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**Attitudes of Healthcare Providers and Mothers
toward the Attendance of A companion During
Labor at Al Shifa Hospital in Gaza City**

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the Attendance of A companion During Labor at Al
Shifa Hospital in Gaza City**

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Thesis Approval

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Dedication

I would like to convey my sincere gratitude to my husband and my children who encouraged me all the way through this study ... without their encouragement and support, this thesis wouldn't come to the end ...

All the kind feelings to my father and my mother who were praying for me all the time

Special thanks to my brother for his support which provided me with extra energy to complete my study

I would like to express my appreciations to all my colleagues in Al Shifa Maternity Hospital who contributed to the completion of this thesis.

Bothaina A. Al Raheem Shaikh Khalil

Declaration

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

Signed:

Bothaina A. Al Raheem Shaikh Khalil

...../...../.....

Acknowledgement

First of all, praise to Allah, the lord of the world, and peace and blessings of Allah be upon our prophet Muhammad, all thanks for Allah who granted me the capability to accomplish this thesis.

I would like to express my deepest thanks to the academic staff at Al Quds University for the knowledge and skills they provided through my study.

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Abstract

Presence of a companion by a family member during labour may enhance labour process by providing continuous emotional support and reassurance to the mother. The purpose of the study was to assess the attitudes of mothers and healthcare providers toward the attendance of companions during labour at Al Shifa Maternity Hospital in Gaza city. The researcher used descriptive cross-sectional analytic design. The sample of the study consisted of 272 mothers in labour and 134 healthcare providers (37 physicians and 97 nurses and midwives). For data collection two questionnaires developed by the researcher to assess the healthcare providers' attitudes towards companion during labour, and mothers' attitudes towards companion during labour. The results indicated that mean age of mothers was 25.51 years, 92.6% are housekeepers, and 73.5% had low monthly income by less than 500 New Israeli Shekel, 38.2% were primiparous, and 96% had normal delivery. The results indicated that 87.9% of mothers prefer to have a companion during labour, and about 90% of women prefer to have their mothers as a companion during labour. The results also indicated high positive attitudes toward presence of a companion with overall mean score 4.021 out of 5 and weighted percentage 80.42%, and the results revealed lower attitudes among older women and higher attitudes among low income mothers. The results also indicated insignificant differences in attitudes toward having a companion during labour related to level of education, work, number of deliveries, and status of current delivery.

For healthcare providers, the results showed the attitudes toward having a companion during labour was with mean score 3.45 out of 5 and weighted percentage 69.0%. In addition, midwives and obstetricians had higher positive attitudes toward having a companion during labour compared to General Practitioners and nurses, and there were insignificant differences in attitudes toward companionship related to qualification, gender, age of healthcare providers, and years of experience. The study concluded that the majority of women in labour preferred to have their mothers as a companion during childbirth, and women in labour have higher positive attitudes toward having a companion during labour compared to healthcare providers (80.42 vs. 69.0).

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List of Abbreviations

CBR	Crude Birth Rate
CS	Cesarean Section
GPs	General Practitioners
GS	Gaza Strip
JDs	Jordanian Dinars
ICM	International Confederation of Midwives
MoH	Ministry of Health
NGOs	Non-Governmental Organizations
NIS	New Israeli Shekel
NVD	Normal Vaginal Delivery
PNA	Palestinian National Authority
PCBS	Palestinian Center Bureau of Statistics
SMC	Shifa Medical Complex
SPSS	Statistical Package for Social Sciences
UAE	United Arab Emirates
UNRWA	United Nations Relief and Works Agency for the Palestinian Refugees in the Near East
WB	West Bank
WHO	World Health Organization

Chapter One

1.1 Introduction

Pregnancy is a pleasant event for married women, passing the pregnancy course and giving birth safely is the optimal goal for every pregnant woman, her spouse and for healthcare providers. Labour is a stressful event with painful experience for women, that pain relief (pharmacological and nonpharmacological) during labor is an essential part of care that all women have the choice and access to a range of pain relief options. Nonpharmacological options of pain relief and comfort include continuous support from a companion, directed breathing and relaxation techniques, massage, labouring in water and the use of transcutaneous electrical nerve stimulation in early labour (World Health Organization - WHO, 2015).

Some women reported the experience of labour and birth as an empowering, ecstatic or even orgasmic event, and for other women the experience of childbirth might be stressful and painful. Causes of stress and anxiety include lack of familiarity with health providers, hospital environment and routines, pain and discomfort from birth itself or from interventions, worry and uncertainty about what is happening to them, problems of communication, lack of empathy, and feeling of loneliness during the process of labour and childbirth (Simkin, 2007). So, Presence of companion by a family member or a trained labour support person during labour may enhance labour process by providing continuous emotional support and reassurance to the mother, feelings of control and competence, and reducing reliance on medical interventions (Hodnett et al., 2011).

Support to women during labour from a companion is practiced worldwide including United States, Canada, United Kingdom, some parts of western and northern Europe, Mexico, parts of Latin America, Asia and Africa, and some studies showed that various individuals serve as birth companions including mothers, sisters, male partners, friends and siblings (Kungwimba et al., 2013). Furthermore, the attendance of a companion during labour has been recommended by WHO to improve labour outcomes and women's satisfaction with care. It has also been identified as a key element in the WHO vision of quality of care for pregnant women and newborns (WHO, 2015).

A number of health service-related barriers and facilitating factors were identified in the implementation of companion of choice at birth in hospital settings. These varied according to resources available in the facility and to the people providing support, thus the implementation of this practice requires the commitment of the management of health care facilities to change institutional policies and to provide the appropriate physical space that respects women's and their companion's privacy (Yuenyong et al., 2012).

Attitudes are mental and emotional entity that inheres in, or characterizes a person. They are complex and an acquired state through experiences. It is an individual's predisposed state of mind regarding a value and it is precipitated through a responsive expression toward a person, place, thing, or event, which in turn influences the individual's thought and action (Perloff, 2016).

The researcher believes that attitudes will be reflected in the behavior and interaction of healthcare providers with their patients, so, having positive attitude is essential aspect to safe and quality care. Attitudes and behaviors of maternal health care providers are important elements of quality as they influence both positively and negatively how women, their partners and families perceive and experience maternal health care. Lack of respectful

care from providers may lead to dissatisfaction with the health system, diminishing the likelihood of seeking antenatal care, delivery and postnatal services (WHO, 2014).

In this regard, influencing the attitudes of healthcare providers is necessary for the successful implementation of a companionship during labour and this could be achieved through sensitization activities including the provision of evidence-based information, through minimizing system barriers such as avoid overloading the staff and resolving issues of space and privacy, affecting providers' behaviors and sharing of women's positive experiences with this practice to motivate their participation (Kabakian-Khasholian and Portela, 2017).

1.2 Research problem

The maternity hospital at Al Shifa Medical Complex (SMC) is the biggest one in Gaza strip (GS) with the highest number of deliveries take place. In the maternity hospital, around 11000 deliveries and 500 cesarean section are performed every year. Total number of nurses and midwives working in the obstetric hospital is 166, and the number of physicians and obstetricians is 65 (SMC report, 2018). These numbers reflected high workload compared to number of midwives and obstetricians working in the place.

Evidence for companion at birth emanates from a Cochrane systematic review conducted in 2013 showing that presence of a companion at birth increases the likelihood of vaginal births, therefore reduces the need for cesarean section (CS) and the use of forceps or vacuum during vaginal births. In addition, it reduces the need to use pain medications during labour, it shortens the duration of labour and improves women's satisfaction with care, it also improves Apgar scores of the newborns (Kabakian-Khasholian and Portela, 2017).

1.3 Justification of the study

Childbirth is special event for healthcare providers, mothers, and their families. Globally, women in labour and delivery undergo enduring experiences of painful discomfort, fear, anxiety and tensions. During labour, mothers need closed observation and monitoring of the progress of labour, and continuous support is inevitable to enhance delivery. Research has demonstrated that women greatly value and benefit from the presence of someone they trust during labour and childbirth to provide emotional, psychological and practical support and advice (Kabakian-Khasholian et al., 2015). Theories that try to explain the effects of labour support on childbirth outcomes hypothesize that labour support enhances labour physiology and mothers' feelings of control and competence, reducing reliance on medical interventions (Hodnett et al., 2011). The supportive care may include having someone (mother, sister, mother in law) who reassures and praise the woman, assist with comfort measures such as touch, massage, help in taking a shower, and help the woman in ambulation, but not interfering in medical care interventions.

1.4 Goal of the study

The goal of the study is to assess the attitudes of healthcare providers and mothers toward the attendance of companions during labour at Al Shifa maternity hospital in Gaza city in order to propose a new protocol for companionship during labour in maternity hospitals.

1.5 Objectives of the study

- To assess the attitudes of health care providers toward the attendance of companion during labour.
- To determine the attitudes of mothers toward the attendance of companion during labour.

- To explore the factors that affect the attitudes of healthcare providers toward the attendance of companion during labour.
- To identify the factors that affect the attitudes of mothers toward the attendance of companion during labour.
- To suggest recommendations for future adoption of protocols of having a companion for each mother during labour.

1.6 Questions of the study

- What are the attitudes of healthcare providers toward the attendance of companions during labour at Al Shifa maternity hospital in Gaza?
- What are the attitudes of mothers toward the attendance of companions during labour at Al Shifa maternity hospital in Gaza?
- What are the factors that affect the attitudes of healthcare providers toward the attendance of companion during labour?
- What are the factors that affect the attitudes of mothers toward the attendance of companion during labour?
- What are the recommendations for future adoption of protocols of having a companion for each mother during labour?

1.7 Context of the study

1.7.1 Sociodemographic context

Palestine lies within an area of 27,000 Km², 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 WB 5,655 Km², GS 365 Km² and east Jerusalem. At the end of December 2017 total population of Palestinians was 4,952,168 in WB and GS (3,008,770 in WB and 1,943,398 in GS). The population density (capita/km²) is 811 in

Palestine (526 in WB and 5,239 in GS). The Crude Birth Rate (CBR) in the Palestinian territory estimated to be about 30.9/1000 population in 2016 (28.5/1000 in WB and 35.8/1000 in GS), and more than 56,000 live births every year in GS (PCBS, 2017).

1.7.2 Economic context

Economic status in the Palestine is very low especially in GS due to siege against the strip. According to the Palestinian Expenditure and Consumption Survey 2017, the average monthly expenditure of household on various goods and services amounted to 934.9 Jordanian Dinars (JDs) (for household size of 5.5 of individuals), and it was 1143.6 JDs in the WB (for household size of 5.2 individuals) compared to 556.0 JDs in GS (for household size of 6.1 individuals). The percentage of poverty was 13.9% in the WB, while it reached more than half of population in GS as it was 53.0%, which means four times higher than poverty percentage in the WB. As for the deep poverty line, 5.8% of individuals were below the deep poverty line in the WB and 33.8% of individuals in GS, so the deep poverty percentage in GS was six times higher than the WB. The data showed an increase in poverty percentages in 2017 compared to 2011. The poverty percentages were 25.8% in 2011 while it increased by 13.2% in 2017 to reach 29.2% of individuals were below poverty line. Deep poverty percentages also increased in 2017, as it was 12.9% in 2011 and it increased to 16.8% in 2017. This increase in poverty percentages was mainly because of the sharp increase in poverty in GS. It is worth mentioning that the situation of level of living in GS became worse than it was in 2011. Poverty among individuals in GS was 38.8% in 2011 while it jumped to 53.0% in 2017 with 37% increase. In WB, the situation was different, as the poverty percentages decreased from 17.8% in 2011 to 13.9% in 2017 with about 22.0% decrease. Deep poverty percentages also increased significantly in GS, as the deep poverty percentage was 21.1% in 2011 and became 33.8% in 2017 with an increase by around 60%. In WB, there was a decrease in deep means poverty

percentages, as it was 7.8% in 2011 and became 5.8% in 2017 with a decrease by 25.6%. The significant increase in poverty indicators in GS was the cause of the increase in poverty indicators on the national level (PCBS, 2018).

1.7.3 Health care system

Health care services in Palestine are provided by different sectors. The four major sectors of health care providers are the MoH, Palestinian NGOs, United Nations Relief and Works Agency for Palestinian Refugees in the Near East (UNRWA), and the private sector. The total number of hospitals in Palestine was 81 hospitals, 51 of them in WB including east Jerusalem. The total number of hospital beds in Palestine was 6146 beds with rate of 784 populations per bed (784 in GS and 783 in WB). The number of hospitals in MoH is 27 hospitals with a capacity of 3325 beds which equals 54.1% of total beds in Palestine, of these hospitals, there are 14 hospitals in WB with a capacity of 1661 beds while there are 13 hospitals in GS with a capacity of 1664 beds. The number of physicians working in different centers and units of MoH is 2529 physicians, with 5.3 physicians per 10,000 population of Palestine; 4.1 physician per 10,000 populations in WB and 7.0 physician per 10,000 populations in GS, and 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 (MOH, 2017).

1.7.4 Health and maternity services in Gaza Strip

Public hospitals in the GS provide life-saving healthcare for 1715 patients every day, including 113 newborns, 100 patients in intensive care units, 702 patients requiring hemodialysis, 200 patients in need of surgery, 100 women in need of obstetric surgeries, and 500 patients in need of emergency care. Hospitals in GS are already over-stretched, with a bed occupancy rate of over 90%. With the closure of some hospitals due to shortage

of fuel, the extra burden placed on the remaining hospitals in operation will further strain the delivery of services, including surgery, emergency departments, intensive care units and maternity services. Under-resourced public hospitals also face severe shortages in medicines and medical supplies. In January 2018, 40% of the essential drugs were completely depleted. This includes drugs used in emergency departments and other critical units (WHO, 2018).

The Israeli-Palestinian conflict has been ongoing for long years, resulting in a never-ending state of conflict and instability. There is clear evidence regarding the impact of protracted conflict and war on women, infants, health system and the health workforce and assessment of various health sectors placed human resource problems among the major deficiencies of the current Palestinian health-care system (Mataria et al, 2009).

There is severe shortage of nurses and midwives in MoH hospitals as more than half of the Palestinian births (55%) occur in public hospitals free of charge, midwives attend almost all vaginal births, except for instrumental deliveries, and nurses are the main staff in the post-partum wards (Maghari, 2015). According to latent reports, there are only 114 midwives (5 have diploma certificate, and 109 have bachelor or higher degree) working in 9 governmental hospitals in WB and 208 midwives are working in governmental hospitals in GS (93 holds bachelor degree and 115 have 2-years diploma) (MoH, 2014). It is worth to say that since 2014, the MoH employed a few numbers of new nurses and midwives with temporary contracts and after 2016 till now no new midwives employed and part of nurses and midwives working in maternity hospitals are new graduate volunteers or students in their college practical training (Verbal interview with Director of Nursing, MoH 2018).

1.7.5 Al Shifa Medical Complex (SMC)

It was established in 1946 in the western middle area of Gaza city, on a land 42000 m², serving more than 500,000 citizens in Gaza City. The complex includes three hospitals, surgery, medical and maternity hospital. The overall beds in the hospital are 704. The maternity hospital was established in 1986 and it have been renovated and expanded on 1994 after the Palestinian National Authority took over the responsibility about GS.

In the maternity hospital, around 11,000 deliveries and 500 CS are performed every year. The maternity hospital consisted of one reception department, Normal Vaginal Department (NVD), natural birth department, high risk department, three departments for admission and post-delivery, Out Patient Clinic, and operating theatre. Total number of nurses and midwives working in the maternity hospital is 166, and the number of physicians and obstetricians is 81 (SMC, 2016). The number of deliveries during the past 4 years 2014 – 2017 ranged between 11,000 – 14,000 deliveries per year. This year big part of the maternity hospital (the old building) was unsafe for health services and reconstruction of the building will take place, so, part of maternity service has been transferred to the neighborhood Kamal Odwan Hospital in Beit Lahia so the average number of deliveries decreased to be about 900 per month (SMC, 2018). Work overload besides shortage of nurses and qualified midwives affect quality of care in maternity departments. Bitar and Narrainen (2011) showed that the quality of care provided for women and infants is substandard, the maternal healthcare providers work within a difficult and resource-constrained environment, in addition to high workload, poor compensation, humiliation in the workplace, suboptimal supervision and the absence of professional support and guidance.

1.8 Definition of terms

Labour

Labour is the physiologic process by which the fetus, membranes, umbilical cord, and placenta are expelled from the uterus (US National Institute of Health, 2017).

Companion of choice at birth

Companion of choice at birth is defined as the continuous presence of a support person during labor and birth (Hodnett et al., 2015). In this study, the researcher defined a companion as the presence of a closed relative to the mother during labour (NVD) including her mother, husband, sister, or mother in law to support and encourage her during the labour process.

Attitudes (operational definition)

Attitudes are mental and emotional entity that inheres in, or characterizes a person. It is precipitated through a responsive expression toward a person, place, thing, or event, which in turn influences the individual's thought and action (Perloff, 2016). In this study the researcher defined attitudes as the positive or negative opinions and perceptions of health care providers and mothers toward the presence of companion with the woman during labor process that was measured using 5 points Likert Scale.

1.9 Layout of the study

This study composed from five chapters: introduction, conceptual framework and literature review, methodology, results, discussion, conclusion and recommendations.

The first chapter presented general introduction to the study, with a brief background about the subject of the study. The researcher illustrated the research problem, justification for conducting the study, the goal and objectives of the study, questions of the study, context of the study, and definition of terms.

The second chapter consisted mainly of two parts: the first part is conceptual framework where the researcher provided a schematic diagram of the conceptual framework of the study (designed by the researcher). The second part presented review of literature related to the study topic and variables. In-depth detailed inquiry including previous studies were presented.

The third chapter described methodology including study design, population, sample size and sampling method, setting, period of the study, instruments, data collection and statistical analysis, ethical considerations, and limitation of the study.

The fourth chapter presented the study results and discussion. The researcher presented the results in form of tables and figures that make it easy for the reader to understand and make comments. The results were discussed in respect to available previous studies that directly related to the topic of this study and its objectives.

Finally, in the fifth chapter the researcher presented conclusion, recommendations, and suggestions for further studies in the light of the study results.

Chapter Two

Conceptual framework and literature review

2.1 Conceptual framework

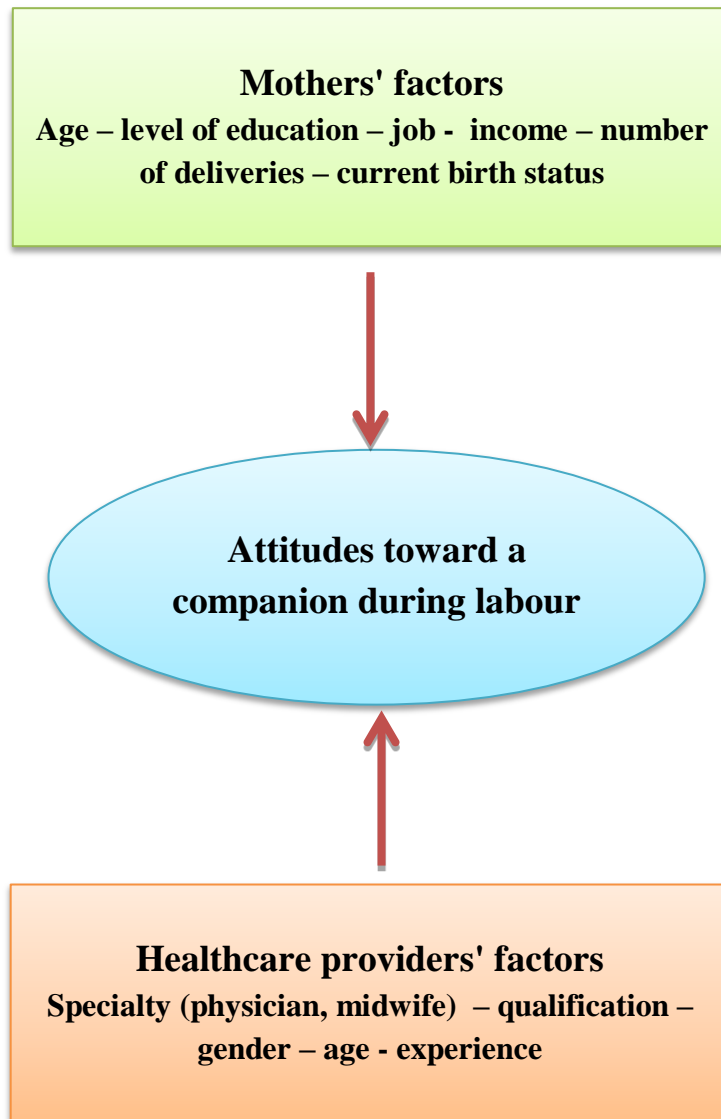


Figure (2.1): Conceptual framework (self-developed)

The conceptual framework was developed by the researcher. The diagram exploring attitudes of healthcare providers and mothers toward having a companion during labour. In addition, the diagram illustrates relevant factors that may affect attitudes toward having a companion during labour.

Healthcare providers factors; these factors identified specialty (physician or midwife), qualification, gender, age, and years of experience. These factors influence attitudes toward having a companion during labour in different ways.

Mothers' factors; these factors include mothers' age, level of education, job, income, number of deliveries, and current birth status.

Several studies examined sociodemographic factors that affect attitudes toward having a companion during labour. It was reported that women with lower income, and those who were less educated had fewer companions (Diniz et al., 2014). Others found that low level of education, poverty, cultural and religious beliefs, health workers negative attitudes contributed to poor companionship (Vehviläinen-Julkunen and Emelonye, 2014). Also, nulliparity and work status were significant factors for the desire of a companion during labour (Olayemi et al., 2008). While other studies showed that age, and level of education, had no impact on decision to have a companion during labour (Al-Mandeel et al., 2013).

2.2 Literature review

2.2.1 Background

Childbirth is a socially and historically shaped event, with wide cultural and geographic variability. Historically and cross-culturally, women have been attended and supported by other women during labour and birth at home (Bohren et al., 2017). However, when hospital birth was established in industrialized countries in the mid-20th century, most women started to deliver without the presence of a person familiar to them. This has been the usual situation in many countries for decades, as the presence of relatives was usually prohibited in institutional births (Diniz et al., 2014). Healthcare providers usually focus on labour outcomes in terms of morbidity and mortality with little or no attention to the psychosocial consequences of birth experience on mothers (Simkin, 2007).

Presence of a companion during labour has also been identified as a key element in the WHO vision of quality of care for pregnant women and newborns (Tuncalp et al., 2015). Different names have been given to the intervention including continuous support during labour, companion of choice at birth, labor companion, emotional support during birth (Kabakian-Khasholian and Portela, 2017).

Although studies have proved the advantages of having companionship during labour, there is still a need to evaluate the introduction of companionship, taking in consideration the effect of cultural beliefs and the infrastructure available at health facilities (Banda et al., 2010).

2.2.2 Psychosocial support during labour

The term social support was used in theology in the early 1900s. Social support is a complex construct with many definitions. social support refers to a social network's

provision of psychological and material resources intended to benefit an individual's capacity to cope with stress (Cohen, 2004). It is worth to say that individuals and their levels of support operate in cultural contexts, which include the ideas, beliefs, and values people hold about persons and their social relationships in which they take part. These contexts can affect the provision and receipt of social support at all levels by influencing an individual's definition of support, appraisal of events as stressful, evaluation of whether social support is in fact supportive, and propensity to give, get, accept, or reject support (Sippel et al., 2015).

The effectiveness of social support depends on the match between the source, type, and timing of social support and the needs and developmental level of the individual or system, and if support provided in a sequence inconsistent with the individual needs, it will neither be effective nor recognized as helpful, thus, social support can be counterproductive or maladaptive, particularly if it is unsolicited, excessive, or is an inappropriate match to one's needs (Bonanno and Diminich, 2013; Song and Chen, 2014).

Theories of social support focus on the perceptions, behaviors and feelings of an individual which determine their response to stress (McCourt, 2009). Social support has been defined as an intentional human interaction whereby assistance and protection are offered to those faced with a stressful life event, generally by significant others such as a family members or friends (Dlugosz, 2013). The protective effect of social support has been referred to as the buffering hypothesis, which states that the deleterious effects of psychosocial stress on health and well-being can be mediated or lessened by a strong support system (McCourt, 2009).

In childbirth situations, some researchers agreed that one of the most effective means of coping with stressful life events is social support which determines a person's health and

well-being (Aktan, 2010; Stapleton et al., 2012). Receiving sufficient social support from significant others and partners is thus crucial in the period of childbirth as it contributes to enjoying positive childbirth-related experiences and satisfaction with life. Continuous social support obtained from close partners during childbirth reduces the level of fear and is evaluated higher than that obtained from other significant others (Sapkota et al., 2013). Conversely, a lack of social support from partners and family is one of the factors in the reduction of life quality and the occurrence of postnatal depression (Sapkota et al., 2013; Webster et al., 2011). Received social support, particularly of instrumental and emotional nature, is especially significant for the physical and emotional well-being of women in the postpartum period, in which they have to cope with fulfilling the social role of mother (Sapkota et al., 2013; Negron et al., 2013).

The concept of social support is difficult to define or measure in the childbirth literature, as perceptions of support are highly subjective. Individual needs of support will differ depending on personal circumstances and preferences, as well as factors that guide cultural and societal norms (McCourt, 2009). Research indicated that the perceived adequacy and appropriateness of social support will impact on its effectiveness, and in order for support to be perceived as effective, it must match the support that is required; for example, if a woman has adequate personal resources and/or social support in labor, professional support may be perceived as intrusive, whereas a woman with minimal social support may feel that professional support is lacking. In addition, support that is given but not perceived as effective can in fact have counter-productive effects, which highlights that not all support can be beneficial (McCourt, 2009).

Childbirth is one of the most profound life experiences a woman will endure. It is an experience that can elicit a range of feelings, recognition of which has highlighted women's

needs for psychological and social support during the birth process (Price et al., 2007). Literature emphasized the importance of positive birthing experience and highlighted it as integral to the mother and baby's well-being, and a major factor that influences the mother's perception of positive experience is how supported she feels throughout childbirth (Hodnett et al., 2011; Price et al., 2007).

Childbirth is an important event, which is highly desired by most women in their reproductive age. Literature reflects that the perinatal period may constitute a stressful experience in the life of women, while assuming a new role in life may lead to a decrease in life quality in terms of both physical and psychological functioning (Da Costa et al., 2006; Torkan et al., 2009; Rowlands and Redshaw, 2012). It has to be stressed that women who have positive emotional experiences related to parturition express long-lasting satisfaction with childbirth and gain a sense of fulfillment (Waldenstrom et al., 2004). Positive perception of childbirth contributes to the heightening of the sense of self-efficient, self-confidence and life satisfaction of women (Gao et al., 2014; Dyrdal et al., 2010). However, some women may find pregnancy and delivery to be among the most traumatic life experiences, and memories of childbirth may be recalled for many years to come or even for the whole life. Negative experiences from childbirth determine the occurrence of postpartum depression and post-traumatic stress disorder (Beck 2004). A review of research on the subject demonstrated that post-Caesarean women more frequently experienced anxiety and helplessness, and had problems with childcare and breastfeeding. Delivery by Caesarean section may be experienced as detrimental, cause the occurrence of a post-traumatic stress disorder, and lessen the satisfaction with childbirth (Karlstöm et al., 2007; Tham et al., 2010; Shorten and Shorten, 2010).

Moreover, it has been asserted that a woman's experience of labor is dependent on the personality and attitude of those present at the birth (Odent, 2005). Hodnett reported that the way in which a woman perceives those supporting her will influence her experiences of their support; the same support received from a midwife or a partner may have different effects on the laboring woman, depending on her relationship with them, and support from someone she loves may be perceived differently from support received from a professional (Dlugosz, 2013).

Labour support is a term used to describe the presence of an empathic person who offers advice, information, comfort measures, and other forms of tangible assistance to help a woman cope with the stress of labour and birth (Hodnett, 2002). Women in labour have a profound need for companionship, empathy and help. Emotional support in the form of encouragement, praise, reassurance, listening and a continuous physical presence are recognized as key components of care during labour (Iliadou, 2012).

Continuous support for a labouring woman by a lay person or a professional is a well-evaluated intervention. Large randomised controlled trials have been carried out all over the world and these have shown positive pregnancy outcomes for mother and baby (Hodnett et al., 2015; Langer, 2007). The supported woman is more likely to give birth without using analgesia, less likely to have a caesarean delivery or instrumental vaginal birth and less likely to report dissatisfaction with her childbirth experience (Hodnett et al., 2015; Langer, 2007; WHO, 2006). The baby benefits from the mother's positive attitude towards her childbirth experience. This fosters mother-to-child bonding and results in successful breastfeeding and successful child-rearing practices. This support is most effective when the caregiver is not an employee of the hospital and when it starts early in labour (Hodnett et al., 2015; Hodnett et al., 2007; Langer, 2007; Hodnett et al., 2002).

There are a number of ways a woman can feel supported in childbirth, and one person may not be able to provide all types of support effectively. While midwives offer professional support, partners and others close to the labouring woman can offer a type of comfort, security and strength, thus the need for a companion during labour is becoming a good intervention that is more universally accepted. Giving birth is one of the most important events in life, which is a highly individual experience. Melender (2002) reported the following factors which women are afraid of during pregnancy and childbirth: fear of childbirth, caesarean section, mother and infant health, health care professionals' actions, and subsequent family life, and fear appears in the form of stress and effects on daily life as to avoid pregnancy and childbirth and a desire to have a caesarean. It has also been shown that women want a sense of security and to feel involved in decisions affecting them during the childbirth period (Wahn et al., 2005). Moreover, in order to provide better individual support to women during childbirth, the health care providers are required to put more focus on psychosocial aspects, but without neglecting medical safety (Nilsson et al., 2013).

2.2.3 Importance of companion of choice during labour

Childbirth is an experience that elicits a range of emotions for the labouring woman which reflected the women's needs for psychosocial support during birth. Research has shown that a mother's perception of a positive birth is influenced by how supported she feels throughout her experience (Dlugosz, 2013). For most women, the experience of childbirth can be stressful and painful. Causes of stress and anxiety include lack of familiarity with providers, hospital environment and routines, pain and discomfort from birth itself or from interventions, worry and uncertainty about what is happening to them, problems of communication, lack of empathy, rude treatment, and loneliness (Bowser and Hill, 2010; Simkin, 2007).

Labour and delivery experience is one of the most significant and stressful experiences in a woman's life, and can have strong physical, emotional, and psychological effects (Khresheh, 2010). A woman's satisfaction with her childbirth experience has immediate and long-term implications for her health and the wellbeing of her newborn. Many factors can improve the satisfaction and brighten the experience of childbirth including more control of labour pain, higher levels of personal control, childbirth preparations, having expectations met, and having a companion of choice (Goodman et al., 2004; Hardin and Bckner, 2004). Many studies have highlighted the benefits of support, both physical and psychological during labour, on the mother and her child including reduced length of labour, fewer emergency cesarean deliveries, reduced need for pain medication, and reduced need for augmentation of labor (Mosallam et al., 2004; Morhason-bello et al., 2009; Kashanian et al., 2010; Sauls 2002; Essex and Pickett, 2008).

WHO recommendations of companion of choice during labour and childbirth emphasized that continuous companionship during labour is recommended for improving labor outcomes (WHO, 2014), and that continuous companionship during labour is recommended for improving women's satisfaction with services (WHO, 2015). Research has consistently demonstrated that women greatly value and benefit from the presence of someone they trust during labour and childbirth to provide emotional, psychological and practical support and advice (Kabakian-Khasholian et al., 2015).

Allowing and supporting the presence of a woman's companion of choice during labour and childbirth is an effective intervention that is respectful of women's autonomy and can be an important aspect of improving quality of care during labour and childbirth (WHO, 2016). The supportive care may include having someone who is continuously present and who reassures and praises her, assists with measures for physical comfort including

(providing comforting touch, massage, warm bath or shower, promoting adequate fluid intake), and undertakes any necessary advocacy on her behalf (Hodnett et al., 2015). In addition, continuous support by a companion during labour improves childbirth outcomes, including enhancing the physiological process of labour, and that support has clinically meaningful benefits, including shorter labour with increased rates of spontaneous vaginal birth, decreased usage of intrapartum analgesia and CS, and increased satisfaction with childbirth experience (WHO, 2016). Moreover, women who had support by a companion reported less fear and distress during labour, which also appeared to act as a buffer against adverse aspects of medical interventions, also, companion of choice at birth increases the likelihood of vaginal births, therefore reduces the need for caesarean sections and the use of forceps or vacuum during vaginal births. In addition, it reduces the need to use pain medications during labour, it shortens the duration of labour and improves women's satisfaction with care, and also improves Apgar scores of the newborns (Hodnett et al., 2013). In addition, Mosallam et al., (2004) conducted a study in United Arab Emirates (UAE) found that women who had a companion had significantly shorter duration of labour, less need for analgesia, oxytocin augmentation and neonatal intensive care.

Iliadou (2012) reported that women in labour have a profound need for companionship, and that continuous support appears to have a greater beneficial impact than intermittent support, and healthcare providers are in unique position to educate parents about the importance of social support around the time of childbirth.

Support during childbirth is not a new issue in the field of maternal health care. A recent review of 17 qualitative studies and described the importance of social support in pain control because the presence of a supportive person helps the mother feel that pain was more bearable and that they can do something about it, such as breathing and relaxation

techniques, and a Cochrane review article, found that continuous support should be the norm rather than the exception and all women should be allowed and encouraged to have supportive people with them continuously during labour (Hodnett et al., 2011). Such support has been an essential element of the labour and delivery systems of many Western countries. Moreover, Kabakian-Khasholian et al., (2015) concluded that implementing labour companionship can improve women's childbirth experiences and outcomes. Another cross-sectional study carried out in Malawi 2010 aimed to examine the acceptability and experience of supportive companionship during childbirth by mothers, health professionals and supportive companions found that the majority of supported women (99.5%), companions (96.6%) and health professionals (96%) found that supportive companionship was beneficial, mainly for psychological and physical support to the labouring woman and for providing assistance to healthcare providers. Some companions (39.3%) unwillingly accompanied the women they were supporting and 3.5% of companions mentioned that their presence in the labour ward was an opportunity for them to learn how to conduct deliveries (Banda et al., 2010).

2.2.4 Attitudes towards companionship during labour and childbirth

In GS, governmental hospitals do not have a clear policy on permitting the presence of a supportive companion, such as a family member or a friend during childbirth and there is no chance to provide one-to-one nursing care because of staff shortages, and that leaves labouring women alone for intermittent periods of time, especially in the first stage of labor. The labour and delivery experience is one of the most significant and stressful experiences in a woman's life, and can have strong physical, emotional, and psychological effects (Khresheh, 2010).

In a review article carried out by Hodnett et al., (2011), the reviewers concluded that continuous support should be the norm rather than the exception and all women should be allowed and encouraged to have supportive people with them continuously during labour. However, most developing countries do not routinely encourage women to have support during childbirth despite the existence of studies indicating the importance of such practice. For instance, a study conducted in the United Arab Emirates (UAE) to evaluate women's preference in psychosocial support during labour revealed a high preference for support, and similar results were found in Jordan, Nigeria, South Africa and Iran (Mosallam et al., 2004; Brown et al., 2007; Kashanian et al., 2010; Khresheh, 2010). Another exploratory qualitative study carried out in Iran included 25 women concluded that women believed that the presence of a companion, e.g. their husband, a family member, or a doula, during labour helped them better deal with the labour process, particularly when they felt lonely (Najafi et al., 2017).

One of the main differences between developed and developing countries on the presence of a companion during labour can be the preferred person to attend childbirth. In Western countries, support by the husband is the standard procedure while in developing countries women prefer the support of a female relative; support by the husband is neither acceptable nor appreciated (Mosallam et al., 2004). This is probably a reflection of the differences in family structure, sociocultural norms, relationships and ties (Al-Mandeel et al., 2013). Hodnett et al., (2015) reported that the most beneficial form of support appears to be from a person who is not a member of the woman's social network, is not hospital staff and who has some experience or has received some informal training, however, in the absence of such a person, the support from a person of choice from among the woman's family or friends improves women's satisfaction with care.

A study conducted in Brazil showed that 57.1% of women had a companion during labour, 38.1% had a companion at the time of delivery (Dulfe et al., 2016). In addition, Diniz et al., (2014) found that 24.5% of women had no companion at all, 18.8% had continuous companionship and 56.7% had partial companionship, and only 1.4% of the women did not want to have a companion. Another study aimed to identify the attitudes of women to the presence of their husband in the labour room during childbirth found that 64% of women had positive attitudes towards the presence of the husband in the delivery room (El-Magrabi and Mohamed, 2012). Furthermore, a study conducted by Kabakian-Khasholian (2015) demonstrated that women benefit from and value the presence of a support person during labour, to provide psychological, physical, emotional, informational and practical support. Another prospective cohort study conducted in three governmental hospitals in Saudi Arabia included 402 women showed that 45.3% of women preferred the presence of a companion during labour while 54.7% of women did not prefer the presence of any companion, and that 58% of women preferred to have their mother as a companion and 51% preferred their husband as a labour companion (Al-Mandeel et al., 2013).

A randomized controlled clinical trial carried out in Brazil included 212 primiparous women found that the women in the support group were more satisfied with labor (median 88.0 vs. 76.0, $p < 0.0001$) and delivery (median 91.4 vs. 77.1, $p < 0.0001$), and that the presence of a companion of the woman's choice had a positive influence on her satisfaction with the birth process and did not interfere with other events and interventions (Bruggemann et al., 2007). Another randomized, two-group controlled clinical trial conducted in Thailand found that women who had a companion had a significantly shorter duration of active labour and were more satisfied with their childbirth experiences than those who did not have a companion (Yuenyong et al., 2012). Another study carried out in Malawi reported that supportive companionship for women during labour is highly

acceptable among mothers and health professionals, and the community (Banda et al., 2010).

In addition, continuous support during labour and delivery facilitates birth, enhances the mother's memory of the experience, strengthens mother-infant bonding, increases breastfeeding success, and significantly reduces many forms of medical intervention, including cesarean delivery and the use of analgesia, anesthesia, vacuum extraction, and forceps (Pascali-Bonaro and Kroeger, 2004). Another study conducted in UAE included 400 women reported that birth attendant continuously accompanied (59.3%) participants including mother (59.5%), sister (31.2%), friend (7.2%), other family member (1.3%) or husband (0.8%), also, 87.5% of participants felt that psychosocial support during childbirth is essential and best provided by non-professional attendant or midwife/obstetrician (Mosallam et al., 2004).

Different studies reflected variations in the attitudes of health care providers toward companion of choice during labour. Some studies revealed positive attitudes as health care providers perceived the presence of the companion was helpful in reducing the dependency of women on the staff, and this was mainly important in settings with shortage of nursing and midwifery staff, also, the presence of a companion was noted to positively influence the behavior of the staff towards women (Bruggemann et al., 2007; Maimbolwa et al., 2001).

Other studies reported negative attitudes and resistance in acceptance of companions to labour wards, nurses and midwives reported their doubts about the role of the companion and expected less cooperation of women with the staff throughout labour and birth in the presence of the companion (Qian et al., 2001; Banda et al., 2010). Health care providers also reported concerns about companions who are not part of the hospital staff, interfering

in medical decisions and about cross infections in the labour and delivery ward (Maimbolwa et al., 2001; Qian et al., 2001; Kabakian-Khasholian et al., 2015).

A qualitative study aimed to explore the perspectives about labour companionship in three Arab countries (Lebanon, Syria, and Egypt) included 69 women, 57 female relatives, and 28 obstetricians found that women reported that being alone during labour raises feelings of fear and anxiety. They reported appreciating professional support, but found comfort in the psychological support offered by family members during labour. Midwives and nurses pointed to structural factors related to the organization of care and to the marginalization of their role as barriers to implementing best practices. Obstetricians referred to the absence of prenatal education classes, and social norms as factors impeding the organization of labour support initiatives (Kabakian-Khasholian et al., 2015).

A hospital-based cross-sectional study included 224 randomly selected antenatal women receiving care in Nigeria in 2008, aimed to identify the attitude and preferences of women about social support during childbirth and also to identify variables that may influence their decisions. The results indicated that 75% of respondents desired companionship in labour, approximately 86% preferred their husband as companion while 7% and 5% wanted their mother and siblings as support person respectively. Reasons for their desire for social support were emotional (80.2%), spiritual (17.9%), errands (8.6%) and physical activity (6.8%) (Olayemi et al., 2008).

2.2.5 Factors affecting companionship during labour

A number of individual-level and system-level factors pertaining to the policies, organization and management of health care have been reported to be associated with positive childbirth experiences, such as women's involvement in the decision-making process, access to information, familiarity with the care provider, support during labour

and type of birth (Hodnett, 2002; Lobel and DeLuca, 2007; Fair and Morrison, 2012; Leap et al., 2010; Bryanton et al., 2008).

2.2.5.1 Mothers' and family factors

Mothers and their families play an important role in accepting or rejecting presence of companionship during labour. A review included 41 published studies found that women and their families expressed appreciation for the continuous presence of a person to provide support during childbirth (Kabakian-Khasholian and Portela, 2017).

It is worth to say that several sociodemographic factors contribute to the positive or negative attitudes toward having a companion during labour. A study conducted in Nigeria found that factors such as low level of education, and poverty have contributed to poor companionship participation in labour and delivery (Vehviläinen-Julkunen and Emelonye, 2014). Another study conducted in Brazil by Diniz et al. (2014) reported that women with lower income, and those who were less educated had fewer companions at any moment of birth. Earlier study carried out in Nigeria included 224 women examined socio-demographic variables associated with choice of companion during labour found that nulliparity and work status were statistically significant for the desire of a companion during labour (Olayemi et al., 2008). Other studies reflected that demographic factors such as education, age, socio-economic status, and marital status have been found to have little relationship with childbirth satisfaction (Hodnett, 2002; Goodman et al., 2004).

In contrary, a study conducted in Saudi Arabia showed that age and level of education had no impact on their decision to have a companion during labour, and more than one-third of participants thought that having a companion during labour would not help (Al-Mandee et al., 2013).

2.2.5.2 Health care providers' factors

In spite of the overwhelming evidence of benefits when a labouring woman receives continuous support from a lay person, implementation of the companionship during labour sometimes meets resistance, particularly from healthcare providers working in maternity units, and this resistance is present even in environments where staffing levels are low; that is, situations where companions would be of benefit or comfort to a labouring woman (WHO, 2006; Maimbolwa et al., 2001).

A study carried out by Kabakian-Khasholian et al., (2015) reported that limited knowledge among healthcare providers and managers about the benefits of labour companionship, and negative attitudes of healthcare providers towards labour companionship were factors that contribute to resistance of having a companion during labour. Another study conducted in Nigeria found that factors such as health workers negative attitudes contributed to poor companionship participation in labour and delivery (Vehviläinen-Julkunen and Emelonye, 2014).

To increase healthcare providers' acceptance of the presence of companion during labour, Olayemi et al., (2008) reported that efforts such as influencing the attitudes of healthcare providers by informing them about the evidence on companion of choice at birth and motivating them by sharing positive birth experiences are considered to be necessary for the successful implementation of companion of choice during labour.

2.2.5.3 Cultural and organizational factors

Despite clear evidence and the growing emphasis on respectful maternity care, many health care facilities still do not permit women to have a companion of choice during labour and childbirth. Several organizational factors may act as barriers toward having companionship during labour including; the absence of institutional policies that allowing

women to have a companion of choice during labour and childbirth, and the physical infrastructure of health care facilities, which limits privacy and contributes to overcrowding in the labour wards and difficulties in maintaining hygiene standards (Kabakian-Khasholian et al., 2015).

In addition, in some societies, cultural norms and religious beliefs do not support the attendance of a companion during labour. A study conducted in Nigeria found that factors such as culture, and religious beliefs, have contributed to poor companionship participation in labour and delivery (Vehviläinen-Julkunen and Emelonye, 2014). In this regard, a review included 41 published studies found that facility-related constraints and cultural norms were identified as barriers to companionship during labour (Kabakian-Khasholian and Portela, 2017). Another study conducted in Saudi Arabia showed that 64.1% of women reported that the most common reason for not preferring to have a companion was their fear of being exposed most of the time to their companion (Al-Mandeel et al., 2013).

In the maternity hospital at SMC, the attendance of a companion during labour is permitted in the ward before and after delivery, but inside the delivery room companions are not allowed during delivery of the baby, which is attributed to the narrow place with high number of deliveries 24-hours a day (between 30 to 40 deliveries). Interview with midwives in the delivery room reflected that midwives and obstetricians resist presence of a companion in the delivery room at time of delivery because they believe that attendance of a companion will disturb them from doing their work and they do not feel comfortable and that may increase the chance of making mistakes (verbal interview, 2018).

The researcher believes that maternity hospitals should develop and implement a policy that supports birth companions, and to do so, maternity hospitals need to re-allocate resources and spaces to ensure having a suitable place for companions, and at the same time maintaining privacy in labour rooms.

Chapter Three

3.1 Study design

The researcher used descriptive, analytical, cross sectional design. The cross-sectional design is useful for descriptive purposes and it measures the variables of the study, that carried out on a population at a point of time or over a short period. Cross-sectional studies are usually quick and cheap. Also, cross sectional designs examine the relationship between variables, are economical, quick and managed easily (Polit and Beck, 2016).

3.2 Study population

The study population consisted of all healthcare providers (midwives and obstetricians) who are working in the maternity hospital at SMC. Their total number is 201 (145 nurses and midwives and 56 obstetricians and physicians). In addition, the population of study consisted of all pregnant women who are in labor and admitted to the maternity hospital at SMC. Each month, around 1,100 women were giving birth in the maternity hospital, but in the year 2017 part of the maternity hospital building is under reconstruction thus part of maternity services were transferred to the Kamal Odwan Hospital in Beit Lahia so the average number of deliveries decreased to be about 900 per month.

3.3 Sample size and sampling method

The sample of the study is convenience sample from healthcare providers (obstetricians, physicians, midwives, and nurses) who are working in the maternity department and a sample of women who are in labour and admitted to maternity hospital in SMC during data collection period.

By using the sample size calculator program at 95% confidence level and confidence interval 5, the sample size for health care providers was 132 healthcare providers. The

number of healthcare providers who agreed to participated in the study was 134 healthcare providers (37 physicians and 97 nurses and midwives). For the mothers in labor, sample size was 269 mothers, and the number of appropriate questionnaires was 272.

Sample size for health care providers

Confidence Level: 95% 99%

Confidence Interval:

Population:

Sample size needed:

Sample size for mothers

Confidence Level: 95% 99%

Confidence Interval:

Population:

Sample size needed:

3.4 Study setting

The study has been conducted in the maternity hospital at SMC.

3.5 Period of the study

The study has been carried out during the period from January to December 2018. Data collection took place from April to June 2018.

3.6 Eligibility criteria

3.6.1 Inclusion criteria

- Male and female physicians and obstetricians working in Maternity Hospital at SMC.
- Midwives and nurses working in Maternity Hospital at SMC.
- Pregnant women who are in active labour and admitted to the Maternity Hospital at SMC during the period of data collection with vaginal delivery birth.

3.7 Instruments of the study

After reviewing previous studies and literature, the researcher prepared two questionnaires:

- Attitudes towards companionship during labour (for healthcare providers).
- Attitudes towards companionship during labour (for mothers).

3.7.1 Description of questionnaires

1. Attitudes towards companionship during labor (for healthcare providers)

The questionnaire consisted of the following parts: (Annex 1)

- First part: personal information (specialty, qualification, gender, age, and years of experience).
- Second part: consisted of 26 items distributed on 4 domains;
 - a. Mothers' factor: consisted of 6 items.
 - b. Family factor: consisted of 6 items.
 - c. Cultural factor: consisted of 6 items.
 - d. Hospital and healthcare provider factor: consisted of 8 items.

Scoring for items by using five-points Likert scale as follows:

(5) Strongly agree, (4) Agree, (3) Neutral, (2) Disagree, (1) Strongly Disagree

2. Attitudes towards companionship during labor (for mothers).

The questionnaire consisted of the following parts: (Annex 2)

- First part: personal information (age, level of education, job, monthly income, number of deliveries, and current birth status).
- Second part: consisted of 30 items distributed on 4 domains;
 - a. Mothers' factor: consisted of 10 items.
 - b. Family factor: consisted of 8 items.
 - c. Cultural factor: consisted of 6 items.
 - d. Hospital and healthcare provider factor: consisted of 6 items.

Scoring for items by using five-points Likert scale as follows:

(5) strongly agree, (4) agree, (3) neutral, (2) disagree, (1) strongly disagree

3.8 Pilot study

The questionnaires were evaluated by experts (Annex 3) to assess all the components and the context of the instrument, in order to ensure that it is valid and relevant and their comments were taken in consideration. Then, A pilot study was conducted to examine reliability of questionnaires. Internal consistency and Cronbache alpha coefficient were used (Annex 8).

3.9 Data collection

Data have been collected by the researcher and two assistant midwives after being trained by the researcher on how to use the questionnaires in data collection. Each questionnaire

has a consent form in the first page that asks the participants to participate in the study voluntarily. Time allocated for filling the questionnaire was 15-20 minutes.

Data collection took place during morning, evening, and night shift for eligible women who were in active labour before delivery. Women who were categorized as high risk and those who delivered by CS mode were excluded from the study.

3.10 Data entry and analysis

The researcher used SPSS program (version 20) for data entry and analysis. Statistical analysis included frequencies, means, and standard deviation. Advanced statistical procedures used including (t) test, and One-way ANOVA.

3.11 Ethical and administrative considerations

Before starting the study, agreement from Al Quds university have been obtained, then approval to carry out the study was obtained from Helsinki Committee (annex 4) and MoH (annex 5). Also, voluntary participation and confidentiality of information were maintained.

3.12 Limitation of the study

The study was restricted for mothers who had vaginal delivery while those delivered by CS were not included in the study. Also, the study was limited to mothers who delivered in the maternity hospital in SMC. Moreover, husbands were not included as potential companions during labour.

Chapter Four

Results and discussion

This chapter presents the findings of statistical analysis of data. Description of demographic characteristics of study participants was illustrated and the results of different variables and dimensions were identified, moreover, the differences between selected variables were explored as illustrated below.

4.1 Mothers' part

4.1.1 Sociodemographic characteristics of mothers

Table (4.1): Distribution of mothers according to demographic variables (n= 272)

Variable	n	Percent
Age		
16 – 20 years	61	22.4
21 – 25 years	101	37.2
26 – 30 years	62	22.8
31 years and more	48	17.6
Total	272	100.0
Mean age = 25.51 SD = 5.82		
Level of education		
Prep school	27	9.9
Secondary school	125	46.0
University	120	44.1
Work status		
Housekeeper	252	92.6
Working / employed	20	7.4
Family income		
< 500 NIS	200	73.5
501 – 1000 NIS	44	16.5
1001 – 1500 NIS	15	5.5
1501 NIS and more	13	4.8

Results from table (4.1) revealed that 272 mothers, their mean age 25.51 ± 5.82 years, and more than one third of mothers 101 (37.2%) aged between 21 – 25 years, the highest percentage of mothers had secondary education 125 (46%), followed by 120 (44.1%) of mothers had university education, which indicated that the majority of mothers had secondary school education and university education. Moreover, the vast majority of mothers 252 (92.6%) were housekeepers, and the majority of mothers 226 (83.1%) had low family income less than 500 NIS.

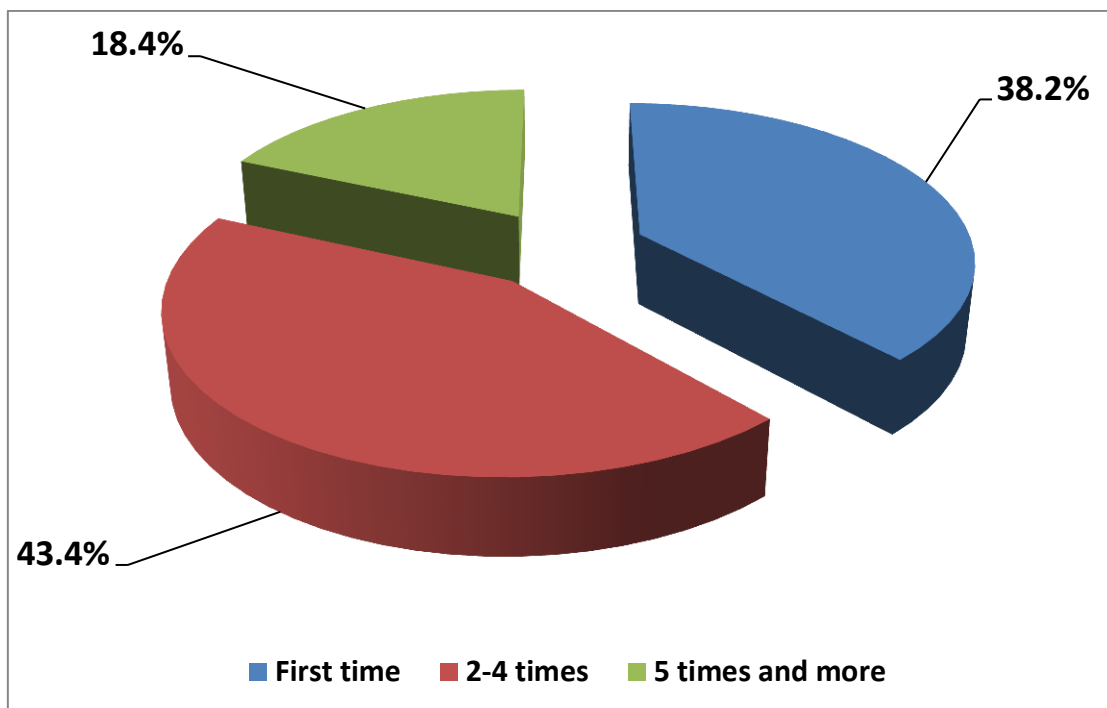


Figure (4.1): Distribution of mothers by number of deliveries

Figure 4.1 showed that the highest number of mothers 118 (43.4%) had 2 – 4 deliveries, followed by 104 (38.2%) were primiparous, and 50 (18.4%) delivered 5 times and more.

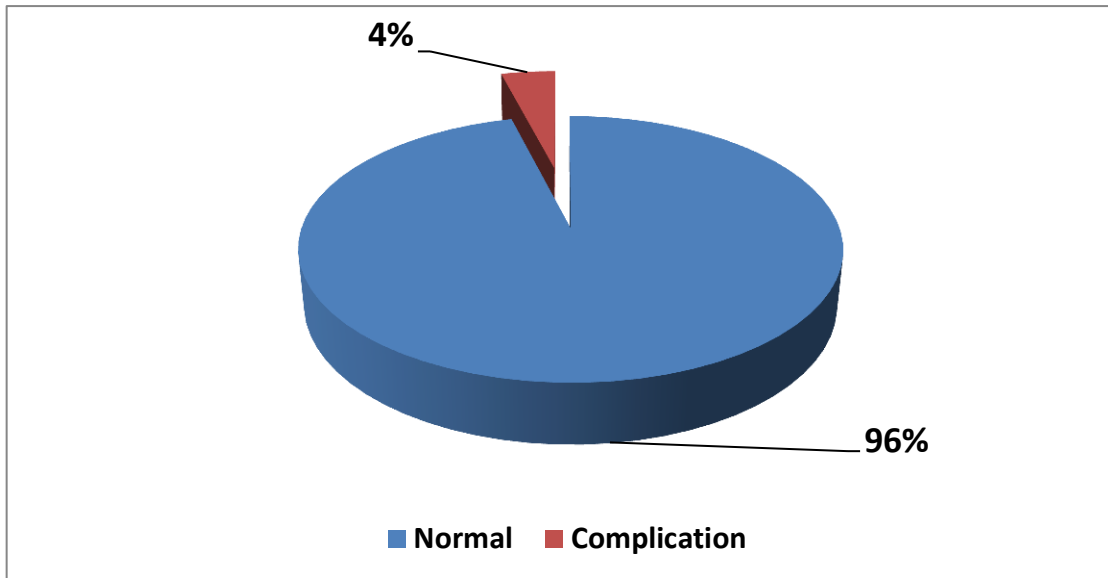


Figure (4.2): Distribution of mothers by status of current delivery

Figure 4.2 showed that the vast majority of mothers 261 (96%) had normal delivery, while 11 (4%) had complications such as postpartum hemorrhage, vaginal tear and laceration.

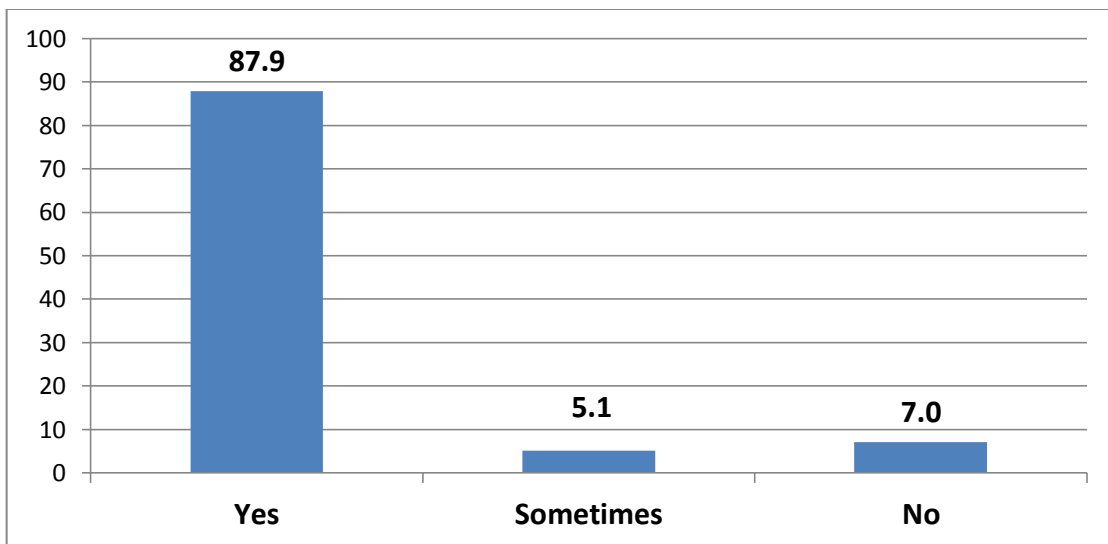


Figure (4.3): Distribution of mothers by preference to have a companion during labour

Figure 4.3 showed that the majority of mothers 239 (87.9%) said that they preferred to have a companion during labour.

4.1.2 Attitudes of mothers toward having companion during labour

**Table (4.2a): Mothers' attitudes toward having companion during labour
(Mothers' factors)**

Rank	Statement	S. agree	Agree	Neutral	Disagree	S. disagree	Mean	S.D.	Weighted %
1	Presence of a companion is pleasurable for me	71.0	19.5	3.7	5.1	0.7	4.54	0.84	90.8
2	The companion provides emotional support to me	67.6	22.4	6.6	2.6	0.7	4.53	0.79	90.6
3	Presence of companion decreases my anxiety	67.3	20.6	4.4	6.6	1.1	4.46	0.93	89.2
4	The companion provides social support to me	62.1	23.9	9.2	4.0	0.7	4.42	0.87	88.4
5	The companion is stabilizing my psychological status	64.3	23.9	4.8	4.0	2.9	4.42	0.96	88.4
6	Presence of a companion increases my self-confidence	61.4	25.0	7.4	5.1	1.1	4.40	0.91	88.0
7	Presence of companion creates a feeling of confidence in me	59.6	24.6	7.7	5.5	2.6	4.33	1.00	86.6
8	The companion provides opportunity to express my suffering to familiar person	53.3	23.5	11.8	8.1	3.3	4.15	1.11	83.0
9	Presence of companion is decreasing my embarrassment	51.5	24.6	11.8	8.1	4.0	4.11	1.14	82.2
10	Presence of companion decreases the pain of delivery	47.8	26.5	10.7	10.3	4.8	4.02	1.19	80.4
Overall							4.342	0.812	86.84

Table 4.2a indicated that the highest scores obtained in the statement "Presence of a companion is pleasurable for me" with mean score 4.54 and weighted percentage 90.8%, followed by "The companion provides emotional support to me" with mean score 4.53 and weighted percentage 90.6%, and the lowest score was in "Presence of companion is decreasing the pain of delivery" with mean score 4.02 and weighted percentage 80.4%.

**Table (4.2b): Mothers' attitudes toward having companion during labour
(Family factors)**

Rank	Statement	S. agree	Agree	Neutral	Disagree	S. disagree	Mean	S.D.	Weighted %
1	Presence of a companion gives a sense of security to my family	70.2	22.8	2.6	3.3	1.1	4.57	0.79	91.4
2	Presence of a companion is calming for my family	69.1	22.4	3.3	3.3	1.8	4.53	0.85	90.6
3	Presence of a companion is pleasant for my family	66.2	25.0	4.0	3.3	1.5	4.51	0.84	90.2
4	Presence of a companion decreases the anxiety of my family	65.1	26.1	2.9	3.7	2.2	4.48	0.89	89.6
5	Presence of a companion is satisfying my husband	66.5	24.3	2.9	3.7	2.6	4.48	0.91	89.6
6	Presence of a companion is respect to my family	57.4	24.3	9.6	5.1	3.7	4.26	1.06	85.2
7	Presence of a companion is increasing trust between my family and healthcare providers	54.4	27.2	10.3	5.5	2.6	4.25	1.01	85.0
8	Presence of a companion strengthens my family relationships with healthcare providers	51.5	29.4	11.8	5.1	2.2	4.22	0.99	84.4
Overall							4.417	0.773	88.34

Table 4.2b indicated that the highest score obtained in the statement "Presence of a companion gives a sense of security to my family" with mean score 4.57 and weighted percentage 91.4% followed by "Presence of a companion is calming for my family" with

mean score 4.53 and weighted percentage 90.6%, while the lowest score was obtained in "Presence of a companion strengthens my family relationships with healthcare providers" with mean score 4.22 and weighted percentage 84.4%.

**Table (4.2c): Mothers' attitudes toward having companion during labour
(Cultural factors)**

Rank	Statement	S. agree	Agree	Neutral	Disagree	S. disagree	Mean	S.D.	Weighted %
1	I prefer to have my mother with me as a companion	77.9	10.3	2.6	2.2	7.0	4.50	1.12	90.0
2	Presence of a companion is against my religion	48.9	26.5	8.8	8.5	7.4	4.01	1.25	80.2
3	I prefer to have my mother in law with me as a companion	51.8	19.5	7.0	6.3	15.4	3.86	1.48	77.2
4	I prefer to have my sister with me as a companion	42.6	20.2	12.9	7.4	16.9	3.64	1.50	72.8
5	Presence of a companion is welcomed in our culture	34.9	27.9	13.6	5.1	18.4	3.55	1.46	71.0
6	I prefer to have my husband as a companion	41.2	14.7	6.6	8.8	28.7	3.30	1.71	66.0
Overall							3.813	0.834	76.26

Table 4.2c indicated that the highest score obtained in the statement "I prefer to have my mother with me as a companion" with mean score 4.50 and weighted percentage 90%, followed by "presence of a companion is against my religion" with mean score 4.01 and weighted percentage 80.2, while the lowest score was in "I prefer to have my husband as a companion" with mean score 3.30 and weighted percentage 66%.

Table (4.2d): Mothers' attitudes toward having companion during labour**(Hospital & Health care providers factors)**

Rank	Statement	S. agree	Agree	Neutral	Disagree	S. disagree	Mean	S.D.	Weighted %
1	The health care providers allow the companion to help in providing some care to me.	37.1	27.6	23.2	6.3	5.9	3.83	1.16	76.6
2	The hospital policy allows the presence of a companion during labor.	20.6	21.0	5.9	11.4	41.2	3.68	1.64	73.6
3	The department environment facilitates the presence of a companion by respecting privacy of me and other mothers.	37.1	21.3	11.8	11.4	18.4	3.47	1.52	69.4
4	The health care providers allow me to have a companion during labor.	34.9	18.0	12.9	15.1	19.1	3.34	1.54	66.8
5	The midwives and nurses are supportive to presence of a companion during childbirth.	22.4	23.2	12.1	15.1	27.2	2.98	1.54	59.6
6	The physicians are supportive to presence of a companion during childbirth.	18.8	18.4	9.9	16.2	36.8	2.66	1.56	53.2
Overall							3.164	1.178	63.28

Table 4.2d showed that the highest score was in the statement "The health care providers allow the companion to help in providing some care to me" with mean score 3.83 and weighted percentage 76.6%, followed by "The hospital policy allows the presence of a companion during labour" with mean score 3.68 and weighted percentage 73.6%, while the lowest scores obtained in "The physicians are supportive to presence of a companion

during childbirth" with mean score 2.66 and weighted percentage 53.2%, followed by "The midwives and nurses are supportive to presence of a companion during childbirth" with mean score 2.98 and weighted percentage 59.6.

Table (4.3): Ranking of overall mean scores of mothers' attitudes toward having a companion during labour

Rank	Domain	Number of items	Mean	SD	Percent
1	Family factors	8	4.417	0.773	88.34
2	Mothers' factors	10	4.342	0.812	86.84
3	Cultural factors	6	3.813	0.834	76.26
4	Hospital & health care providers factors	6	3.164	1.178	63.28
Overall average		30	4.021	0.716	80.42

Table 4.3 presented calculation of mean scores for each domain and overall average score for attitudes of mothers toward having a companion during labour. The results showed that the highest score was in the family factors domain with mean score 4.417 and weighted percentage 88.34%, followed by mothers' factors domain with mean score 4.342 and weighted percentage 86.84%, cultural factors domain with mean score 3.813 and weighted percentage 76.26%, while the lowest score was in the hospital and health care providers factors domain with mean score 3.164 and weighted percentage 63.28%. The overall mean score was 4.021 and weighted percentage 80.42%.

4.1.3 Attitudes of mothers toward having companion during labour and selected variables

Table (4.4a): Attitudes of mothers toward having companion during labour and age (n= 272)

Domain	Age (years)	n	Mean (SD)	F	P value
Mothers' factors	16 – 20	61	4.48 (0.68)	3.383	0.019 *
	21 – 25	101	4.44 (0.67)		
	26 – 30	62	4.24 (0.83)		
	31 and more	48	4.06 (1.09)		
Family factors	16 – 20	61	4.57 (0.61)	3.046	0.029 *
	21 – 25	101	4.50 (0.70)		
	26 – 30	62	4.28 (0.79)		
	31 and more	48	4.21 (0.77)		
Cultural factors	16 – 20	61	3.96 (0.65)	3.729	0.012 *
	21 – 25	101	3.87 (0.81)		
	26 – 30	62	3.84 (0.70)		
	31 and more	48	3.46 (1.12)		
Hospital & Health care providers factors	16 – 20	61	3.19 (0.98)	0.423	0.736
	21 – 25	101	3.24 (1.20)		
	26 – 30	62	3.06 (1.13)		
	31 and more	48	3.07 (1.40)		
Overall	16 – 20	61	4.14 (0.56)	3.159	0.025 *
	21 – 25	101	4.10 (0.62)		
	26 – 30	62	3.93 (0.66)		
	31 and more	48	3.78 (1.01)		

* Statistically significant at ≤ 0.05 (One way ANOVA)

Table 4.4a showed that there were statistically significant differences in attitudes toward having a companion during labour related to age in mothers' factors (F= 3.383, P= 0.019), in family factors (F= 3.046, P= 0.029), in cultural factors (F= 3.729, P= 0.012), and in total

scores ($F= 3.159$, $P= 0.025$), but differences were insignificant in hospital and health care providers factors ($F= 0.423$, $P= 0.736$). Post hoc Scheffe test revealed that mothers aged 31 years old and more had lower attitudes toward having a companion during labour compared to mothers aged 16 – 20 years and mothers aged 21 – 25 years.

Table (4.5): Attitudes of mothers toward having companion during labour and level of education (n = 272)

Domain	Level of education	n	Mean (SD)	F	P value
Mothers' factors	Prep school	27	4.04 (1.19)	2.194	0.113
	Secondary school	125	4.35 (0.79)		
	University	120	4.40 (0.70)		
Family factors	Prep school	27	4.19 (1.06)	1.276	0.281
	Secondary school	125	4.43 (0.77)		
	University	120	4.45 (0.68)		
Cultural factors	Prep school	27	3.46 (0.95)	3.039	0.050 *
	Secondary school	125	3.80 (0.85)		
	University	120	3.90 (0.76)		
Hospital & Health care providers factors	Prep school	27	2.99 (1.37)	1.242	0.291
	Secondary school	125	3.28 (1.19)		
	University	120	3.07 (1.10)		
Overall	Prep school	27	3.75 (1.03)	2.039	0.132
	Secondary school	125	4.04 (0.71)		
	University	120	4.05 (0.620)		

* Statistically significant at ≤ 0.05 (One way ANOVA)

Table 4.5 showed that there were statistically insignificant differences in attitudes toward having a companion during labour related to level of education in all domains and the total

score, but differences were statistically significant in cultural factors ($F= 3.039$, $P= 0.050$). Post hoc Scheffe test indicated that mothers with university education had higher attitudes toward having a companion during labor compared to mothers with prep school education.

Table (4.6): Attitudes of mothers toward having companion during labour and work status (n = 272) (t test)

Domain	Work status	n	Mean	SD	t	P value
Mothers' factors	Housekeeper	252	4.34	0.80	0.101	0.920
	Working	20	4.32	0.90		
Family factors	Housekeeper	252	4.42	0.77	0.403	0.687
	Working	20	4.35	0.77		
Cultural factors	Housekeeper	252	3.82	0.82	0.586	0.558
	Working	20	3.70	0.96		
Hospital & Health care providers factors	Housekeeper	252	3.19	1.17	1.706	0.089
	Working	20	2.73	1.16		
Overall	Housekeeper	252	4.03	0.71	0.851	0.396
	Working	20	3.89	0.77		

Table 4.6 showed that there were statistically insignificant differences between mothers who are working and those who are not working (housekeepers) in all domains and the overall scores of attitudes scale.

Table (4.7): Attitudes of mothers toward having companion during labour and family income (n = 272)

Domain	Monthly income	n	Mean (SD)	F	P value
Mothers' factors	< 500 NIS	200	4.42 (0.71)	4.925	0.002 *
	501 – 1000 NIS	44	3.92 (0.95)		
	1001 – 1500 NIS	15	4.34 (1.11)		
	≥1501 NIS	13	4.50 (0.95)		
Family factors	< 500 NIS	200	4.50 (0.66)	5.163	0.002 *
	501 – 1000 NIS	44	4.02 (0.95)		
	1001 – 1500 NIS	15	4.25 (1.08)		
	≥1501 NIS	13	4.56 (0.85)		
Cultural factors	< 500 NIS	200	3.89 (0.75)	2.318	0.076
	501 – 1000 NIS	44	3.56 (0.98)		
	1001 – 1500 NIS	15	3.62 (0.97)		
	≥1501 NIS	13	3.65 (1.16)		
Hospital & Health care providers factors	< 500 NIS	200	3.32 (1.13)	6.445	0.000 *
	501 – 1000 NIS	44	2.50 (1.03)		
	1001 – 1500 NIS	15	3.06 (1.36)		
	≥1501 NIS	13	3.00 (1.42)		
Overall	< 500 NIS	200	4.12 (0.60)	6.972	0.000 *
	501 – 1000 NIS	44	3.59 (0.84)		
	1001 – 1500 NIS	15	3.92 (1.01)		
	≥1501 NIS	13	4.05 (0.92)		

* Statistically significant at ≤ 0.05 (One way ANOVA)

Table 4.7 showed that there were statistically significant differences at 0.05 in attitudes toward having a companion during labour related to monthly income in mothers' factors (F= 4.925, P= 0.002), family factors (F= 5.163, P= 0.002), hospital and health care providers factors (F= 6.445, P= 0.000), and overall score of the scale (F= 6.972, P= 0.000), but differences were insignificant in cultural factors (F= 2.318, P= 0.076). Post hoc Scheffe test indicated that mothers with low income of less than 500 NIS had higher attitudes toward having a companion during labour compared to mothers with higher income.

Table (4.8): Attitudes of mothers toward having companion during labour and number of deliveries (n = 272)

Domain	Number of deliveries	n	Mean (SD)	F	P value
Mothers' factors	First time	104	4.46 (0.57)	4.442	0.013 *
	2 – 4	118	4.36 (0.80)		
	5 and more	50	4.05 (1.14)		
Family factors	First time	104	4.51 (0.55)	2.692	0.070
	2 – 4	118	4.42 (0.81)		
	5 and more	50	4.20 (0.99)		
Cultural factors	First time	104	3.97 (0.61)	7.003	0.001 *
	2 – 4	118	3.82 (0.84)		
	5 and more	50	3.45 (1.09)		
Hospital & Health care providers factors	First time	104	3.16 (1.02)	1.989	0.139
	2 – 4	118	3.04 (1.21)		
	5 and more	50	3.44 (1.36)		
Overall	First time	104	4.11 (0.48)	2.419	0.091
	2 – 4	118	4.00 (0.72)		
	5 and more	50	3.85 (1.02)		

* Statistically significant at ≤ 0.05 (One way ANOVA)

Table 4.8 showed that there were statistically significant differences at 0.05 in attitudes toward having a companion during labour related to number of deliveries in mothers factors (F= 4.442, P= 0.013) and cultural factors (F= 7.003, P= 0.001), but there were insignificant differences in the family factors domain (F= 2.692, 0.070), hospital and health care provider factors domain (F= 1.989, P= 0.139), and the total score of the scale (F= 2.419, F= 0.091). Post hoc Scheffe test indicated that primiparous mothers had higher attitudes toward having a companion during labour compared to mothers who delivered 5 times and more.

Table (4.9): Attitudes of mothers toward having companion during labour and status of current delivery (n = 272)

Domain	status of current delivery	n	Mean	SD	t	P value
Mothers' factors	Normal	261	4.33	0.814	-0.731	0.465
	Complications	11	4.51	0.776		
Family factors	Normal	261	4.42	0.766	0.284	0.777
	Complications	11	4.35	0.977		
Cultural factors	Normal	261	3.83	0.822	1.834	0.068
	Complications	11	3.36	1.040		
Hospital & Health care providers factors	Normal	261	3.16	1.173	0.038	0.970
	Complications	11	3.15	1.367		
Overall	Normal	261	4.02	0.710	0.243	0.808
	Complications	11	3.96	0.874		

(T test)

Table 4.9 showed that there were statistically insignificant differences in attitudes toward having a companion during labour related to status of current delivery in mothers' factors domain (t= 0.731, P= 0.465), family factors domain (t= 0.284, P= 0.777), cultural factors domain (t= 1.834, P= 0.068), hospital and health care providers factor domain (t= 0.038, P= 0.970), and overall score of the scale (t= 0.243, P= 0.808).

4.2 Healthcare providers' part

4.2.1 Sociodemographic characteristics of healthcare providers

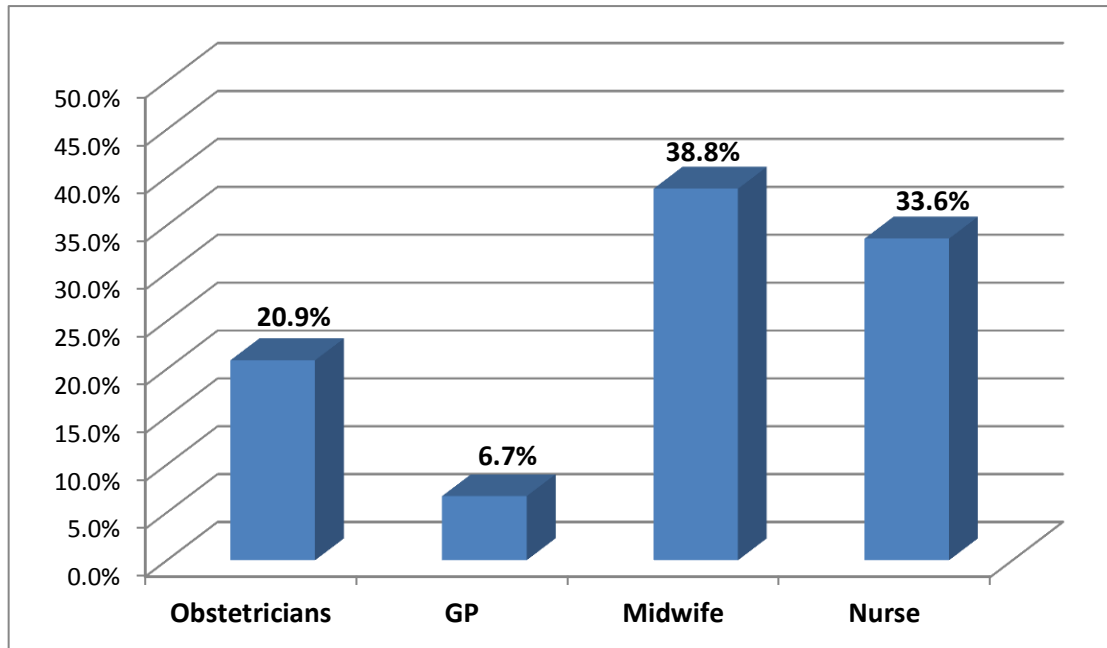


Figure (4.4): Distribution of healthcare providers by specialty

Figure 4.4 illustrated that 134 healthcare providers participated in the study divided as follows: 28 (20.9%) obstetricians, 9 (6.7%) general practitioners, 52 (38.8%) midwives, and 45 (33.6%) nurses.

**Table (4.10): Distribution of healthcare providers by gender and years of experience
(n = 134)**

Variable	Category	Specialty of healthcare providers			
		Obstetrician n (%)	GP n (%)	Midwife n (%)	Nurse n (%)
Gender	Male	14 (50.0)	4 (44.4)	0	0
	Female	14 (50.0)	5 (55.6)	52 (100.0)	45 (100.0)
	Total	28 (100.0)	9 (100.0)	52 (100.0)	45 (100.0)
Years of experience	1 – 5 years	8 (28.6)	6 (66.7)	20 (38.5)	7 (15.6)
	6 – 10 years	4 (14.3)	1 (11.1)	15 (28.8)	10 (22.2)
	11 – 15 years	3 (10.7%)	1 (11.1)	10 (19.2)	15 (33.3)
	16 years and more	13 (46.4)	1 (11.1)	7 (13.5)	13 (28.9)
	Total	28 (100.0)	9 (100.0)	52 (100.0)	45 (100.0)
			Mean = 10.582 SD= 7.128 years		

Table 4.10 showed that 50% of obstetricians and 4 (55.6%) of GPs were females. For years of experience, the results showed that 13 (46.4%) of obstetricians had an experience of 16 years and more, 6 (66.7%) of GPs had an experience of 1 – 5 years, 20 (38.5%) of midwives had an experience of 1 – 5 years, and 15 (33.3%) of nurses had an experience of 11 - 15 years. These results reflected variations in experience of healthcare providers who participated in the study.

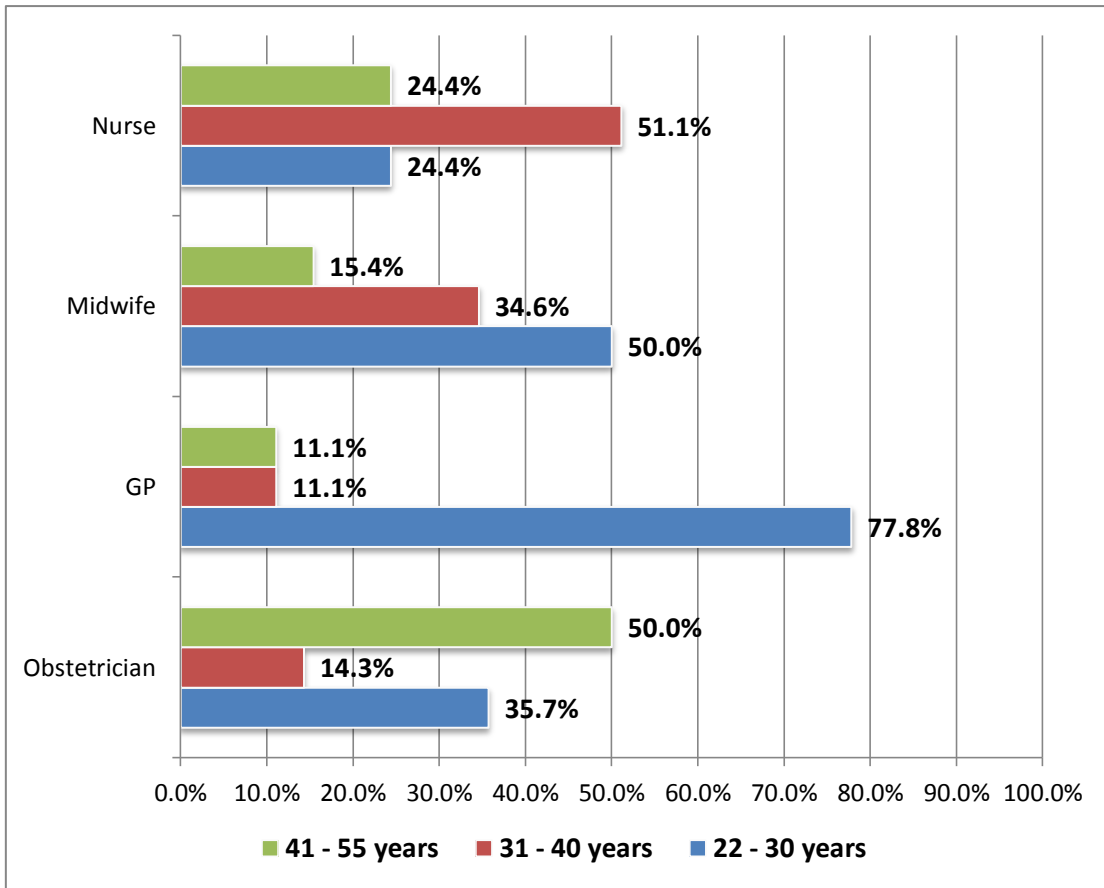


Figure (4.5): Distribution of healthcare providers by specialty and age

Figure 4.5 showed that 14 (50%) of obstetricians aged 41 - 55 years, 7 (77.8%) of GPs aged 22 – 30 years, 26 (50%) of midwives aged 22 – 30 years, and 23 (51.1%) of nurses aged 31 – 40 years. These results reflected variations in age of healthcare providers who participated in the study.

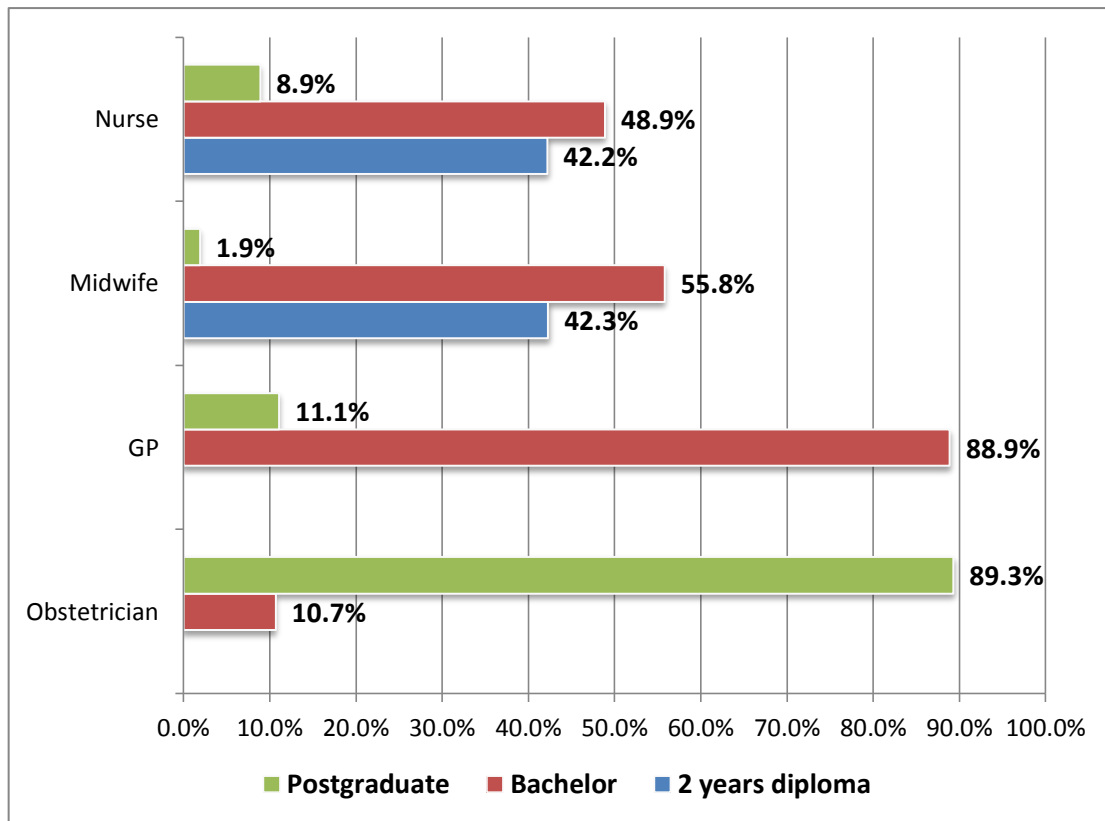


Figure (4.6): Distribution of healthcare providers by specialty and qualification

Figure 4.6 showed that 25 (89.3%) of obstetricians had postgraduate studies, 8 (88.9%) of GPs had bachelor degree, 29 (55.8%) of midwives had bachelor degree, and 22 (48.9%) of nurses had bachelor degree. In general, the results indicated that 30.6% of healthcare providers had 2 years diploma certificate, 46.3% had bachelor degree, and 23.1% had postgraduate studies.

4.2.2 Attitudes of healthcare providers toward having a companion during labour

Table (4.11a): Attitudes of healthcare providers toward having companion during labour (Mothers' factors)

No.	Statement	Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Mean	S.D.	Weighted %
1	I believe that the companion provides help to the mother in nonmedical activities (ambulation, massage, toileting).	39.6	42.5	11.2	3.0	3.7	4.11	0.97	82.2
2	I believe that presence of companion increases the mother's feeling of security.	34.3	48.5	11.9	4.5	0.7	4.11	0.83	82.2
3	I believe that presence of a companion improves emotional state of the mother.	37.3	47.0	9.0	2.2	4.5	4.10	0.97	82.0
4	I believe that presence of a companion acts as social support to the mother.	31.3	47.8	11.2	6.7	3.0	3.97	0.98	79.4
5	I believe that presence of companion helps in preventing frustration of mothers.	29.9	45.5	16.4	6.7	1.5	3.95	0.93	79.0
6	I believe that presence of companion will increase tolerance of labour pain.	23.1	46.3	17.9	10.4	2.2	3.77	0.99	75.4
Overall							4.00	0.70	80.0

Findings of table 4.11a indicated that the highest scores obtained in the statement "I believe that the companion provides help to the mother in nonmedical activities (ambulation, massage, toileting)" with mean score 4.11 and weighted percentage 82.2%, and "I believe that presence of companion increases the mother's feeling of security" with mean score 4.11 and weighted percentage 82.2%, while the lowest score was in the statement "I believe that presence of companion will increase tolerance of labour pain"

with mean score 3.77 and weighted percentage 75.4%. The overall mean score was 4.00 and weighted percentage 80.0.

Table (4.11b): Attitudes of healthcare providers toward having companion during labour (Family factors)

No.	Statement	Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Mean	S.D.	Weighted %
7	Presence of a companion is pleasant for mother's family.	17.9	51.5	20.9	6.0	3.7	3.73	0.94	74.6
8	Presence of a companion gives a sense of security to the family members.	15.7	53.7	18.7	8.2	3.7	3.69	0.95	73.8
9	Presence of a companion is calming for mother's family.	14.2	53.0	19.4	9.0	4.5	3.63	0.98	72.6
10	I believe that presence of a companion decreases the anxiety of the family.	17.2	49.3	17.2	11.2	5.2	3.61	1.06	72.2
11	Presence of a companion helps in building trust relationship between family and healthcare providers.	14.9	41.0	28.4	11.9	3.7	3.51	1.00	70.2
12	I believe that presence of companion strengthens the relationship between family and healthcare providers.	11.9	38.8	29.1	12.7	7.5	3.35	1.08	67.0
Overall							3.59	0.75	71.8

Findings of table 4.11b showed that the highest scores obtained in the statement "Presence of a companion is pleasant for mother's family" with mean score 3.73 and weighted percentage 74.6% followed by "Presence of a companion gives a sense of security to the family members" with mean score 3.69 and weighted percentage 73.8%, while the lowest score obtained in "I believe that presence of companion strengthens the relationship between family and healthcare providers" with mean score 3.35 and weighted percentage 67%. The overall mean score was 3.59 and weighted percentage 71.8.

Table (4.11c): Attitudes of healthcare providers toward having companion during labour (Cultural factors)

No.	Statement	Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Mean	S.D.	Weighted %
13	I prefer to have the mother as a companion with her daughter during labour.	24.6	37.3	20.1	11.2	6.7	3.61	1.16	72.2
14	I believe that presence of a companion is welcomed in our culture.	13.4	42.5	20.9	15.7	7.5	3.38	1.12	67.6
15	I prefer to have the sister as a companion with the woman during labour.	11.9	32.8	23.9	14.9	16.4	3.08	1.27	61.6
16	I believe that presence of a companion is against my religious beliefs.	12.7	18.7	29.9	24.6	14.2	2.91	1.22	58.2
17	I prefer to have the husband as a companion with his wife during labour.	15.7	20.1	18.7	17.2	28.4	2.77	1.44	55.4
18	I prefer to have the mother in law as a companion during labour.	8.2	15.7	29.9	17.9	28.4	2.57	1.27	51.4
Overall							3.05	0.73	61.0

Findings of table 4.11c showed that the highest score obtained in the statement "I prefer to have the mother as a companion with her daughter during labour" with mean score 3.61 and weighted percentage 72.2%, followed by "I believe that presence of a companion is welcomed in our culture" with mean score 3.38 and weighted percentage 67.6%, and the lowest score obtained in "I prefer to have the mother in law as a companion during labour"

with mean score 2.57 and weighted percentage 51.4%. The overall mean score was 3.05 and weighted percentage 61.0.

Table (4.11d): Attitudes of healthcare providers toward having companion during labour (Hospital & Health care providers factors)

No.	Statement	Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Mean	S.D.	Weighted %
19	I encourage the mothers to choose a companion during labour.	34.3	38.8	11.9	8.2	6.7	3.85	1.17	77.0
20	I believe that presence of a companion puts the healthcare team under pressure.	25.4	30.6	23.9	12.7	7.5	3.53	1.21	70.6
21	The hospital environment supports the attendance of a companion during labour through ensuring privacy of all clients.	25.4	23.1	24.6	14.9	11.9	3.35	1.32	67.0
22	I support the presence of a companion during labour.	13.4	33.6	26.1	13.4	13.4	3.20	1.23	64.0
23	Our hospital has a clear written policy that encourages the attendance of a companion with mother during labour.	19.4	26.9	20.1	21.6	11.9	3.20	1.30	64.0
24	I believe that presence of a companion is helpful to the healthcare team.	11.9	27.6	26.1	16.4	17.9	2.99	1.28	59.8
25	I support the modification of hospital policy to allow the husband to be a companion during labour.	17.9	22.4	18.7	21.6	19.4	2.97	1.39	59.4
26	I support the modification of hospital environment to allow the husband to be a companion during labour.	17.2	22.4	15.7	20.9	23.9	2.88	1.44	57.6
Overall							3.25	0.80	65.0

Findings of table 4.11d showed that the highest scores obtained in the statement "I encourage the mothers to choose a companion during labour" with mean score 3.85 and

weighted percentage 77%, followed by "I believe that presence of a companion puts the healthcare team under pressure" with mean score 3.53 and weighted percentage 70.6%, while the lowest score obtained in "I support the modification of hospital environment to allow the husband to be a companion during labour" with mean score 2.88 and weighted percentage 57.6%. The overall mean score was 3.25 and weighted percentage 65.0.

Table (4.12): Ranking of overall mean scores of attitudes of healthcare providers toward having companion during labour (n = 134)

Rank	Domain	Number of items	Mean	SD	Percent
1	Mothers' factors	6	4.00	0.70	80.0
2	Family factors	6	3.59	0.75	71.8
3	Hospital & Health care providers factors	8	3.25	0.80	65.0
4	Cultural factors	6	3.05	0.73	61.0
Overall average		26	3.45	0.60	69.0

Table 4.12 presented calculation of mean scores for each domain and overall average score for attitudes of healthcare providers toward having a companion during labour. The results showed that the highest score was in the mothers' factors domain with mean score 4.00 and weighted percentage 80.0%, while the lowest score was in cultural factors domain with mean score 3.05 and weighted percentage 61%. The overall mean score was 3.45 and weighted percentage 69.0%.

Table (4.13): Attitudes of healthcare providers toward having companion during labour and specialty (n = 134)

Domain	Specialty	n	Mean	SD	F	P value
Mothers' factors	Obstetrician	28	4.08	0.77	0.842	0.473
	GP	9	3.90	0.41		
	Midwife	52	4.08	0.54		
	Nurse	45	3.88	0.84		
Family factors	Obstetrician	28	3.77	0.84	4.291	0.006 *
	GP	9	3.51	0.76		
	Midwife	52	3.76	0.63		
	Nurse	45	3.28	0.76		
Cultural factors	Obstetrician	28	2.75	0.65	6.913	0.000 *
	GP	9	3.00	0.35		
	Midwife	52	3.39	0.66		
	Nurse	45	2.88	0.77		
Hospital & Health care providers factors	Obstetrician	28	3.36	0.72	2.302	0.080
	GP	9	2.95	0.50		
	Midwife	52	3.41	0.83		
	Nurse	45	3.05	0.81		
Overall	Obstetrician	28	3.48	0.58	3.762	0.012 *
	GP	9	3.31	0.41		
	Midwife	52	3.64	0.55		
	Nurse	45	3.25	0.63		

* Statistically significant at ≤ 0.05 (One way ANOVA)

Table 4.13 showed that there were statistically significant differences at 0.05 in attitudes of health care providers toward having a companion during labour related to specialty and these differences were significant in family factors domain (F= 4.291, P= 0.006), cultural factors domain (F= 6.913, P= 0.000), and overall scores (F= 3.762, P= 0.012), while

differences were insignificant in family factors domain ($F= 0.842$, $P= 0.473$), and hospital and health care providers factors domain ($F= 2.302$, $P= 0.080$). Post hoc Scheffe test indicated that midwives and obstetricians had higher positive attitudes toward having a companion during labour compared to GPs and nurses.

Table (4.14): Attitudes of healthcare providers toward having companion during labour and qualification (n = 134)

Domain	Qualification	n	Mean	SD	F	P value
Mothers' factors	2 years diploma	41	3.98	0.90	0.638	0.530
	Bachelor	62	3.95	0.54		
	Postgraduate	31	4.13	0.69		
Family factors	2 years diploma	41	3.44	0.93	1.859	0.160
	Bachelor	62	3.59	0.56		
	Postgraduate	31	3.78	0.83		
Cultural factors	2 years diploma	41	3.14	0.86	3.028	0.052
	Bachelor	62	3.14	0.61		
	Postgraduate	31	2.77	0.71		
Hospital & Health care providers factors	2 years diploma	41	3.35	1.02	0.927	0.398
	Bachelor	62	3.15	0.66		
	Postgraduate	31	3.31	0.71		
Overall	2 years diploma	41	3.47	0.80	0.082	0.921
	Bachelor	62	3.44	0.43		
	Postgraduate	31	3.48	0.57		

(One way ANOVA)

Table 4.14 showed that there were statistically insignificant differences in attitudes toward having a companion during labour related to qualification of healthcare provider; mothers' factors ($F= 0.638$, $P= 0.530$), family factor ($F= 1.859$, $P= 0.160$), cultural factors ($F= 3.028$, $P= 0.052$), hospital and health care providers factors ($F= 0.927$, $P= 0.398$), and overall score ($F= 0.082$, $P= 0.921$).

Table (4.15): Attitudes of healthcare providers toward having companion during labour and gender (n = 134)

Domain	Gender	n	Mean	SD	t	P
Mothers' factors	Male	18	3.92	0.78	0.520	0.604
	Female	116	4.01	0.69		
Family factors	Male	18	3.75	0.93	0.948	0.345
	Female	116	3.56	0.72		
Cultural factors	Male	18	2.79	0.66	1.647	0.102
	Female	116	3.10	0.78		
Hospital & Health care providers factors	Male	18	3.14	0.71	0.592	0.555
	Female	116	3.26	0.81		
Overall	Male	18	3.38	0.66	0.568	0.571
	Female	116	3.47	0.59		

Table 4.15 showed that there were statistically insignificant differences in attitudes toward having a companion during labour related to gender of healthcare provider; mothers'

factors ($t= 0.520$, $P= 0.604$), family factor ($t= 0.948$, $P= 0.345$), cultural factors ($t= 1.647$, $P= 0.102$), and hospital and healthcare providers factors ($t= 0.592$, $P= 0.555$), and overall score ($t= 0.568$, $P= 0.571$).

Table (4.16): Attitudes of healthcare providers toward having companion during labour and age (n = 134)

Domain	Age	n	Mean	SD	F	P value
Mothers' factors	22 – 30 years	54	3.96	0.55	4.112	0.019 *
	31 – 40 years	46	3.84	0.84		
	41 – 55 years	34	4.28	0.63		
Family factors	22 – 30 years	54	3.50	0.68	2.251	0.109
	31 – 40 years	46	3.51	0.84		
	41 – 55 years	34	3.82	0.72		
Cultural factors	22 – 30 years	54	3.12	0.62	0.373	0.689
	31 – 40 years	46	3.01	0.77		
	41 – 55 years	34	3.01	0.84		
Hospital & Health care providers factors	22 – 30 years	54	3.33	0.69	0.551	0.578
	31 – 40 years	46	3.20	0.84		
	41 – 55 years	34	3.17	0.90		
Overall	22 – 30 years	54	3.47	0.52	0.785	0.458
	31 – 40 years	46	3.37	0.68		
	41 – 55 years	34	3.54	0.59		

* Statistically significant at ≤ 0.05 (One way ANOVA)

Table 4.16 showed that there were statistically significant differences in mothers' factors domain ($F= 4.112$, $P= 0.019$) and the differences were in favor of healthcare providers'

aged 41 – 55 years. While insignificant differences found in family factors ($F= 2.251$, $P= 0.109$), cultural factors ($F= 0.373$, $P= 0.689$), and hospital and health care providers factors ($F= 0.551$, $P= 0.578$), and overall score ($F= 0.785$, $P= 0.458$).

Table (4.17): Attitudes of healthcare providers toward having companion during labour and experience (n = 134)

Domain	Experience	n	Mean	SD	F	P value
Mothers' factors	1 – 5 years	41	4.00	0.64	0.135	0.939
	6 – 10 years	30	4.02	0.51		
	11 – 15 years	29	3.93	0.81		
	16 years and more	34	4.04	0.82		
Family factors	1 – 5 years	41	3.57	0.69	0.056	0.983
	6 – 10 years	30	3.56	0.81		
	11 – 15 years	29	3.63	0.73		
	16 years and more	34	3.60	0.82		
Cultural factors	1 – 5 years	41	3.16	0.68	1.485	0.222
	6 – 10 years	30	3.18	0.59		
	11 – 15 years	29	3.00	0.76		
	16 years and more	34	2.86	0.85		
Hospital & Health care providers factors	1 – 5 years	41	3.28	0.64	2.564	0.058
	6 – 10 years	30	3.53	0.81		
	11 – 15 years	29	3.12	0.72		
	16 years and more	34	3.04	0.94		
Overall	1 – 5 years	41	3.49	0.56	0.832	0.479
	6 – 10 years	30	3.58	0.50		
	11 – 15 years	29	3.40	0.61		
	16 years and more	34	3.36	0.70		

(One way ANOVA)

Table 4.17 showed that there were statistically insignificant differences in mothers' factors ($F= 0.135$, $P= 0.939$), family factors ($F= 0.056$, $P= 0.983$), cultural factors ($F= 1.485$, $P= 0.222$), hospital and health care providers factors ($F= 2.564$, $P= 0.058$), and overall score ($F= 0.832$, $P= 0.479$).

4.2.3 Comparison of attitudes of healthcare providers and mothers

Table (4.18): Comparison of overall mean scores of attitudes of mothers and healthcare providers toward having companion during labour

Domain	Mothers			Healthcare providers		
	Mean	SD	Percent	Mean	SD	Percent
Mothers' factors	4.342	0.812	86.84	4.00	0.70	80.0
Family factors	4.417	0.773	88.34	3.59	0.75	71.8
Cultural factors	3.813	0.834	76.26	3.05	0.73	61.0
Hospital & health care providers factors	3.164	1.178	63.28	3.25	0.80	65.0
Overall average	4.021	0.716	80.42	3.45	0.60	69.0

Comparison of mean scores of domains reflected that mothers have higher scores in all domains and overall average which indicated that mothers have higher attitudes (m= 4.021) toward having a companion during labour compared to health care providers (m= 3.45).

4.3 Discussion

4.3.1 Mothers part

The results of the study indicated that age of mothers ranged between 16 – 45 years with mean age 25.511 ± 5.828 , and less than half of mothers had university education which reflected a young age, well-educated population. The results also indicated that the vast majority of mothers were housekeeper and the majority have low income which reflected the general conditions of unemployment and increased levels of poverty in GS. The results indicated that more than one third of mothers were primiparous, and the vast majority had NVD without complications.

Previous studies reflected variations in demographic characteristics. The study of Olayemi et al. (2008) found that women age ranged between 18 – 44 years with a mean age of 31 ± 4.27 years, approximately half of the women were between 30 and 34 years, about three quarters had university education while one fifth had secondary school education. In addition, there were equal proportions of those who had two and three pregnancies while about one fifth have four or more pregnancies, and about half of them were nulliparous. The researcher attributed these differences to cultural issues as in the Palestinian society as marriage at teen age is common, and nowadays due to the hard-economic situation many parents tend to have their daughters marry at young age even before continuing their university education because they can't afford to pay for university education, and to decrease family expenses.

The results of the study reflected that mothers exhibited high positive attitudes towards having a companion of choice during labour, and the majority of them stated that they prefer to have a companion during labour. The study results were consistent with Iliadou (2012) who emphasized that women in labour have a profound need for companionship,

empathy and help. In addition, Olayemi et al., (2008) found that about three fourth of mothers wanted a companion to be present to offer social support during their labour, and the majority of these women preferred their husband, while very few wanted their mothers or their siblings as companion during labor. Also, Dulfe et al., (2016) found that more than half of women had a companion during labour, more than one third had a companion at the time of delivery, and Diniz et al., (2014) found that one quarter of women had no companion at all, almost one fifth had continuous companionship and more than half of women had partial companionship, while Al-Mandeel et al., (2013) reported that less than half of women preferred the presence of a companion during labour while more than half of women did not prefer the presence of any companion.

The results indicated that mothers need a companion during labour because the companion of choice provides psychosocial support, decrease mothers' anxiety, and increase self-confidence. Khresheh, (2010) mentioned that labor and delivery is one of the most significant and stressful experiences in a woman's life, and can have strong physical, emotional, and psychological effects. Thus, presence of a companion is essential during labour and childbirth. These results were consistent with Hodnett et al., (2015) who reported that women who had support by a companion reported less fear and distress during labour, which also appeared to act as a buffer against adverse aspects of medical interventions. Furthermore, Kabakian-Khasholian (2015) illustrated that women reported that being alone during labour raises feelings of fear and anxiety, and women benefit from and value the presence of a support person during labour to provide psychological, physical, emotional, informational and practical support.

The researcher believes that women in labour regardless of their race, ethnicity or nationality prefer to have a companion during childbirth and that could be explained in the

context that labour and childbirth is a stressful event for the mother and presence of a support person with her is essential for her psychosocial well-being and increase her self-confidence and cooperation with healthcare providers and that would make the delivery easier and safer.

The results also indicated that presence of companion decreases the pain of delivery. This result was supported by the results obtained by Hodnett et al., (2011) who emphasized the importance of social support in pain control, and Mosallam et al., (2004) found that women who had a companion had significantly less need for analgesia, and WHO (2016) reported that continuous support by a companion during labour decreased the usage of intrapartum analgesia. The researcher agreed that presence of a companion will support the mother in moving around, also, the companion will make distraction for the mother and that would make her feel less pain and more comfortable.

The results also reflected high positive attitudes toward having a companion during childbirth with mean score 4.021 and weighted percentage 80.42%. The results showed that the majority of women prefer to have their mothers as a companion, and others prefer to have their mother in law, their sisters, and others prefer to have their husband as a companion. Similar results obtained by Najafi et al., (2017) who reported that women believed that the presence of a companion, e.g. their husband, a family member, or a doula, during labor helped them better deal with the labor process, particularly when they felt lonely, and El-Magrabi and Mohamed, (2012) found that more than two thirds of women had positive attitudes towards the presence of the husband in the delivery room, while Al-Mandeel et al., (2013) reflected that more than half of women preferred to have their mother as a companion and half of them preferred their husband as a childbirth companion. Furthermore, Mosallam et al., (2004) reported that birth attendant accompanied two thirds

of mothers during labour, of them, two thirds were mother, one third were sisters, while few companions were friends or other family members, also, the vast majority of participants felt that psychosocial support during labour is essential and best provided by non-professional attendant. In addition, Olayemi et al., (2008) found that three quarters of mothers desired companionship in labour, and the majority preferred their husband as companion while very few wanted their mother and siblings as support person respectively. Reasons for social support were emotional, spiritual, and physical activity. These results reflected variations in preference of companion of choice as some women prefer to have their mothers, others prefer to have their husbands, or sisters, or mothers in law.

In my opinion, these differences could be related to cultural differences and societal norms and beliefs. For example, in our society, it is unacceptable to have the husband as a companion, and having a man sitting between women is rejected and may cause embarrassment to other women in the labour room, while in western communities, it is normal practice to have the husband stay with his wife during childbirth.

The results also indicated that older women (31 years old and more) had lower attitudes toward having companion during labor. The results indicated insignificant differences in attitudes toward having a companion during labour related to level of education, work, number of deliveries, and status of current delivery, but there were significant differences in attitudes toward having a companion during labour related to income and that mothers with low income had higher attitudes toward having a companion during labour. Diniz et al., (2014) reported that women with lower income, those who were less educated, and who used the public sector had fewer companions during childbirth. Also, Vehviläinen-Julkunen and Emelonye (2014) found that factors such as low level of education, poverty,

culture, religious beliefs, and health workers negative attitudes contributed to low companionship in labour and delivery. Moreover, Olayemi et al., (2008) found that nulliparity and work status were statistically significant factors for the desire of a companion during labour. While Al-Mandeel et al., (2013) found that level of education, antenatal, intrapartum or postpartum status had no impact on their decision to have a companion during labour, and more than one-third of participants thought that having a companion during labour would not help, and the most common reason for not preferring to have a companion was their fear of being exposed most of the time to their companion. In my opinion, variations in results could be attributed to differences in study settings, cultural differences, beliefs and norms, hospital policy, and rules and regulations. In addition, some factors such as age, level of education would influence the way of thinking and behaving, and it is assumed that older women and highly educated women would be more mature and could adjust to the stressful events during labour better than younger and low educated women.

4.3.2 Healthcare providers' part

The results also indicated that healthcare providers have above moderate positive attitudes toward having a companion during labour with mean score 3.45 and weighted percentage 69.0%. Furthermore, the results reflected that healthcare providers emphasized that the presence of companion is necessary and can help the mother in some physical activities like ambulation, massage, toileting.

In my opinion, presence of a companion will help and support the mother in some non-medical activities such as ambulation, going to toilet, and moving in bed. In this regard, A report published by WHO (2016) stated that allowing and supporting the presence of a woman's companion of choice during labor and childbirth is an effective intervention that

is respectful of women's autonomy and can be an important aspect of improving quality of care during labor and childbirth. In addition, Hodnett et al., (2015) emphasized that the supportive care may include having someone who is continuously present and who reassures and praises mothers, assists with measures for physical comfort including providing comforting touch, massage, warm bath or shower, promoting adequate fluid intake.

From my experience as a midwife supervisor working in the maternity hospital in Al Shifa Medical complex, I support and encourage the presence of companionship during labour, and encourage my subordinates to accept the presence of a companion during labour. In addition, I give instructions to the companion about ways of helping and supporting the mother during her ambulation and going to toilet. I believe that if the midwives give adequate instructions and teaching to the companion, much benefits will be gained for the mother and for healthcare providers. The workload in the maternity hospital is heavy, and having the companion help in non-medical activities will give the midwife adequate time to concentrate on other activities and tasks that need skills and experience of the midwife.

The results indicated significant differences in attitudes toward having a companion during labor related to specialty and that midwives and obstetricians had higher positive attitudes toward having a companion during labour compared to GPs and nurses, but there were insignificant differences related to qualification (diploma, bachelor, and postgraduate).

In my opinion, the midwives and obstetricians are available all the time in labour room compared to nurses and general practitioners who are working in the postnatal wards and that increase their understanding of the physical and psychological needs of mothers in labour compared to nurses and GPs, thus they will support and encourage the idea of having a companion with mothers during the stressful event of labour, and they are aware

that if the mother is comfortable and have good psychological status, she will be more cooperative and that will make the delivery more smooth and less painful.

The results also indicated insignificant differences in attitudes toward having a companion during labour related to gender, age of health care providers, and years of experience. It is worth to say that differences in attitudes toward companionship during labour are attributed to personal and organizational factors. Some authors reported that a number of individual-level and system-level factors pertaining to the policies, organization and management of health care have been reported to be associated with positive childbirth experiences, such as women's involvement in the decision-making process, access to information, familiarity with the care provider, support during labour and type of birth (Hodnett, 2002; Lobel and DeLuca, 2007; Fair and Morrison, 2012; Leap et al., 2010; Bryanton et al., 2008).

In my opinion, giving the mother and her companion the chance to ask questions and respond to their worries is an important role of midwives in the maternity department, and that will alleviate mothers' anxiety and stress. In addition, organizational factors such as structure of the building should be modified to have appropriate waiting areas with comfortable seats and TV screen to decrease relatives' anxiety and wait in a place that do not make crowd and noise in the department, also, policies and procedures should be reviewed and clearly support the presence of a companion during labour so it becomes part of hospital's norms.

Despite advances of maternity services, many health care facilities still do not permit women to have a companion of choice during labour and childbirth, and this could be related to absence of national or institutional policies, the physical infrastructure of health care facilities which limits privacy, limited knowledge among healthcare providers and

managers about the benefits of labour companionship, and negative attitudes of healthcare providers towards companionship (Kabakian-Khasholian et al., 2015).

4.3.3 Discussion summary

In general, the results indicated that mothers have higher positive attitudes toward having a companion during labour compared to health care providers (80.42 vs. 69.0). This result indicated that presence of companion during labour is more welcomed by mothers than healthcare providers and presence of companion is helpful to mothers in different aspects physically, psychologically, and socially. This result was supported with Banda et al., (2010) who found that supportive companionship for women during labour and childbirth is highly acceptable among mothers and health professionals, and that the vast majority of women and health professionals found that supportive companionship was beneficial, mainly for psychological and physical support to the labouring woman and for providing assistance to healthcare providers. Moreover, several studies found high preference for support during labor; in Jordan (Mosallam et al., 2004), in Nigeria (Brown et al., 2007), in South Africa (Kashanian et al., 2010), and in Iran (Khresheh, 2010).

From the researcher's point of view, many healthcare providers do not accept the presence of a companion because they may feel insecure and do not want to have others looking at them when they are performing their care practice. The researcher believes that more efforts are needed to influence the attitudes of health care providers for the successful implementation of companion of choice in Al Shifa hospital, and that could be attained by highlighting the positive perspectives of companionship during labour and how it contributes to better outcome of labor including shorter duration of labour, less use of analgesic medication, and less interventional procedures (Hodnett et al., 2015).

Chapter Five

Conclusion and recommendations

5.1 Conclusion

This study assessed the attitudes of both mothers and healthcare providers toward presence of a companion during labour in Al Shifa maternity hospital. The results revealed that the vast majority of mothers prefer to have a companion during labour. Most of women perceive presence of a companion as helpful and supportive. The findings of the study are encouraging in that mothers, and healthcare providers perceive the companion as a person who provides help and physical and psychological support to the labouring woman.

The study results reflected that the majority of mothers prefer to have a companion during delivery and childbirth and that presence of companion provides emotional and social support and decrease anxiety of mothers and their families as well. In addition, the vast majority of women prefer to have their mothers as a companion of choice during labour, and labouring mothers need a companion because the companion provides psychosocial support, decrease mothers' anxiety, decrease labour pain, and increase self-confidence.

For healthcare providers, the results reflected lower attitudes towards having a companion during labour compared to mothers, and that more than half of health care providers support the modification of hospital policy and environment to allow for attendance of companion during labour.

The study highlighted the need for developing evidence-based health policies to integrate presence of a companion of choice as part of maternity services and as part of quality of care in maternity departments.

5.2 Recommendations

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

For mothers and families

- Encourage the women to choose a companion of choice during labour to help in some nonmedical activities such as ambulation, bathing, and feeding.
- Encourage the women to bring the companion of choice with them during antenatal visits to receive information and instructions about the role of companion during labour.

For healthcare providers

- Encourage healthcare providers to accept and welcome the presence of companion during labour and consider this issue as part of quality of maternity care.
- Encourage the attendance of companion of choice to build a trust relationship between healthcare providers and mothers and their families.

For organization

- Modify the structure of maternity departments to be suitable for attendance of a companion and promote privacy for the mothers in labour.
- Develop a written policy allowing attendance of companions during labour as part of the rights for labouring women.

5.3 Suggestions for further research

- To conduct further study aiming to examine attitudes toward having a companion during labour in all labour departments at governmental hospitals in Gaza Strip.

- To conduct a study aiming to explore the psychosocial impact of companionship on labouring mothers.
- To conduct a study aiming to compare perspectives about childbirth experience between mothers who had a companion during labour and mothers who did not have a companion.

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Annexes

بسم الله الرحمن الرحيم

السيدة الفاضلة ... السيد الفاضل:

السلام عليكم ورحمة الله وبركاته

بين أيديكم استبانة خاصة برسالة الماجستير التي أقوم بإجرائها وهي بعنوان
"اتجاهات كل من مقدمي الخدمة الصحية والأمهات نحو وجود مرافق / مرافقة أثناء الولادة في
مستشفى الشفاء بمدينة غزة"

Attitudes of Healthcare Providers and Mothers Toward the Attendance of A companion During Labor at Al Shifa Hospital in Gaza City

يرجى الاستجابة على جميع فقرات الاستبانة بشكل صادق، مع العلم أنه لا توجد إجابات خاطئة ولكن
إجابتك تعبر عن رأيك الشخصي، كما أن المعلومات التي سيتم جمعها سوف تستخدم لأغراض البحث
العلمي فقط، ونلفت انتباهك بأن كتابة الاسم الشخصي اختياري وغير ملزم.

الباحثة

بثينة الشيخ خليل
جوال / 0599377009

Annex (1): Questionnaire of healthcare providers' attitudes towards companion during labour

Personal information:

Specialty (physicians): Obstetrician General practitioner Midwife Nurse

Qualification: 2 years diploma Bachelor Postgraduate

Gender: Male Female

Age: years

Years of experience: years

Please put (X) mark in appropriate column for the following statements:

No.	Domains & Items	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
Mothers' factor (score 30)		1	2	3	4	5
1	I believe that presence of a companion improves emotional state of the mother.					
2	I believe that presence of a companion acts as social support to the mother.					
3	I believe that the companion provides help to the mother in nonmedical activities (ambulation, massage, toileting, ...).					
4	I believe that presence of companion will increase tolerance of labor pain.					
5	I believe that presence of companion increases the mother's feeling of security.					
6	I believe that presence of companion helps in preventing frustration of mothers.					
Family factor (score 30)		1	2	3	4	5
7	I believe that presence of companion strengthens the relationship between family and healthcare providers.					
8	I believe that presence of a companion decreases the anxiety of the family.					
9	Presence of a companion is calming for mother's family.					
10	Presence of a companion is pleasant for mother's family.					
11	Presence of a companion helps in building trust relationship between family and healthcare providers.					
12	Presence of a companion gives a sense of security to the family members.					

Cultural factor (score 30)		1	2	3	4	5
13	I believe that presence of a companion is welcomed in our culture.					
14	I believe that presence of a companion is against my religious beliefs.					
15	I prefer to have the husband as a companion with his wife during labor.					
16	I prefer to have the mother as a companion with her daughter during labor.					
17	I prefer to have the sister as a companion with the woman during labor.					
18	I prefer to have the mother in law as a companion during labor.					
Hospital and healthcare provider factor (score 40)		1	2	3	4	5
19	I believe that presence of a companion is helpful to the healthcare team.					
20	I believe that presence of a companion puts the healthcare team under pressure.					
21	I support the presence of a companion during childbirth.					
22	I encourage the mothers to choose a companion during labor.					
23	Our hospital has a clear written policy that encourages the attendance of a companion with mother during labor.					
24	The hospital environment supports the attendance of a companion during labor through ensuring privacy of all clients.					
25	I support the modification of hospital environment to allow the husband to be a companion during labor					
26	I support the modification of hospital policy to allow the husband to be a companion during labor					

استبانة مقدمي الخدمات الصحية نحو وجود مرافق للأم أثناء الولادة

معلومات شخصية:

التخصص: أخصائي نساء وتوليد طبيب عام قابلة ممرضة
 الدرجة العلمية: دبلوم سنتان بكالوريوس دراسات عليا
 الجنس: ذكر أنثى
 العمر: سنة
 سنوات الخبرة: سنة

يرجى وضع علامة (X) في العمود المناسب مقابل كل فقرة مما يلي:

الرقم	الفقرة	غير موافق بشدة	غير موافق	محايد	موافق	موافق بشدة
	البعد الخاص بالأم (30 درجة)	5	4	3	2	1
1	أعتقد أن وجود مرافق / مرافقة أثناء الولادة يحسن الحالة النفسية للأم.					
2	أعتقد أن وجود مرافق / مرافقة أثناء الولادة يعزز الدعم الاجتماعي للأم.					
3	أعتقد أن وجود مرافق / مرافقة أثناء الولادة يساعد في بعض الأعمال الغير طبية (المشي، المساج، الحمام، ...)					
4	أعتقد أن وجود مرافق / مرافقة أثناء الولادة يساعد في تخفيف آلام المخاض.					
5	أعتقد أن وجود مرافق / مرافقة أثناء الولادة يؤدي إلى شعور الأم بالأمان.					
6	أعتقد أن وجود مرافق / مرافقة أثناء الولادة يقلل مستوى الإحباط لدى الأم.					
	البعد الخاص بالعائلة (30 درجة)	5	4	3	2	1
7	أعتقد أن وجود مرافق / مرافقة أثناء الولادة يعزز العلاقة بين الطاقم الطبي وعائلة الأم.					
8	أعتقد أن وجود مرافق / مرافقة أثناء الولادة يقلل مستوى القلق لدى أفراد عائلة الأم.					
9	أعتقد أن وجود مرافق / مرافقة أثناء الولادة يساعد على تهدئة عائلة الأم.					
10	أعتقد أن وجود مرافق / مرافقة أثناء الولادة أمر سار لعائلة الأم.					

					أعتقد أن وجود مرافق / مرافقة أثناء الولادة يساعد في بناء الثقة مع مقدمي الخدمة الصحية.	11
					أعتقد أن وجود مرافق / مرافقة أثناء الولادة يمنح العائلة الشعور بالأمان.	12
5	4	3	2	1	البعد الخاص بثقافة المجتمع (30 درجة)	
					أعتقد أن الثقافة السائدة في المجتمع الفلسطيني ترحب بوجود مرافق / مرافقة أثناء الولادة.	13
					أعتقد أن وجود مرافق / مرافقة أثناء الولادة يتعارض مع التعاليم الدينية.	14
					أنا أفضل وجود الزوج كمرافق لزوجته أثناء الولادة.	15
					أنا أفضل أن تكون أم المرأة مرافقة لابنتها أثناء الولادة.	16
					أنا أفضل أن تكون إحدى أخوات المرأة مرافقة لأختها أثناء الولادة.	17
					أنا أفضل أن تكون الحماة مرافقة لزوجة ابنها أثناء الولادة.	18
5	4	3	2	1	البعد الخاص بالمستشفى ومقدمي الخدمة الصحية (40 درجة)	
					أعتقد أن وجود مرافق / مرافقة أثناء الولادة يعتبر عاملاً مساعداً للطاقم الطبي.	19
					أعتقد أن وجود مرافق / مرافقة أثناء الولادة يضع الطاقم الطبي تحت ضغط نفسي.	20
					أنا أدمع وجود مرافق / مرافقة أثناء الولادة.	21
					أنا أشجع الأمهات على اختيار مرافق / مرافقة أثناء الولادة.	22
					في مستشفانا يوجد قانون واضح ومكتوب يشجع وجود مرافق / مرافقة أثناء الولادة.	23
					بيئة المستشفى تعزز وجود مرافق / مرافقة أثناء الولادة من حيث المحافظة على خصوصية الأمهات.	24
					أنا أدمع إجراء تعديلات في بيئة المستشفى تسمح بوجود الزوج كمرافق لزوجته أثناء الولادة.	25
					أنا أدمع إجراء تعديلات في أنظمة وقوانين المستشفى تسمح بوجود الزوج كمرافق لزوجته أثناء الولادة.	26

شكراً لكم على حسن تعاونكم ،،،

Annex (2): Questionnaire of mothers' attitudes towards companion during labor

Personal information:

1. Age of mother: years
2. Education level: Prep. Secondary University
3. Job: Housewife Working / employed
4. Monthly income:NIS
5. Number of deliveries: First time 2-4 times 5 times &more
6. Current birth status: Normal Complicated

7.	Do you prefer to have a companion during labor and child birth?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Sometimes
----	---	------------------------------	-----------------------------	------------------------------------

Please put (X) mark in appropriate column for the following statements:

No.	Domains & Items	Strongly disagree	disagree	Neutral	Agree	Strongly agree
Mothers' factors (score 50)		1	2	3	4	5
1	Presence of a companion is pleasurable for me.					
2	The companion provides emotional support to me.					
3	The companion provides social support to me.					
4	The companion provides opportunity to express my suffering to familiar person.					
5	Presence of a companion increases my self-confidence.					
6	Presence of companion is decreasing the pain of delivery.					
7	Presence of companion creates a feeling of confidence in me.					
8	Presence of companion decreases my anxiety.					
9	Presence of companion is decreasing my embarrassment					
10	The companion is stabilizing my psychological status					

Family factors (score 40)		1	2	3	4	5
11	Presence of a companion strengthens my family relationships with healthcare providers.					
12	Presence of a companion decreases the anxiety of my family.					
13	Presence of a companion is calming for my family.					
14	Presence of a companion is pleasant for my family.					
15	Presence of a companion is increasing trust between my family and healthcare providers.					
16	Presence of a companion gives a sense of security to my family.					
17	Presence of a companion is satisfying my husband					
18	Presence of a companion is respect to my family					
Cultural factors (score 30)		1	2	3	4	5
19	Presence of a companion is welcomed in our culture					
20	Presence of a companion is against my religious beliefs.					
21	I prefer to have my mother with me as a companion during labor					
22	I prefer to have my husband as a companion with me during labor.					
23	I prefer to have my sister with me as a companion during labor					
24	I prefer to have my mother in law with me as a companion during labor					
Hospital & health care providers factors (score 30)		1	2	3	4	5
25	The hospital policy allows the presence of a companion during labor.					
26	The department environment facilitates the presence of a companion by respecting privacy of me and other mothers.					
27	The health care providers allow me to have a companion during labor.					
28	The health care providers allow the companion to help in providing some care to me.					
29	The midwives and nurses are supportive to presence of a companion during childbirth.					
30	The physicians are supportive to presence of a companion during childbirth.					

استبانة الأمهات نحو وجود مرافق للأم أثناء الولادة

معلومات شخصية:

1. عمر الأم: سنة
2. المستوى التعليمي: إعدادي ثانوي جامعي
3. العمل: ربة بيت عاملة / موظفة
4. الدخل الشهري: شيكل
5. العدد الكلي للولادات: أول مرة 2 - 4 مرات 5 مرات فأكثر
6. حالة الولادة الحالية: طبيعية حدثت مضاعفات
7. هل تفضلين وجود مرافقة / مرافق لك أثناء الولادة؟ نعم لا أحيانا

السيدة الفاضلة / يرجى وضع علامة (X) في العمود المناسب مقابل كل فقرة مما يلي:

الرقم	الأبعاد والفقرات				
	موافقة بشدة	موافقة	محايدة	غير موافقة	غير موافقة بشدة
	5	4	3	2	1
1					وجود مرافق / مرافقة أثناء الولادة يعطيني شعور بالسعادة.
2					وجود مرافق / مرافقة أثناء الولادة يمدني بالدعم النفسي.
3					وجود مرافق / مرافقة أثناء الولادة يمدني بالدعم الاجتماعي.
4					وجود مرافق / مرافقة أثناء الولادة يمنحني الفرصة للتعبير عن همومي لشخص معروف لدي وأثق به.
5					وجود مرافق / مرافقة أثناء الولادة يمنحني الثقة بالنفس.
6					وجود مرافق / مرافقة أثناء الولادة يقلل من ألام المخاض.
7					وجود مرافق / مرافقة أثناء الولادة يمنحني شعورا بالثقة .
8					وجود مرافق / مرافقة أثناء الولادة يقلل لدي الشعور بالقلق.
9					وجود مرافق / مرافقة أثناء الولادة هو أمر يقلل شعوري بالإحراج .
10					وجود مرافق / مرافقة أثناء الولادة يؤدي إلى استقرار حالتي النفسية .
	5	4	3	2	1
11					وجود مرافق / مرافقة أثناء الولادة يقوي العلاقات بين أفراد عائلتي ومقدمي الخدمات الصحية.

					وجود مرافق / مرافقة أثناء الولادة يقلل مستوى القلق لدى أفراد عائلتي.	12
					وجود مرافق / مرافقة أثناء الولادة يمنح عائلتي شعور بالسكينة والهدوء.	13
					وجود مرافق / مرافقة أثناء الولادة يمنح عائلتي الشعور بالسعادة.	14
					وجود مرافق / مرافقة أثناء الولادة يساعد في بناء الثقة بين عائلتي وبين مقدمي الخدمة الصحية.	15
					وجود مرافق / مرافقة أثناء الولادة يمنح عائلتي الشعور بالأمان.	16
					وجود مرافق / مرافقة أثناء الولادة يمنح زوجي الشعور بالرضا.	17
					وجود مرافق / مرافقة أثناء الولادة يعبر عن الاحترام لعائلتي.	18
5	4	3	2	1	البعد الخاص بثقافة المجتمع (30 درجة)	
					وجود مرافق / مرافقة أثناء الولادة أمر مرحب به مع الثقافة السائدة في مجتمعنا.	19
					وجود مرافق / مرافقة أثناء الولادة يتعارض مع تعاليم الدين الإسلامي.	20
					أفضل وجود أمي كمرافقة معي أثناء الولادة.	21
					أفضل وجود زوجي كمرافق معي أثناء الولادة.	22
					أفضل أن تكون אחتي مرافقة معي أثناء الولادة.	23
					أفضل وجود حماتي كمرافقة معي أثناء الولادة.	24
5	4	3	2	1	البعد الخاص بالمستشفى و مقدمي الخدمة الصحية (30 درجة)	
					سياسة المستشفى تسمح بوجود مرافق / مرافقة معي أثناء الولادة.	25
					طبيبة قسم الولادة تلاءم وجود مرافق / مرافقة أثناء الولادة مع احترام خصوصية الأم و باقي الأمهات.	26
					يسمح مقدمي الخدمات الصحية بوجود مرافق / مرافقة معي أثناء الولادة.	27
					مقدمي الخدمات الصحية يسمحون للمرافق / المرافقة بالمساعدة في تقديم بعض الرعاية لي.	28
					تدعم القابلات والحكيمات فكرة وجود مرافق / مرافقة أثناء الولادة.	29
					يدعم الأطباء فكرة وجود مرافق / مرافقة أثناء الولادة.	30

مع تمنياتي لكن بالسلامة ،،،

Annex (3): List of experts

Name	Place of work
Dr. Khitam Abu Hamad	Al Quds University
Dr. Motasem Salah	University College of Applied Sciences
Dr. Yousef Eljeesh	Islamic University – Gaza
Dr. Arefa Al Buhairy	Islamic University – Gaza
Dr. Samer al Nawajha	University College of Applied Sciences
Dr. Ahmad Najem	Al-Azhar University – Gaza

Annex (4): Approval from Helsinki Committee



المجلس الفلسطيني للبحوث الصحي Palestinian Health Research Council

تعزيز النظام الصحي الفلسطيني من خلال مأسسة استخدام المعلومات البحثية في صنع القرار

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

Helsinki Committee

For Ethical Approval

Date: 05/02/2018

Number: PHRC/HC/308/18

Name: BOTHAINA. ELSHAIKHKHALIL

الاسم:

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

نفيدكم علماً بأن اللجنة قد ناقشت مقترح دراستكم
حول:

Attitude of health care providers and mothers toward the attendance of companion during labor in Al-Shifa hospital – Gaza.

The committee has decided to approve the above mentioned research. Approval number PHRC/HC/308/18 in its meeting on 05/02/2018

و قد قررت الموافقة على البحث المذكور عاليه
بالرقم والتاريخ المذكوران عاليه

Signature

Member

Member

5/21/2018

Chairman

5/21/2018

General 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:-

E-Mail: pal.phrc@gmail.com

Gaza - Palestine

غزة - فلسطين
شارع النصر - مفترق الحيون

Annex (5): Approval from MoH

State of Palestine
Ministry of health



دولة فلسطين
وزارة الصحة

التاريخ: 08/04/2018
رقم المراسلة 207691

السيد: رامي عيد سليمان العبادله المحترم

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

السلام عليكم ،،،

الموضوع/ تسهيل مهمة الباحثة//بثينة الشيخ خليل

// التفاصيل

بخصوص الموضوع أعلاه،يرجى تسهيل مهمة الباحثة/بثينة عبدالرحيم الشيخ خليل
الملتحقه ببرنامج ماجستير التمريض - تخصص صحة الأم والطفل- جامعة القدس أبوديس في إجراء بحث بعنوان:-
"Attitudes of Healthcare Providers and Mothers toward the
Attendance of A companion During Labor at Al- Shifa Hospital"
حيث الباحثة بحاجة لتعبئة استبانة من عدد من مقدمي الخدمات الصحي للنساء في مرحلة الولادة وكذلك تعبئة استبانة من عدد
من النساء بعد الولادة في مستشفى النساء والتوليد بمجمع الشفاء الطبي.
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 -



التحويلات

إجراءاتكم بالخصوص (08/04/2018)	← رامي عيد سليمان العبادله (مدير عام بالوزارة)	■ محمد ابراهيم محمد السرساوي (مدير دائرة)
إجراءاتكم بالخصوص (09/04/2018)	← عبد اللطيف محمد محمد الحاج (مدير عام بالوزارة)	■ رامي عيد سليمان العبادله (مدير عام بالوزارة)
إجراءاتكم بالخصوص (09/04/2018)	← مدحت عباس خضر حسن (مدير عام بالوزارة)	■ عبد اللطيف محمد محمد الحاج (مدير عام بالوزارة)
إجراءاتكم بالخصوص (09/04/2018)	← حسن محمد خليل حافظ اللوح (مدير)	■ ()
إجراءاتكم بالخصوص (09/04/2018)	← رافت حامد يوسف حمدونه (مدير دائرة)	■ ()
إجراءاتكم بالخصوص (09/04/2018)	← زهير محمود احمد نوفل (مدير دائرة التمريض)	■ ()
إجراءاتكم بالخصوص (09/04/2018)	← محمد علي محمد الحسانينه (طبيب مسجل مساعد / ممارس عام)	■ حسن محمد خليل حافظ اللوح (مدير)

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Annex (6): Number of deliveries in Al Shifa Maternity Hospital 2014 – 2017

Month	Mode of delivery	2014	2015	2016	2017
January	NVD	1110	1012	1237	1467
	CS	388	344	437	450
February	NVD	966	885	1016	1130
	CS	310	327	379	366
March	NVD	967	878	896	1093
	CS	337	330	367	359
April	NVD	857	600	916	981
	CS	291	258	285	341
May	NVD	827	836	803	1101
	CS	291	286	315	353
June	NVD	979	883	878	1389
	CS	350	352	311	334
July	NVD	1242	1196	1187	1544
	CS	400	446	381	434
August	NVD	1330	1244	1340	1269
	CS	372	451	455	488
September	NVD	1358	1124	1247	1217
	CS	374	450	417	425
October	NVD	1252	1174	1319	1243
	CS	380	440	400	444
November	NVD	1131	1140	1195	1133
	CS	1531	432	440	399
December	NVD	1032	1124	1232	1185
	CS	350	400	431	413
Total	NVD	13051	12096	13266	14752
	CS	5377	4516	4618	4809

NVD = Normal Vaginal Delivery CS = Cesarean Section

Health care providers' questionnaire

Correlation between each statement and total score of mothers' factors domain and family factors domain

Mothers' factors domain			Family factors domain		
No.	Correlation value	<i>P</i> value	No.	Correlation value	<i>P</i> value
1	0.755	**	7	0.660	**
2	0.807	**	8	0.769	**
3	0.709	**	9	0.783	**
4	0.719	**	10	0.776	**
5	0.751	**	11	0.752	**
6	0.689	**	12	0.787	**

** = significance at 0.01

Correlation between each statement and total score of cultural factors domain and hospital and health care provider factors domain

Cultural factors domain			Hospital and health care provider factors domain		
No.	Correlation value	<i>P</i> value	No.	Correlation value	<i>P</i> value
13	0.625	**	19	0.538	**
14	0.507	**	20	0.407	**
15	0.476	**	21	0.721	**
16	0.686	**	22	0.647	**
17	0.729	**	23	0.619	**
18	0.514	**	24	0.636	**
			25	0.656	**
			26	0.700	**

** = significance at 0.01

Correlation between each domain and total score of attitudes towards companionship during labor (for healthcare providers)

Domain	Correlation value	P value
Mothers' factors	0.781	**
Family factors	0.777	**
Cultural factors	0.768	**
Hospital and health care provider factors	0.843	**

** = significance at 0.01

Cronbache alpha coefficient for attitudes towards companionship during labor (for healthcare providers)

Domain	No. of items	Coefficient value
Mothers' factors	6	0.832
Family factors	6	0.846
Cultural factors	6	0.612
Hospital and health care provider factors	8	0.767
Total score	26	0.892

Mothers' questionnaire

Correlation between each statement and total score of mothers' factors domain and family factors domain

Mothers' factors domain			Family factors domain		
No.	Correlation value	<i>P</i> value	No.	Correlation value	<i>P</i> value
1	0.855	**	11	0.799	**
2	0.862	**	12	0.781	**
3	0.858	**	13	0.862	**
4	0.824	**	14	0.883	**
5	0.870	**	15	0.868	**
6	0.677	**	16	0.883	**
7	0.871	**	17	0.839	**
8	0.818	**	18	0.807	**
9	0.841	**			
10	0.859	**			

** = significance at 0.01

Correlation between each statement and total score of cultural factors domain and hospital and health care provider factors domain

Cultural factors domain			Hospital and health care provider factors domain		
No.	Correlation value	<i>P</i> value	No.	Correlation value	<i>P</i> value
19	0.431	**	25	0.797	**
20	0.393	**	26	0.713	**
21	0.657	**	27	0.806	**
22	0.617	**	28	0.731	**
23	0.694	**	29	0.823	**
24	0.698	**	30	0.835	**

** = significance at 0.01

Correlation between each domain and total score of attitudes towards companionship during labor (for mothers)

Domain	Correlation value	P value
Mothers' factors	0.878	**
Family factors	0.901	**
Cultural factors	0.784	**
Hospital and health care provider factors	0.685	**

** = significance at 0.01

Cronbache alpha coefficient for attitudes towards companionship during labor (for mothers)

Domain	No. of items	Coefficient value
Mothers' factors	10	0.947
Family factors	8	0.938
Cultural factors	6	0.605
Hospital and health care provider factors	6	0.873
Total score	30	0.939

Attitudes of mothers toward having companionship during labour
(Post hoc Scheffe test for age)

Domain	Age	Mean difference	P value
Mothers' factors	(31 and more) – (16 - 20)	-4.164	0.067
	(31 and more) – (21 - 25)	-3.777	0.067
	(31 and more) – (26 - 30)	-1.764	0.727
Family factors	(31 and more) – (16 - 20)	-2.881	0.117
	(31 and more) – (21 - 25)	-2.311	0.203
	(31 and more) – (26 - 30)	-0.549	0.975
Cultural factors	(31 and more) – (16 - 20)	-2.978	0.022*
	(31 and more) – (21 - 25)	-2.445	0.048*
	(31 and more) – (26 - 30)	-2.256	0.132
Overall	(31 and more) – (16 - 20)	-10.768	0.077
	(31 and more) – (21 - 25)	-9.592	0.087
	(31 and more) – (26 - 30)	-4.536	0.745

* Statistically significant at 0.05

عنوان الدراسة: اتجاهات كل من مقدمي الخدمة الصحية والأمهات نحو وجود مرافق / مرافقة أثناء الولادة في مستشفى الشفاء بمدينة غزة.

إعداد: بثينة الشيخ خليل

إشراف: د. حمزة عبد الجواد

ملخص الدراسة

هدفت الدراسة الحالية إلى معرفة اتجاهات كل من مقدمي الرعاية الصحية والأمهات نحو وجود مرافق أو مرافقة أثناء الولادة في مستشفى الشفاء بغزة، كما هدفت إلى معرفة الفروق في تلك الاتجاهات التي تعزى لبعض المتغيرات. وقد كانت عينة الدراسة عينة عرضية تكونت عينة الدراسة من مجموعتين: 134 من مقدمي الرعاية الصحية (37 طبيب و 97 قابلة وممرضة)، 272 سيدة من السيدات اللاتي تم إدخالهن في قسم الولادة. لجمع البيانات فقد قامت الباحثة بإعداد أداة الدراسة وهي مكونة من استبانتين (استبانة خاصة بمقدمي الرعاية الصحية واستبانة خاصة بالأمهات) لقياس الاتجاه نحو وجود مرافق أثناء الولادة وقد تم عرض الاستبانتين على مجموعة من المحكمين للتأكد من مدى صلاحيتها كأداة للدراسة، كما تم إجراء دراسة استطلاعية وتبين أن معامل الثبات ألفا كرونباخ بلغ 0.892 لاستبانة مقدمي الرعاية الصحية وبلغ 0.939 لاستبانة الأمهات. وقد تم استخدام البرنامج الإحصائي المحوسب SPSS لتحليل البيانات، والتي تضمنت التكرارات، المتوسطات الحسابية، النسب المئوية، اختبار (ت)، واختبار تحليل التباين الأحادي.

بينت نتائج الدراسة أن متوسط أعمار السيدات اللاتي شاركن في الدراسة بلغ 25.51 سنة، 92.6% من السيدات ربات بيوت، 73.5% من ذوي الدخل المتدني أقل من 500 شيكل شهرياً، 38.2% كانت الولادة الأولى لهن، و96% ولدن ولادة طبيعية بدون مضاعفات.

وأظهرت النتائج أن 87.9% من السيدات يفضلن وجود مرافقة أثناء الولادة، والغالبية العظمى يفضلن وجود أمهاتهن كمرافقات أثناء الولادة، كما بينت النتائج وجود اتجاهات إيجابية عالية لدى السيدات نحو وجود مرافقة أثناء الولادة بمتوسط درجات بلغ 4.02 وبوزن نسبي بلغ 80.42%، وقد كانت الاتجاهات منخفضة لدى السيدات الأكبر عمراً، في حين كانت الاتجاهات أعلى لدى السيدات من ذوي الدخل المتدني، في حين لم توجد فروقات في اتجاهات السيدات تعزى لكل من المستوى التعليمي، العمل (ربة بيت / تعمل)، عدد الولادات السابقة، وحالة الولادة الحالية.

بالنسبة لمقدمي الرعاية الصحية تبين وجود اتجاهات إيجابية نحو وجود مرافقة أثناء الولادة بدرجة أعلى من المتوسط، حيث بلغ متوسط الدرجات 3.45 بوزن نسبي 69%. وأظهرت النتائج أن كل من أخصائي النساء والولادة والقابلات كان لديهن اتجاهات إيجابية أعلى من الأطباء العاميين والممرضات، في حين لم توجد فروقات ذات دلالة إحصائية في الاتجاه نحو وجود مرافقة أثناء الولادة تعزى لكل من الدرجة العلمية، الجنس، العمر، وسنوات الخبرة.

بشكل عام بينت النتائج أن الأمهات كانت لديهن اتجاهات إيجابية نحو وجود مرافقة أثناء الولادة بدرجة أعلى من مقدمي الرعاية الصحية (80.42 مقابل 69%). في الإجمال بينت الدراسة أنه بالرغم من الفوائد المثبتة لوجود مرافقة أثناء الولادة إلا أن هذا النهج يواجه أحياناً تحفظاً من قبل مقدمي الرعاية الصحية لعوامل قد تتعلق بالثقافة وبيئة العمل.