientation) ,and if their response is highly satisfied , satisfied ,neutral ,dissatisfied , highly dissatisfied.

Midwife:

A midwife is a person who, having been regularly admitted to a midwifery educational program, duly recognized in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery (ICM,2005).

MMR :

The number registered maternal death due to birth or pregnancy related complication per 100000 registered live births

UNFPA:

Works to build the knowledge and the capacity to respond to needs in population and family planning, to promote awareness in both developed and developing countries.

Chapter Two

Conceptual framework and literature review

2.1 Conceptual framework

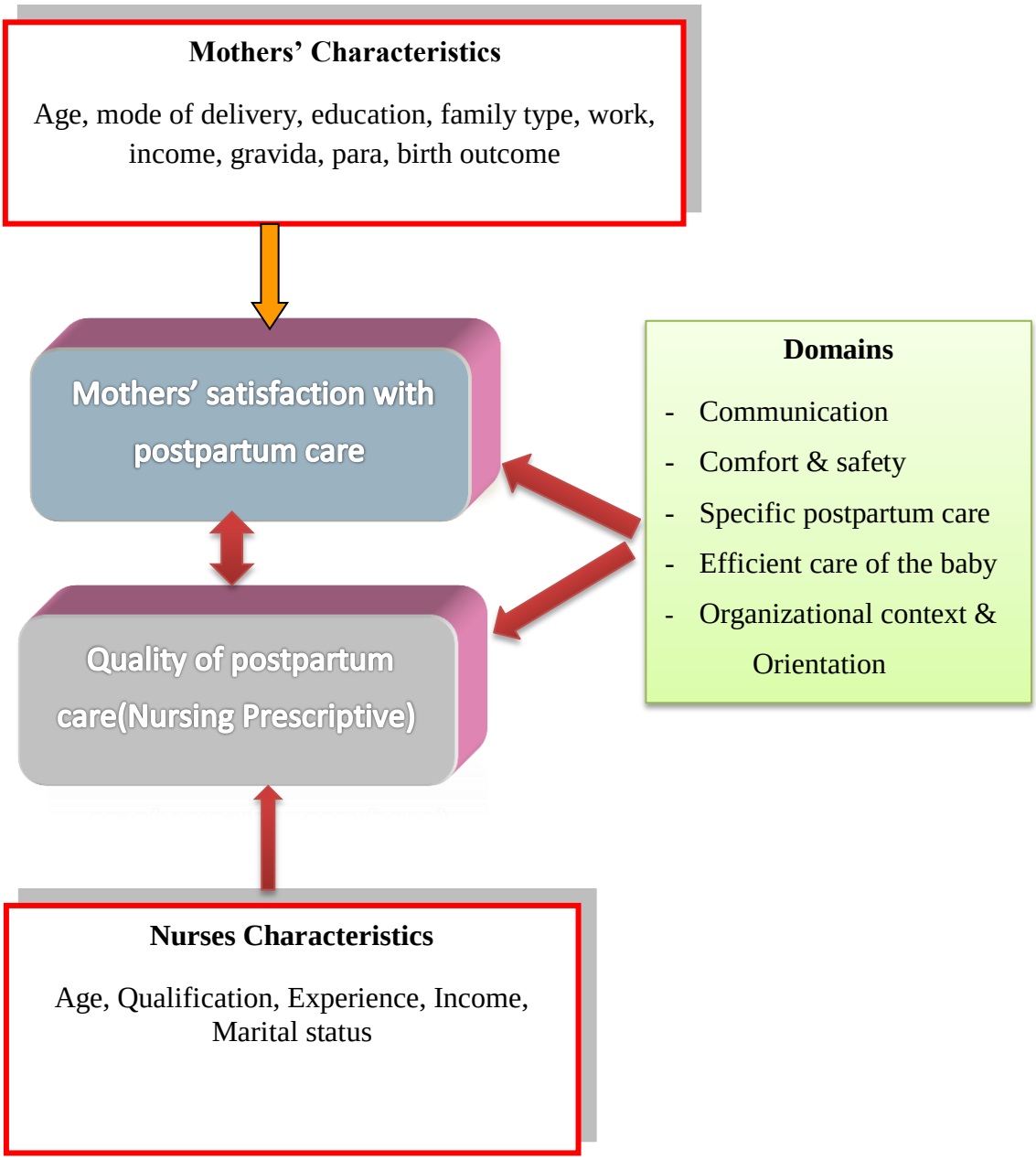

Figure (2.1): Diagram of conceptual framework (self-developed framework)

Conceptual framework is the map that guides the research process. The diagram showing how satisfaction with postpartum nursing care is influenced by several factors including mothers' characteristics such as age, level of education, number of deliveries, and family income. In addition, nurses' characteristics include age, qualification, years of experience, income, and marital status. Determinants of mothers' satisfaction and quality of care included different aspects: communication, comfort and safety, specific postpartum care, efficient care of baby, and organizational context and orientation. The diagram showed how these factors are interrelated and influencing mothers' satisfaction and quality of postpartum care.

2.2 Literature review

2.2.1 Background

World Health Organization described the PP as the most critical and yet the most neglected phase in the lives of mothers and babies; most maternal and/or newborn deaths occur during the postnatal period (WHO, 2014).

Evaluating the perception of mothers with nursing care guarantees the quality of assistance, and it is linked to improve the quality of the health services, which in turn will increase the survival of patients and decreases maternal mortality (MM) (Fernandez .2014).

According to reports of WHO, about 830 women died every day due to complications of pregnancy and childbirth. Almost all of these deaths occurred in low-resource settings, and most could have been prevented. The primary causes of MM are hemorrhage, hypertension, infections, and indirect causes, mostly due to interaction between pre-existing medical conditions and pregnancy.

The risk of a woman in a developing country dying from a maternal-related cause during her lifetime is about 33 times higher compared to a woman living in a developed

countries. MM is a health indicator that shows very wide gaps between rich and poor, urban and rural areas, both between countries and within them (WHO 2015).

The postpartum period is a phase of both physical and emotional adaptation, when the woman experiences the dilemma between the expectations that were built during the pregnancy and the reality following childbirth (Penna et al., 2006).

Demographic and Health Surveys (DHS, 2004) showed that, one of the most significant contributions of the measure demographic and health surveys program is the creation of an internationally comparable body of data on the demographic and health characteristics of populations in developing countries. The DHS comparative reports series examines these data across countries in a comparative framework. The DHS analytical studies series focuses on specific topics. The principal objectives of both series are to provide information for policy formulation at the international level and to examine individual country results in an international context. Whereas comparative reports are primarily descriptive, Analytical studies have a more analytical approach.

DHS found that maternal mortality continues to be high in many countries of the developing world. Focused antenatal care (ANC) and childbirth with a skilled attendant have been highlighted as effective interventions to reduce this burden. However, understanding of conditions such as postpartum hemorrhage—the largest killer—and its occurrence in the early postpartum period have shown the importance of early and universal postpartum care (PPC). This study was undertaken to analyze the variables (occurrence, timing, and background characteristics) associated with receipt of postpartum care in 30 developing countries representing the major regions of the world. Data from Demographic and Health Surveys carried out between 1999 and 2004 were used in the study. Results showed that about half of all births in these countries continue to occur outside health institutions, and in seven out of ten births mothers do not receive any

postpartum care. of the non-institutional births for which mothers receive postpartum care, the average timing of the first postpartum checkup is three days after birth. If all births are counted—assuming institutional births receive postpartum care 12 hours after delivery—the average timing of postpartum care is two days following delivery (DHS, 2004).

2.2.2 What to Expect after Delivery?

Immediately after delivery, the baby will likely to be placed on his mother's chest while a nurse evaluates the baby's condition. Transition is the period after birth when the baby's body is adjusting to being outside mother's womb. Some babies may need oxygen or extra nursing care to transition. A small number may need to be transferred to the neonatal intensive care unit for extra care. However, most new babies stay in the room with their mother (Patterson et al., 2011).

In the first hours after delivery, the mother holds her baby and attempt skin-to-skin contact. This helps ensure optimal bonding and the smoothest possible transition. If the mother is planning to breastfeed, which is highly recommended, the baby will likely try to suck from her. During this time, the mother will stay in the room where she had her baby. During this period, the nurse will monitor mother's blood pressure, heart rate, and the amount of vaginal bleeding, and check to make sure mother's uterus is becoming firmer (Patterson et al., 2011).

2.2.3 Contractions, Bleeding, and Pain

Once the mother delivers her baby, the heavy contractions are over. However, her uterus still needs to contract to shrink back to its normal size and prevent heavy bleeding. Breastfeeding also helps the uterus contract. These contractions may be somewhat painful but they are important. As the uterus becomes firmer and smaller, the mother is less likely to have heavier bleeding. Blood flow should gradually decrease during her first day.

Mothers may notice a few smaller clots passing when her nurse presses on her uterus to check it. For some women, the bleeding does not slow down and may even become heavier. This may be caused by a small piece of placenta that remains in the lining of her uterus. Rarely a minor surgery is needed to remove it (Patterson et al., 2011).

2.2.4 Care of the Vagina and Perineum

The area between mother's vagina and rectum is called the perineum. Even if she did not have a tear or an episiotomy, the area may be swollen and somewhat tender. To relieve pain or discomfort:

- Using ice packs in the first 24 hours after birth decreases the swelling and helps with the pain.
- Instruct her to take warm baths, but wait until 24 hours after she has given birth. Also, use clean linens and towels and make sure the bathtub is clean each time she uses it.
- Take medicine like ibuprofen to relieve pain.
- Some women are worried about bowel movements after delivery. They may receive stool softeners. Passing urine may hurt during the first day. Most often this discomfort goes away in a day or so (Patterson et al., 2011).

2.2.5 Caring for the baby

Holding and caring for the new born is exciting. Most women feel that it makes up for the long journey of pregnancy pain and discomfort of labor. Nurses and breastfeeding specialists are available to answer questions and help them. Keeping the baby in the room with mom helps her to bond with her new family member. If the baby must go to the nursery for health reasons, she must use this time and rest as much as she can. Taking care of a newborn is a full-time job and can be tiring. Some women feel sadness or an

emotional letdown after delivery. These feelings are common and are nothing to feel ashamed about it. Mother must talk with her health care provider, nurses, and partner (Isley, Katz, 2017).

2.2.6 Danger signs for the woman

All women and their families need to be aware of danger signs during the postnatal period. Review the emergency plans they made during pregnancy and see whether they are still valid. Remind women to bring their maternal health record with them even for an emergency visit. It is important that you discuss danger signs with every woman as the majority of maternal deaths occur in the first week after birth. Consider making a tool or an aid for women to take home with them following birth (WHO, 2013).

2.2.7 Postpartum danger signs in the women

The mother should go to the hospital or health center immediately, day or night if she has any of the following danger signs: vaginal bleeding has increased, fits, fast or difficult breathing, fever and too weak to get out of bed, severe headaches with blurred vision, calf pain, redness or swelling; shortness of breath and chest pain.

Furthermore, the mother should go to the health center as soon as possible if she has any of the following signs: swollen, red or tender breasts or nipples, problems urinating, or leaking, increased pain or infection in the perineum, infection in the area of the wound (redness, swelling, pain, or pus in wound site), smelly vaginal discharge, and severe depression or suicidal behavior (WHO, 2013).

2.2.8 Danger signs for the newborn

As for the mother, there are also danger signs for the newborn that the mothers and the families need to identify and respond to immediately. Advice the mother and family to seek medical assistance immediately if the baby has any of the following signs: difficulty

in breathing or in drowning, fits, fever, feels cold, bleeding, yellow palms and soles of feet, diarrhea. The mother should go to the health center as soon as possible if a baby has any of the following signs: difficulty feeding (poor attachment, not suckling well), and taking less than 8 feeds in 24 hours. Other symptoms include pus from the eyes or skin pustules, irritated cord with pus or blood, yellow eyes or skin, ulcers or thrush (white patches) in the mouth (WHO, 2013).

2.3 NICE guidelines

The NICE is a quality standard guidelines covers routine postnatal care for women and their babies (and their partners and families, if appropriate). This includes feeding support, advice on safe sleeping, and recognizing and managing health problems in women and their babies. It describes high-quality care in priority areas for improvement (NICE, 2015).

2.3.1 Why this quality standard is needed?

Postnatal care is the individualized care provided to meet the needs of a mother and her baby following childbirth. Although the postnatal period is uncomplicated for most women and babies, care during this period needs to address any variation from expected recovery after birth. For the majority of women, babies and families, the postnatal period ends 6–8 weeks after the birth. However, for some women and babies, the postnatal period should be extended in order to meet their needs. This is particularly important where a woman or baby has developed complications and remains vulnerable to adverse outcomes. For example, this could include women who have poor support networks, have developed a postnatal infection or other health problem that is continuing to impact on their daily lives, or women who are at risk of mental health problems or infant attachment problems(NICE, 2015).

2.3.2 How this quality standard supports delivery of outcome frameworks?

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritized set of specific, concise and measurable statements. They draw on existing guidance, which provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement. This quality standard, in conjunction with the guidance on which it is based, should contribute to the improvements outlined in the following 2 outcomes frameworks published by the Department of Health (NICE,2015).

List of quality statements:

Nice guidelines recommended some statements that help in postpartum care, in these statements the term 'women' is used to refer to mothers of babies.

Statement 1. The woman and baby's individualized postnatal care plan is reviewed and documented at each postnatal contact

Statement 2. Women are advised, within 24 hours of the birth, of the symptoms and signs of conditions that may threaten their lives and require them to access emergency treatment.

Statement 3. Women or main carers of babies are advised, within 24 hours of the birth, of the symptoms and signs of potentially life threatening conditions in the baby that require emergency treatment.

Statement 4. Women, their partner or the main carers are given information on the association between co sleeping and sudden infant death syndrome (SIDS) at each postnatal contact.

Statement 5. Women receive breastfeeding support from a service that uses an evaluated, structured program.

Statement 6. Information about bottle feeding is discussed with women or main carers of formula fed babies.

Statement 7. Babies have a complete 6–8 week physical examination.

Statement 8. Women with a body mass index (BMI) of 30 kg/m2 or more at the 6–8 week postnatal check are offered a referral for advice on healthy eating and physical activity.

Statement 9. Women have their emotional wellbeing, including their emotional attachment to their baby, assessed at each postnatal contact.

Statement 10. Women who have transient psychological symptoms ('baby blues') that have not resolved at 10–14 days after the birth should be assessed for mental health problems.

Statement 11. Parents or main carers who have infant attachment problems receive services designed to improve their relationship with their baby. Other quality standards that should also be considered when choosing, commissioning or providing a high quality postnatal care service are listed in related NICE quality standards(NICE,2015)

2.4 The role of the nurses in postpartum care

Nurses and midwives have an important role in providing postpartum care, many training courses are done to improve their knowledge and skills, also to encourage them WHO determined the international day of the midwife, celebrated every year on 5th of May, offers an opportunity to celebrate the contributions of midwives to the health and wellbeing of a nation. Who is a midwife and what can she do that a doctor or nurse cannot do? A question which many women, husbands, mother-in laws, but also other health care professionals and the wider community members may be asking themselves. Communicating the range of services that a midwife can deliver to her clients is therefore a task, which needs to be taken on by relevant Government and non-government institutions.

(http://www.thedailystar.net/supplements/unfpa-supplement/saving-the-lives-mothers-and-babies-1218646).

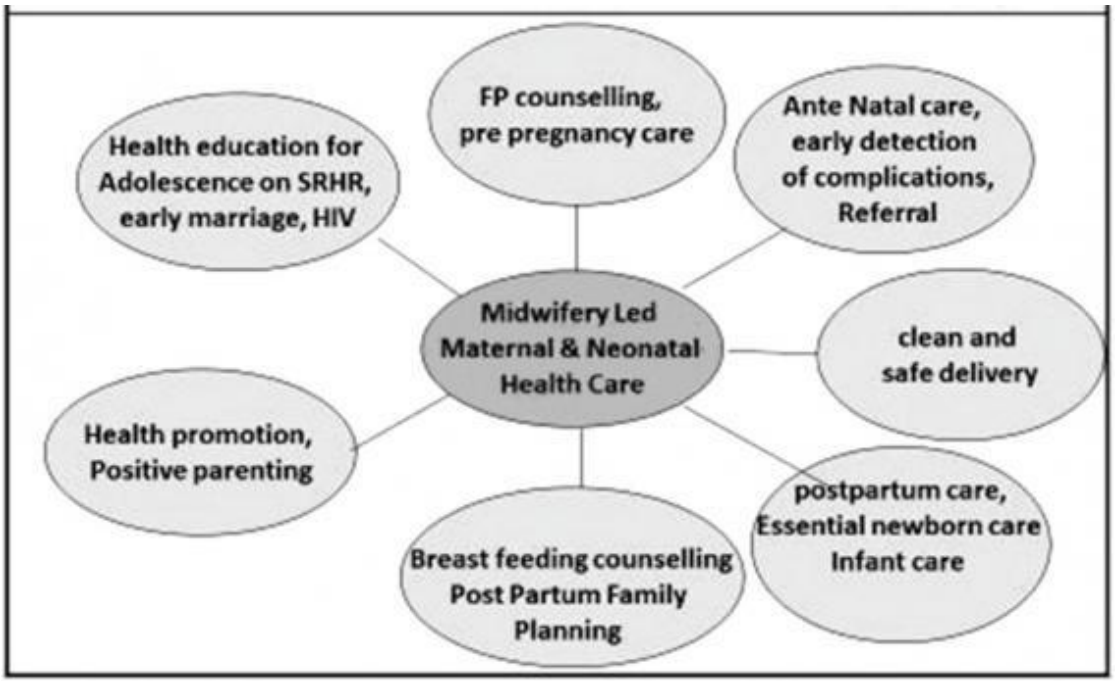

Figure 2.2. Midwives deliver a continuum of care

2.5 Midwife role:

There is a heightened recognition of the midwife role and how it is different to that of a nurse. Midwives have their own register now, and you do not have to first be a registered nurse in order to become a midwife. Models of care which enable midwifery continuity of care are now commonplace around the country, which was certainly not the case 10 or 20 years ago (Informa Inights .2015). .

2.6 Midwifery education :

There have been a lot of changes in midwifery education and therefore, graduate midwives in the past 20 years. Midwifery is now recognised as a separate discipline to nursing and there are now new education programs available to become a midwife; 3 year direct entry program (Bachelor of Midwifery) and a 4 year double degree (Bachelor of Nursing and Bachelor of Midwifery).

Midwifery graduates in 2015 are:

- Educated via national education standards that uniform across the country – previously each state and territory had different standards – and national competency standards which identify woman centred care and primary health care as fundamental for midwives.
- Better equipped to work across a full scope of practices including antenatal, labour and birth, and the post-partum period.
- Able to provide midwifery continuity of care as they are exposed to such throughout their course in which they follow women throughout pregnancy, birth and post-partum.
- More aware of the broader health issues and the unique role of the midwife in primary health care(Informa Inights .2015). .

2.7 Midwifery future

Midwives will be able to provide women with increased access to midwifery continuity of care through models of care in hospital and in private models through the role of the eligible midwife. This will mean a higher level of autonomy for midwives, and increased opportunities for effective collaboration with obstetrics and other disciplines to provide more choice for women for midwifery continuity of care is now very clear in terms of clinical outcomes and maternal satisfaction. Every Australian woman deserves access to models that facilitate care by a known midwife. Increasingly, public health services are developing such models, and private providers are also entering the market. Both these developments will provide more opportunities for midwives to work in a flexible way, preferably based in the community rather than limited to hospitals .Midwifery continuity of care can also be provided in rural and remote locations through the placement of maternity care in the community, or primary health care setting. These roles may also incorporate aspects of women's, children's, and sexual and reproductive health as required. Midwives

may need to undergo some extra training to provide some of these additional roles (Informa Inights .2015).

Mothers' sense of security in the early postnatal period is related to maternity health care, social support, sense of control, the mother's own attitudes, general wellbeing and support from the partner (Persson et al., 2007; Persson & Dykes, 2009).

A study conducted in China aimed to assess mothers' perspectives on the quality of postpartum care in Central Shanghai. The researchers used semi structure interviews on fifty postpartum mothers who attended the maternal and child health centers in the two sub-district areas. The result showed that 90% were primiparous, and half did not consider the postpartum services to be of high quality. They defined high quality as full satisfaction of the mother. Their perception of quality influenced by their concern about childcare, an area in which they expressed the need for further improvement**.** The study concluded that to improve quality of services, greater emphasis should be placed on the following aspects: (1) health education on childcare; (2) more time allocation for discussion with health workers during their postpartum home visits so their questions and concerns could be addressed effectively; (3) access to health workers in times of need rather than during officially prescribed home visits; and (4) provision of continuous training for maternal and child health workers with respect to childcare (Lomoro et al., 2002).

In Palestine, a cross sectional study carried out in WB by Dhaher et al., (2008). The study aimed to identify factors associated with lack of PPC among Palestinian women. The results indicated that more than two-thirds of women considered PPC necessary (66.1%), but only 36.6% of women received PPC. Use of PPC was also higher among women who delivered in a private hospital as compared to those who delivered in a public hospital. The study concluded that the higher use of PPC among high-risk women is appropriate, but some clinically dangerous conditions

can also occur in low-risk women. Future efforts should therefore focus on providing PPC to a larger number of low-risk women.

Also there was a study done in Gaza Strip, This study assessed the causes and contributing factors to maternal mortality that occurred in the Gaza-Strip between July 2014 and June 2015. It was a retrospective study that used both quantitative and qualitative data. The data were collected from available medical records, investigation reports, death certificates, and field interviews with healthcare professionals as well as families. Results A total of 18 maternal mortalities occurred in Gaza between 1st July 2014 and June 30th 2015. The most striking deficiency was very poor medical documentation which was observed in 17 cases (94%). In addition, poor communication between doctors and women and their families or among healthcare teams was noticed in nine cases (50%). These were repeatedly described by families during interviews. Further aspects surfacing in many interviews were distrust by families towards clinicians and poor understanding of health conditions by women. Other factors included socioeconomic conditions, poor antenatal attendance and the impact of the 2014 war. Low morale among medical staff was expressed by most interviewed clinicians, as well as the fear of being blamed by families and management in case of adverse events. Substandard care and lack of appropriate supervision were also found in some cases (Bottcher,et,al .(2018).

In Iraq, a study carried out by Mohammed (2015). The study aimed to assess maternal satisfaction with quality of nursing care during labor and delivery in Sulaimani teaching hospital, the study aims to assess quality of nursing care offered during intrapartum and postpartum periods, patient satisfaction with care and to find the relationship between maternal satisfaction and some variables, its findings indicated that the women were satisfied with the care they received during labor and delivery. The study concluded that several factors might influence mothers' satisfaction such as giving birth to

a healthy baby; the timing of assessment might affect mothers' satisfaction, and the mothers might feel hesitant to criticize the care they received because their health care providers were still involved.

In Egypt, a study conducted by Lamadah and El Naggar (2014). The study aimed to determine mothers' satisfaction with quality of PPC and discharge-teaching plan. The results revealed that 71.0% of mothers were not satisfied by the quality of PPC provided to them. In addition, 83.0% of mothers were not satisfied by the instructions of the discharge-teaching plan. In addition, the older, low educated, rural area resident, housewives women and those who had low parity were more satisfied with the quality of PPC and discharge teaching plan.

In Egypt, a study carried out by Al Battawi and Hafez (2017) aimed to assess mothers' satisfaction with PPC at Al-Shatby Maternity University Hospital. The results found that less than half of the mothers were minimally satisfied, about one-quarter of them were either moderately satisfied or satisfied to some extent, and 5% of the mothers were not satisfied at all.

A study of(Women's Experience of Facility-Based Childbirth Care and Receipt of an Early Postnatal Check for Herself and Her Newborn) was conducted in Northwestern Tanzania to examine the situation in Tanzania. Their sample included 732 women aged 15–49 years who had given birth in a health facility during the previous two years, retospective models were used to investigate the association between women's experiences of care during childbirth and the receipt of early postnatal checks before discharge. Overall, 73.1% of women reported disrespect and abuse, 60.1% were offered a birth companion, 29.1% had a choice of birth position, and 85.5% rated facility cleanliness as good. About half of mothers (46.3%) and newborns (51.4%) received early postnatal checks before discharge. The results suggested that a missed opportunity in providing an

early postnatal check is an indication of poor quality of the continuum of care for mothers and newborns. Improved quality of care at one stage can predict better care in subsequent stages (Bishanga,e, al .2019). In United Kingdom (UK), a study conducted to assess midwifery views of the quality improvement process and their engagement with quality improvement process. The results reflected that all the midwives were aware of the revisions introduced, and two-thirds felt that these improvements were appropriate to meet the women's physical and emotional health, information, and support needs. Some midwives considered that the introduction of new maternal postnatal records increased their workload. The results also showed that 78% of midwives said that they would measure uterine involution, 89% would assess vaginal loss, 82% would examine the woman's legs, and 78% of midwives reported that they would observe a woman's perineum at each contact. Moreover, one-third of the midwives would check the woman's temperature. When asked what other observations they would undertake at each contact, two midwives said they would ask about emotional wellbeing and two midwives said that they would ask about pain relief needs. The study concluded that involvement of midwives was essential to the success of the quality improvement initiative (Bick et al., 2011)

Improving healthcare performance is an increasing challenge globally. High quality service provision and enhanced patient experience are a common element of healthcare policy in many industrialized countries (Bick et al., 2011).

A study was done in in Tigray health facilities, Ethiopia in 2015/16, this study therefore, aims to assess quality of postnatal care services offered to mothers. 123 Midwives who are providing postnatal care during the time of study were observed while giving postnatal care. Human and material resources were assessed for provision of comprehensive and quality postnatal care in all the hospitals. All the facilities scored below 80% showing that the quality of postnatal care offered to clients in the hospitals of Tigray

was poor and below standard. The mid-wives were responsible for managing the entire maternity care involving the antenatal, labor and delivery and postnatal wards thus no priority is given for postnatal care. The midwives in all hospitals did not take any training on postnatal care. Human and material resources were inadequate for provision of comprehensive and quality postnatal care in all the hospitals. The process of service provision which entails client monitoring and examination was not in line with the Postnatal WHO recommendation due to lack of essential equipment and workload (Berhe,et.al.2016).

Also another study was done in Ethiopia; a cross-sectional study design was employed to collect data through direct observation of the performance of 144 midwives selected from 57 health facilities. Data were collected from January to February 2015 by 12 experienced midwives (male and female) who were trained on basic emergency obstetric care and had previous experience with data collection.

Competence of midwives was found to be low to provide safe and quality maternity care in the region. Male gender, availability of complete job aids and receiving recognition/awards for better performance were predicted competence. That was required attention and investment from Tigray regional health bureau and health development partners working on maternal and child health. Competence based in-service training, on-the-job mentoring, availing up to dated standard job aids, recognition of high performing midwives are recommended to improve the quality of maternity care in public health facilities of the region. Moreover, affirmative actions including on-the-job training and supervision are needed to improve the competence of female midwives (Goshu.et. al.2018).

A study in Pakistan (Good on paper: the gap between programme theory and real-world context in Pakistan's Community Midwife programme) was conducted to

understand why skilled birth attendance—an acknowledged strategy for reducing maternal deaths—has been effective in some settings but is failing in Pakistan and to demonstrate the value of a theory-driven approach to evaluating implementation of maternal healthcare interventions.

Data revealed gaps between programme theory, assumptions and reality on the ground. The design of the programme failed to take into account: the incongruity between the role of a midwife and dominant class and gendered norms that devalue such a role; market and consumer behavior that prevented community midwives from establishing private practices; the complexity of public–private sector cooperation. Uniform deployment policies failed to consider existing provider density and geography, so greater attention to programme theory and the 'real-world' setting during design of maternal health strategies is needed to achiev e consistent results in different contexts (Momtaz,et ,al .2015).

A study was done in Iran, the study aimed to evaluate maternal satisfaction of postpartum care and its association with midwifery care at the urban health centers of Mashhad, Iran in 2012. It was conducted on 411 mothers selected via multistage sampling from 16 urban health centers . Among the aspects of midwifery care, 92% of postnatal women were satisfied with consultation and training, 92.3% were satisfied with the technical competency of midwives, and 96.6% were satisfied with the communication skills of midwives. Moreover, high levels of maternal satisfaction of midwifery services were reported in dimensions of providing demographic and delivery history, use of dietary supplements and breastfeeding, and performing physical examinations (blood pressure measurement and scleral examination). However, no significant coloration was observed between maternal satisfaction and quality of care ($P<0.05$). According to the results of that

study, the majority of mothers were satisfied with the quality of postnatal care and midwifery services (Mirzaei.et, al. 2015) .

2.8 The International Mother Baby Childbirth Organization (IMBCO) launched.

The International Childbirth Initiative(ICI)

The mother baby-family maternity care model is fully integrated into the ICI which embodied principles and 12 steps to safe and respectful maternity care, in addition, have written policies, implemented in education and practice and available for review, these steps are:

Step 1 Provide respect, dignity and informed choice

Treat everywoman and newborn with respect and dignity, fully informing and communicating with the woman and her family

in decision making about care for herself and her baby in a culturally safe and sensitive manner ensuring her the right to informed consent and refusal. Incorporate a rights-based approach, preventing exclusion and maltreatment of the marginalized and socioeconomically disadvantaged, and including protection of HIV-positive women and women who experience perinatal loss. Under no circumstances is physical, verbal or emotional abuse of women, their newborns and their families ever allowed.

Step 2 Provide free or affordable care with cost transparency.

Respect every woman's right to access and receive non-discriminatory and free or affordable care throughout the continuum

of childbearing. Inform families about what charges can be anticipated, if any, and how they might plan to pay for services. Make costs for prenatal education and antenatal, intrapartum and postpartum care visible, transparent and in line with national guidelines. Include risk pooling for complications (no additional charge for caesarean delivery or other complications). Forbid under-the-table payments and routinely enforce

this rule. Under no circumstances should a woman or baby be refused care or detained after birth for lack of payment.

Step 3 Routinely provide mother baby-family maternity care.

Incorporate value- and partnership-based care grounded in evidence-based practice and driven by health needs and

Expectations as well as by health outcomes and cost effectiveness. Base care provision on what women want for their newborns and families during the childbirth continuum. Optimize the normal bio-psycho-social processes of childbirth by promoting the midwifery philosophy and scope of practice for most women, within a system that ensures multi-disciplinary collaboration, communication and care for women and newborns, including those with obstetric-neonatal risk and/or complications. Ensure that this MotherBaby-Family care model is available at all levels of care and in any setting and is provided by individual skilled health workers with the full scope of competencies, or within a team with combined competencies.

Step 4 Offer continuous support.

Inform the mother of the benefits of continuous support during labour and birth, and affirm her right to receive such support from companion(s) of her choice. These include father, partner, family member, or others.

Step 5 Provide pain relief measures.

Offer drug-free comfort and pain relief measures as safe first options, explaining their benefits for facilitating normal

birth. Educate women (and their companions) about how to use these methods, including breathing, touch, holding, massage and relaxation techniques

Step 6 Provide evidence-based practice.

Provide and promote specific evidence-based practices proven to be beneficial in supporting the normal physiology of labor‹birth, and the postpartum and neonatal periods such as :

- Facilitating immediate and sustained skin-to-skin mother baby contact for warmth, attachment, breastfeeding initiation, and developmental stimulation, and ensuring that MotherBaby stay together.
- Delaying cord clamping to facilitate the transfer of nutrients to the newborn .
- Reliably carrying out all elements considered part of Essential Newborn Care including: ensuring the mother's full access to her ill or premature infant, kangaroo care, and supporting the mother to provide her own milk (or other human milk) to her baby when breastfeeding is not possible .

Step 7 Avoid harmful practices.

Avoid potentially harmful procedures that have insufficient evidence of benefit outweighing risk for routine or frequent use in normal pregnancy, labor, birth and the postpartum and neonatal period. When considered for a specific situation, their use should be supported by best available evidence that the benefits are likely to outweigh the potential harms and are consistent with national and/or international guidelines and recommendations, and should be fully discussed with the mother to ensure her informed consent .

Step 8 Enhance wellness and prevent illness.

Promotion of wellness and prevention of illness are the foundations of improving maternal and newborn health. Implement educational and public health measures that enhance wellness and prevent illness and complications

Step 9 Provide emergency care and transport.

Provide access to skilled emergency treatment for life-threatening complications. Ensure that staff are trained in timely recognition of potentially dangerous conditions and complications and in providing effective treatment or stabilization, and have established links for consultation and an accessible and reliable system of transport**.**

Step 10 Have a supportive human resource policy

in place for recruitment and retention of all staff, and to ensure that staff are safe, secure, and encouraged and enabled to provide quality care in a respectful and positive work environment.

Step 11 Provide a care continuum.

Provide a continuum of collaborative maternal and newborn care with all relevant health care educators, providers, institutions and organizations.

Step 12 Promote breastfeeding and skin-to-skin contact.

Achieve the 10 Steps of the revised Baby-Friendly Hospital Initiative (2018) protecting, promoting and supporting breastfeeding in facilities providing maternity services (ICI.2018).

So the researcher found that there is a need for this study based on the above literature review and made her hard efforts to concentrate on postpartum care to decrease MMR.

Chapter Three

Methodology

This chapter describes the methods and steps of conducting the study. It begins with describing the research design, population, sampling design and procedure for selecting the study participants. In addition, development of study instruments, data collection and statistical analysis, ethical considerations, and limitation of the study.

3.1 Study design

The researcher used descriptive, analytical, cross sectional design. This design is appropriate for describing the status of phenomena or for describing relationships among variables. It involves the collection of data once during a single period of data collection (Polit and Beck, 2012).

3.2 Study population

The study population consisted of all the nurses and midwives who are working in postpartum departments at governmental maternity hospitals in Gaza Strip. In addition, mothers who are newly delivered in these departments. The total numbers of nurses and midwives in 2018, and the mean numbers of mothers who delivered in 2016 and 2017 were as shown in (annex 1).

3.3 Sample size and sampling method

The sample of the study consisted of all the nurses and midwives who are working in postpartum departments (census) response rate was 100%. In addition, the sample of the study consisted of purposively 428 mothers from PP departments at the governmental hospitals in Gaza strip. The sample size (Annex 1) based on the mean number of women admitted to postpartum departments in 2016 and 2017, the researcher used 95% confidence level and 5% for population of 10-100000 (Jiroj wong et al, 2011). Scientific distribution

of mothers from each hospital as presented in (Annex 1),but there is an increasing in mothers' numbers in working setting as follows: Al Shifa hospital 100, Kamal Odwan 81, Nasser hospital 105, Al Emaratey hospital 73, and Shohada Al Aqsa 69 mothers.

3.4 Setting of the study

The study carried out at governmental maternity hospitals in GS: Al Shifa Maternity Hospital (Kamal Odwan hospital included because at the time of data collection, part of Al Shifa maternity hospital was reconstructed and part of the services transferred to Kamal Odwan hospital), Shohada Al Aqsa, Naser Medical Complex, and Al Emaratey maternity hospital.

3.5 Period of the study

The study commenced from May 2018 to March 2019. Data collection and analysis took place from August 2018 to January 2019.

3.6 Eligibility criteria

3.6.1 Inclusion criteria for mothers

- All postpartum women who delivered in governmental hospitals and stay in the postpartum department for 1 - 6 hours.
- Had normal vaginal delivery or cesarean section without any complications.

3.6.2 Exclusion criteria

- Women who had any postpartum complications.
- Women admitted to postpartum department for other medical or gynecological problems.

3.7 Instruments of the study

After review of literature and previous studies, the researcher developed three instruments for data collection: self-structured questionnaire to measure mothers' satisfaction with PPC designed for mothers, another questionnaire to measure quality of PPC designed for nurses, and observational checklist to observe nursing care. Description of questionnaires as follows:

3.7.1 Mothers' Satisfaction from Postpartum Care (Annex 3)

The questionnaire consisted of the following parts:

- Personal data: including hospital name, mode of delivery, age, educational level, family type, working status, monthly income, gravida, para, and birth outcome.
- Communication domain: consisted of 6 items.
- Comfort and safety domain: consisted of 5 items.
- Specific postpartum care: consisted of 17 items.
- Efficient care of the baby: consisted of 7 items.
- Organizational context and orientation: consisted of 8 items.

Response on items of the questionnaire using 5-points Likert scale. Scoring of items: (5) highly satisfied, (4) satisfied, (3) neutral, (2) dissatisfied, (1) highly dissatisfied.

3.7.2 Quality of postpartum care (Annex 4)

The questionnaire consisted of the following parts:

- Personal data: including hospital name, age, qualification, years of experience, monthly income, and marital status.
- Communication domain: consisted of 6 items
- Comfort and safety domain: consisted of 5 items
- Specific postpartum care domain: consisted of 18 items

- Efficient care of the baby domain: consisted of 8 items
- Organizational context and orientation domain: consisted of 8 items
- Specific for CS women domain: consisted of 13 items

Response on items of the questionnaire using 5-points Likert scale. Scoring of items: (5) always, (4) often, (3) sometimes, (2) seldom, (1) never.

3.7.3 Observation checklist (Annex 5)

The checklist consisted of the following parts:

- Communication domain: consisted of 6 items
- Comfort and safety domain: consisted of 5 items
- Specific postpartum care domain: consisted of 17 items
- Efficient care of the baby domain: consisted of 8 items
- Organizational context & Orientation domain: consisted of 8 items
- Specific for CS women domain: consisted of 13 items

Response on items of the checklist using 3-points Likert scale. Scoring of items: (3) always, (2) sometimes, (1) no.

3.8 Pilot study

The researcher conducted a pilot study on a sample of 36 women, selected randomly from postpartum departments in the assigned hospitals and 10 nurses and midwives two nurse and midwife from these hospitals . After conducting the pilot study and performing reliability procedures, needed modifications applied to study instruments, I excluded the pilot sample from samples of mothers, but included it in sample of nurses and midwives.

3.8.1 Validity

A. Face validity:

To ensure clarity of questionnaires, the researcher distributed the questionnaire to a panel of experts in this field for face and judged content validity. The researcher made modifications on the questionnaire items according to experts' comments .

B. Internal consistency:

To check internal consistency, the researcher calculated the correlation between each item and the dimension it belongs to, then calculated the correlation between dimensions and the total score of the scale. The results are illustrated below.

Satisfaction questionnaire (for mothers)

1. Validity

Table (3.1): Correlation between each statement and total score of communication domain and comfort and safety domain

Communication domain			**Comfort and safety domain**		
No.	**Correlation value**	***P* value**	**No.**	**Correlation value**	***P* value**
1	0.767	**	1	0.772	**
2	0.742	**	2	0.716	**
3	0.761	**	3	0.752	**
4	0.857	**	4	0.756	**
5	0.737	**	5	0.791	**
6	0.803	**			

** = significance at 0.01 * = significance at 0.05

Table (3.1) showed that there was statistically significant correlation between each item and total score of the communication domain.

Table (3.2): Correlation between each statement and total score of specific postpartum care domain

Specific postpartum care domain					
No.	**Correlation value**	***P* value**	**No.**	**Correlation value**	***P* value**
1	0.619	**	10	0.834	**
2	0.726	**	11	0.771	**
3	0.795	**	12	0.766	**
4	0.661	**	13	0.812	**
5	0.852	**	14	0.659	**
6	0.686	**	15	0.548	**
7	0.809	**	16	0.808	**
8	0.827	**	17	0.755	**
9	0.792	**			

** = significance at 0.01 * = significance at 0.05

Table (3.2) showed that there was statistically significant correlation between each item and total score of the specific postpartum care domain.

Table (3.3): Correlation between each statement and total score of efficient baby care domain and organizational context & orientation

Efficient baby care domain			***Organizational context***		
No.	**Correlation value**	***P* value**	**No.**	**Correlation value**	***P* value**
1	0.647	**	1	0.697	**
2	0.689	**	2	0.719	**
3	0.600	**	3	0.777	**
4	0.657	**	4	0.521	**
5	0.758	**	5	0.784	**
6	0.824	**	6	0.728	**
7	0.861	**	7	0.774	**
8	0.412	*	8	0.616	**

** = significance at 0.01 * = significance at 0.05

Table (3.3) showed that there was statistically significant correlation between each item and total score of the efficient baby care domain.

Table (3.4): Correlation between each dimension and total score of mothers' satisfaction scale

Dimension	**Correlation value**	***P* value**
Communication	0.714	**
Comfort and safety	0.737	**
Specific postpartum care	0.956	**
Effect care of baby	0.894	*
Organizational context and orientation	0.865	**

** = significance at 0.01 * = significance at 0.05

Table (3.4) showed that there was statistically significant correlation between total score of each domain and the total score of the questionnaire.

2. **Reliability**

Cronbache alpha method

The researcher used Cronbache alpha method to find the reliability for each dimension and the total score of the scale. The results are shown in table (4.5).

Table (4.5): Cronbache alpha coefficient for satisfaction of mothers

Dimension	**No. of items**	**Alpha value**
Communication	6	0.868
Comfort and safety	5	0.810
Specific postpartum care	17	0.948
Efficient care of baby	8	0.839
Organizational context and orientation	8	0.848
Total score	**44**	**0.965**

Table (4.5) showed that alpha coefficient of the total score of the questionnaire was 0.965 which indicated that the questionnaire is highly reliable.

Quality of postpartum care (for nurses)

1. Validity

Table (4.6): Correlation between each statement and total score of communication domain and comfort and safety domain

Communication domain			**Comfort and safety domain**		
No.	**Correlation value**	***P* value**	**No.**	**Correlation value**	***P* value**
1	0.233	//	1	0.401	*
2	0.394	*	2	0.538	**
3	0.555	**	3	0.656	**
4	0.438	*	4	0.755	**
5	0.465	**	5	0.672	**
6	0.626	**			

** = significance at 0.01 * = significance at 0.05 // = not significant

Table (4.6) showed that there was statistically significant correlation between each item and the total score of communication domain.

Table (4.7): Correlation between each statement and total score of specific postpartum care domain

Specific postpartum care domain					
No.	**Correlation value**	***P* value**	**No.**	**Correlation value**	***P* value**
1	0.422	*	10	0.508	**
2	0.484	*	11	0.068	//
3	0.459	*	12	0.425	*
4	0.090	//	13	0.368	*
5	0.322	//	14	0.416	*
6	0.368	*	15	0.394	*
7	0.517	**	16	0.389	*
8	0.606	**	17	0.134	//
9	0.602	**	18	0.078	//

** = significance at 0.01 * = significance at 0.05 // = not significant

Table (4.7) showed that there was statistically significant correlation between each item and the total score of specific postpartum care domain.

Table (4.8): Correlation between each statement and total score of efficient baby care domain and organizational context & orientation

Efficient baby care domain					
No.	**Correlation value**	***P* value**	**No.**	**Correlation value**	***P* value**
1	0.594	**	1	0.341	//
2	0.537	**	2	0.348	*
3	0.420	*	3	0.639	**
4	0.416	*	4	0.855	**
5	0.456	**	5	0.793	**
6	0.462	**	6	0.488	**
7	0.586	**	7	0.485	**
8	0.668	**	8	0.415	*

** = significance at 0.01 * = significance at 0.05 // = not significant

Table (4.8) showed that there was statistically significant correlation between each item and the total score of efficient baby care domain.

Table (4.9): Correlation between each statement and total score of specific care for CS women domain

Specific care for CS women domain					
No.	**Correlation value**	***P* value**	**No.**	**Correlation value**	***P* value**
1	0.442	**	8	0.607	**
2	0.693	**	9	0.743	**
3	0.774	**	10	0.551	**
4	0.676	**	11	0.682	**
5	0.535	**	12	0.781	**
6	0.784	**	13	0.301	//
7	0.533	**			

** = significance at 0.01 * = significance at 0.05 // = not significant

Table (4.9) showed that there was statistically significant correlation between each item and the total score of specific care for CS women domain.

Table (4.10): Correlation between each dimension and total score of quality of postpartum care scale

Dimension	Correlation value	*P* value
Communication	0.513	**
Comfort and safety	0.680	**
Specific postpartum care	0.785	**
Effect care of baby	0.866	**
Organizational context and orientation	0.598	**
Specific care for CS women	0.496	**

** = significance at 0.01 * = significance at 0.05

Table (3.10) showed that there was statistically significant correlation between total score of each domain and the total score of the questionnaire.

2. Reliability

Cronbache alpha method

The researcher used Cronbache alpha method to find the reliability for each dimension and the total score of the scale. The results are shown in table (4.11).

Table (4.11): Cronbache alpha coefficient for quality of postpartum care

Dimension	No. of items	Alpha Coefficient value
Communication	6	0.153
Comfort and safety	5	0.566
Specific postpartum care	18	0.618
Effect care of baby	8	0.606
Organizational context and orientation	8	0.772
Specific care for CS women	13	0.859
Total score	**58**	**0.852**

Table (4.11) showed that alpha coefficient of the total score of the questionnaire was 0.852 which indicated that the questionnaire is highly reliable.

3.9 Data Collection

The researcher collected data with assistance of five nurses. The researcher trained these nurses and gave them instructions about filling the questionnaires. Data was collected from the mothers using face-to-face interview with each mother, and from nurses by self-administered questionnaire. In addition, data collected for the checklist by direct observation of nurses during providing care to the mothers and their babies in the postpartum department. Time estimation for each questionnaire about 20 minutes.

In addition, a consent form was placed in front of each questionnaire and asked the participants for voluntary participation in the study. (Annex 2)

3.10 Data entry and analysis

The researcher got assistance from a statistician for data entry and analysis using SPSS program version 22. Data entry and analysis included the following process:

- Overview of questionnaires.
- Designing data entry model.
- Coding and data entry into the computer.
- Data cleaning to ensure accurate entry of data. This process was achieved by checking out a random of questionnaires and performing descriptive statistics for all the variables.

Data analysis included

- Frequencies, percentage, means, and standard deviation.
- To find differences in levels of satisfaction, and quality of postpartum care in relation to demographic variables, the researcher used (t) test and One way ANOVA.

- To examine validity of the questionnaires, the researcher used Pearson correlation test, and for reliability, the researcher used Cronbache alpha coefficient method.

3.11 Ethical and administrative considerations

Before starting the study, the researcher obtained approval from Al-Quds University. In addition, the researcher obtained approval from Helsinki Committee (Annex 6), and approval from MOH (Annex 7) to conduct the study. Participants were assured about confidentiality of obtained data.

3.12 Limitations of the Study

- Difficulty in including all eligible nurses included in the study due to working rotation shifts especially night shift.
- Hawthorne effect could happen during observation of practice of nurses.

Chapter Four

Results and Discussion

In this chapter, the results of the study are presented and discussed in relation to literature and previous studies. The results were obtained from 428 newly delivered mothers, 115 nurses and midwives and 10 checklists.

4.1 Descriptive results

4.1.1 Socio demographic characteristics of the mothers

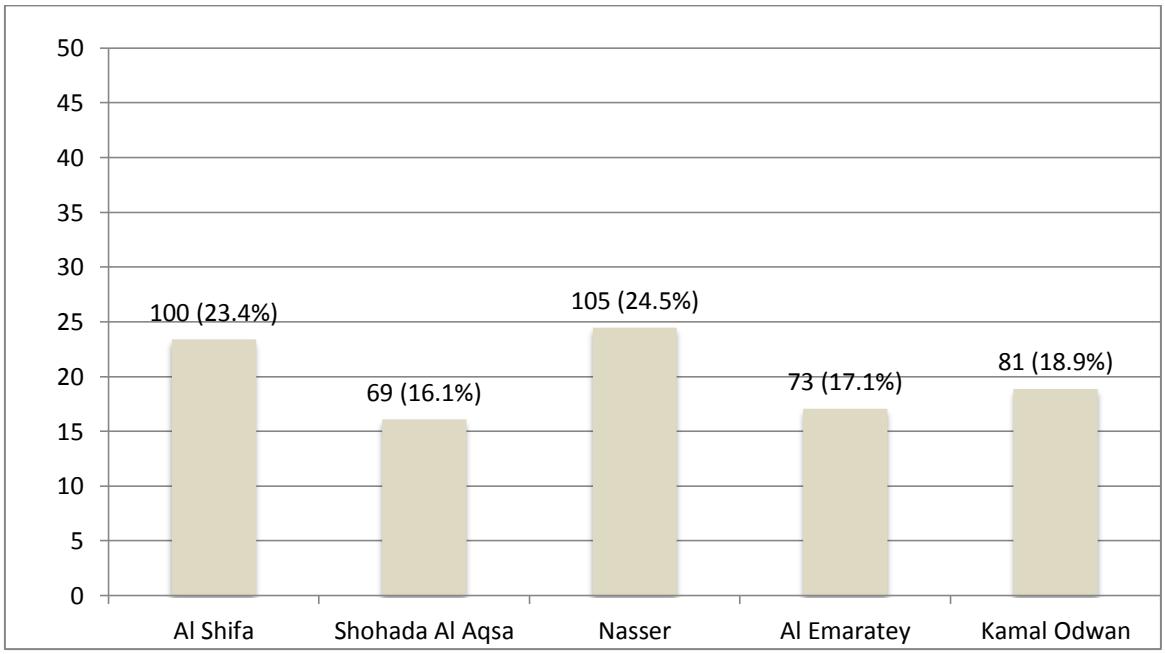

Figure (4.1): Distribution of mothers by hospitals

As the researcher mentioned before scientific distribution of mothers from each hospital as followed in Annex 1,but there is an increasing in mothers' numbers in working setting as in Figure 4.1 which showed that the sample of the study consisted of 428 mothers from five governmental maternity hospitals in GS; 100 (23.4%) from Al Shifa maternity hospital, 69 (16.1%) from Shohada Al Aqsa hospital, 105 (24.5%) from Nasser hospital, 73 (17.1%) from Al Emaratey hospital, and 81 (18.9%) from Kamal Odwan hospital.

Table (4.1): Socio demographic characteristics of postpartum mothers:

Variable	Frequency	Percent
Age		
≤ 20 years	65	15.2
21 – 25 years	148	34.6
26 – 30 years	118	27.6
31 – 35 years	64	15.0
36 years and more	33	7.7
Total	428	100.0
Mean age = 26.32 SD = 5.86		
Level of education		
Elementary school	10	2.3
Preparatory school	46	10.7
Secondary school	193	45.1
University	179	41.8
Type of family		
Nuclear	218	50.9
Extended	210	49.1
Occupational status		
Housewife	399	93.2
Working / employed	29	6.8
Family income monthly		
< 1832 NIS	382	89.3
1832 – 2293 NIS	42	9.8
> 2293 NIS	4	0.9

Table 4.1 showed that the mean age of the mothers was 26.32±5.86 years, 148 (34.6%) aged between 21 – 25 years and 118 (27.6%) aged between 26 – 30 years, 193 (45.1%) of mothers had secondary school education, and 179 (41.8%) of the mothers had university education. This result was consistent with a study carried out in Kenya which showed that the mean age of the mothers was 26±4.9 years, 39.9% of the mothers aged between 20 - 24 years, and 4.3% aged 35 years and more, 43.1% of the mothers had secondary school education, and 29.8% had university education (Najoka, 2015). This results reflects

that the Palestinian women are well educated and the Palestinian society encourage and support the education of women as well as men.

The results also showed that half of mothers live in nuclear families, 399 (93.2%) were housewives, 382 (89.3%) had low income below the poverty line.

4.1.2 Mode of delivery of mothers

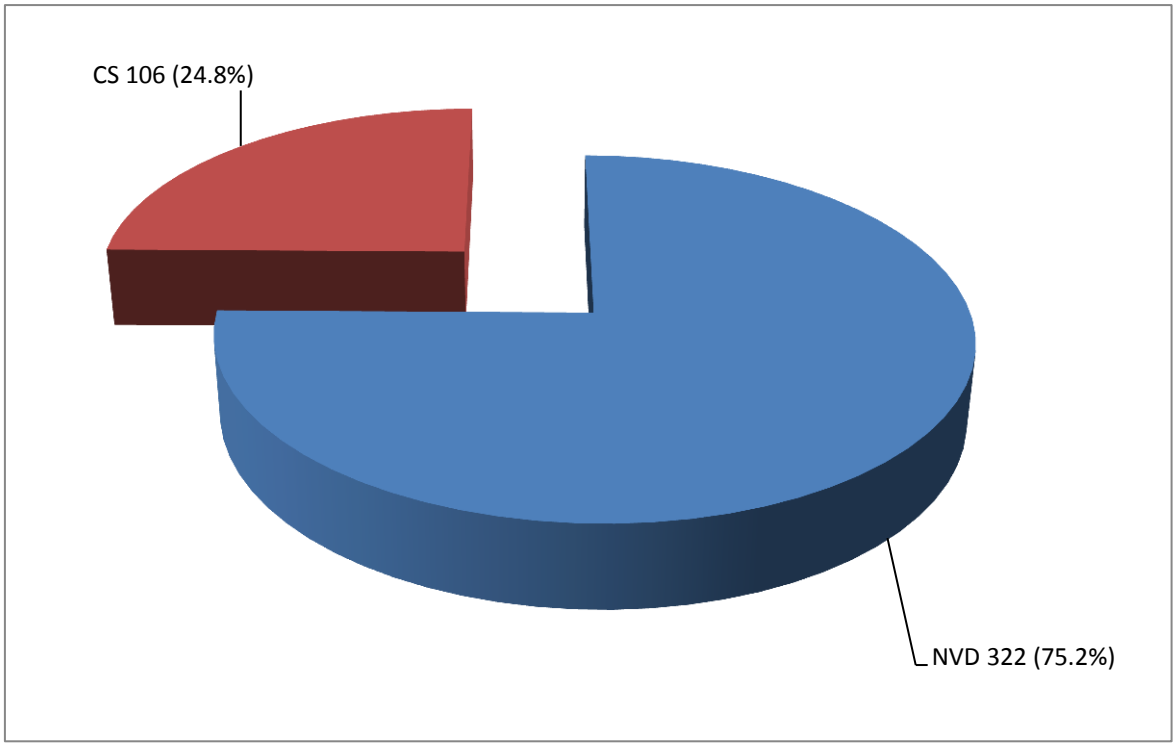

Figure (4.2): Distribution of mothers by mode of delivery

Figure (4.2) showed that more than two third of mothers (75.2) had NVD, while 106 (24.8%) of them delivered by CS mode. This result is high compared to estimates published by WHO (2015) which stated that CS rate should not exceed 10-15%, and when CS rates in a country move towards 10%, there is a significant decrease in maternal and newborn deaths, but when the rate goes over 10%, there is no evidence that death rates improve, therefore the risks outweigh the benefits.

In addition, data from 121 countries between 1990 and 2014 showed that the global average CS rate was 25% to 75% with increase by 12.4% (McCulloch, 2018). Decreasing

CS rates is not as simple as setting a goal and sticking to it. There is a need and efforts towards NVD and providing the foundations which make it more achievable, such as continuity of care and high quality birth education. Moreover, health systems need to develop a culture that values, promotes, and supports vaginal birth to reduce unnecessary CS as much as possible.

Table (4.2): Distribution of mothers by obstetric history

Variable	Frequency	Percent
Number of pregnancies		
First time	141	32.9
2 – 4 times	213	49.8
5 times and more	74	17.3
Number of deliveries		
First time	129	30.1
2 – 4 times	211	49.3
5 times and more	88	20.6
Current birth outcome		
Single baby	410	95.8
Twins	18	4.2

Table 4.2 showed that 211 (49.3%) of mothers were pregnant 2 to 4 times, 213 (49.3%) delivered 2 to 4 times, and 410 (95.8%) gave birth to a single baby in the current pregnancy. These results reflected that the highest frequency of mothers were pregnant and delivered 2 – 4 times, and the majority of them delivered single baby. These results were consistent with the results of Najoka (2015) which showed that 49.3% of mothers had 2 to 4 pregnancies, 49.8% had 2 to 4 deliveries, 53.9% had 2 to 3 children.

4.1.3 Socio demographic characteristics of nurses and midwives

Table (4.3): Nurses and midwives by sociodemographic characteristics

Variable	Frequency	Percent
Age		
20 – 25 years	23	20.0
26 – 30 years	40	34.8
31 – 35 years	33	28.7
36 – 40 years	11	9.6
41 years and more	8	7.0
Mean age = 30.965 SD = 6.007		
Qualification		
Diploma (2 years)	32	27.8
Bachelor	70	60.9
Postgraduate	13	11.3
Years of experience		
1 – 5 years	41	35.7
6 – 10 years	48	41.7
11 years and more	26	22.6
Monthly income		
< 1832 NIS	82	71.3
1832 – 2293 NIS	23	20.0
> 2293 NIS	10	8.7
Marital status		
Single	22	19.1
Married	89	77.4
Divorced	4	3.5

NIS= New Israeli Shekel

Table (4.3) showed that the mean age of nurses and midwives was 30.96±6.007 years, 40 (34.8%) of nurses aged 26 – 30 years, 33 (28.7%) aged 31 – 35 years, while 8 (7%) aged 41 years and more.

Also, 70 (60.9%) of nurses have bachelor degree, 13 (11.3%) had postgraduate studies, 48 (41.7%) had an experience between 6 – 10 years, and 26 (22.6%) had

experience of 11 years and more, 82 (71.3%) had income less than 1832 NIS. Moreover, 89 (77.4%) of nurses were married and 22 (19.1%) were single.

These results reflects the trend of nurses' age in GS. The majority of nurses are from the young age as the majority of them are 35 years old and less, the majority of them have experience of 10 years and less, and about two-thirds of them have bachelor degree in nursing, which revealed the willingness to study nursing and choosing nursing as their career. In addition, the majority of them were married and have low income. The researcher attributed the low income to the current circumstances in GS with political division and siege of GS which led to decrease the national income and in consequence decrease the salary of staff in the governmental sector as they receive 40% of their salary monthly.

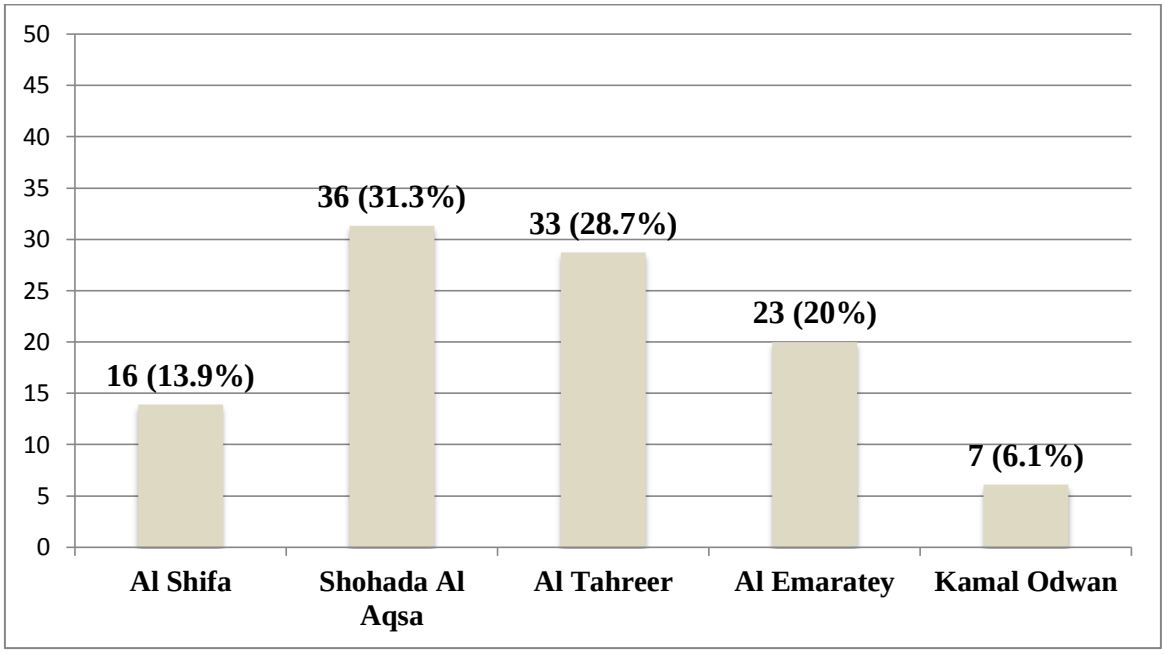

Figure (4.3): Distribution of nurses and midwives by hospitals

Figure (4.3) showed that the highest number of nurses who agreed to participate in the study were from Shohada Al Aqsa hospital 36 (31.3%), followed by Al Tahreer hospital 33 (28.7%), Al Emaratey hospital 23 (20%), Al Shifa hospital 16 (13.9%), and Kamal Odwan 7 (6.1%).

The maternity unit in Shohada Al Aqsa consists of one room for receiving mothers in labor pain, three rooms for labor (two small rooms for first and second stage of labor, and the third for labor room), and two rooms for postpartum care, therefore, the number of nurses is the highest among hospitals. The number of nurses from Al Shifa maternity hospital is

lower than other hospitals because it is going under new construction and part of the maternity services transferred to other places such Kamal Odwan hospital .

4.2 Mothers' satisfaction with postpartum care

Mothers' satisfaction with postpartum care has been measured through five domains namely; communication, comfort and safety, specific postpartum care, efficient care of baby, and organizational context and orientation.

Table (4.3a): Mothers' satisfaction from postpartum care (Communication domain)

	Communication items	Highly satisfied	Satisfied	Neutral	Dissatisfied	Highly dissatisfied	Mean	SD	Weighted %	Rank
1	Level of satisfaction about how nurses answered your questions.	**24.1**	**58.2**	**9.6**	**7.7**	**0.5**	**3.97**	**0.82**	**79.4**	**3**
2	Level of satisfaction from interpersonal relations with nurses.	**19.4**	**60.3**	**15.7**	**4.4**	**0.2**	**3.94**	**0.73**	**78.8**	**4**
3	Level of satisfaction from interpersonal relations with my family	**18.5**	**56.8**	**18.0**	**5.6**	**1.2**	**3.85**	**0.82**	**77.0**	**6**
4	Level of satisfaction about the way nurses communicated with you.	**21.5**	**54.0**	**16.6**	**7.2**	**0.7**	**3.88**	**0.84**	**77.6**	**5**
5	Level of satisfaction about the way nurses answered questions asked by me concerning my health status.	**23.8**	**57.7**	**12.4**	**5.4**	**0.7**	**3.98**	**0.80**	**79.6**	**2**
6	Level of satisfaction from the way nurse dealt with me (dignity and	**26.4**	**57.9**	**10.7**	**4.2**	**0.7**	**4.05**	**0.77**	**81.0**	**1**
	Overall						**3.94**	**0.62**	**78.8**	

Table (4.3a) presented items related to communication. The results showed that the highest scores obtained in the statement "satisfaction from the way nurse dealt with me (dignity and respect)" with mean score 4.05 and weighted percentage 78.8% followed by the statement "satisfaction about the way nurses answered questions asked by me concerning my health status" with mean score 3.98 and weighted percentage 79.6%, while the lowest score was in the statement "satisfaction from interpersonal relations with my family members" with mean score 3.85 and weighted percentage 77%. The general satisfaction from communication domain was above moderate with mean score 3.94 and weighted percentage 78.8%.

Studies of women's views of maternity care reported that good communication is central in determining women satisfaction with the care that they receive (Rowe et al., 2002). A study carried out in Iraq revealed that nurses' communication improved levels of postnatal satisfaction especially when nurses communicated in mothers' own language and they felt free to talk and when nurses answered all doubts asked by mothers concerning treatment results and prognosis. Takacs et al., (2015) suggested that in order to improve satisfaction with care in maternity hospitals the main efforts need be directed primarily at midwife support during labour and delivery and at communication and provision of information by staff employed in child care. In this regard it is also required to strengthen psychological competence of health care professionals, especially in communication, and deepen their knowledge in perinatal psychology. In addition, Mohammed (2015) found that all respondents mentioned that if the interpersonal relationships with their caregivers were good (politeness, kindness, and patience), then they were satisfied with their care even when other factors were not addressed. If a positive caregiver attitude was attained, the client found the hospital safe enough for future use (Al-Battawi, 2017).

From the researcher observation ,she noticed that there were differences in communication patterns between nurses which affect mothers' satisfaction and affect their feelings towards these hospitals, some nurses showed good communication with mothers and talk with them in simple language with smile and some nurses were busy and did not have adequate time to set with mothers and talk to them, on the other side mothers said that they are satisfied from the way the nurse deal with them in dignity and respect these differences are related to their perspective of the best way of communication .

Table (4.3b): Mothers' satisfaction from postpartum care (Comfort and safety domain)

	Comfort and safety items	Highly satisfied	Satisfied	Neutral	Dissatisfied	Highly dissatisfied	Mean	SD	Weighted %	Rank
1	Level of satisfaction from the amount of help I got from nurses.	**22.9**	**61.7**	**11.7**	**3.5**	**0.2**	**4.03**	**0.71**	**80.6**	**1**
2	Level of satisfaction from the way nurses approached me.	**17.8**	**61.0**	**15.4**	**5.4**	**0.5**	**3.99**	**2.08**	**79.8**	**2**
3	Level of satisfaction from nurses' assistance in keeping myself clean & groomed.	**16.6**	**52.8**	**17.3**	**11.4**	**1.9**	**3.70**	**0.93**	**74.0**	**5**
4	Level of satisfaction about the feeling of safe and secured during hospital stay.	**23.8**	**58.4**	**11.0**	**6.1**	**0.7**	**3.98**	**0.80**	**79.6**	**3**
5	Level of satisfaction about the feeling of comfort throughout stay in postpartum ward.	**23.6**	**54.2**	**11.4**	**9.6**	**1.2**	**3.89**	**0.91**	**77.8**	**4**
	Overall						**3.92**	**0.73**	**78.4**	

Table (4.3b) presented items related to comfort and safety. The results showed that the highest scores obtained in the statement "satisfaction from the amount of help I got from nurses" with mean score 4.03 and weighted percentage 80.6% followed by the statement "satisfaction from the way nurses approached me" with mean score 3.99 and weighted percentage 79.8%, while the lowest score was in the statement "satisfaction from nurses assistance in keeping myself clean & groomed" with mean score 3.70 and weighted percentage 74%. The general satisfaction from comfort and safety domain was above moderate with mean score 3.92 and weighted percentage 78.4%.

A study carried out in Turkey measured levels of comfort by using postpartum comfort scale, found that the total mean score of satisfaction with comfort and safety measures among the women who had vaginal delivery was above moderate 82.33±15.71 (Erkayaa et al., 2017). Furthermore, Mohammed (2015) reported that if the mother found the hospital as a safe place for childbirth, she then planned to use the hospital again, and eventually recommending the hospital to her family and friends.

Table (4.3c): Mothers' satisfaction from postpartum care (Specific postpartum care domain)

Specific postpartum care items		Highly satisfied	Satisfied	Neutral	Dissatisfied	Highly dissatisfied	Mean	SD	Weighted %	Rank
1	Level of satisfaction from nurses' assistance when I needed to go to toilet.	13.8	50.9	13.1	20.3	1.9	3.54	1.02	70.8	12
2	Level of satisfaction about nurses' information regarding how to keep my perineum hygienic.	16.6	49.8	13.3	18.5	1.9	3.60	1.02	72.0	9
3	Level of satisfaction from nurses' assistance in early ambulation.	17.1	58.9	11.4	11.9	0.7	3.79	0.88	75.8	3
4	Level of satisfaction about the frequency nurses checked my vital signs (BP, P, R, Temp).	33.6	57.7	6.1	2.3	0.2	4.22	0.68	84.4	1
5	Level of satisfaction about how nurses taught me about involution of uterus.	25.5	46.3	10.5	17.1	0.7	3.78	1.03	75.6	4
6	Level of satisfaction from nurses teaching about how to perform uterus massage.	20.3	45.1	13.3	20.6	0.7	3.63	1.04	72.6	6
7	Level of satisfaction from nurses teaching about breast examination including tenderness, cracked nipples, and engorgement.	14.3	42.1	16.6	25.7	1.4	3.42	1.06	68.4	14
8	Level of satisfaction from nurses' explanation about care of my breast.	11.7	44.2	16.1	26.2	1.9	3.37	1.05	67.4	17
9	Level of satisfaction from nurses' information regarding nutrition in postnatal period.	16.4	54.9	10.5	16.4	1.9	3.67	0.99	73.4	5
10	Level of satisfaction from nurses' information about sleep and rest in postnatal period.	14.5	53.5	14.0	16.8	1.2	3.63	0.96	72.6	7
11	Level of satisfaction from the way nurses administered medication / treatment.	23.8	58.2	9.8	7.7	0.5	3.97	0.82	79.4	2
12	Level of satisfaction from nurses' information regarding lochia flow in postpartum period.	16.8	49.3	12.9	20.3	0.7	3.61	1.01	72.2	8
13	Level of satisfaction from nurses' information regarding how to detect excessive bleeding during puerperal period.	15.7	50.7	11.7	20.6	1.4	3.58	1.02	71.6	11
14	Level of satisfaction from nurses advice about postpartum exercise.	13.1	43.5	16.1	23.6	3.7	3.38	1.09	67.6	16
15	Level of satisfaction from nurses assistance with episiotomy care.	12.1	43.0	18.0	25.5	1.4	3.39	1.03	67.8	15
16	Level of satisfaction from nurses information about signs and symptoms of postpartum infection.	15.0	44.9	16.6	22.9	0.7	3.50	1.02	70.0	13
17	Level of satisfaction from nurses information about the importance of postpartum follow up visits.	17.1	46.7	15.4	20.1	0.7	3.59	1.01	71.8	10
	Overall						**3.63**	**0.73**	**72.6**	

Table (4.3c) presented items related to specific postpartum care. The results showed that the highest scores obtained in the statement "satisfaction about the frequency nurses checked my vital signs" with mean score 4.22 and weighted percentage 84.4% followed by the statement "satisfaction from the way nurses administered medication / treatment" with mean score 3.97 and weighted percentage 79.4%, while the lowest score was in the statement "satisfaction from nurses' explanation about care of my breast" with mean score 3.37 and weighted percentage 67.4%. The general satisfaction from Specific postpartum care domain was above moderate with mean score 3.63 and weighted percentage 72.6%.

These results were inconsistent with the results obtained by Al-Battawi and Hafez (2017) which revealed that postnatal mothers were minimally satisfied with provided nursing care specific to postnatal period such as that related to advice about postnatal exercise, importance of family planning and postnatal follow up visits, teaching regarding neonatal condition, immunization and weaning. These results can be related to mothers' short postpartum hospital stay which lead to insufficient time for nurses to address a new mother's learning needs effectively. The mother's length of stay in the hospital after routine vaginal delivery has decreased substantially over the past several decades. In some settings, stays of less than 24 hours have been encouraged in recent years. In Egypt, the average woman stays in the hospital is half a day after giving birth. Insufficient time to educate or support women within facilities can reduce maternal confidence or cause breastfeeding problems, maternal depression, or dissatisfaction with care.

Table (4.3d): Mothers' satisfaction from postpartum care (Efficient care of my baby domain)

	Efficient care of my baby items	Highly satisfied	Satisfied	Neutral	Dissatisfied	Highly dissatisfied	Mean	SD	Weighted %	Rank
1	Level of satisfaction from nurses assistance with giving care (bath, diaper care, cord and eye care) for my baby.	15.0	54.2	15.2	13.8	1.9	3.66	0.95	**73.2**	3
2	Level of satisfaction from nurses information about signs and symptoms of neonatal infection.	15.4	48.8	14.7	19.9	1.2	3.57	1.01	**71.4**	5
3	Level of satisfaction from nurses teaching about the importance of colostrum and breast feeding.	28.5	48.1	9.3	12.9	1.2	3.89	0.99	**77.8**	1
4	Level of satisfaction from nurses assistance to position my baby during and after breast feeding.	19.9	47.7	12.6	19.2	0.7	3.66	1.02	**73.2**	4
5	Level of satisfaction from nurses teaching how to burp my baby after breast feeding.	14.0	48.6	15.0	21.7	0.7	3.53	1.00	**70.6**	6
6	Level of satisfaction from nurses teaching about rooming in, bonding and attachment.	14.0	47.7	15.7	21.3	1.4	3.51	1.02	**70.2**	7
7	Level of satisfaction from nurses education about immunization of my baby.	14.3	45.6	16.8	22.0	1.4	3.49	1.02	**69.8**	8
8	Level of satisfaction from nurses identification of your baby via identity bracelet.	18.7	57.2	14.3	8.6	1.2	3.83	0.86	**76.6**	2
	Overall						**3.64**	**0.76**	**72.8**	

Table (4.3d) presented items related to efficient care of the baby. The results showed that the highest scores obtained in the statement "satisfaction from nurses teaching about the importance of colostrum and breast feeding" with mean score 3.89 and weighted

percentage 77.8% followed by the statement "satisfaction from nurses identification of your baby via identity bracelet" with mean score 3.83 and weighted percentage 76.6%, while the lowest score was in the statement "satisfaction from nurses education about immunization of my baby" with mean score 3.49 and weighted percentage 69.8%. The general satisfaction from Efficient care of my baby domain was above moderate with mean score 3.64 and weighted percentage 72.8%.

These results were consistent with the results obtained by Al-Battawi and Hafiz (2017) which indicated that the postpartum mothers were fully satisfied with gained information about the importance of colostrum and exclusive breast feeding, but inconsistent results obtained by Buchko et al., (2012) which reflected that mothers reported dissatisfaction with inadequate information about breastfeeding and the need for more information about newborn care, and when mothers felt informed and empowered they feel better when discharged from the hospital and this confidence was translated into higher satisfaction scores. Another study conducted by Weiss and Lokken (2009) found that poor quality discharge education was associated with more newborn emergency room or urgent care visits. Nurses need to know what strategies facilitate an efficient postpartum educational process in the hospital setting.

Also, the study of (Buchko et al., 2012) found that many mothers received most of their education on the day of discharge, and no specific time was assigned to specific topics. Teaching resources were inefficiently located in the unit, and handouts were not always available. Furthermore, this process did not allow for systematic assessment and documentation of individual education needs, which resulted in mothers either not receiving information they wanted or receiving irrelevant information.

Table (4.3e): Mothers' satisfaction from postpartum care (Organizational context & Orientation domain)

	Organizational context & Orientation items	Highly satisfied	Satisfied	Neutral	Dissatisfied	Highly dissatisfied	Mean	SD	Weighted %	Rank
1	Level of satisfaction from the way nurses welcomed me on admission to postpartum ward.	**18.5**	**60.3**	**12.4**	**7.2**	**1.6**	**3.86**	**0.85**	**77.2**	**3**
2	Level of satisfaction from the way nurses oriented me to the health team members.	**14.5**	**49.3**	**12.4**	**21.5**	**2.3**	**3.52**	**1.05**	**70.4**	**6**
3	Level of satisfaction from the way nurses oriented me to the postpartum unit (toilet , bathroom, washing area ……).	**12.1**	**52.3**	**11.7**	**21.3**	**2.6**	**3.50**	**1.03**	**70.0**	**8**
4	Level of satisfaction from received information about visiting hours for my family.	**14.7**	**45.1**	**18.2**	**20.8**	**1.2**	**3.51**	**1.01**	**70.2**	**7**
5	Level of satisfaction from the calm (no noise) during my stay in the ward.	**13.3**	**58.2**	**13.3**	**11.9**	**3.3**	**3.66**	**0.96**	**73.2**	**4**
6	Level of satisfaction from the neatness and organization of my room.	**15.0**	**53.0**	**13.8**	**15.9**	**2.3**	**3.62**	**0.99**	**72.4**	**5**
7	Level of satisfaction from the interrelationship between nurses and physicians.	**16.8**	**66.4**	**11.4**	**5.1**	**0.2**	**3.94**	**0.71**	**78.8**	**2**
8	Level of satisfaction from the cooperation between physicians and nurses.	**17.5**	**71.0**	**8.9**	**2.3**	**0.2**	**4.03**	**0.61**	**80.6**	**1**
	Overall						**3.70**	**0.63**	**74.0**	

Table (4.3e) presented items related to organizational context and orientation. The results showed that the highest scores obtained in the statement "satisfaction from the cooperation between physicians and nurses" with mean score 4.03 and weighted percentage 80.6% followed by the statement "satisfaction from the interrelationship between nurses and physicians" with mean score 3.94 and weighted percentage 78.8%, while the lowest score was in the statement "satisfaction from the way nurses oriented me to the postpartum unit (toilet , bathroom, washing area)" with mean score 3.50 and weighted percentage 70%. The general satisfaction from Organizational context & Orientation domain was above

moderate with mean score 3.70 and weighted percentage 74%.

The life of newly postpartum women is very serious so physicians and nurses cooperate together to keep it in the first priority. Mohammed (2015) reported that if a positive caregiver attitude was attained, the client found the hospital safe enough for future use. On the other hand, the hospital was not found to be safe enough because of negative attitudes such as shouting, ignoring or whispering, this led to plans not to use the hospital in future.

Table (4.4): General satisfaction with postpartum care

General satisfaction	Highly satisfied	Satisfied	Neutral	Dissatisfied	Highly dissatisfied	Mean	SD	Weighted %
How do you rate your overall satisfaction during your stay in postpartum ward?	**18.9**	**53.0**	**17.5**	**8.6**	**1.9**	**3.78**	**0.91**	**75.6**

Table (4.4) presented the general satisfaction of mothers with postpartum care. The results showed that 18.9% of mothers stated that they were highly satisfied and 53% were satisfied. In general, the mothers expressed above moderate satisfaction with mean score 3.78 and weighted percentage 75.6%.

A study carried out in Egypt found inconsistent results which showed that about three quarters of mothers were not satisfied with the quality of postnatal care provided to them. In addition, the majority of women were not satisfied by the instructions of the discharge teaching plan. Furthermore, the older, low educated, rural area resident, housewives mothers and those who had low parity were more satisfied with the quality of postpartum care and discharge teaching plan (Lamada and El Naggar, 2014).

Our results reflected that mothers expressed higher satisfaction with postpartum care in GS compared to mothers in the neighborhood country of Egypt, and that could be attributed to

the continuous monitoring and upgrading of maternity services in GS through special educational and training programs supported by international agencies such as WHO, NORWAC, and these programs included natural safe delivery model, Early Essential Neonatal Care (EENC), and the near-miss committee.

4.2.1 Association between mothers' satisfaction with postpartum care and selected variables

Table (4.5): Differences in mothers' satisfaction with postpartum care related to hospital name (One way ANOVA)

Domains		Sum of squares	df	Mean square	F	*P value*
Communication	Between Groups	817.669	4	204.417	16.684	*0.000* *
	Within Groups	5182.845	423	12.253		
	Total	6000.514	427			
Comfort and safety	Between Groups	420.251	4	105.063	8.306	*0.000* *
	Within Groups	5350.672	423	12.649		
	Total	5770.923	427			
Specific postpartum care	Between Groups	19785.43	4	4946.357	44.267	*0.000* *
	Within Groups	47265.81	423	111.740		
	Total	67051.24	427			
Efficient care of my baby	Between Groups	3761.966	4	940.492	32.594	*0.000* *
	Within Groups	12205.70	423	28.855		
	Total	15967.67	427			
Organizational context & Orientation	Between Groups	1906.904	4	476.726	22.068	*0.000* *
	Within Groups	9137.984	423	21.603		
	Total	11044.89	427			
Overall	Between Groups	79700.89	4	19925.222	36.718	*0.000* *
	Within Groups	229545.2	423	542.660		
	Total	*309246.1*	*427*			

* = significant at 0.05

Table (4.6): Post hoc Scheffe test (for hospital name)

Domain	Health care setting	Mean difference	*P value*
Communication	(Al Emaratey) – (Al Shifa)	2.809	*0.000* *
	(Al Emaratey) – (Shohada Al Aqsa)	4.152	*0.000* *
	(Al Emaratey) – (NMC)	3.693	*0.000* *
	(Al Emaratey) – (Kamal Odwan)	3.490	*0.000* *
Comfort and safety	(Al Emaratey) – (Al Shifa)	1.766	*0.036* *
	(Al Emaratey) – (Shohada Al Aqsa)	2.775	*0.000* *
	(Al Emaratey) – (NMC)	2.406	*0.001* *
	(Al Emaratey) – (Kamal Odwan)	2.888	*0.000* *
Specific postpartum care	(Al Emaratey) – (Al Shifa)	3.109	*0.456 //*
	(Al Emaratey) – (Shohada Al Aqsa)	10.696	*0.000* *
	(Al Emaratey) – (NMC)	18.869	*0.000* *
	(Al Emaratey) – (Kamal Odwan)	8.738	*0.000* *
Efficient care of my baby	(Al Emaratey) – (Al Shifa)	2.006	*0.210 //*
	(Al Emaratey) – (Shohada Al Aqsa)	4.385	*0.000* *
	(Al Emaratey) – (NMC)	8.527	*0.000* *
	(Al Emaratey) – (Kamal Odwan)	4.751	*0.000* *
Organizational context & Orientation	(Al Emaratey) – (Al Shifa)	1.819	*0.169 //*
	(Al Emaratey) – (Shohada Al Aqsa)	4.371	*0.000* *
	(Al Emaratey) – (NMC)	6.077	*0.000* *
	(Al Emaratey) – (Kamal Odwan)	2.960	*0.004* *
Overall	(Al Emaratey) – (Al Shifa)	11.510	*0.000* *
	(Al Emaratey) – (Shohada Al Aqsa)	26.383	*0.000* *
	(Al Emaratey) – (NMC)	39.576	*0.000* *
	(Al Emaratey) – (Kamal Odwan)	*22.828*	*0.000* *

* = significant at 0.05 // = not significant

Table (4.5) showed that there were statistically significant differences in satisfaction with postpartum nursing care between the hospitals; communication (F= 16.684, P= 0.000), Comfort and safety (F= 8.306, P= 0.000), Specific postpartum care (F= 44.267, P= 0.000), Efficient care of my baby (F= 32.594, P= 0.000), Organizational context & Orientation (F= 22.068, P= 0.000), and overall satisfaction (F= 36.718, P= 0.000). To determine the direction of satisfaction, the researcher used Post hoc Scheffe test (Table 4.6) and the results showed that mothers who delivered in Al Emaratey hospital expressed higher satisfaction with

postpartum care compared to other hospitals. In the researcher opinion, this results could be attributed to the construction of the hospital as a specialized hospital for obstetric services only, small size hospital with seven beds in the postpartum department and 12 beds in the CS department. In addition, all the staff are qualified midwives with variant experiences. Moreover, the hospital has its own written protocols that organize the tasks and performance of obstetricians and midwives.

Table (4.7): Differences in mothers' satisfaction with postpartum care related to age (One way ANOVA)

Domains		Sum of squares	df	Mean square	F	P value
Communication	Between Groups	77.510	4	19.378	1.384	0.239
	Within Groups	5923.004	423	14.002		
	Total	6000.514	427			
Comfort and safety	Between Groups	77.141	4	19.285	1.433	0.222
	Within Groups	5693.782	423	13.460		
	Total	5770.923	427			
Specific postpartum care	Between Groups	395.796	4	98.949	0.628	0.643
	Within Groups	66655.45	423	157.578		
	Total	67051.24	427			
Efficient care of my baby	Between Groups	103.898	4	25.974	0.693	0.597
	Within Groups	15863.77	423	37.503		
	Total	15967.67	427			
Organizational context & Orientation	Between Groups	56.775	4	14.194	0.546	0.702
	Within Groups	10988.11	423	25.977		
	Total	11044.89	427			
Overall	Between Groups	18448.844	4	461.211	0.635	0.638
	Within Groups	307401.3	423	726.717		
	Total	309246.1	427			

Table (4.7) showed that there were statistically insignificant differences in satisfaction with PPC related to age of the mother; communication (F= 1.384, P= 0.239), comfort and safety (F= 1.433, P= 0.222), specific PPC (F= 0.628, P= 0.643), efficient care of my baby (F=

0.693, P= 0.597), organizational context and orientation (F= 0.546, P= 0.702), and overall score (F= 0.635, P= 0.638).

This result was consistent with the results obtained by Najoka (2015) who found that there was no statistical significant association between age and utilization of PPC, and the proportion of women who utilized PPC was highest at ages 25-29 years, and Mirzaei (2016) found that there was no significant association between the level of maternal satisfaction and age.

In addition, Al-Battawi and Hafiz (2017) found different levels of mothers' satisfaction with PPC as 21% were minimally satisfied, 26% moderately satisfied and 15% fully satisfied. Moreover, about one-third of mothers stated that nurses communicated with them in a language that they understand, and 22% said that they felt free to talk about their interests. In addition, 25% of mothers were minimally satisfied and 20% of the mothers were moderately satisfied with comfort measures during their hospital stay. Also, 41% of mothers were minimally satisfied with nursing care specific to postpartum period while 5% were fully satisfied.

Moreover, a study carried out in Iran found that there was significant relationship between satisfaction with PPC and women's age (Naghizadeh et al., 2014). Our results indicated that mothers have no differences in satisfaction with PPC regardless of their age. This result was convenient because protocols of PPC are available in all the maternity departments and midwives offer the needed care according to these protocols to ensure that all the mothers receive safe, quality care during their stay in the hospital regardless of their age, and that explains the results which obtained by this study.

Table (4.8): Differences in mothers' satisfaction with postpartum care related to level of education (One way ANOVA)

Domains		Sum of squares	df	Mean square	F	*P value*
Communication	Between Groups	21.610	3	7.203	0.511	*0.675*
	Within Groups	5978.904	424	14.101		
	Total	6000.514	427			
Comfort and safety	Between Groups	16.034	3	5.345	0.394	*0.758*
	Within Groups	5754.889	424	13.573		
	Total	5770.923	427			
Specific postpartum care	Between Groups	519.120	3	173.040	1.103	*0.348*
	Within Groups	66532.12	424	156.915		
	Total	67051.24	427			
Efficient care of my baby	Between Groups	136.854	3	45.618	1.222	*0.301*
	Within Groups	15830.82	424	37.337		
	Total	15967.67	427			
Organizational context & Orientation	Between Groups	58.967	3	19.656	0.759	*0.518*
	Within Groups	10985.92	424	25.910		
	Total	11044.89	427			
Overall	Between Groups	1711.917	3	570.639	0.787	*0.502*
	Within Groups	307534.2	424	725.317		
	Total	*309246.1*	*427*			

Table (4.8) showed that there were statistically insignificant differences in satisfaction with postpartum care related to mothers' level of education; communication (F= 0.511, P= 0.675), comfort and safety (F= 0.394, P= 0.758), specific postpartum care (F= 1.103, P= 0.348), efficient care of my baby (F= 1.222, P= 0.301), organizational context and orientation (F= 0.759, P= 0.518), and overall score (F= 0.787, P= 0.502).

The study results were inconsistent with the results obtained by Najoka (2015) who found that more than half of mothers (55%) who attended PPC services had college level of education, and there was significant association between mothers' level of education and utilization of PPC services. Another study carried out in Iran found that mothers with primary education, secondary education and high school diploma had higher satisfaction with midwifery services compared to those with higher levels of education (Mirzaei et al., 2015). In addition, Mohammed (2015)

reported that education helps the mothers to identify their health needs and expectations during postpartum period, and education is a mean that enables women to gain access of knowledge and to control many events in their life. Furthermore, a study carried out in Iran by Naghizadeh et al., (2014) found that there was significant relationship between satisfaction with PPC and women's education. Moreover, Mirzaei et al., (2016) found that there was significant correlation between maternal satisfaction of postpartum care and education level.

The researcher's opinion is that mothers with high level of education will have lower level of satisfaction because educated mothers have higher expectations and evaluate the nursing care according to their knowledge, while mothers with low education will have higher level of satisfaction because they have lower expectations and have better perception and appreciate any care they receive from nurses.

Table (4.9): Differences in mothers' satisfaction from postpartum care related to family type (T test)

Domain	Family type	N	Mean	SD	t	*P value*
Communication	Nuclear	218	4.003	0.650	1.816	*0.070 //*
	Extended	210	3.893	0.593		
Comfort and safety	Nuclear	218	4.047	0.581	3.601	*0.000* *
	Extended	210	3.795	0.849		
Specific postpartum care	Nuclear	218	3.840	0.624	6.201	*0.000* *
	Extended	210	3.415	0.782		
Efficient care of my baby	Nuclear	218	4.425	0.726	6.419	*0.000* *
	Extended	210	3.904	0.934		
Organizational context & Orientation	Nuclear	218	3.832	0.612	4.169	*0.000* *
	Extended	210	3.580	0.635		
Overall	Nuclear	218	3.981	0.545	5.892	*0.000* *
	Extended	*210*	*3.636*	*0.656*		

* = significant at 0.05 // = not significant

Table (4.9) showed that there were statistically insignificant differences in mothers' satisfaction with communication related to type of family (t= 1.816, P= 0.070). The results

also showed that there were statistically significant differences in satisfaction with the other domains of satisfaction, and mothers who live in nuclear families expressed higher satisfaction with comfort and safety (t= 3.601, P= 0.000), higher satisfaction with specific postpartum care (t= 6.201, P= 0.000), higher satisfaction with efficient care of my baby (t= 6.419, P= 0.000), higher satisfaction with organizational context and orientation (t= 4.169, P= 0.000) and higher satisfaction with allover postpartum care (t= 5.892, P= 0.000).

Inconsistent results obtained by a study conducted in Nepal showed that there is no statistical significant association between mothers' satisfaction from PPC and socio demographic characteristics including type of family (Pantha and Kafle, 2018). Another study carried out in El-Shatby maternity university hospital in Egypt is consistent with the study results which reported that about two-thirds of the mothers lived in extended family and they did not express satisfaction from PPC (Al-Battawi and Hafez, 2017).

The researcher's opinion is that insignificant communication in postpartum departments is related to short stay in the department. Most of mothers stay in the department about 4 hours, then discharge home. In addition, work overload, overcrowd in the department make it difficult to the nurses to set and talk with mothers about health education after going home.

Table (4.10): Differences in mothers' satisfaction from postpartum care related to work status (T test)

Domain	Work status	N	Mean	SD	t	*P value*
Communication	Working	29	3.821	0.729	1.139	*0.255 //*
	Do not work	399	3.958	0.616		
Comfort and safety	Working	29	3.848	0.751	0.573	*0.567 //*
	Do not work	399	3.929	0.734		
Specific postpartum care	Working	29	3.789	0.513	1.642	*0.109 //*
	Do not work	399	3.620	0.749		
Efficient care of the baby	Working	29	4.453	0.566	2.661	*0.011 **
	Do not work	399	4.149	0.888		
Organizational context & Orientation	Working	29	3.676	0.630	0.279	*0.781 //*
	Do not work	399	3.710	0.636		
Overall	Working	29	3.887	0.502	0.674	*0.501 //*
	Do not work	*399*	*3.779*	*0.634*		

* = significant at 0.05 // = not significant

Table (4.10) showed that there were statistically significant differences in mothers' satisfaction with efficient care of their babies (t= 2.661, P= 0.011) and that mothers who are working expressed higher satisfaction with the care of their babies. The results also showed that there were statistically insignificant differences in satisfaction with the other domains of satisfaction; communication (t= 1.139, P= 0.255), comfort and safety (t= 0.573, P= 0.567), specific postpartum care (t= 1.642, P= 0.109), organizational context and orientation (t= 0.279, P= 0.781) and allover postpartum care (t= 0.674, P= 0.501). These results reflected insignificant differences in mothers' satisfaction with PPC related to mothers' work. These results were consistent with the results obtained by Mohammed (2014) which showed that more than three-quarters of mothers were housewives, while about one-fifth of them were working. Moreover, the results obtained by Najoka (2015) found that one-third of mothers who have formal employment utilized PPC services and one-fourth of mothers who have self-employment utilized PPC services, and there was

significant statistical association between the mothers' employment status and utilization of PPC services. In addition, a study carried out in Iran found that there was significant relationship between satisfaction with PPC and women's job (Naghizadeh et al., 2014). In addition, Mirzaei (2016) found no significant association between the level of maternal satisfaction and employment status (Mirzaei et al., 2016). The researcher's opinion that mothers who are working or employed have better chance to gain awareness and understanding about pregnancy and delivery issues because they come in contact and talk with other women at work about pregnancy and delivery-related issues, and that would increase their knowledge which is acquired from the experience of other women.

Table (4.11): Differences in mothers' satisfaction with postpartum care related to monthly income (One way ANOVA)

Domains		**Sum of squares**	**df**	**Mean square**	**F**	***P value***
Communication	Between Groups	4.450	2	2.225	0.158	*0.854*
	Within Groups	5996.065	425	14.108		
	Total	6000.514	427			
Comfort and safety	Between Groups	31.992	2	15.996	1.185	*0.307*
	Within Groups	5738.931	425	13.503		
	Total	5770.923	427			
Specific postpartum care	Between Groups	58.559	2	29.279	0.186	*0.831*
	Within Groups	66992.68	425	157.630		
	Total	67051.67	427			
Efficient care of my baby	Between Groups	60.298	2	30.149	0.806	*0.448*
	Within Groups	15907.37	425	37.429		
	Total	15967.67	427			
Organizational context & Orientation	Between Groups	46.916	2	23.458	0.906	*0.405*
	Within Groups	10997.97	425	25.878		
	Total	11044.89	427			
Overall	Between Groups	622.973	2	311.486	0.429	*0.651*
	Within Groups	308623.2	425	726.172		
	Total	*309246.1*	*427*			

Table (4.11) showed that there were statistically insignificant differences in satisfaction with postpartum care related to family income; communication (F= 0.158, P= 0.854), comfort and safety (F= 1.185, P= 0.307), specific postpartum care (F= 0.186, P= 0.831),

efficient care of my baby (F= 0.806, P= 0.448), organizational context and orientation (F= 0.906, P= 0.405), and overall score (F= 0.429, P= 0.651).These results indicated that there were insignificant differences in mothers' satisfaction with PPC related to family income. These results were inconsistent with the results of Varghese and Rajagopal (2012) who found significant association between mothers' satisfaction with PPC and monthly income, and Kartal et al., (2018) who found that postnatal comfort was higher among mothers who had high income. The researcher's opinion; this result was convenient because most of the women who give birth in governmental hospitals have approximately similar income, and consequently have similar levels of satisfaction with the care they received.

Table (4.12): Differences in mothers' satisfaction from postpartum care related to number of pregnancies (One way ANOVA)

Domains		**Sum of squares**	**df**	**Mean square**	**F**	***P value***
Communication	Between Groups	57.801	2	28.900	2.067	*0.128*
	Within Groups	5942.713	425	13.983		
	Total	6000.514	427			
Comfort and safety	Between Groups	7.226	2	3.613	0.266	*0.766*
	Within Groups	5763.697	425	13.562		
	Total	5770.923	427			
Specific postpartum care	Between Groups	90.000	2	45.000	0.286	*0.752*
	Within Groups	66961.24	425	157.556		
	Total	67051.24	427			
Efficient care of the baby	Between Groups	4.378	2	2.189	0.058	*0.943*
	Within Groups	15963.29	425	37.561		
	Total	15967.67	427			
Organizational context & Orientation	Between Groups	52.989	2	26.495	1.024	*0.360*
	Within Groups	10991.90	425	25.863		
	Total	11044.89	427			
Overall	Between Groups	473.599	2	236.799	0.326	*0.722*
	Within Groups	308772.5	425	726.524		
	Total	*309246.1*	*427*			

Table (4.12) showed that there were statistically insignificant differences in satisfaction with postpartum care related to number of pregnancies; communication (F= 2.067, P=

0.128), comfort and safety (F= 0.266, P= 0.766), specific postpartum care (F= 0.286, P= 0.752), efficient care of my baby (F= 0.058, P= 0.943), organizational context and orientation (F= 1.024, P= 0.360), and overall score (F= 0.326, P= 0.722).

This result was consistent with the results obtained by Mirzaei et al., (2016) who found that there was no significant association between the level of maternal satisfaction and number of pregnancies.

Table (4.13): Differences in mothers' satisfaction from postpartum care related to number of deliveries (One way ANOVA)

Domains		**Sum of squares**	**df**	**Mean square**	**F**	***P value***
Communication	Between Groups	37.426	2	18.713	1.334	0.265
	Within Groups	5963.088	425	14.031		
	Total	6000.514	427			
Comfort and safety	Between Groups	0.378	2	0.189	0.014	0.986
	Within Groups	5770.545	425	13.578		
	Total	5770.923	427			
Specific postpartum care	Between Groups	501.089	2	250.545	1.600	0.203
	Within Groups	66550.15	425	156.589		
	Total	67015.24	427			
Efficient care of my baby	Between Groups	93.797	2	46.899	1.256	0.286
	Within Groups	15873.87	425	37.350		
	Total	15967.67	427			
Organizational context & Orientation	Between Groups	24.330	2	12.165	0.469	0.626
	Within Groups	11020.56	425	25.931		
	Total	11044.89	427			
Overall	Between Groups	979.742	2	489.871	0.675	0.510
	Within Groups	308266.4	425	725.333		
	Total	309246.1	427			

Table (4.13) showed that there were statistically insignificant differences in satisfaction with postpartum care related to number of deliveries; communication (F= 1.334, P= 0.265), comfort and safety (F= 0.014, P= 0.986), specific postpartum care (F= 1.600, P= 0.203),

efficient care of my baby (F= 1.256, P= 0.286), organizational context and orientation (F= 0.469, P= 0.626), and overall score (F= 0.675, P= 0.510).

These results indicated that there were no significant differences in mothers' satisfaction with PPC. The researcher's results were consistent with the results obtained by Mirzaei et al., (2016) who found that there was no significant association between the level of maternal satisfaction and parity. On the other hand, inconsistent results obtained in a study carried out in Nepal which found that multiparous postnatal mothers were more likely to be satisfied with delivery service than primiparous mothers (Pantha and Kafle, 2015).

The researcher's opinion; nurses offer their nursing care according to protocols and guidelines specified for PPC, and these protocols had been established by support from WHO and MOH, and nurses have been trained on these guidelines through workshops and training programs. Therefore, all the nurses would follow these guidelines during their work regardless of parity status of the mothers, and that would lead to similar levels of satisfaction among primiparous and multiparous mothers.

Table (4.14): Differences in mothers' satisfaction with postpartum care related to mode of delivery (T test)

Domain	Mode of delivery	N	Mean	S. deviation	t	*P value*
Communication	NVD	322	3.913	3.701	- 2.075	*0.039* *
	CS	106	4.058	3.832		
Comfort and safety	NVD	322	3.885	3.886	- 1.906	*0.057 //*
	CS	106	4.041	2.884		
Specific postpartum care	NVD	322	3.628	12.583	- 0.170	*0.865 //*
	CS	106	3.642	12.427		
Efficient care of my baby	NVD	322	4.158	6.068	- 0.456	*0.648 //*
	CS	106	4.203	6.277		
Organizational context & Orientation	NVD	322	3.703	5.060	- 0.312	*0.755 //*
	CS	106	3.725	5.185		
Overall	NVD	322	3.798	27.110	- 0.789	*0.431 //*
	CS	*106*	*3.853*	*26.343*		

* = significant at 0.05 // = not significant

Table (4.14) showed that there were statistically significant differences in mothers' satisfaction with communication related to mode of delivery and that mothers who delivered by CS expressed higher satisfaction with communication compared to mothers who had NVD (t= - 2.075, p= 0.039). The results also showed that there were statistically insignificant differences in satisfaction with the other domains of satisfaction; comfort and safety (t= - 1.906, P= 0.057), specific postpartum care (t= - 0.170, P= 0.865), efficient care of my baby (t= - 0.456, P= 0.648), organizational context and orientation (t= - 0.312, P= 0.755), and overall score (t= - 0.789, P= 0.431).

These results indicated that there were no statistical significant differences in overall satisfaction of mothers about PPC related to mode of delivery. Inconsistent results obtained by Mirzaei et al., (2016) who found significant correlation between maternal satisfaction of postpartum care and mode of delivery, while Kartal et al., (2018) found that psycho-spiritual comfort was higher among mothers who had vaginal delivery.

The researcher's opinion; Immediate postpartum period for CS mothers is critical period that requires close observation and monitoring to prevent and/or early detection of complications that may occur therefore, they need periodic assessment and close monitoring, which in consequence increase the mothers' satisfaction from the care they receive.

Table (4.15): Differences in mothers' satisfaction from postpartum care related to birth outcome (T test)

Domain	Birth outcome	N	Mean	S. deviation	t	*P value*
Communication	Single tone	410	3.958	0.621	1.385	*0.167*
	Twins	18	3.750	0.679		
Comfort and safety	Single tone	410	3.925	0.738	0.271	*0.786*
	Twins	18	3.877	0.672		
Specific postpartum care	Single tone	410	3.627	0.736	0.568	*0.570*
	Twins	18	3.728	0.760		
Efficient care of my baby	Single tone	410	4.168	0.875	0.181	*0.857*
	Twins	18	4.206	0.857		
Organizational context & Orientation	Single tone	410	3.713	0.635	0.711	*0.477*
	Twins	18	3.604	0.650		
Overall	Single tone	410	3.812	0.626	0.058	*0.953*
	Twins	*18*	*3.803*	*0.629*		

Table (4.15) showed that there were statistically insignificant differences in satisfaction with postpartum care related to birth outcome; communication (t= 1.385, P= 0.167), comfort and safety (t= 0.271, P= 0.786), specific postpartum care (t= 0.568, P= 0.570), efficient care of my baby (t= 0.181, P= 0.857), organizational context and orientation (t= 0.711, P= 0.477), and overall score (t= 0.058, P= 0.953).

These results indicated that mothers who gave birth to one baby and those who gave birth to twins expressed similar levels of satisfaction from PPC. I believe that the optimum goal for any mother is to pass the pregnancy and labour period safely and deliver healthy baby or babies. Being in labour is a stressful event with considerable physical and emotional impact, and nurses play a major role in helping mothers pass this period safely with the best possible comfort. So, feeling safe, secure and comfort will lead to satisfaction of mothers.

4.3 Quality of postpartum care (Nurses and midwives part):

In this study, the researcher addressed an important component of reproductive health. Review of the literature showed that very little attention has been paid to PPC. The delivery of a new baby is a time of joy. Yet, for many mothers, it is a time of fear, confusion, and sometimes isolation. So that, after delivery both the mother and the baby will have health concerns that need to be addressed carefully (Littleson and Engebretson 2009).

Nurses and midwives have an important role in giving PPC, so they must be adequately knowledgeable and skillful. In this part of the study, the researcher assessed the quality of PPC from the nurses' perspective.

Table (4.16a): Quality of postpartum care (Communication domain)

	Statement	Always	Often	Sometimes	Seldom	Never	Mean	S.D.	Weighted %	Rank
1	I answer all the mother's questions promptly with positive attitude.	69.6	22.6	7.0	0.9	0	4.60	0.65	**92.0**	3
2	I maintain good interpersonal relations with the mother.	69.6	24.3	5.2	0.9	0	4.62	0.62	**92.4**	2
3	I maintain good interpersonal relations with the mother's family.	43.5	37.4	13.9	5.2	0	4.19	0.86	**83.8**	6
4	I communicate with mothers in a language that they understand.	79.1	17.4	0.9	1.7	0.9	4.72	0.65	**94.4**	1
5	I answer questions asked by mothers concerning her health status.	60.9	33.9	3.5	1.7	0	4.53	0.65	**90.6**	5
6	I treat mothers with dignity and respect.	70.4	22.6	4.3	1.7	0.9	4.60	0.73	**92.0**	4
	Overall						**4.54**	**0.46**	**90.8**	

Table (4.16a) presented items related to communication. The results showed that the highest score obtained in the statement " I communicate with mothers in a language that they understand." with mean score 4.72 and weighted percentage 94.4% followed by the statement "I maintain good interpersonal relations with the mother" with mean score 4.62 and weighted percentage 92.4%, while the lowest score was in the statement "I maintain

good interpersonal relations with the mother's family" with mean score 4.19 and weighted percentage 83.8%. The general score of communication domain was high with mean score 4.54 and weighted percentage 90.8%.

Through the researcher observation, she noticed that there were differences in communication patterns between nurses which affect mothers' satisfaction and affect their feelings towards these hospitals, some nurses showed good communication with mothers and talk with them in simple language with smile and some nurses were busy and do not have adequate time to set with mothers and talk to them. On the other hand, mothers said that they are satisfied from the way the nurse deal with them in dignity and respect. These differences are related to their own vision of the best way of communication. A study conducted in Iraq to evaluate communication behaviors of midwives reported that communication plays an important role in midwifery services. Low communication skills of midwives can lead to dissatisfaction with the care provided, and to determine the level of communication skills of midwives, their communication skills did not correlate with age, marital status, work experience, interest in job, life satisfaction, and experience, there was a significant correlation between some individual characteristics of midwives, such as experience of natural vaginal delivery, satisfaction with previous deliveries, marital status, job satisfaction, and age, with the score of communicative behavior (Katebi et al.2016) . Another study carried out by Mohammed (2015) reported that behaviors that reflect positive attitudes towards clients, such as being patient with clients, politeness, not shouting at them and not belittling them, along with a good level of competence, are important for patient satisfaction. These findings agreed with that found by Jewkes et al., (1998) who found that nice nurses were those who explained procedures and did not shout at or speak rudely to women. However, Mohammed, (2015) reported that clients' sources of dissatisfaction include negative behaviors of caregivers (ineffective communication, neglect and unfriendliness) such as shouting at them, ignoring them, frowning at them, belittling them, and whispering among caregivers that make clients uncomfortable.

Table (4.16b): Quality of postpartum care (Comfort and safety)

	Statement	Always	Often	Sometimes	Seldom	Never	Mean	S.D.	Weighted %	Rank
1	I offer help to mothers when needed.	75.7	21.7	2.6	0	0	4.73	0.50	**94.6**	**1**
2	I approach mothers in a calm manner.	47.0	46.1	3.5	0.9	2.6	4.33	0.81	**86.6**	**5**
3	I assist mothers in keeping herself clean & groomed.	56.5	30.4	9.6	3.5	0	4.40	0.80	**88.0**	**4**
4	I keep mothers safe and secured during their stay in postpartum unit.	66.1	24.3	5.2	4.3	0	4.52	0.78	**90.4**	**3**
5	I keep mothers comfort during their stay in postpartum unit.	69.6	24.3	4.3	0.9	0.9	4.60	0.69	**92.0**	**2**
	Overall						**4.52**	**0.51**	**90.4**	

Table (4.16b) presented items related to comfort and safety. The results showed that the highest score obtained in the statement "I offer help to mothers when needed" with mean score 4.73 and weighted percentage 94.6% followed by the statement "I keep mothers comfort during their stay in postpartum unit" with mean score 4.60 and weighted percentage 92%, while the lowest score was in the statement "I approach mothers in a calm manner" with mean score 4.33 and weighted percentage 86.6%. The general score of comfort and safety domain was high with mean score 4.52 and weighted percentage 90.4%.

Inconsistent results obtained by Kartal et al., (2018) who found that mothers expressed moderate comfort levels from the PPC they received. It is obvious to say that the level of comfort of the patients is an indicator of the quality of nursing care and the level of sensitivity of the nurses (Erdemir and Cirlak, 2013). In addition, Lamadah, El-aggar (2014) reported that if a positive caregiver attitude was attained, the client will feel comfort, safe, and recommend the hospital for future care.

Moreover, with the increased need for free access to maternity services, hospitals face considerable challenges in providing safe and satisfying care. While providers claimed to use most of the beneficial practices, reported practices do not always reflect actual care. However, periodic assessment gives a general overview and identifies essential challenges

to change. Avoiding harmful practices would improve quality. Governmental hospitals are critically understaffed with obstetricians and midwives, raising the issues of minimal human resources for safe childbirth and staff motivation, both crucial in promoting change towards quality of care (Fathala, 2003).

Table (4.16c): Quality of postpartum care (nurses and midwives perspective) (Specific postpartum care)

	Statement	Always	Often	Sometimes	Seldom	Never	**Mean**	**S.D.**	**Weighted %**	**Rank**
1	I assist mothers to go to toilet.	43.5	20.0	20.9	9.6	6.1	3.85	1.25	**77.0**	18
2	I inform mothers regarding how to keep their perineum hygienic.	55.7	25.2	18.3	0.9	0	4.35	0.80	**87.0**	15
3	I assisted mothers in early ambulation.	48.7	31.3	11.3	4.3	4.3	4.15	1.07	**83.0**	16
4	I check and record vital signs regularly (BP, P, R, Temp).	85.2	10.4	2.6	1.7	0	4.79	0.56	**95.8**	1
5	I teach mothers about involution of uterus.	71.3	19.1	7.8	0.9	0.9	4.59	0.74	**91.8**	8
6	I teach mothers about uterus massage.	76.5	15.7	4.3	3.5	0	4.65	0.72	**93.0**	5
7	I assess mothers' breast for any tenderness, cracked nipples, and engorgement.	52.2	36.5	7.8	3.5	0	4.37	0.77	**87.4**	14
8	I explain to mothers how to take care of her breast.	53.0	39.1	4.3	1.7	1.7	4.40	0.80	**88.0**	13
9	I teach mothers about nutrition in postnatal period.	63.5	25.2	8.7	2.6	0	4.49	0.76	**89.8**	10
10	I inform mothers about importance of sleep and rest in postpartum period.	62.6	24.3	10.4	1.7	0.9	4.46	0.81	**89.2**	11
11	I administer medication / treatment at proper time.	82.6	15.7	0	1.7	0	4.79	0.52	**95.8**	2
12	I assess and record lochia flow in postpartum period.	71.3	23.5	2.6	0.9	1.7	4.61	0.74	**92.2**	7
13	I teach mothers regarding how to detect excessive bleeding during puerperal period.	72.2	21.7	5.2	0.9	0	4.65	0.62	**93.0**	6
14	I advise mothers about postpartum exercise.	52.2	22.6	14.8	5.2	5.2	4.11	1.16	**82.2**	17
15	I assist mothers with episiotomy care.	70.4	17.4	7.8	2.6	1.7	4.52	0.88	**90.4**	9
16	I inform mothers how to detect signs and symptoms of postpartum infection.	76.5	16.5	6.1	0.9	0	4.68	0.62	**93.6**	4
17	I inform mothers about the importance of postpartum follow up visits.	60.0	29.6	7.0	3.5	0	4.46	0.77	**89.2**	12
18	I check Rh for the mother and give anti D as needed.	82.6	13.0	2.6	0.9	0.9	4.75	0.62	**95.0**	3
	Overall						**4.48**	**0.42**	**89.6**	

Table (4.16c) presented items related to specific postpartum care. The results showed that the highest score obtained in the statement "I check and record vital signs regularly; BP, P, R, Temp" with mean score 4.79 and weighted percentage 95.8% followed by the statement "I administer medication / treatment at proper time" with mean score 4.79 and weighted percentage 95.8%, while the lowest score was in the statement "I assist mothers to go to toilet" with mean score 3.85 and weighted percentage 77%. The general score of specific postpartum care domain was high with mean score 4.48 and weighted percentage 89.6%. A study conducted in Malawi by Chimtembo et al., (2013) showed that there were disparities between midwives' responses during interview and what they did during actual practice. During the interviews, 62% of the midwives reported that they monitored mothers' conditions at least once during the fourth stage of labour, 13% stated that they monitored the mothers twice, and the remaining 25% admitted that they monitored women soon after delivery due to pressure of work. However, during observation on actual practice, none of the midwives assessed women during the first hour of delivery, Furthermore, none of the women was checked when being transferred from the labor ward to the postpartum ward. However, the only women that were assessed soon after delivery were those who presented with a risk condition such as postpartum hemorrhage or anemia.Maternity nurses expressed concerns about meeting educational needs of new mothers during their brief stay in the hospital. The nurses attributed their concerns to lack of time and the amount of information they were required to provide to the new mothers and their families to care for the newborn at home (Buchko et al., 2012). In my opinion, immediately after delivery, the mothers are weak and vulnerable to complications. Therefore, close monitoring and specific interventions should be employed during the immediate postpartum period to detect complications early and avoid further deterioration of the mothers' condition. However, some of these interventions are neglected or missed due to work overload and shortage of nurses.

Table (4.16d): Quality of postpartum care (Efficient care of baby)

	Statement	Always	Often	Sometimes	Seldom	Never	**Mean**	**S.D.**	**Weighted %**	**Rank**
1	I assist mothers with giving care (bath, diaper care, cord and eye care) for my baby.	67.8	20.9	9.6	0.9	0.9	4.53	0.77	**90.6**	4
2	I inform mothers about how to detect signs and symptoms of neonatal danger signs.	60.9	31.3	5.2	1.7	0.9	4.49	0.75	**89.8**	6
3	I teach mothers about the importance of colostrum and breast feeding.	80.0	15.7	4.3	0	0	4.75	0.52	**95.0**	1
4	I assist mothers to position her baby during and after breast feeding.	69.6	23.5	3.5	3.5	0	4.59	0.72	**91.8**	2
5	I teach mothers how to burp her baby after breast feeding.	66.1	23.5	5.2	2.6	2.6	4.47	0.91	**89.4**	7
6	I teach mothers about rooming in, bonding and attachment.	63.5	30.4	4.3	1.7	0	4.55	0.66	**91.0**	3
7	I educate mothers about immunization of her baby.	55.7	30.4	10.4	2.6	0.9	4.37	0.84	**87.4**	8
8	I check baby identification regularly and before discharge.	66.1	21.7	8.7	3.5	0	4.50	0.79	**90.0**	5
	Overall						**4.53**	**0.46**	**90.6**	

Table (4.16d) presented items related to efficient care of the baby. The results showed that the highest score obtained in the statement "I teach mothers about the importance of colostrum and breast feeding" with mean score 4.75 and weighted percentage 95% followed by the statement "I assist mothers to position her baby during and after breast feeding" with mean score 4.59 and weighted percentage 91.8%, while the lowest score was in the statement "I educate mothers about immunization of her baby" with mean score 4.37 and weighted percentage 87.4%. The general score of efficient care of baby domain was high with mean score 4.53 and weighted percentage 90.6%.

As reported by Buchko et al., (2012), the amount of education that is mandated by government and regulatory agencies and recommended by professional organizations for the postpartum mother may be overwhelming, and brief postpartum hospital stays leave insufficient time for nurses to address a new mother’s learning needs effectively.

Devastating outcomes for the infant and family may result when new mothers do not understand newborn care issues prior to discharge. Moreover, Weiss and Lokken (2009) found that poor quality discharge education was associated with more newborn emergency or urgent care visits, and nurses need to know what strategies facilitate an efficient postpartum educational process in the hospital setting.

Table (4.16e): Quality of postpartum care (Organizational context & Orientation)

	Statement	Always	Often	Sometimes	Seldom	Never	**Mean**	**S.D.**	**Weighted %**	**Rank**
1	I welcome every mother on admission to postpartum ward.	64.3	29.6	5.2	0.9	0	4.57	0.63	**91.4**	1
2	The mother is oriented to the health team members.	51.3	36.5	7.8	4.3	0	4.34	0.80	**86.8**	4
3	The mother is oriented to the postpartum unit (toilet, bathroom, washing area ……).	52.2	36.5	4.3	6.1	0.9	4.33	0.88	**86.6**	5
4	The mother receives information about visiting hours for her	50.4	33.0	7.8	4.3	4.3	4.20	1.05	**84.0**	8
5	I work hard to maintain the ward calm (no noise).	53.9	32.2	9.6	1.7	2.6	4.33	0.91	**86.6**	6
6	I try to maintain client's room neat and organized.	52.2	34.8	9.6	1.7	1.7	4.33	0.85	**86.6**	7
7	I have good relationship with physicians.	55.7	35.7	5.2	3.5	0	4.43	0.75	**88.6**	3
8	I cooperate with physicians for the wellbeing of clients.	66.1	27.0	4.3	2.6	0	4.56	0.70	**91.2**	2
	Overall						**4.39**	**0.56**	**87.8**	

Table (4.16e) presented items related to organizational context and orientation. The results showed that the highest score obtained in the statement "I welcome every mother

on admission to postpartum ward" with mean score 4.57 and weighted percentage 91.4% followed by the statement "I cooperate with physicians for the wellbeing of clients" with mean score 4.56 and weighted percentage 91.2%, while the lowest score was in the statement "The mother receives information about visiting hours for her family" with mean score 4.20 and weighted percentage 84%. The general score of efficient care of baby domain was high with mean score 4.39 and weighted percentage 87.8%.

Through the researcher's observation, she noticed that in some hospitals the department of postpartum is admitting prenatal women and women in the first stage of labour, so nurses do not give adequate care for postpartum women.

In Australia, similar results were reported where a review of PPC revealed that the services were provided in very busy environments thus compromising the quality of care, when midwives have to provide care in busy environments, the challenge they face is to prioritize some areas of health care over others (Chimtembo et al., 2013).

Table (4.16f): Quality of postpartum care (Specific care for CS women)

	Statement	Always	Often	Sometimes	Seldom	Never	**Mean**	**S.D.**	**Weighted %**	**Rank**
1	I check and record vital signs in immediate post op as follow (every 15 minutes in first hour, then every 30 minutes in second hour, and every hour for the next 4 hours).	85.7	10.7	2.7	0	0.9	4.80	0.56	**96.0**	1
2	I observe the wound (surgical site) for signs of bleeding every 30 minutes for the first 4 hours.	69.6	23.2	4.5	1.8	0.9	4.58	0.74	**91.6**	12
3	I check and record amount of blood from drains every shift.	74.1	17.0	6.3	1.8	0.9	4.61	0.76	**92.2**	11
4	I position the woman in left lateral position until recovery of full consciousness.	68.8	19.6	8.9	1.8	0.9	4.53	0.80	**90.6**	13

5	I observe for risk of airway obstruction in the immediate post op period.	75.0	20.5	2.7	0.9	0.9	4.67	0.66	**93.4**	8
6	I ensure adequate IV fluids until patient passed urine and bowel sound have returned.	82.1	13.4	3.6	0.9	0	4.76	0.55	**95.2**	2
7	Keep input/output records including drains and gastric tube if any?	75.9	19.6	1.8	2.7	0	4.68	0.64	**93.6**	7
8	Check Hb routinely on the first post-operative day, and again as instructed.	83.9	10.7	3.6	1.8	0	4.76	0.60	**95.2**	3
9	Encourage passive leg movement, deep breathing, postnatal exercise and early ambulation to prevent DVT.	73.2	20.5	3.6	1.8	0.9	4.63	0.72	**92.6**	9
10	Encourage early and regular passing of urine.	80.4	14.3	3.6	0.9	0.9	4.72	0.66	**94.4**	5
11	Assist the mother to breastfeed her baby as soon as possible.	74.1	17.9	5.4	1.8	0.9	4.62	0.74	**92.4**	10
12	Give prophylactic antibiotic therapy as ordered.	81.3	14.3	3.6	0.9	0	4.75	0.55	**95.0**	4
	Overall						**4.68**	**0.48**	**93.6**	
	Average for all domains						**4.50**	**0.39**	**90.0**	

Table (4.16f) presented items related to specific care for CS women. The results showed that the highest score obtained in the statement "I check and record vital signs in immediate post op as follow (every 15 minutes in first hour, then every 30 minutes in second hour, and every hour for the next 4 hours." with mean score 4.80 and weighted percentage 96% followed by the statement "I ensure adequate IV fluids until patient passed urine and bowel sound have returned" with mean score 4.76 and weighted percentage 95.2%, while the lowest score was in the statement "I position the woman in left lateral position until recovery of full consciousness" with mean score 4.53 and weighted percentage 90.6%. The general score of specific care for CS women domain was high with

mean score 4.68 and weighted percentage 93.6%. the average score of quality of postpartum care was high with mean score 4.50 and weighted percentage 90%.

A study carried out in Cameron indicated consistent results as 27.3% of nurses said that they take some actions to prevent respiratory tract infection (RTI) by placing the patient's head on the side to prevent aspiration of gastric content and also to encourage airway clearance. None of the nursed taught patient deep breathing and coughing exercises to clear off and mobilize secretion in the respiratory tract. This clearly indicates that post-operative CS patients are at high risk of developing RTI. None of the nurses mentioned hand washing as an effective way of preventing infection (Ntsama et al., 2013).

A very important aspect of nursing practice is left out during the management of CS patients which is bed making, and this has also been mention by Babara in her report (Barbara et al., 2010).

During bed making, a milieu for effective education, better nurse-patient relationship and assessment of the surgical site and its immediate environment is created as similarities was reported by Suzanne et al., (2010). In addition, Cumber et al., (2017) found that 41.7% of the nurses could effectively manage DVT by ambulating and doing leg exercise with the patients. This could be because the nurses have inadequate knowledge and skills in assessing and preventing DVT. Nurses will better manage a complication if they can easily identify risk factors to it.

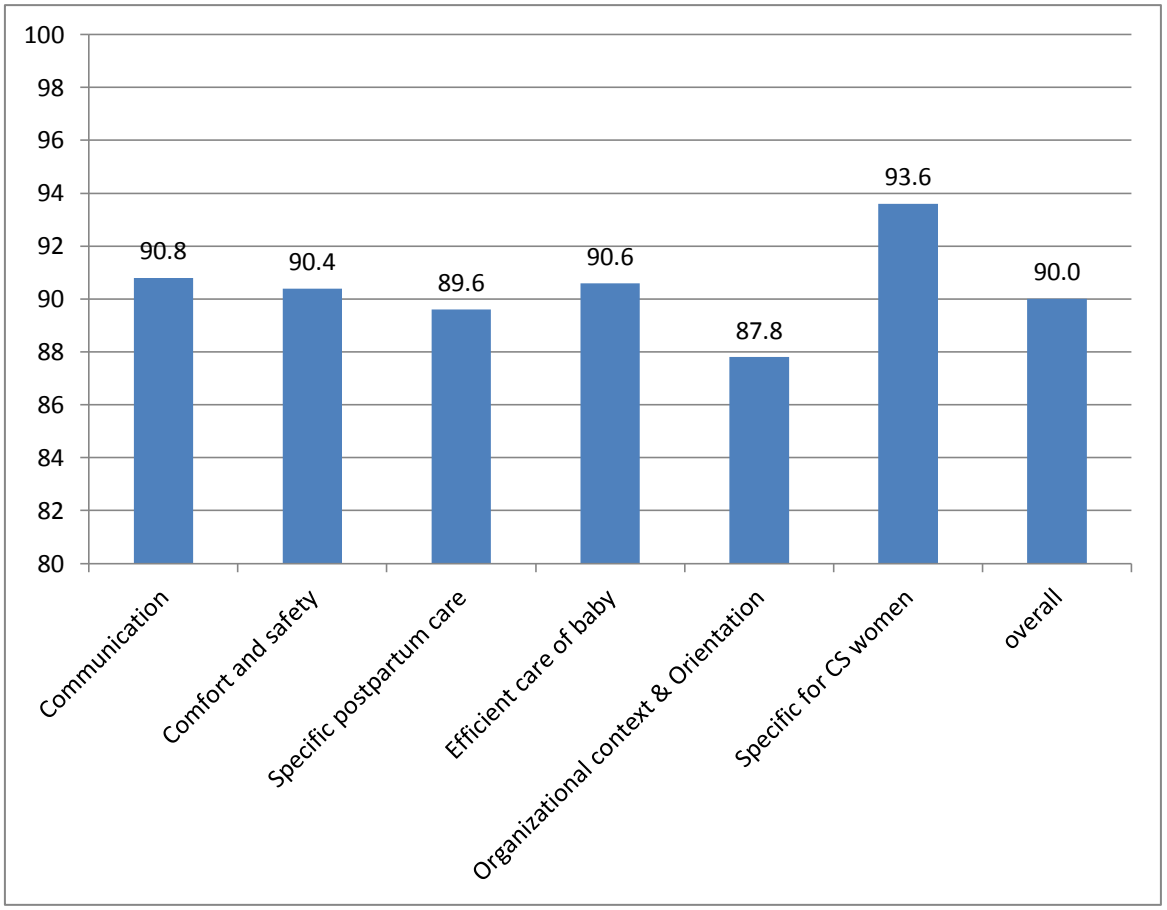

Figure (4.5): Quality of care in postpartum ward (Levels of quality domains of PPC) .

Figure (4.5) summarize the aspects of quality of PPC from the nurses' perspective. The results reflected high quality of PPC in governmental maternity hospitals in GS. This is inconsistent with the results obtained by Najoka, (2015) who found that lower levels of PPC presented in Kenya. Their results showed that maternal observation accounted for 27.5%, maternal physical examination accounted for 25.5%, and newborn physical examination accounted for 19.5%.

The researcher results revealed high qualification and skills of nurses and midwives. In addition, these results showed nurses' and midwives' concern about the wellbeing of mothers and their newborns during their stay in the hospital, and this increases confidence in nurses' skills and their ability to offer safe, quality care.

4.3.1 Differences in quality of postpartum care related to selective variables.

Table (4.17): Differences in quality levels of postpartum care related to hospital name

Domains		Sum of squares	df	Mean square	F	*P value*
Communication	Between groups	105.031	4	26.258	3.710	*0.007 **
	Within groups	778.499	110	7.077		
	Total	883.530	114			
Comfort and safety	Between groups	41.058	4	10.264	1.603	*0.179 //*
	Within groups	704.542	110	6.405		
	Total	745.600	114			
Specific postpartum care	Between groups	779.780	4	194.945	3.721	*0.007 **
	Within groups	5762.863	110	52.390		
	Total	6542.643	114			
Efficient care of baby	Between groups	118.341	4	29.585	2.194	*0.074 //*
	Within groups	1483.607	110	13.487		
	Total	1601.948	114			
Organizational context & Orientation	Between groups	44.703	4	11.176	0.543	*0.705 //*
	Within groups	2264.341	110	20.585		
	Total	2309.043	114			
Specific for CS women	Between groups	2145.044	4	536.261	4.521	*0.002 **
	Within groups	13046.90	110	118.608		
	Total	15191.95	114			
Overall	Between groups	6350.035	4	1587.509	3.266	*0.014 **
	Within groups	53465.74	110	486.052		
	Total	*59815.77*	*114*			

* = significant at 0.05 // = not significant

Table (4.17) showed that there were statistically insignificant differences between hospitals in comfort and safety (F= 1.603, P= 0.179), efficient care of baby (F= 2.194, P= 0.074), and organizational context and orientation (F= 0.543, P= 0.705). Moreover, there were statistically significant differences in communication (F= 3.710, P= 0.007) and Post hoc Scheffe test (Table 4.18) indicated that the lowest score in communication was in Kamal Odwan hospital compared to other hospitals. Also, there were statistically significant differences in specific postpartum care between hospitals (F= 3.721, P= 0.007) and Post hoc Scheffe test indicated that the lowest score in specific postpartum care was in Kamal Odwan hospital. Furthermore, there were statistically significant differences in specific care for CS women between hospitals (F= 4.521, P= 0.021) and Post hoc Scheffe test indicated that the lowest score in specific care for CS women was in Al Shifa

hospital. Also, there were statistically significant differences in overall quality of postpartum care between hospitals (F= 3.266, P= 0.014) and Post hoc Scheffe test indicated that the lowest score in quality of postpartum care was in Kamal Odwan hospital.

Table (4.18): Post hoc Scheffe test (for hospital name)

Domain	Place of work	Mean difference	*P value*
Communication	(Al Shifa) – (Kamal Odwan)	4.294	*0.016* *
	(Shohada Al Aqsa) – (Kamal Odwan)	3.496	*0.045* *
	(NMC) – (Kamal Odwan)	3.311	*0.070* //
	(Al Emaratey) – (Kamal Odwan)	2.509	*0.318* //
Specific postpartum care-	(Al Shifa) – (Kamal Odwan)	12.294	*0.010* *
	(Shohada Al Aqsa) – (Kamal Odwan)	9.996	*0.030* *
	(NMC) – (Kamal Odwan)	10.129	*0.028* *
	(Al Emaratey) – (Kamal Odwan)	9.204	*0.077* //
Specific for CS women	(Shohada Al Aqsa) – (Al Shifa)	12.458	*0.008* *
	(NMC) – (Al Shifa)	11.026	*0.031* *
	(Al Emaratey) – (Al Shifa)	9.701	*0.120* //
	(Kamal Odwan) – (Al Shifa)	2.732	*0.989* //
Overall	(Al Shifa) – (Kamal Odwan)	22.125	*0.304* //
	(Shohada Al Aqsa) – (Kamal Odwan)	30.472	*0.029* *
	(NMC) – (Kamal Odwan)	30.424	*0.032* *
	(Al Emaratey) – (Kamal Odwan)	*24.956*	*0.151* //

* = significant at 0.05 // = not significant

Kamal Odwan hospital is a small hospital owned by military medical services and offer pediatric services mainly to the north governorate. Due to reconstruction of Al Shifa maternity hospital, part of maternity services including some obstetricians and nurses were allocated temporarily in Kamal Odwan hospital to offer maternity services to the north governorate. The hospital is not well-designed for maternity services like the other hospitals, and that explained the low quality of PPC compared to the other hospitals.

Table (4.19): Differences in quality of postpartum care related to age

Domains		Sum of squares	df	Mean square	F	*P value*
Communication	Between groups	4.119	4	1.030	0.129	*0.972*
	Within groups	879.411	110	7.995		
	Total	883.530	114			
Comfort and safety	Between groups	11.950	4	2.988	0.448	*0.774*
	Within groups	733.650	110	6.670		
	Total	745.600	114			
Specific postpartum care	Between groups	292.738	4	73.185	1.288	*0.279*
	Within groups	6249.905	110	56.817		
	Total	6542.643	114			
Efficient care of baby	Between groups	63.820	4	15.955	1.141	*0.341*
	Within groups	1538.128	110	13.983		
	Total	1601.948	114			
Organizational context & Orientation	Between groups	10.108	4	2.527	0.121	*0.975*
	Within groups	2298.936	110	20.899		
	Total	2309.043	114			
Specific for CS women	Between groups	1216.794	4	304.199	2.394	*0.055*
	Within groups	13975.15	110	127.047		
	Total	15191.95	114			
Overall	Between groups	2423.246	4	605.811	1.161	*0.332*
	Within groups	57392.53	110	521.750		
	Total	*59815.77*	*114*			

Table (4.19) showed that there were statistically insignificant differences in quality of postpartum care related to age of the nurse; communication (F= 0.129, P= 0.972), comfort and safety (F= 0.448, P= 0.774), specific postpartum care (F= 1.288, P= 0.279), efficient care of my baby (F= 1.141, P= 0.341), organizational context and orientation (F= 0.121, P= 0.975), specific care for CS women (F= 2.394, P= 0.055). Overall score (F= 1.161, P= 0.332). According to age distribution of nurses in the study, the vast majority of them were young and middle-age nurses (35 years old and less). This distribution will be reflected in nurses' behavior, attitudes, and ability to work as a team with approximately similar ways of communication between themselves and with their clients. In addition, compliance to guidelines and protocols that control and define nurses' interventions will lead to quality of care. In my opinion, other factors may affect quality of care such as work overload,

cooperation between nurses and obstetricians, work environment, and availability of equipment and materials that are necessary to offer care with high quality.

Table (4.20): Differences in quality of postpartum care related to qualification

Domains		**Sum of squares**	**df**	**Mean square**	**F**	***P value***
Communication	Between groups	8.284	2	4.142	0.530	*0.590*
	Within groups	875.246	112	7.815		
	Total	883.530	114			
Comfort and safety	Between groups	9.433	2	4.716	0.718	*0.490*
	Within groups	736.167	112	6.573		
	Total	745.600	114			
Specific postpartum care	Between groups	124.161	2	62.080	1.083	*0.342*
	Within groups	6418.483	112	57.308		
	Total	6542.643	114			
Efficient care of baby	Between groups	26.188	2	13.094	0.931	*0.397*
	Within groups	1575.759	112	14.069		
	Total	1601.948	114			
Organizational context & Orientation	Between groups	10.707	2	5.359	0.261	*0.771*
	Within groups	2298.326	112	20.521		
	Total	2309.043	114			
Specific for CS women	Between groups	114.571	2	57.285	0.426	*0.654*
	Within groups	15077.38	112	134.619		
	Total	15191.95	114			
Overall	Between groups	680.226	2	340.113	0.644	*0.527*
	Within groups	59135.55	112	527.996		
	Total	*59815.77*	*114*			

Table (4.20) showed that there were statistically insignificant differences in quality of postpartum care related to qualification of the nurse; communication (F= 0.530, P= 0.590), comfort and safety (F= 0.718, P= 0.490), specific postpartum care (F= 1.083, P= 0.342), efficient care of my baby (F= 0.931, P= 0.397), organizational context and orientation (F= 0.261, P= 0.771), specific care for CS women (F= 0.426, P= 0.654). Overall score (F= 0.644, P= 0.527). This result indicated no significant differences in PPC related to nurses' qualification. The researcher believes that standards of nursing care are controlled by presence of specific protocols and policies that identify and determine tasks and responsibilities for each level of qualification. Nursing education in GS is well-designed in different levels of qualification, and graduates of nursing colleges usually considered as

safe practitioners with adequate knowledge and skills to practice nursing safely in different settings. In addition, through their work, nurses and midwives gain more experience and confidence in their capabilities which in turn lead to improvement in quality of care they provide to their clients. It is obvious to say that the quality of care that nurses provide is influenced by individual nurse characteristics such as knowledge and experience, as well as human factors. The quality of care is also influenced by the systems nurses work in, which involve not only staffing levels, but also the needs of all the patients a nurse or nursing staff is responsible for, the availability and organization of other staff and support services, and the climate and culture created by leaders in that setting (Clarke and Donaldson, 2008).

Table (4.21): Differences in quality of postpartum care related to years of experience

Domains		**Sum of squares**	**df**	**Mean square**	**F**	***P value***
Communication	Between groups	6.730	2	3.365	0.430	*0.652 //*
	Within groups	876.801	112	7.829		
	Total	883.530	114			
Comfort and safety	Between groups	21.302	2	10.651	1.647	*0.197 //*
	Within groups	724.298	112	6.467		
	Total	745.600	114			
Specific postpartum care	Between groups	403.764	2	201.882	3.683	*0.028 **
	Within groups	6138.879	112	54.811		
	Total	6542.643	114			
Efficient care of baby	Between groups	88.722	2	44.361	3.283	*0.041 **
	Within groups	1513.226	112	13.511		
	Total	1601.948	114			
Organizational context & Orientation	Between groups	91.871	2	45.935	2.320	*0.103 //*
	Within groups	2217.173	112	19.796		
	Total	2309.043	114			
Specific for CS women	Between groups	558.237	2	279.118	2.136	*0.123 //*
	Within groups	14633.71	112	130.658		
	Total	15191.95	114			
Overall	Between groups	4411.330	2	2205.665	4.459	*0.014 **
	Within groups	55404.44	112	494.683		
	Total	*59815.77*	*114*			

* = significant at 0.05 // = not significant

Table (4.21) showed that there were statistically insignificant differences in quality of postpartum care related to years of experience; communication (F= 0.430, P= 0.652), comfort and safety (F= 1.647, P= 0.197), organizational context and orientation (F= 2.320, P= 0.103), and specific care for CS women (F= 2.136, P= 0.123).

The results also showed that there were statistically significant differences in specific postpartum care (F= 3.683, P= 0.028) and as presented in table (4.22), nurses with experience of 1 – 5 years obtained lowest scores compared to other nurses. In addition, there were statistically significant differences in efficient care of baby (F= 3.283, P= 0.041), and there were statistically significant differences in overall score (F= 4.459, P= 0.014) and these differences were in favor of nurses with 6 - 10 years of experience.

According to Post hoc Scheffe test, nurses and midwives with 1 - 5 years of experience have the lowest mean score in providing quality of care. In my opinion, this result is logic, because novice nurses are safe practitioners, and through experience and learning from their colleagues, nurses gain more skills and expertise. According to the results obtained by Kieft et al., (2014), participants mentioned three key aspects related to expertise, namely knowledge, technical skills and communicative capabilities. Nurses and midwives should maintain and follow both existing developments in knowledge and skills. In addition, participants indicated that nurses must have technical skills in order to provide effective and safe care. Furthermore, participants mentioned that nurses must have communicative capabilities. Participants said that nurses serve as spokespersons for patients who are often in vulnerable positions. Participants mentioned that this expertise is important for patients because it is related to the quality of care.

Table (4.22): Post hoc Scheffe test (for experience)

Domain	Years of experience	Mean difference	*P value*
Specific postpartum care	(1 – 5 years) – (6 – 10 years)	-4.272	*0.028 **
	(1 – 5 years) - (≥11 years)	-2.354	*0.450 //*
Efficient care of baby	(1 – 5 years) – (6 – 10 years)	-1.772	*0.081 //*
	(1 – 5 years) - (≥11 years)	0.022	*1.000 //*
Overall	(1 – 5 years) – (6 – 10 years)	-14.060	*0.014 **
	(1 – 5 years) - (≥11 years)	*-8.984*	*0.277 //*

* = significant at 0.05 // = not significant

Table (4.22) showed that nurses who have 6 – 10 years of experience expressed higher scores in specific PPC and overall aspects of quality of nursing care.

Table (4.23): Differences in quality of postpartum care related to marital status

Domains		Sum of squares	df	Mean square	F	*P value*
Communication	Between groups	9.285	2	4.642	0.595	*0.553 //*
	Within groups	874.246	112	7.806		
	Total	883.530	114			
Comfort and safety	Between groups	13.257	2	6.628	1.014	*0.366 //*
	Within groups	732.343	112	6.539		
	Total	745.600	114			
Specific postpartum care	Between groups	28.055	2	14.028	0.241	*0.786 //*
	Within groups	6514.588	112	58.166		
	Total	6542.643	114			
Efficient care of baby	Between groups	9.079	2	4.539	0.319	*0.727 //*
	Within groups	1592.869	112	14.222		
	Total	1601.948	114			
Organizational context & Orientation	Between groups	55.488	2	27.744	1.379	*0.256 //*
	Within groups	2253.556	112	20.121		
	Total	2309.043	114			
Specific for CS women	Between groups	1285.498	2	642.749	5.177	*0.007 **
	Within groups	13906.45	112	124.165		
	Total	15191.95	114			
Overall	Between groups	489.211	2	244.606	0.462	*0.631 //*
	Within groups	59326.56	112	529.701		
	Total	*59815.77*	*114*			

* = significant at 0.05 // = not significant

Table (4.23) showed that there were statistically insignificant differences in quality of postpartum care related to marital status; communication (F= 0.595, P= 0.553), comfort and safety (F= 1.014, P= 0.366), specific postpartum care (F= 0.241, P= 0.786), efficient care of baby (F= 0.319, P= 0.727), organizational context and orientation (F= 1.379, P= 0.256), and overall score (F= 0.462, P= 0.631). While the results showed that there were statistically significant differences in specific care for CS women (F= 2.177, P= 0.007). As presented in table (4.24), nurses and midwives who were married obtained higher scores in specific care for CS women compared to nurses who were divorced. The researcher's opinion; this result was logic, because marriage and having a family is one of the major goals in our life. In addition, marriage usually leads to stability in the nurses and midwives life and help them to deal with their clients with empathy and help mothers to overcome their pain and respond to their needs.

Table (4.24): Post hoc Scheffe test (marital status)

Domain	Marital status	Mean difference	*P value*
Specific care for CS women	(married) – (single)	5.456	*0.125 //*
	(married) - (divorced)	*15.115*	*0.033 **

* = significant at 0.05 // = not significant

Table (4.25): Differences in quality of postpartum care related to income

Domains		Sum of squares	df	Mean square	F	*P value*
Communication	Between Groups	35.979	2	17.989	2.377	*0.097 //*
	Within Groups	847.552	112	7.567		
	Total	883.530	114			
Comfort and safety	Between Groups	13.255	2	6.627	1.014	*0.366 //*
	Within Groups	732.345	112	6.539		
	Total	745.600	114			
Specific postpartum care	Between Groups	284.113	2	142.056	2.542	*0.083 //*
	Within Groups	6258.531	112	55.880		
	Total	6542.643	114			
Efficient care of baby	Between Groups	10.634	2	5.317	0.374	*0.689 //*
	Within Groups	1591.314	112	14.208		
	Total	1601.948	114			
Organizational context & Orientation	Between Groups	105.461	2	52.731	2.680	*0.073 //*
	Within Groups	2203.582	112	19.675		
	Total	2309.043	114			
Specific for CS women	Between Groups	364.940	2	182.470	1.378	*0.256 //*
	Within Groups	14827.01	112	132.384		
	Total	15191.95	114			
Overall	Between Groups	3210.067	2	1605.034	3.176	*0.046 **
	Within Groups	56605.71	112	505.408		
	Total	*59815.77*	*114*			

* = significant at 0.05 // = not significant

Table (4.26): Post hoc Scheffe test (income)

Domain	Income (IS)	Mean difference	*P value*
Overall	(>2293) – (<1832)	-17.914	*0.063 //*
	(>2293) - (1832 - 2293)	*-20.326*	*0.062 //*

// = not significant

Table (4.25) showed that there were statistically insignificant differences in quality of postpartum care related to income; communication (F= 2.377, P= 0.097), comfort and safety (F= 1.014, P= 0.366), specific postpartum care (F= 2.542, P= 0.083), efficient care of baby (F= 0.374, P= 0.689), organizational context and orientation (F= 2.680, P= 0.073), and overall score (F= 0.462, P= 0.631), and specific care for CS women (F= 1.378, P=

0.256). The results also showed that there were statistically significant differences in overall score (F= 3.176, P= 0.046), but Post hoc Scheffe test (table 4.26) did not show significant differences in overall scores related to income.

These results indicated that there were considerable differences in overall quality of care related to income, but these differences were not statistically significant as shown by Post hoc Scheffe test.

In my opinion, salary is an important aspect for employees because for most of them it is the main source of income. The economic status is generally very hard in GS and affected all aspects of the life. Nurses and other governmental employees are receiving 40% of their salary from Gaza and those who belongs to Ramallah government receive 50% of their salaries. This situation complicated nurses' life, and may affect their ability to work with their optimal potentials. Many nurses seek a second part-time job to improve their income but that may affect their ability to do the best in their original work. Comparison between nurses' perspective and observation of practice, there was a considerable gap between the two scores. According to nurses' perspective, the results indicated high quality of PPC accounted for 90%, but according to observations from the checklist, the overall score was 67.3% (tab**le 4.16f** and table 4.28).

4.4 Observation checklist

10 observational checklists was done and experts of statistics analyzed them as shown

Table (4.27a): Scores of checklist observation (Communication domain)

Items	Always	Sometimes	No	Mean	SD	%	Rank
1. The nurse respond to all the mother's questions promptly with	60.0	30.0	10.0	2.50	0.70	83.3	3
2. The nurses maintain a good interpersonal relations with the	50.0	40.0	10.0	2.40	0.69	80.0	5
3. The nurses maintain a good interpersonal relations with the	40.0	50.0	10.0	2.30	0.67	76.6	6
4. The nurses communicate with mothers in a language that they	100.0	0	0	3.0	0.00	100.0	1
5. The nurses answer questions asked by mothers concerning their health	70.0	30.0	0	2.70	0.48	90.0	2
6. The nurses treat mothers with dignity and respect.	70.0	10.0	20.0	2.50	0.84	83.3	4

Table (4.27a) presented the observed communication patterns of nurses with their clients. The highest score was in "The nurses communicate with mothers in a language that they understand" with mean score 3.0 and weighted percentage 100%, followed by "The nurses answer questions asked by mothers concerning their health status" with mean score 2.70 and weighted percentage 90%, while the lowest score was in "The nurses maintain a good interpersonal relations with the mother's family" with mean score 2.30 and weighted percentage 76.6%.

These results indicated that nurses communicate with their clients in a good manner that is appreciated by mothers. A study carried out in Iran by Navvabi and Asri (2003) found that nursing students were not good communicators in their clinical practice. This result raised the need to focus on communication and its important value as an aspect of quality of care, Therefore, emphasis on communication should be part of nursing education in all the nursing colleges. Moreover, it is worth to say that mankind is a social being by nature, thus, in the healthcare field clients feel comfort when they found that nurses understand their complaint and answer them in easy and understandable language.

Table (4.27b): Scores of checklist observation (Comfort and safety domain)

Items	Always	Sometimes	No	Mean	SD	%	Rank
1. The nurses offer help to mothers when needed.	80.0	20.0	0	2.80	0.42	93.3	1
2. The nurses approach mothers in a calm manner.	40.0	50.0	10.0	2.30	0.67	76.6	5
3. The nurses assist mothers in keeping self-clean & groomed.	50.0	50.0	0	2.50	0.52	83.3	2
4. The nurses keep mothers safe and secured during their stay in postpartum unit.	40.0	60.0	0	2.40	0.51	80.0	3
5. The nurses keep mothers comfort during their stay in postpartum unit.	40.0	60.0	0	2.40	0.51	80.0	4

Table (4.27b) presented the observed comfort and safety measures performed by nurses. The highest score was in "The nurses offer help to mothers when needed" with mean score 2.80 and weighted percentage 93.3%, followed by "The nurses assist mothers in keeping self-clean and groomed" with mean score 2.50 and weighted percentage 83.3%, while the lowest score was in "The nurses approach mothers in a calm manner" with mean score 2.30 and weighted percentage 76.6%.

These results reflected that nurses take necessary measures to help mothers feel comfort and safe. Being in labor is an event accompanied with fear and anxiety for many mothers, and feeling safe and secure is a major goal for mothers during labor process. The nurses play an important role in achieving this goal for mothers and that could be attained by responding properly to their queries, and their complaints. The nurses' tasks and responsibilities involve both medical-related interventions and non-medical activities. Having adequate time to talk with mothers, helping mothers in dressing and cleaning, decrease noise and crowd to the minimal level, and fulfill their needs will increase mothers' feeling of safety and security, and that will increase mothers' trust in nursing care.

Table (4.27c): Scores of checklist observation (Specific postpartum care domain)

Items	Always	Sometimes	No	Mean	SD	%	Rank
1. The nurses assist mothers to go to toilet.	40.0	40.0	20.0	2.20	0.78	73.3	11
2. The nurses inform mothers regarding how to keep their perineum hygienic.	40.0	60.0	0	2.40	0.51	80.0	3
3. The nurses assist mothers in early ambulation.	50.0	40.0	10.0	2.40	0.69	80.0	4
4. The nurses check and record vital signs regularly (BP, P, R, Temp).	100.0	0	0	3.00	0.00	100.0	1
5. The nurses teach mothers about involution of uterus.	50.0	30.0	20.0	2.30	0.82	76.6	8
6. The nurses teach mothers about uterus massage.	40.0	50.0	10.0	2.30	0.67	76.6	9
7. The nurses assess mothers' breast for any tenderness, cracked nipples, and engorgement.	30.0	20.0	50.0	1.80	0.91	60.0	16
8. The nurses explain to mothers how to take care of her breast.	10.0	40.0	50.0	1.60	0.69	53.3	17
9. The nurse teach mothers about nutrition in postnatal period.	50.0	30.0	20.0	2.30	0.82	76.6	10
10. The nurse inform mothers about importance of sleep and rest in postpartum period.	40.0	40.0	20.0	2.20	0.78	73.3	12
11. The nurses administer medication / treatment at proper time.	80.0	20.0	0	2.80	0.42	93.3	2
12. The nurses assess and record lochia flow in postpartum period.	50.0	40.0	10.0	2.40	0.69	80.0	5
13. The nurses teach mothers regarding how to detect excessive bleeding during puerperal period.	40.0	40.0	20.0	2.20	0.78	73.3	13
14. The nurses advise mothers about postpartum exercise.	40.0	20.0	40.0	2.00	0.94	66.6	14
15. The nurses assist mothers with episiotomy care.	40.0	60.0	0	2.40	0.51	80.0	6
16. The nurse inform mothers how to detect signs and symptoms of postpartum infection.	40.0	60.0	0	2.40	0.51	80.0	7
17. The nurses inform mothers about the importance of postpartum follow up visits.	30.0	30.0	40.0	1.90	0.87	63.3	15

Table (4.27c) presented the observed specific postpartum care performed by nurses. The highest score was in "The nurses check and record vital signs regularly (BP, P, R, Temp)" with mean score 3.0 and weighted percentage 100%, followed by "The nurses administer medication / treatment at proper time" with mean score 2.80 and weighted percentage 93.3%, and "The nurses inform mothers regarding how to keep their perineum hygienic" with mean score 2.40 and weighted percentage 80%, while the lowest score was in "The

nurses explain to mothers how to take care of her breast" with mean score 1.60 and weighted percentage 53.3%.

These results revealed variations in scores obtained in some activities. Specific interventions related to direct care such as checking and recording vital signs and administration of medication had the highest scores, while activities related to health education and instructions about breast-care and breast-feeding had the lowest scores. In my opinion, nurses usually focus on activities they think essential to prevent and or detect complications such as postpartum hemorrhage, so they check vital signs and inspect perineal area for bleeding, and perform uterine massage. However, short stay of mothers in the ward (around 4 hours and sometimes even less) do not give the nurses adequate time to set with the mothers and talk about other issues such as breast-care and breast-feeding. In addition, many mothers are multiparous and have an experience in breast-care and breast-feeding, so they do not feel that they are in need for instructions in this issue.

Table (4.27d): Scores of checklist observation (efficient care of the baby)

Items	Always	Sometimes	No	Mean	SD	%	Rank
1. The nurses assist mothers with giving care (bath, diaper care, cord and eye care) for my baby.	40.0	60.0	0	2.40	0.51	80.0	1
2. The nurses inform mothers about how to detect signs and symptoms of neonatal infection.	20.0	20.0	60.0	1.60	0.84	53.3	7
3. The nurses teach mothers about the importance of colostrum and breast feeding.	30.0	50.0	20.0	2.10	0.73	70.0	3
4. The nurse assist mothers to position her baby during and after breast feeding.	30.0	20.0	50.0	1.80	0.91	60.0	5
5. The nurses teach mothers how to burp her baby after breast feeding.	20.0	40.0	40.0	1.80	0.78	60.0	6
6. The nurses teach mothers about rooming in, bonding and attachment.	20.0	60.0	20.0	2.00	0.66	66.6	4
7. The nurses educate mothers about immunization of her baby.	10.0	30.0	60.0	1.50	0.70	50.0	8
8. The nurses check baby identification regularly and before discharge.	50.0	40.0	10.0	2.40	0.69	80.0	2

Table (4.27d) presented the observed efficient care of the baby performed by nurses. The highest score was in "The nurses assist mothers with giving care (bath, diaper care, cord

and eye care) for my baby" with mean score 2.40 and weighted percentage 80%, followed by "The nurses check baby identification regularly and before discharge" with mean score 2.40 and weighted percentage 80%, and "The nurses teach mothers about the importance of colostrum and breast feeding" with mean score 2.10 and weighted percentage 70%, while the lowest score was in "The nurses educate mothers about immunization of her baby" with mean score 1.50 and weighted percentage 50%. These results indicated that all aspects concerning health education about the care of the mother and her baby are at moderate level compared to other aspects of PPC.

The researcher' opinion; going home with a new baby is an exciting event, but it can be scary too, because newborns have many needs, like frequent feedings and diaper changes, cord care, and immunization. Mothers especially primiparous, need extensive health education and instructions about proper care of their baby. In addition, the nurse and midwive should refer the mother to the primary health care center for further follow up and immunization program for her baby.

Table (4.27e): Scores of checklist observation (Organizational context and orientation)

Items	Always	Sometimes	No	Mean	SD	%	Rank
1. The nurses welcome the mother on admission to postpartum ward.	50.0	50.0	0	2.50	0.52	83.3	1
2. The nurses orient the mother to the health team members.	40.0	60.0	0	2.40	0.51	80.0	2
3. The nurses orient the mother to the postpartum unit (toilet, bathroom, washing area ……).	40.0	20.0	40.0	2.00	0.94	66.6	7
4. The nurses inform the mother about visiting hours for her family.	30.0	30.0	40.0	1.90	0.87	63.3	8
5. The nurses work hard to maintain the ward is calm (no noise).	30.0	60.0	10.0	2.20	0.63	73.3	5
6. Nurses maintains client's room neat and organized.	40.0	50.0	10.0	2.30	0.67	76.6	4
7. There is good interrelationship between nurses and physicians	40.0	60.0	0	2.40	0.51	80.0	3
8. Nurses cooperate with physicians for the wellbeing of clients.	40.0	40.0	20.0	2.20	0.78	73.3	6

Table (4.27e) presented the observed organizational context and orientation. The highest score was in "The nurses welcome the mother on admission to postpartum ward" with mean score 2.50 and weighted percentage 83.3%, followed by "The nurses orient the mother to the health team members" with mean score 2.40 and weighted percentage 80%, and "There is good interrelationship between nurses and physicians" with mean score 2.40 and weighted percentage 80%, while the lowest score was in "The nurses inform the mother about visiting hours for her family" with mean score 1.90 and weighted percentage 63.3%.

These results showed variations in scoring. The items that under control of the nurses had higher scores such as welcoming the mother on admission and orientation to the ward, while other aspects are related to the organization and the system had lower scores such as visiting hours, and control of noise and crowd. The researcher's opinion; minimizing the number of visitors and controlling of noise are a multidisciplinary issue that need cooperation of nurses, physicians, security personnel, and administration. During the immediate postpartum period, the mother is weak, and exhausted, and she is in need for rest and comfort. Therefore, hospital administration should take further steps and decisions to control the crowd and noise in maternity hospitals to maintain safe, quiet environment which is essential for the well-being of the mother and her baby.

Table (4.27f): Scores of checklist observation (Specific care for CS women)

Items	Always	Sometimes	No	Mean	SD	%	Rank
1. The nurses check and record vital signs in immediate post op as follow (every 15 minutes in first hour, then every 30 minutes in second hour, and every hour for the next 4 hours).	60.0	40.0	0	2.60	0.54	86.6	4
2. The nurses observe the wound (surgical site) for signs of bleeding every 30 minutes for the first 4 hours.	40.0	40.0	20.0	2.20	0.83	73.3	10
3. The nurses check and record amount of blood from drains every shift.	60.0	20.0	20.0	2.40	0.89	80.0	7
4. The nurses position the woman in her lateral position until recovery of full consciousness.	40.0	20.0	40.0	2.00	1.00	66.6	11
5. The nurses observe for risk of airway obstruction in the immediate post op period.	60.0	20.0	20.0	2.40	0.89	80.0	8
6. The nurses ensure adequate IV fluids until patient passed urine and bowel sound have returned.	60.0	40.0	0	2.60	0.54	86.6	5
7. The nurses keep input/output records including drains and gastric tube if any.	80.0	20.0	0	2.80	0.44	93.3	1
8. The nurses check Hb routinely on the first post-operative day, and again as instructed.	80.0	20.0	0	2.80	0.44	93.3	2
9. The nurses clean the wound and keep it dry and inspect for signs and symptoms of inflammation.	60.0	40.0	0	2.60	0.54	86.6	6
10. The nurses encourage passive leg movement, deep breathing, postnatal exercise and early ambulation to prevent DVT.	40.0	20.0	40.0	2.00	1.00	66.6	12
11. The nurses encourage early and regular passing of urine.	60.0	20.0	20.0	2.40	0.89	80.0	9
12. The nurses assist the mother to breastfeed her baby as soon as possible.	20.0	40.0	40.0	1.80	0.83	60.0	13
13. The nurses give prophylactic antibiotic therapy as ordered.	80.0	20.0	0	2.80	0.44	93.3	3

Table (4.27f) presented the observed specific care for CS women. The highest score was in "The nurses keep input/output records including drains and gastric tube if any" with mean score 2.80 and weighted percentage 93.3%, followed by "The nurses check Hb routinely on the first post-operative day, and again as instructed" with mean score 2.80 and weighted percentage 93.3%, and "The nurses give prophylactic antibiotic therapy as ordered" with mean score 2.80 and weighted percentage 93.3%, while the lowest score was in "The nurses assist the mother to breastfeed her baby as soon as possible" with mean score 1.80 and weighted percentage 60%.

The postpartum period is one of the most challenging times for mothers and families. This period can be even more challenging for mothers who have had CS delivery. Nurses have to be careful in assessing and monitoring the mothers in the immediate post-operative period especially vital signs, inspection of wound for bleeding, IV fluid intake and output. In addition, the nurse and midwife will help the mother in breast-feeding of her baby, and other activities such as early ambulation and personal hygiene. The researcher's opinion that mothers who deliver by CS mode have better chance for health education and receiving instructions about her health and her baby because they stay longer time in the ward compared to NVD. Therefore, nurses and midwives have adequate time to set and talk with the mothers, give her instructions and respond to her questions and concerns.

Table (4.28): Mean scores and percentage of all checklists s domains

Domain	Mean	SD	%	Rank
1. Communication	2.56	0.47	85.3	1
2. Comfort and safety	2.48	0.42	82.6	2
3. Specific postpartum care	2.27	0.50	75.6	4
4. Efficient care of baby	1.95	0.57	65.0	6
5. Organizational context & Orientation	2.23	0.56	74.3	5
6. Specific care for CS women	2.41	0.54	80.3	3
Overall	**2.02**	**0.52**	**67.3**	

Table (4.28) showed that the highest score was in communication with mean score 2.56 and weighted percentage 85.3%, followed by comfort and safety with mean score 2.48 and weighted percentage 82.6%, specific care for CS women with mean score 2.41and weighted percentage 80.3%, specific postpartum care with mean score 2.27 and weighted percentage 75.6%, organizational context and orientation with mean score 2.23 and

weighted percentage 74.3%, and the lowest score was in efficient care of the baby with mean score 1.95 and weighted percentage 65%. The overall score of observed performance was above moderate (0-30 low,31-60 moderate, 61-90 above moderate, 91-100 high), with mean score 2.02 and weighted percentage 67.3%.

Inconsistent results obtained by a study carried out in different countries in Africa. The results showed that few women received postpartum care during the first week after childbirth; 25 % in Burkina Faso, 33 % in Kenya, 41 % in Malawi, and 40 % in Mozambique (Duysburgh et al., 2015). Another study carried out in West Bank, Palestine showed that only 36.7% of mothers received PPC. Among those who received PPC only 30.2% received counselling regarding family planning, while about two-thirds received counselling regarding breastfeeding (Dhaher et al., 2008).

PPC includes interventions directed toward the mother and her baby, and even her family. It is essential to give appropriate advice and instructions to prepare the mother for this new stage of her life before being discharged from the hospital. In addition to direct medical-related interventions to the mother and her baby such as checking vital signs, giving medication, physical assessment and inspection for abnormalities, the nurses also perform other nonmedical interventions such as communication, health education, assurance of the mother, and maintaining safe environment for the mother and her baby. The researcher' results reflected that the overall observed practice was above moderate, which raised the need to pay extra attention to different aspects of PPC including care of the baby.

4.5 Challenges and implications

4.5.1 Challenges to improve mothers' satisfaction with postpartum care

The researcher asked the mothers about issues that will increase their satisfaction with postpartum care. The majority of mothers talked about things related to comfort and privacy. The mothers complained of overcrowd, in each room there are 5 to 6 beds. They prefer to have one or two beds in each room, and that will make the room less crowded, give the mothers a chance to rest and sleep, and give them more privacy. Also, they

complain about the number of visitors and that the visitors are present all the time. In addition, they said that the toilets are inadequate and warm water is not available all the time, therefore, they can't take a shower to clean their body. Some mothers said that the number of nurses is not enough compared to the number of deliveries, so the nurses did not have time to talk with the mothers and did not have adequate instructions about self-care and care of her baby.

These challenges are measuring, and by putting more efforts and attention, the nurses can make the difference and increase level of mothers' satisfaction with postpartum care in the maternity hospitals in GS.

4.5.2 Implications to improve quality of postpartum care

The researcher asked the nurses about ways to improve23 quality of postpartum care. Most of the nurses mentioned that the number of nurses assigned each shift is inadequate compared to the number of women admitted to the ward. Also, they said that some nurses are newly employed and some are volunteers with low experience, and that affects the quality of care. In addition, the nurses complained that the doors are open all the time, and they can't control the visitors. They wanted specific time for visits and to have two visitors for every mother. Some nurses said that they can't approach the mother because the room is full of visitors.

Some of the nurses talked about written protocols and guidelines and the need to enforce these guidelines so that every nurse can do her tasks in a standard way.

Nursing care is the corner stone in the health system and play a major role in quality of healthcare services. Therefore, focusing on standards of care and empowering the nurses with support system from stakeholders will attain higher quality of nursing care in healthcare facilities.

Chapter Five

Conclusion, recommendations, and suggestions for further research

5.1 Conclusion

Providing high-quality PPC is a challenge for nurses because the postpartum period is a critical period for both the mother and her baby. This study aimed to identify mothers' satisfaction with PPC, and to assess quality of PPC at governmental maternity hospitals in GS. The study included 428 mothers (mean age 26.32±5.86 years), 115 nurses and midwives (mean age 30.965±6.007 years), and observation checklist about PPC practice of nurses.

The results of the study indicated that the mothers expressed above moderate satisfaction with PPC (0-30 low,31-60 moderate, 61-90 above moderate, 91-100 high), they received during their stay in postpartum department. In addition, the results reflected high quality PPC in governmental maternity hospitals in GS from the nurses' and midwives perspective. Moreover, observation of nurses and midwives indicated above moderate level of PPC. The study results revealed weakness in the provision of health education to the mothers and that could be related to work overload and short stay of mothers in postpartum department.

According to the weak points of nursing and midwives, the study raised the need to have unified, written protocols and guidelines that specify and describes nurses' and midwives' interventions during the postpartum period for the mother and her baby.

5.2 Recommendations

In the light of study results, the researcher recommends the following:

- Establish a steering committee of nurses and midwives to follow the Palestinian protocols and guidelines to optimize PPC at maternity hospitals.

- The need for discharge planning which should start from admission .
- The need to prolong the postpartum stay in the hospital to give nurses and midwives the opportunity to evaluate the mothers' condition and offer appropriate health education and instructions to mothers about care of herself and her baby.
- Health care providers in the hospitals should have a continuous education on the weakest points of nursing care specially communication and interpersonal relationship about the postpartum care.
- The need to include health educational pamphlets and instructions about PPC during antenatal visits, so mothers will be prepared and aware about necessary activities after delivery to care for herself and her baby.
- The need to integrate primary health care centers in home visits for newly delivered mothers and making follow up programss after discharge from the hospital to ensure continuity of care and early detection of complications.

5.3 Suggestions for further research:

- To assess mothers' awareness and understanding of the importance of PPC and follow up for the well-being of them and their babies.
- To evaluate adequacy of the health system to offer high quality maternity services.
- To conduct a study aiming to focus on psychological and emotional aspects during postpartum period.

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Annexes

Annex 1: Number of nurses, midwives and admitted postpartum women in governmental hospitals in Gaza Strip

Hospital	Admitted Postpartum Women 2016		Admitted Postpartum Women 2017	Mean Value	Percentage	Proportional Stratified Sample of PP mothers	Nurses Team
Shifa Medical Complex	CS	4618	4809	4713	44.6%	45	10 Nurses
	NVD	13266	14852	14059		133	6Nurses
Nasser Medical Complex	CS	2086	2158	2122	23.68%	20	16 Nurses
	NVD	7696	7978	7837		75	17 Nurses
Shohada Alaqsa	CS	1364	1270	1317	15.59%	13	14 Nurses
	NVD	5203	5280	5241		50	22Nurses
Alemarati	CS	1360	1488	1424	16.06%	14	11 nurses
	NVD	5070	5592	5331		50	12Nurses
Total	CS + NVD	40663	43427	42044	100%	400	115 nurses

Number of nurses, midwives and admitted postpartum women in Kamal Odwan Hospital

Number of nurses ad midwife	Number of mothers
7	81

Annex 2: Consent form

بسم الله الرحمن الرحيم

عزيزتي الحكيمة الفاضلة:

السلام عليكم ورحمة الله وبركاته

بين أيديكم استبانة خاصة برسالة الماجستير تهدف لتحديد مستوى جودة الرعاية الصحية المقدمة بعد الولادة في مستشفيات وزارة الصحة في محافظات غزة.

يرجى الإجابة على جميع فقرات الاستبانة بشكل أمين، حيث أنه لا توجد إجابات خاطئة ولكن ذلك للتعبير عن رأيك الشخصي، مع العلم أن المعلومات التي سيتم جمعها سوف تستخدم لأغراض البحث العلمي فقط، ولا داعي لكتابة اسمك الشخصي.

نشكركم على حسن تعاونكم

الباحثة

وفاء ابوجبر

Annex 3A: Mothers' Satisfaction from Postpartum Care

Personal information:

1	Hospital name:	……..
2	Mode of delivery:	☐ NVD ☐ CS
3	Age of mother:	…….. years
4	Education level:	☐ Elementary ☐ Prep. ☐ Secondary ☐ University
	Family type	☐ Nuclear ☐ Extended
5	Working status:	☐ Working ☐ Housewife
6	Monthly income:	☐ less than 1832 IS ☐ 1832 - 2293 IS ☐ more than 2293 IS
7	Gravida:	☐ First time ☐ 2 – 4 times ☐ 5 times & more
8	Para:	☐ First time ☐ 2 – 4 times ☐ 5 times & more
9	Current birth outcome:	☐ Single baby ☐ Twins

less than 1832 IS (low income), 1832 - 2293 IS (middle income), more than 2293 IS (high income)

Satisfaction from postpartum care:

No.	Items	Highly satisfied	Satisfied	Neutral	Dissatisfied	Highly dissatisfied
Communication						
1	Level of satisfaction about how nurses answered your questions.					
2	Level of satisfaction from interpersonal relations with nurses.					
3	Level of satisfaction from interpersonal relations with my family members.					
4	Level of satisfaction about the way nurses communicated with you.					
5	Level of satisfaction about the way nurses answered questions asked by me concerning my health status.					
6	Level of satisfaction from the way nurse dealt with me (dignity and respect).					
Comfort and safety						
1	Level of satisfaction from the amount of help I got from nurses.					
2	Level of satisfaction from the way nurses approached me.					
3	Level of satisfaction from nurses assistance in keeping myself clean & groomed.					
4	Level of satisfaction about the feeling of safe and secured during hospital stay.					
5	Level of satisfaction about the feeling of comfort throughout stay in postpartum ward.					
Specific postpartum care						
1	Level of satisfaction from nurses assistance when I needed to go to toilet.					
2	Level of satisfaction about nurses information regarding how					

	to keep my perineum hygienic.					
3	Level of satisfaction from nurses assistance in early ambulation.					
4	Level of satisfaction about the frequency nurses checked my vital signs (BP, P, R, Temp).					
5	Level of satisfaction about how nurses taught me about involution of uterus.					
6	Level of satisfaction from nurses teaching about how to perform uterus massage.					
7	Level of satisfaction from nurses teaching about breast examination including tenderness, cracked nipples, and engorgement.					
8	Level of satisfaction from nurses explanation about care of my breast.					
9	Level of satisfaction from nurses information regarding nutrition in postnatal period.					
10	Level of satisfaction from nurses information about sleep and rest in postnatal period.					
11	Level of satisfaction from the way nurses administered medication / treatment.					
12	Level of satisfaction from nurses information regarding lochia flow in postpartum period.					
13	Level of satisfaction from nurses information regarding how to detect excessive bleeding during puerperal period.					
14	Level of satisfaction from nurses advise about postpartum exercise.					
15	Level of satisfaction from nurses assistance with episiotomy care.					
16	Level of satisfaction from nurses information about signs and symptoms of postpartum infection.					
17	Level of satisfaction from nurses information about the importance of postpartum follow up visits.					
Efficient care of my baby						
1	Level of satisfaction from nurses assistance with giving care (bath, diaper care, cord and eye care) for my baby.					
2	Level of satisfaction from nurses information about signs and symptoms of neonatal infection.					
3	Level of satisfaction from nurses teaching about the importance of colostrum and breast feeding.					
4	Level of satisfaction from nurses assistance to position my baby during and after breast feeding.					
5	Level of satisfaction from nurses teaching how to burp my baby after breast feeding.					
6	Level of satisfaction from nurses teaching about rooming in, bonding and attachment.					
7	Level of satisfaction from nurses education about immunization of my baby.					
Organizational context & Orientation						
1	Level of satisfaction from the way nurses welcomed me on admission to postpartum ward.					
2	Level of satisfaction from the way nurses oriented me to the health team members.					
3	Level of satisfaction from the way nurses oriented me to the postpartum unit (toilet , bathroom, washing area ……).					
4	Level of satisfaction from received information about visiting hours for my family.					
5	Level of satisfaction from the calm (no noise) during my stay in the ward.					

6	Level of satisfaction from the neatness and organization of my room.					
7	Level of satisfaction from the interrelationship between nurses and physicians.					
8	Level of satisfaction from the cooperation between physicians and nurses.					
Overall satisfaction						
	How you rate your overall satisfaction during your stay in postpartum ward?					

In your opinion. What are the main challenges that you face in the hospital?

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Thank you for your cooperation

بسم الله الرحمن الرحيم

Annex-3B:

السيدة الفاضلة:

السلام عليكم ورحمة الله وبركاته

بين أيديكم استبانة خاصة برسالة الماجستير تهدف لتحديد مستوى جودة الرعاية الصحية المقدمة بعد الولادة في مستشفيات وزارة الصحة في محافظات غزة.

يرجى الاستجابة على جميع فقرات الاستبانة بشكل أمين، حيث أنه لا توجد إجابات خاطئة ولكن ذلك للتعبير عن رأيك الشخصي، مع العلم أن المعلومات التي سيتم جمعها سوف تستخدم لأغراض البحث العلمي فقط، ولا داعي لكتابة اسمك الشخصي.

نشكر حسن تعاونكم.

الباحثة

وفاء جبر

أولاً: البيانات الشخصية

اسم المستشفى: .....

طريقة الولادة: □ طبيعية □ قيصرية

العمر: ..... سنة

المستوى التعليمي: □ ابتدائي □ إعدادي □ ثانوي □ جامعي

نوع العائلة: □ نووية □ ممتدة

العمل: □ تعمل □ لا تعمل

الدخل الشهري بالشيكل: □ أقل من 1832 شيكل □ 1832 – 2293 شيكل □ أكثر من 2293 شيكل

عدد مرات الحمل: □ أول مرة □ 2 – 4 مرات □ 5 مرات فأكثر

عدد مرات الولادة: □ أول مرة □ 2 – 4 مرات □ 5 مرات فأكثر

نتيجة الحمل: □ ولادة طفل واحد □ ولادة توأم

الرضى عن الرعاية الصحية بعد الولادة

ضعي علامة (x) مقابل كل عبارة مما يلي:

الرقم	العبـــــارة	راضية بشكل كبير	راضية	محايدة	غير راضية	غير راضية بشكل كبير
	الاتصال والتواصل					
1	مدى الرضى عن كيفية إجابة الممرضات عن أسئلتك.					
2	مدى الرضى عن علاقتك بالممرضات.					
3	مدى الرضى عن علاقة أفراد أسرتك بالممرضات.					
4	مدى الرضى عن كيفية الاتصال والتواصل مع الممرضات.					
5	مدى الرضى عن كيفية إجابة الممرضات عن أسئلتك المتعلقة بوضعك الصحي.					
6	مدى الرضى عن كيفية تعامل الممرضات معك (باحترام وكرامة)					
	الراحة والشعور بالأمان					
1	مدى الرضى عن مساعدة الممرضات لك.					
2	مدى الرضى عن كيفية تجاوب الممرضات معك.					
3	مدى الرضى عن قيام الممرضات بتقديم المساعدة في نظافتك الشخصية وظهورك بشكل مرتب / لائق.					
4	مدى الرضى عن درجة الشعور بالأمن والأمان أثناء مكوثك في القسم					
5	مدى الرضى عن درجة الشعور بالراحة أثناء مكوثك في القسم					
	العناية التمريضية بعد الولادة					
1	مدى الرضى عن قيام الممرضات بمساعدتك عن الحاجة للذهاب إلى الحمام.					
2	مدى الرضى عن المعلومات التي قدمتها الممرضات حول كيفية المحافظة على نظافة جسمك (منطقة ومحيط المهبل).					
3	مدى الرضى عن قيام الممرضات بتقديم المساعدة في التحرك المبكر خارج السرير.					
4	مدى الرضى عن قيام الممرضات بفحص علامات الحياة (ضغط، حرارة، نبض، تنفس).					
5	مدى الرضى عن المعلومات التي قدمتها الممرضات حول عودة الرحم إلى الوضع الطبيعي.					
6	مدى الرضى عن التعليمات التي قدمتها الممرضات حول العناية بالثدي					
7	مدى الرضى عن المعلومات التي قدمتها الممرضات حول التغذية السليمة بعد الولادة.					

الرقم	العبـــــارة	راضية بشكل كبير	راضية	محايدة	غير راضية	غير راضية بشكل كبير
8	مدى الرضى عن المعلومات التي قدمتها الممرضات حول الراحة والنوم في فترة ما بعد الولادة.					
9	مدى الرضى عن كيفية قيام الممرضات بإعطاء الأدوية والعلاجات لك					
10	مدى الرضى عن المعلومات التي قدمتها الممرضات حول نزول الدم والإفرازات بشكل طبيعي بعد الولادة.					
11	مدى الرضى عن المعلومات التي قدمتها الممرضات حول نزول الدم بشكل غير طبيعي (نزيف) بعد الولادة.					
12	مدى الرضى عن النصائح التي قدمتها الممرضات حول ممارسة التمارين الرياضية بعد الولادة.					
13	مدى الرضى عن المساعدة التي قدمتها الممرضات للعناية بشق العجان / بضع المهبل (ابيسيوتومي).					
14	مدى الرضى عن المعلومات التي قدمتها الممرضات حول مظاهر الالتهابات بعد الولادة.					
15	مدى الرضى عن المعلومات التي قدمتها الممرضات حول ضرورة المتابعة الطبية بعد الولادة.					
العناية بالطفل المولود						
1	مدى الرضى عن قيام الممرضات بالمساعدة في العناية بطفلك (حمام، تغيير بمبرز، تنظيف الحبل السري).					
2	مدى الرضى عن المعلومات التي قدمتها الممرضات حول مظاهر الالتهابات لدى الأطفال حديثي الولادة.					
3	مدى الرضى عن المعلومات التي قدمتها الممرضات حول أهمية الرضاعة الطبيعية.					
4	مدى الرضى عن المساعدة التي قدمتها الممرضات في وضع الطفل أثناء وبعد الرضاعة.					
5	مدى الرضى عن المساعدة التي قدمتها الممرضات حول كيفية تجشؤ الطفل بعد الرضاعة.					
6	مدى الرضى عن التعليمات التي قدمتها الممرضات حول كيفية حمل الطفل واحتضانه بطريقة صحيحة.					
7	مدى الرضى عن المعلومات التي قدمتها الممرضات حول ضرورة تطعيم الطفل حسب برنامج الرعاية الأولية.					
التنظيم والمعرفة بالمستشفى						
1	مدى الرضى عن كيفية استقبال الممرضات لك عند الدخول للقسم.					
2	مدى الرضى عن قيام الممرضات بتعريفي على فريق العمل في القسم.					

الرقم	العبـــــارة	راضية بشكل كبير	راضية	محايدة	غير راضية	غير راضية بشكل كبير
3	مدى الرضى عن قيام الممرضات بتعريفي على القسم (الحمام، دورة المياه، مكان الغسيل، ....).					
4	مدى الرضى عن قيام الممرضات بتعريفي أوقات الزيارة المسموحة لأقاربي.					
5	مدى الرضى عن مستوى الهدوء في القسم.					
6	مدى الرضى عن تنظيم وترتيب الغرفة التي أمكث بها.					
7	مدى الرضى عن العلاقة التفاعلية بين الممرضات والأطباء في القسم.					
8	مدى الرضى عن التعاون بين الممرضات والأطباء في القسم.					
الرضى العام						
	ما هي درجة الرضى العام عن فترة مكوثك في القسم بعد الولادة؟					

أختي الفاضلة حسب وجهة نظرك ماهي أهم التحديات التي واجهتك خلال فترة وجودك في أقسام ما بعد الولادة؟

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شكرا لتعاونكم

Annex 4A: Quality of Postpartum Care (Nurses Questionnaire)

Personal information:

1	Hospital name:	……..
3	Age of nurse:	……. years
4	Qualification:	☐ Diploma (2 years) ☐ Bachelor ☐ Postgraduate
5	Years of experience:	☐ 1 - 5 year ☐ 6 – 10 years ☐ 11 years and more
6	Monthly income:	☐less than 1832 IS ☐ 1832 - 2293 IS ☐ more than 2293 IS
7	Marital status:	☐ Single ☐ Married ☐ Divorced / widow

less than 1832 IS (low income), 1832 - 2293 IS (middle income), more than 2293 IS (high income)

Quality of postpartum care:

No.	Items	Always	Often	Sometimes	Seldom	Never
Communication						
1	I answer all the mother's questions promptly with positive attitude.					
2	I maintain a good interpersonal relations with the mother.					
3	I maintain a good interpersonal relations with the mother's family.					
4	I communicate with mothers in a language that they understand.					
5	I answer questions asked by mothers concerning her health status.					
6	I treat mothers with dignity and respect.					
Comfort and safety						
1	I offer help to mothers when needed.					
2	I approach mothers in a calm manner.					
3	I assist mothers in keeping herself clean & groomed.					
4	I keep mothers safe and secured during their stay in postpartum unit.					
5	I keep mothers comfort during their stay in postpartum unit.					
Specific postpartum care						
1	I assist mothers to go to toilet.					
2	I inform mothers regarding how to keep their perineum hygienic.					
3	I assisted mothers in early ambulation.					
4	I check and record vital signs regularly (BP, P, R, Temp).					
5	I teach mothers about involution of uterus.					
6	I teach mothers about uterus massage.					
7	I assess mothers' breast for any tenderness, cracked nipples, and engorgement.					
8	I explain to mothers how to take care of her breast.					
9	I teach mothers about nutrition in postnatal period.					
10	I inform mothers about importance of sleep and rest in postpartum period.					
11	I administer medication / treatment at proper time.					

12	I assess and record lochia flow in postpartum period.					
13	I teach mothers regarding how to detect excessive bleeding during puerperal period.					
14	I advise mothers about postpartum exercise.					
15	I assist mothers with episiotomy care.					
16	I inform mothers how to detect signs and symptoms of postpartum infection.					
17	I inform mothers about the importance of postpartum follow up visits.					
18	I check Rh for the mother and give anti D as needed.					
Efficient care of baby						
1	I assist mothers with giving care (bath, diaper care, cord and eye care) for my baby.					
2	I inform mothers about how to detect signs and symptoms of neonatal danger signs.					
3	I teach mothers about the importance of colostrum and breast feeding.					
4	I assist mothers to position her baby during and after breast feeding.					
5	I teach mothers how to burp her baby after breast feeding.					
6	I teach mothers about rooming in, bonding and attachment.					
7	I educate mothers about immunization of her baby.					
8	I check baby identification regularly and before discharge.					
Organizational context & Orientation						
1	I welcome every mother on admission to postpartum ward.					
2	The mother is oriented to the health team members.					
3	The mother is oriented to the postpartum unit (toilet , bathroom, washing area ……).					
4	The mother receives information about visiting hours for her family.					
5	I work hard to maintain the ward calm (no noise).					
6	I try to maintain client's room neat and organized.					
7	I have good relationship with physicians.					
8	I cooperate with physicians for the wellbeing of clients.					
Specific for CS women						
1	I check and record vital signs in immediate post op as follow (every 15 minutes in first hour, then every 30 minutes in second hour, and every hour for the next 4 hours).					
2	I observe the wound (surgical site) for signs of bleeding every 30 minutes for the first 4 hours.					
3	I check and record amount of blood from drains every shift.					
4	I position the woman in left lateral position until recovery of full consciousness.					
5	I observe for risk of airway obstruction in the immediate post op period.					
6	I ensure adequate IV fluids until patient passed urine and bowel sound have returned.					
7	Keep input/output records including drains and gastric tube if any.					
8	Check Hb routinely on the first post-operative day, and again as instructed.					
9	Clean the wound and keep it dry and inspect for signs and symptoms of inflammation.					
10	Encourage passive leg movement, deep breathing, postnatal exercise and early ambulation to prevent DVT.					

11	Encourage early and regular passing of urine.					
12	Assist the mother to breastfeed her baby as soon as possible.					
13	Give prophylactic antibiotic therapy as ordered.					

In your opinion, what are the challenges that prevent offering high quality of postpartum care?

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Thank you for your cooperation

Annex 4B:

أولاً: البيانات الشخصية

اسم المستشفى: .....

العمر: ..... سنة

المستوى التعليمي: □ دبلوم سنتان □ بكالوريوس □ دراسات عليا

سنوات الخبرة: □ 1 – 5 سنوات □ 6 – 10 سنوات □ 11 سنة فأكثر

الدخل الشهري بالشيكل: □ أقل من 1832 شيكل □ 1832 – 2293 شيكل □ أكثر من 2293 شيكل

الحالة الاجتماعية: □ آنسة □ متزوجة □ مطلقة / أرملة

تقييم جودة الرعاية ما بعد الولادة

ضعي علامة (x) مقابل كل عبارة مما يلي:

الرقم	العبـــارة	راضية بشكل كبير	راضية	محايدة	غير راضية	غير راضية بشكل كبير
	الاتصال والتواصل					
1	أقوم بالإجابة على أسئلة الأم مباشرة وبشكل إيجابي.					
2	أحافظ على علاقة جيدة مع الأمهات.					
3	أحافظ على علاقة جيدة مع عائلات / مرافقات الأمهات.					
4	أتحدث مع الأمهات بلغة يفهمنها.					
5	أجيب على تساؤلات الأم المتعلقة بوضعها الصحي.					
6	أتعامل مع الأمهات بشكل محترم يحافظ على كرامتها.					
	الراحة والشعور بالأمان					
1	أقدم المساعدة للأمهات عند الحاجة.					
2	أتعامل مع الأمهات بشكل هادئ.					
3	أساعد الأمهات في الحفاظ على النظافة الشخصية والظهور بشكل مرتب / لائق.					
4	أحافظ على شعور الأمهات بالأمن والأمان أثناء مكوثهن في القسم					
5	أحافظ على شعور الأمهات بالراحة أثناء مكوثهن في القسم.					

الرقم	العبـــــارة	راضية بشكل كبير	راضية	محايدة	غير راضية	غير راضية بشكل كبير
العناية التمريضية بعد الولادة						
1	أقوم بمساعدة الأمهات عند الحاجة للذهاب إلى الحمام.					
2	أزود الأمهات بالمعلومات الضرورية حول كيفية المحافظة على نظافة لجسم (منطقة ومحيط المهبل).					
3	أساعد الأمهات في التحرك المبكر خارج السرير.					
4	أقوم بفحص علامات الحياة وتسجيلها (ضغط، حرارة، نبض، تنفس)					
5	أقدم للأمهات معلومات حول عودة الرحم إلى الوضع الطبيعي.					
6	أقوم بتعليم الأمهات كيفية إجراء تدليك الرحم.					
7	أقوم بفحص ثدي الأم (ألام، تشققات، احتقان).					
8	أقوم بتوضيح كيفية العناية بالثدي للأمهات.					
9	أقدم للأمهات معلومات حول التغذية السليمة في فترة ما بعد الولادة					
10	أقدم للأمهات معلومات حول الراحة والنوم بشكل كافي في فترة ما بعد الولادة.					
11	أعطي الأدوية والعلاجات للأمهات في أوقاتها المحددة.					
12	أقوم بفحص وتسجيل كمية الدم والإفرازات التي تخرج من الأمهات بعد الولادة.					
13	أقوم بتعليم الأمهات كيفية التعرف على النزيف الذي قد يحدث بعد الولادة.					
14	أقدم نصائح للأمهات عن ضرورة ممارسة التمارين الرياضية بعد الولادة.					
15	أساعد الأمهات في العناية بشق العجان (episiotomy care) .					
16	أشرح للأمهات علامات حدوث التهابات ما بعد الولادة.					
17	أشرح للأمهات ضرورة المتابعة الطبية بعد الولادة.					
18	أقوم بفحص العامل الريسومي (RH) للأمهات وإعطاء حقنة (antiD) حسب الحاجة.					
العناية بالطفل المولود						
1	أقوم بمساعدة الأم في العناية بطفلها (حمام، تغيير بمبرز، تنظيف الحبل السري).					
2	أشرح للأمهات حول مظاهر الالتهابات لدى الأطفال حديثي الولادة.					
3	أشرح للأمهات أهمية الرضاعة الطبيعية.					

الرقم	العبـــــارة	راضية بشكل كبير	راضية	محايدة	غير راضية	غير راضية بشكل كبير
4	أقدم المساعدة للأم في وضع الطفل بشكل صحيح أثناء وبعد الرضاعة					
5	أقوم بتعليم الأمهات حول كيفية تجشؤ الطفل بعد الرضاعة.					
6	أقوم بتعليم الأمهات حول كيفية حمل الطفل واحتضانه بطريقة صحيحة					
7	أقوم بالشرح للأمهات حول ضرورة تطعيم الطفل حسب برنامج الرعاية الأولية.					
8	أقوم بالتحقق من الطفل من خلال إسورة التعريف خلال تواجد الطفل في القسم وعند الخروج من القسم.					
التنظيم والمعرفة بالمستشفى						
1	استقبل الأمهات بترحاب عند الدخول للقسم.					
2	أقوم بتعريف الأم على فريق العمل في القسم.					
3	أقوم بتعريف الأمهات على القسم (الحمام، دورة المياه، مكان الغسيل، ....).					
4	أقوم بتعريف الأمهات بأوقات الزيارة المسموحة للأقارب.					
5	أعمل بجد للمحافظة على مستوى مقبول من الهدوء في القسم.					
6	أعمل بجد للمحافظة على غرفة الأمهات نظيفة ومرتبة.					
7	أحافظ على علاقة حسنة مع الأطباء في القسم.					
8	أتعاون مع الأطباء في القسم من أجل مصلحة الأمهات.					
خاص بالأمهات اللاتي ولدن ولادة قيصرية						
1	أقوم بفحص وتسجيل علامات الحياة مباشرة بعد العملية، كل 15 دقيقة أول ساعة، ثم كل 30 دقيقة في الساعة الثانية، ثم كل ساعة خلال الأربع ساعات التالية.					
2	أقوم بفحص مكان العملية كل 30 دقيقة خلال أول أربع ساعات بعد العملية القيصرية.					
3	أقوم بفحص وتسجيل كمية الدم المتجمع في الكيس drain كل مناوبة.					
4	أقوم بوضع الأم على جانبها الأيسر حتى تفيق بشكل كامل من التخدير.					
5	أتفحص مخاطر إغلاق مجرى التنفس في الفترة الحرجة ما بعد العملية.					
6	أعطي الأم كمية كافية من السوائل الوريدية لضمان خروج كمية كافية من البول وحتى تعود حركة الأمعاء لطبيعتها.					
7	أقوم بتسجيل كمية السوائل الداخلة والخارجة.					

الرقم	العبـــــارة	راضية بشكل كبير	راضية	محايدة	غير راضية	غير راضية بشكل كبير
8	يتم فحص الهيموغلوبين أول يوم بعد العملية وحسب الحاجة.					
9	أقوم بعمل غيار على الجرح وفحص علامات الالتهاب في الجرح.					
10	أشجع الأم على إجراء تمارين في السرير، تحريك الأرجل، تنفس عميق، والتحرك المبكر خارج السرير لمنع حدوث جلطات.					
11	أشجع الأم على الذهاب للحمام عدة مرات لتفريغ المثانة.					
12	أقوم بمساعدة الأم في إرضاع طفلها في أقرب وقت ممكن.					
13	يتم إعطاء الأمهات مضاد حيوي لتفادي حدوث التهابات بعد العملية.					

من وجهة نظرك، ما هي أهم التحديات التي تمنعك من تقديم عناية نوعية للأمهات بعد الولادة؟

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شكراً لحسن تعاونكم ،،،،

Annex 5: Checklist observation

Hospital name:	……

Items	Always	Sometimes	No
Communication			
7. The nurse respond to all the mother's questions promptly with positive attitude.			
8. The nurses maintain a good interpersonal relations with the mother.			
9. The nurses maintain a good interpersonal relations with the mother's family.			
10. The nurses communicate with mothers in a language that they understand.			
11. The nurses answer questions asked by mothers concerning their health status.			
12. The nurses treat mothers with dignity and respect.			
Comfort and safety			
6. The nurses offer help to mothers when needed.			
7. The nurses approach mothers in a calm manner.			
8. The nurses assist mothers in keeping self-clean & groomed.			
9. The nurses keep mothers safe and secured during their stay in postpartum unit.			
10. The nurses keep mothers comfort during their stay in postpartum unit.			
Specific postpartum care			
18. The nurses assist mothers to go to toilet.			
19. The nurses inform mothers regarding how to keep their perineum hygienic.			
20. The nurses assist mothers in early ambulation.			
21. The nurses check and record vital signs regularly (BP, P, R, Temp).			
22. The nurses teach mothers about involution of uterus.			
23. The nurses teach mothers about uterus massage.			
24. The nurses assess mothers' breast for any tenderness, cracked nipples, and engorgement.			
25. The nurses explain to mothers how to take care of her breast.			
26. The nurse teach mothers about nutrition in postnatal period.			

Items	Always	Sometimes	No
27. The nurse inform mothers about importance of sleep and rest in postpartum period.			
28. The nurses administer medication / treatment at proper time.			
29. The nurses assess and record lochia flow in postpartum period.			
30. The nurses teach mothers regarding how to detect excessive bleeding during puerperal period.			
31. The nurses advise mothers about postpartum exercise.			
32. The nurses assist mothers with episiotomy care.			
33. The nurse inform mothers how to detect signs and symptoms of postpartum infection.			
34. The nurses inform mothers about the importance of postpartum follow up visits.			
Efficient care of baby			
9. The nurses assist mothers with giving care (bath, diaper care, cord and eye care) for my baby.			
10. The nurses inform mothers about how to detect signs and symptoms of neonatal infection.			
11. The nurses teach mothers about the importance of colostrum and breast feeding.			
12. The nurse assist mothers to position her baby during and after breast feeding.			
13. The nurses teach mothers how to burp her baby after breast feeding.			
14. The nurses teach mothers about rooming in, bonding and attachment.			
15. The nurses educate mothers about immunization of her baby.			
16. The nurses check baby identification regularly and before discharge.			
Organizational context & Orientation			
9. The nurses welcome the mother on admission to postpartum ward.			
10. The nurses orient the mother to the health team members.			
11. The nurses orient the mother to the postpartum unit (toilet , bathroom, washing area ……).			
12. The nurses inform the mother about visiting hours for her family.			
13. The nurses work hard to maintain the ward is calm (no noise).			
14. Nurses maintains client's room neat and organized.			
15. There is good interrelationship between nurses and physicians			
16. Nurses cooperate with physicians for the wellbeing of clients.			

Items	Always	Sometimes	No
Specific for CS women			
14. The nurses check and record vital signs in immediate post op as follow (every 15 minutes in first hour, then every 30 minutes in			
15. The nurses observe the wound (surgical site) for signs of bleeding every 30 minutes for the first 4 hours.			
16. The nurses check and record amount of blood from drains every shift.			
17. The nurses position the woman in left lateral position until recovery of full consciousness.			
18. The nurses observe for risk of airway obstruction in the immediate post op period.			
19. The nurses ensure adequate IV fluids until patient passed urine and bowel sound have returned.			
20. The nurses keep input/output records including drains and gastric tube if any.			
21. The nurses check Hb routinely on the first post-operative day, and again as instructed.			
22. The nurses clean the wound and keep it dry and inspect for signs and symptoms of inflammation.			
23. The nurses encourage passive leg movement, deep breathing, postnatal exercise and early ambulation to			
24. The nurses encourage early and regular passing of urine.			
25. The nurses assist the mother to breastfeed her baby as soon as possible.			
26. The nurses give prophylactic antibiotic therapy as ordered.			

Annex 6: Helsinki Committee

المجلس الفلسطيني للبحث الصحي

Palestinian Health Research Council

Developing the Palestinian health system through institutionalizing the use of evidence in decision making

Helsinki Committee
For Ethical Approval

Date: 05/02/2018 **Number:** PHRC/HC/347/18

Name: WAFA ABUJABER الاسم

We would like to inform you that the committee had discussed the proposal of your study about

نفيدكم علما بأن اللجنة قد ناقشت مقترح دراستكم حول:

The Quality of Postpartum care at Governmental Hospitals in Gaza Strip: Challenges and Implications.

The committee has decided to approve the above mentioned research. Approval number PHRC/HC/347/18 in its meeting on 05/02/2018

و قد قررت الموافقة على البحث المذكور عليه بالرقم والتاريخ المذكورين عليه

Signature

Member Member

Chairman

5/2/2018

Genral Conditions:-

1. Valid for 2 years from the date of approval
2. It is necessary to notify the committee of any change in the approved study protocol
3. The committee appreciates receiving a copy of your final research when completed

Specific Conditions:-

Annex 7: Approval

State of Palestine
Ministry of health

دولة فلسطين
وزارة الصحة

السيد : رامي عيد سليمان العبادله المحترم

التاريخ:17/04/2018
رقم المراسلة 210183

مدير عام بالوزارة /الإدارة العامة لتنمية القوى البشرية - /وزارة الصحة

السلام عليكم ،،،

الموضوع/ تسهيل مهمة الباحثة//وفاء أبوجبر

التفاصيل //
بخصوص الموضوع أعلاه، يرجي تسهيل مهمة الباحثة/ **وفاء محمود أبوجبر**
الملتحقة ببرنامج ماجستير التمريض – تخصص صحة الأم والطفل- جامعة القدس أبوديس في إجراء بحث بعنوان:-
"The Quality of Postpartum Care at Governmental Hospitals in Gaza Strip: Challenges and Implications"
حيث الباحث بحاجة لتعبئة استبانة من عدد من القابلات العاملات في مجمع الشفاء الطبي ومجمع ناصر ومستشفى شهداء الأقصى ومستشفى الهلال الاماراتي وكذلك عدد من الأمهات بعد الولادة في هذه المستشفيات وكذلك تعبئة نموذج ملاحظة في اقسام ما بعد الولادة.
نأمل توجيهاتكم لذوي الاختصاص بضرورة الحصول على الموافقة المستنيرة من النساء اللاتي هن على استعداد للمشاركة في الدراسة ومن ثم تمكين الباحثة من التواصل معهن، بما لا يتعارض مع مصلحة العمل وضمن أخلاقيات البحث العلمي، ودون تحمل الوزارة أي أعباء أو مسئولية.
وتفضلوا بقبول التحية والتقدير،،،
ملاحظة/ البحث حصل على موافقة لجنة اخلاقيات البحث الصحي
ملاحظة / تسهيل المهمة الخاص بالدراسة أعلاه صالح لمدة 6 شهر من تاريخه.

محمد ابراهيم محمد السرساوي
مدير دائرة/الإدارة العامة لتنمية القوى البشرية -

أ. زهير محمود نوفل
مدير عام مجمع الشفاء الطبي

Gaza Tel. (+970) 8-2846949 Fax. (+970) 8-2826295
غزة تلفون. (+970) 8-2846949 فاكس. (+970) 8-2826295

عنوان الدراسة: جودة الرعاية الصحية بعد الولادة في مستشفيات قطاع غزة الحكومية: الدلالات والتحديات.

إعداد: وفاء محمود أبو جبر

إشراف: أ.د. يوسف الجيش

ملخص الدراسة

الخدمات الصحية المقدمة للأمهات بعد الولادة تشكل عنصرا أساسياً في خدمات صحة الأم والطفل في أي مجموعة سكانية. وفقًا لوزارة الصحة الفلسطينية، بلغ معدل وفيات الأمهات في قطاع غزة 100000/30 ولادة حية في عام 2014، و 25 في عام 2015، وهو ما يختلف عن ذلك في الضفة الغربية مع 100/20، 000 في عام 2014 (بوتشر، وآخرون، 2018). الغرض من هذه الدراسة هو تقييم جودة الرعاية بعد الولادة المقدمة في المستشفيات الحكومية في قطاع غزة، وتحديد مدى رضا الأمهات عن الرعاية بعد الولادة، بدأت الدراسة من مايو 2018 حتى مارس 2019، وقد استخدمت الباحثة تصميمًا وصفيًا وتحليليًا مستعرضًا. تكونت عينة الدراسة من 115 ممرضة وقابلة تعمل في أقسام ما بعد الولادة (وحدات الولادة الطبيعي ووحدات الولادة القيصرية) في المستشفيات الحكومية بقطاع غزة (مستشفى الشفاء، مستشفى ناصر، مستشفى شهداء الأقصى، ومستشفى الإماراتي)، و 428 أمهات بعد الولادة من نفس المستشفيات، اختارت الباحثة هذه العينة حسب متوسط عدد حالات 2016 و 2017 لجمع البيانات، وقد طورت الباحثة ثلاث أدوات: جودة رعاية ما بعد الولادة (وجهة نظر تمريض)، ورضا الأمهات عن رعاية ما بعد الولادة، وقائمة تدقيق و مراقبة للرعاية التمريضية، وساعدها خمس ممرضات مدرّبات في جمع البيانات.

لقد تم اختبار أدوات الاستبيان وكان معامل كرو نباخ ألفا 0.965 لقياس الثبات، و 0.852 لجودة الرعاية بعد الولادة. استخدمت الباحثة برنامج SPSS الإصدار (22) لتحليل البيانات، وشمل التحليل الإحصائي التكرارات والنسبة المئوية والمتوسطات الحسابية والانحراف المعياري واختبار (t) واختبار تحليل التباين الأحادي في اتجاه واحد.

أظهرت النتائج أن متوسط عمر الأمهات كان 26.32 ± 5.86 سنة، وكان 75.2 ٪ من الولادة الطبيعية المهبلية، 30.1 ٪ سيدة بكر، 95.8 ٪ لديها طفل واحد. بالإضافة إلى ذلك كان متوسط عمر الممرضات والقابلات30.96 ± 6.007 سنة، 60.9 ٪ حاصلين على درجة البكالوريوس، 71.3 ٪ لديهم دخل منخفض، و 77.4 ٪ كن متزوجات. وأظهرت النتائج أن 18.9٪ من الأمهات كن راضيات بدرجة عالية و 53٪ كن راضيات، وأعربت الأمهات عن رضاهن المتوسط بدرجة 3.78 ونسبة مرجحة 75.6٪. كان هناك رضاً كبيرًا عن رعاية ما بعد الولادة بين الأمهات اللائي يلدن في المستشفى الإماراتي، وبين من يعشن في أسرة نووية، ولكن لم تكن هناك فروق ذات دلالة إحصائية في رضا الأمهات فيما يتعلق بالعمر ومستوى التعليم والعمل والدخل والعدد من الحمل، وعدد الولادات، وطريقة الولادة، ونتائج الولادة. بالإضافة إلى ذلك أشارت النتائج إلى رعاية عالية الجودة بعد الولادة (90 ٪) في المستشفيات الحكومية في قطاع غزة وكانت هناك فروق ذات دلالة إحصائية في جودة رعاية ما بعد الولادة وقد كانت الأدنى في مستشفى كمال عدوان، وأظهرت الدراسة أن الممرضات والقابلات ذوات الخبرة من سنة إلى 5 سنوات لديهن أدنى متوسط درجة في تقديم رعاية جيدة، في حين لم تكن هناك فروق ذات دلالة إحصائية في جودة الرعاية بعد الولادة المتعلقة بعمر الممرضات والقابلات، والمؤهل، والحالة الاجتماعية، و معدل الدخل. علاوة على ذلك كانت النتيجة الإجمالية للأداء المرصود أعلى من المتوسط بدرجة متوسطة 2.02 ونسبة مرجحة 67.3 ٪.

كما عرضت الباحثة التحديات التي تواجه تحسين رضا الأمهات عن رعاية ما بعد الولادة والآثار المترتبة على تحسين جودة هذه الرعاية. في الختام، وفقًا لأضعف نقاط رعاية ما بعد الولادة (وجهة نظر تمريض)،أكدت الدراسة ضرورة تطبيق البروتوكولات والمبادئ التوجيهية الفلسطينية الموحدة والموحدة التي تحدد وتصف تدخلات الممرضات خلال فترة ما بعد الولادة للأم وطفلها.