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Women's Perceptions of Childbirth Services Provided at Governmental Hospitals in Gaza Strip

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Declaration:

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

Signed----------

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Dedication

To my family; parents, wife and son for their help, encouragement and patience

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Abstract

Background and objectives The International Safe Motherhood Initiative was launched in Nairobi, Kenya in 1987, and provided a focus for programs and research concerned with the improvement of maternal health. The quality of care received as perceived by women is an essential aspect of reproductive health, it is essential to understand women's perception of the care provided to them. Although there is no adequate data available regarding satisfaction about the childbirth services at governmental hospitals, however, this study aims to address the issue; therefore the purpose of the study is to assess women perception and experience of childbirth services at governmental hospital in Gaza Strip. Moreover, to provide policymakers with recent evidence- based information from patient experiences and views in order to improve the quality of the maternity services.

Methodology The study was conducted at governmental hospitals in Gaza Strip. A descriptive cross sectional design with a proportional random sample of women who had gave birth in the governmental hospitals at the time of the study was taken. An exit interview questionnaire was developed which concentrated on perspectives with childbirth services provided by health providers. The total sample was 450 women, 223 from the Shifa Hospital, 152 from Naser Hospital, 49 from the European Gaza Hospital, and 53 from Al-Aqsa Hospital. The response rate was 86.9%. SPSS program was used for data entry and analysis.

Results Congruent with what is cited in the literature, there were nine dimensions of women's perceptions on childbirth services at the hospitals as perceived by the women. Findings revealed that, the overall mean of perception scores (maximum 3) was 2.1(70%) in all hospitals indicating that women generally had positive perception about the services they received. The mean of perception scores with loyalty was 2.57, approach of mother care was 2.55, privacy was 2.36, information/communication was 2.34, department culture was 2.28, approach of baby care was 2.14, decision participation was 1.64, counseling was 1.64 and staff attitude and respect was 1.34. The study concluded that the demographics, socio-economic variables including the age, place of living, household monthly income and education level showed a statistically significant impact on perceptions. Also the study revealed that the maternal variables as woman age at first marriage, No of parity and past experience showed a statistically significant impact on the women perception and their satisfaction. On the other hand, age of woman and employment status showed no significant impact on women's perception and satisfaction with childbirth services

Conclusion

Maternity services for women in Gaza Strip should respond to calls for greater women involvement, and introducing policies to support the development of woman-centered maternity services. This can be achieved when the policy makers taking their responsibility for transmitting and implementing the applicable research recommendations in maternity health decisions and policies to gain more satisfaction and more quality health services.

ملخص الدراسة

أكدت المبادرة العالمية لسلامة الأمومة والتي عقدت في نيروبي بكينيا في سنة ١٩٨٧ على ضرورة التركيز والاهتمام بالبرامج والأبحاث التي تهتم بتحسين صحة الأمومة، وخدمات الأمومة تضم العديد من الجوانب التي تؤثر في صحة الأم ، ومن أهم هذه الجوانب نوعية هذه الخدمات المقدمة للمرأة أثناء الولادة والتي تميز من خلال معرفة رأيها ودرجة الرضا عن هذه الخدمات، وبالتالي فمن الضروري معرفة وجهة نظر ورأي السيدات عن الخدمات المقدمة لهن في أقسام الولادة.
وبسبب وجود معلومات غير كافية في قطاع غزة عن هذه الخدمات فقد جاءت هذه الدراسة للعمل على توفير معلومات إحصائية إضافية حول مستوى خدمات الولادة في المستشفيات الحكومية، ومن هنا فان هذه الدراسة تهدف إلى الوقوف الصحيح على الحقائق حول مستوى خدمات الولادة، فهي تتعرف على أراء وخبرات السيدات حول هذا الجانب حتى يتسنى لصناع القرار الاستناد على حقائق ومعلومات واقعية تبنى على أسس وبراهين بحثية سليمة مما يساهم في تحسين جودة الخدمات المقدمة.

طريقة البحث
لقد أجريت هذه الدراسة في المستشفيات الحكومية لقطاع غزة حيث تم اختيار نظام التصميم المقطعي وشملت الدراسة على عينة عشوائية من السيدات عددها ٤٥٠ سيدة من اللواتي انتفعن من خدمات الولادة في هذه المستشفيات أثناء القيام بالدراسة ووزعت كالتالي (206 مستشفى الشفاء، 123 مستشفى ناصر، 54من مستشفى غزة الأوروبي، 71ن مستشفى الأقصى)، وأجريت المقابلة مع كل سيدة على حدة بعد تلقيها الخدمة واستعدادها للخروج من المستشفى)، وكانت نسبة الاستجابة ٨٦,٩%. وقد تم استخدام البرنامج الإحصائي (SPSS) في تدخيل وتحليل المعلومات.

نتائج البحث
توافقا مع الدراسات السابقة تضمنت هذه الدراسة تسعة من المتغيرات التي تؤثر في أراء السيدات حول الخدمات المقدمة أثناء عملية الولادة، فتوصلت الدراسة إلى أن نسبة الآراء الايجابية كانت ٧٠% بشكل عام مما يشير إلى أن السيدات أبدت درجة جيدة من الرضا حول مستوى الخدمات التي قدمت لهن. وأظهرت الدراسة بأن متوسط الآراء في المتغيرات التسعة كان كالتالي: متغير الولاء كان ٢,٥٧، آلية العناية بالأم ٢,٥٥ ، الخصوصية ٢٣٦ ، الاتصال والمعلومات ٢,٣٤، بيئة القسم ٢,٢٨، آلية العناية بالطفر٢,١٤، المشاركة في القرار ١,٦٤، المشورة ١,٦٤، توجهات الفريق والاحترام١,٣٤، مع العلم بان المتوسط الأعلى هو ٣، و أظهرت نتائج الدراسة بان المتغيرات الاجتماعية مثل العمر ومكان السكن ومستوى التعليم، والمتغيرات الاقتصادية مثل الدخل الشهري للأسرة ومتغيرات الأمومة مثل عمر المرأة عند أول زواج وعدد مرات الولادة والخبرات السابقة له دلالات إحصائية تؤثر على الآراء ودرجات الرضا لدى السيدات حول خدمات الولادة. ومن ناحية أخرى أظهرت الدراسة أن الوضع المهني للسيدة ليس له تأثير احصائى على الآراء ودرجة الرضا لديهن حول الخدمة المقدمة.

الخلاصة
خدمات الولادة في قطاع غزة يجب أن تستجيب للأصوات التي تنادى بأهمية المشاركة الفاعلة للمرأة من خلال الاستماع إلى الآراء ووجهات النظر من السيدات حول هذه الخدمات وكذلك إلى ضرورة الاهتمام بتقديم القوانين التي تدعم تطوير خدمات الأمومة ويمكن تحقيق هذه الجوانب من خلال اخذ صناع القرار مسؤولياتهم بتطبيق توصيات البحث من اجل الوصول إلى جودة خدمات ولادة أفضل.

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Abbreviations

ANC	**Ante Natal Care**
ANOVA	**Analysis of Variance**
CDR	**Crude Death Rate**
EGH	**European Gaza Hospital**
GS	**Gaza Strip**
HEDIS	**Health Plan Employer Data and Information Set**
HMIS	**Health Management Information System**
IMT	**International Management Team**
ISMI	**International Safe Motherhood Initiative**
MMR	**Maternal Mortality Ratio**
MOH	**Ministry of Health**
NGOs	**None Governmental Organization**
PCBS	**Palestinian Central Bureau of Statistic**
PHC	**Primary Health Care**
PNA	**Palestinian National Authority**
SPSS	**Statistical Package for Social Science**
UNICEF	**United Nations Children's Funds**
UNRWA	**United Nations Relief and Works Agency**
WB	**West Bank**
WHO	**Word Health Organization**

Definition of terms

Perception:

The women experience, views, attitudes, opinions, satisfaction or perspective about the maternity services they received.

Level of satisfaction:

Level of satisfaction; “The extent to which women are happy and have positive attitudes about the services they receive”.

Labor and delivery:

The period from the onset of establishing Labour until two hours after delivery of placenta.

Childbirth period:

The period from admission the women to hospital for delivery until discharged.

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Introduction

Childbirth is one of life's major events for every woman who has the right to receive childbirth services by health professionals to prevent any postpartum complication and to avoid the increasing in maternal morbidity and mortality, this right increase when the delivery occurred in the hospital. It is the responsibility of all those involved in the provision of childbirth services to achieve a balance between scientific objectivity and a concern for the women wishes. Indeed, if it is accepted that childbirth in hospital is safer for certain types of women, where the risks are high, it must also be safer for cases where the risks are less (Gavin, 1999).

The International Safe Motherhood Initiative was launched in Nairobi, Kenya in 1987, and provided a focus for programs and research concerned with the improvement of maternal health. In the decade, that followed several key international conferences by World Health Organization (WHO) have taken place, giving impetus to the movement. At the World Summit for Children in 1990 over 150 countries endorsed the Plan of Action including the goal of halving maternal mortality rates by the year 2000. Similar statements and declarations were made at the International Conference on Population and Development in Cairo in 1994, and at the Fourth World Conference on Women in Beijing in 1995 (WHO, 2000).

Each year more than 150 million women become pregnant, and more than 15% (23 million women) develop complications needing skilled treatment (United Nations, 1995). Each year, over half a million women die from causes related to pregnancy and childbirth (United Nations Children's Funds UNICEF, 1995). The risk of dying varies from country to country: the lifetime risk of dying from causes related to pregnancy and childbirth in Africa is 1 in 23, compared with 1 in 4000 in North America (United Nations, 1995).

In Palestinian National Authority (PNA) according to Ministry of Health (MOH) report 2002, about 94.85% of births take place in health institutions and 5.2% at home, the vast majority of deliveries took place in hospitals with percentage about 82.3% while deliveries outside hospital took place with percentage 17.7%. The governmental hospitals take the biggest share of total deliveries with percentage 52.1 % (62.9%in Gaza Strip {GS} and 44.6% in West Bank {WB}); it is followed by Nongovernmental organizations (NGOs) hospitals with percentage 29.6% (7.9% in GS and 44.6% in WB). The delivery in United Nations Relief and Works Agency (UNRWA) clinics took place with percentage 4.0% (9.8% in GS where no maternity unit in WB). Home delivery constitutes 5.2% of total deliveries in Palestine (1.2% in GS and 7.9% in WB) (PNA, MOH, 2002).

According to Maram Health Survey 2003, the vast majority of births (93.5%) over the five years preceding the survey took place in medical settings including hospitals (79.6%), health centers (4.0%), maternal-child health centers (2.2%) and private clinics (7.7%), Home deliveries occurred in 4.1% of births, and 2.3% took place elsewhere, including 0.1% of births that occurred at Israeli checkpoints (Maram Project Baseline Health Survey, 2003).

In-order to reach a high quality of services provided by health professionals in our hospitals, we want to know the attitude of the women towards the childbirth services provided during and after delivery in labor and obstetric ward.

The quality of care received as perceived by women is an essential aspect of reproductive health, it is essential to understand women's perception of the care provided to them, in order to inform the debate about practices which neither increase nor decrease risk but may decrease women's satisfaction(Tamar, et al 2000).

This study is an important step in hearing from women on how they view the childbirth services they received. It also helps to tell us where women feel the childbirth care services is serving them well and where the service can improve. We believe this information will help health professionals, health system managers and government in working together to improve childbirth services delivery in the coming years.

Although there is no much data available regarding satisfaction about the childbirth services at governmental hospitals, however, this study aims to address the issue, therefore the purpose of the study is to examine women perspective regarding the childbirth services at labor and obstetric wards in governmental hospital from the clients' perspectives and to make recommendations for improving the quality of care.

Overall goal

The overall goal of the study is to examine women perception and experience of childbirth services at governmental hospitals in the GS. Moreover, the study aims to provide policymakers with recent evidence-based information from patient experiences and views in order to improve maternity services.

Study objectives

The objectives of this study are:

1. To explore the views of women about childbirth services offered at governmental hospitals.

2. To identify the main domains that affect women's perceptions about childbirth services provided at governmental hospitals.

3. To identify factors that affect women perceptions positively, as well as the factors that affect women perceptions negatively.

4. To assess the institutional, demographic and maternal child factors that affect laboring women perceptions and preferences.

5. To provide suggestions and recommendations for future possible interventions.

Research questions

1. What are the women's views about the childbirth services offered at governmental hospitals?

2. What is the level of satisfaction among women who delivered in governmental hospitals?

3. What are the main domains that affect women satisfaction?

4. What are the aspects of care that satisfy women?

5. What aspects of care dissatisfy women?

6. What are the characteristics of women who utilize governmental hospital's services?

7. What are the problems that face women during childbirth?

8. What are the main factors affecting women choice and preference of hospitals?

9. What are the impacts of demographic, institutional and maternal child factors on women perspectives?

10. What are the areas of care, which could need improvement?

Justification of the study

The decision to develop a preliminary study on women's health was based on the recognition of women's health as an important focus in health services research and in the evaluation of health system performance (McKinley, et al, 2002).

WHO represents a concrete step towards achieving the Millennium Development Goal target of reducing by three-quarters the maternal mortality ratio by 2015. The

goal is that all women go safely through pregnancy and childbirth and that their infants are born alive and healthy. “Making Pregnancy Safer” clearly emphasizes the importance of improving health systems in order to advance the health and well-being of women and their infants (WHO, 2003).

Rosemary, et al (2002) said; “*the high quality care depends on recognition that each individual will have a unique experience of health and ill health which will define their own personal health care needs, health care professionals must work in partnership with the patient/client which interpreted as women-centred care (Rosemary, et al 2002)”*.

The vast majority of births (93.5%) over the five years preceding the survey took place in medical settings including hospitals (79.6%), health centers (4.0%), maternal-child health centers (2.2%) and private clinics (7.7%) (Maram Project Baseline Health Survey, 2003**).** Although the great majority of deliveries occurred in hospitals, no studies were conducted to assess women perceptions and views towards childbirth services at these hospitals.

There are many ways of getting information about satisfaction of childbirth services provided and practices, sometimes the belief that services are bad or good is based on an informal impression, gained from women experience or experience of others, and because individual experience is haphazard, and some time misleading, it must be supplemented by the result of formal research studies. Furthermore, making services and care more evidence based will improve quality and will improve health outcomes in women and their babies.

Up to date, there have been few attempts in GS to review childbirth services provided in governmental hospitals, thus to apply an information about childbirth services and factors that influence the women satisfaction regarding this services, the researcher

look to conduct this study to make this information available for Palestinian ministry of health's decision makers and health provider to strengthen the weak points in the services.

Background of the study

This study was conducted in the GS in Palestine, therefore in the following paragraphs provide some information about the geographical context, Palestinian population size, Palestinian economy, distribution of refugees, in Palestine, health care system and services delivery in Palestine. It shows also some selected health indicators in Palestine. Furthermore, it is provides information about the European Gaza Hospital (EGH), Nasser Hospital, Al-Aqsa Hospital and Shifa Hospital.

Geographic Location

Palestine has an important geographic and strategic location; it is situated on the eastern coast of the Mediterranean Sea in the Middle East. It is bordered by Syria and Jordan on the east, by Lebanon on the north, the Gulf of Aqaba on the south and by Egypt and the Mediterranean Sea on the west (MOH, 2003) (Annex 1). The PNA comprises two areas separated geographically: the WB region and GS. The WB lies within an area of 5,800 square kilometer west of the river Jordan. It is divided into nine districts with a population density of 362 inhabitants per one square kilometer (MOH, 2003).

GS region is divided into five governorates: Gaza north, Gaza City, Mid-zone, Khanyounis and Rafah, with a population density of 3,278 inhabitants per one square kilometer. The GS is a narrow Zone of land, bordered on the South by Egypt, Mediterranean Sea on the West, and Israeli occupation on the North & East. It is 46 kilometers long, and 5-12 Kilometers wide with an area of 360 square Kilometers. It

has four towns, fourteen villages and eight refugee camps. A few thousand Israelis settlers live in isolated settlements, which occupied large distance of land about 20% in comparison to their number (MOH, 2003) (Annex 2).

Demographic context

Population size

According to the census conducted by the Palestinian Central Bureau of Statistic (PCBS) in 1997-2003, the midyear population size of the GS in 2002 is 1,261,909 (36.4%) of total population in Palestine. Out of them nearly 50.7% are males and 49.3% are females (MOH, 2003) (Annex 3).

Population growth

It has been observed that the estimated natural increase dropped remarkably in Palestine. According to the reported figures from MOH in 1994, the population growth in Palestine was estimated at 4.5% and gradually dropped down to 3.7% in 1996. It declined in 1997 and 1998 to 3.1%. It is 3% in 2000, but raised again in 2002 to be 3.6% (MOH, 2003).

Births

Despite the progressive decline over the years, the number of live births / 1000 population per year is still high compared with other countries. The crude birth rate (CBR) declined from 46.5/1000 in 1995 to 27.2/1000 population in 2002. In GS, CBR declined from 49.4/1000 (39,885 births) in 1995 to 33.1/1000 (37,735 births) in 2002. (MOH, 2002)

Fertility

According to the MOH, Health Management Information System (HMIS) 2001, the total fertility rate (TFR), which is defined as the average number of children born to

women at age of 15-49 years old, estimated to be 3.3 in WB, and 4.8 in the GS and in Palestine is 3.8. Women of childbearing age (15-49year) comprise 22.1% of the total population (MOH, 2002).

Life expectancy

The average life expectancy at birth of the Palestinian population is 71.85 year in year 2002, while it was 71.50 year in 1998. As in most countries, life expectancy at birth for women is higher than for men (72.6 Vs 71.1 year) (MOH, 2003).

Mortality

The Crude Death Rate (CDR) in Palestine declined from 4.8 deaths per 1000 population in 1997 to 3.1 per 1000 in 2002. There is a difference between the WB and GS. In the WB, the CDR dropped from 4.9 in 1997 to 2.9 in 2002, where it dropped from 4.7 in 1997 to 3.5 in 2002 in GS (MOH, 2003).

Maternal Mortality Ratio

Maternal Mortality Ratio (MMR) is one of the most important indicators to determine the health status for \women. Most maternal deaths are the result of hemorrhage, complication of unsafe abortion, pregnancy induced hypertension, sepses, and obstructive delivery. A number of factors have increased the risk of maternal mortality in refugee settings. During the exodus and emergency phase pregnant women may become malnourished and anemic and are therefore at higher risk of infectious disease. They are exposed to physical and psychological violence. They are often alone and may have to give birth under hazardous condition. In Palestine, although institutionalized deliveries are improved but many risk factors including unrest of the political situation and repeated curfews and frequent closures and separation of Palestinian areas are determinant factors that increase the risk of maternal mortality. Under diagnosis and reporting is a continuous problem in both GS

and WB. The reported MMR is about 13.8 per 100.000 lived births among women aged 15-49 years (21.6 in GS and 7.6 in WB) (MOH, Annual report 2003).

Health Care System context

On the 13th of September 1993, the Palestinian Liberation Organization and the Israeli Government signed the declaration of Principles of Peace. As a result of this agreement, the Palestinian health authority took over the responsibility for health in GS on 17 may 1994. Since then, MOH at PNA immediately began on programs aimed at ensuring continuity of health services and to rehabilitate exciting system, equipment and infrastructure. Today there is a wide net of Primary Health Care (PHC) centers and secondary health care facilities providing health in GS are MOH, UNRWA, NGOs and private health services providers (MOH, 2002).

Hospitals

In Palestine, health providers operated 76 hospitals in 2002, with a ratio of 45,586 persons per hospital and 4, 792 beds with a ratio of 13.8 beds per 10,000 population (MOH, 2003). In GS; there are 24 hospitals (31.5%) of the total hospitals, with a ratio of 52,579. The average bed capacity per hospital is 85.83 beds. In WB including Jerusalem, there are 52 hospitals making 68.42% of the total hospitals. The average bed capacity per hospital is 52.54 beds (MOH, 2003). The distribution of hospitals by specialty in Palestine shows that, there are 38 general hospitals with 2,875 beds, 14 specialized hospitals with 1,340 beds, 4 rehabilitation hospitals with 136 beds and 20 maternity hospitals with 441 beds (MOH, 2003). The MOH managed to provide a balanced pool of beds. It owns and operates 53.1% of the general hospitals beds, 69.9% of specialized hospital beds, and 34.0% of the maternity hospital beds. In Gaza Strip there are 12 hospitals with 1,478 beds, 216 beds were assigned to serve obstetric and gynecology (MOH, 2003).

Primary Health Care Centers

The total number of registered PHC centers in Palestine was 603 (96 PHC center in GS and 507 in WB). Out of which, 375 centers belong to MOH (62%), 51 centers to UNRWA with a low percentage of 8.5%, and NGOs had 177 centers with a percentage of 29.4% of the total centers. In GS, MOH owns and operates 47 PHC centers, about 34 of these centers provide immunization and well child health care. These PHC provide a special health care services in different aspects, 32 centers provide antenatal care, 1 of them have a delivery unit currently operated in Gaza City. Also, there are 72 specialized clinics, 16 family planning clinics, and 22 dental and oral clinics. About 24 centers have laboratories and 10 centers have X-ray units (MOH, 2003).

Locality of the study

European Gaza hospital

EGH is a MOH hospital built in 1993, located in Khanyounes governorate at the southern area of GS. An International Management Team (IMT) took the responsibility to commission the hospital. The hospital services started on 15th July 2000 according to scheduled program the hospital provide services to 400,000 catchments population. On the 15th of October 2000, the management authority transferred to the Palestinian staff. The EGH is considered one of the biggest health investments in the area, with total cost around $60 million. The EGH was conceived by UNRWA and funded by European countries to be a centre of excellence providing much needed secondary plus care services to the southern area of GS. EGH played a very important role in health services development process through introducing new system, such as appointment system and computerized networking system. Today,

the EGH provides a major portion of medical services for Palestinians through a full range of diagnostic and management facilities for patients ranging in age from the neonate to elderly. The EGH is the referral center for medical services. An average 1500 patients per month were admitted to different hospital wards, and 530 patients per month were admitted to medical and surgical wards. In general, the bed occupancy rate in the hospital during 2003 was 75% and the average length of stay was 3.8 days. The staff of EGH come from many experience parts of the world. Some employments are by special contracts for one year and often renewable (European Gaza Hospital Records, 2003). The total number of the physicians in the hospital was 131 physicians and the total number of the nursing staff who is working in different wards in the hospital was 222 nurses. In labor and obstetric department there are 32 beds in obstetric and 12 beds in labor and there is an operating room for cesarean section, the health team who work in labor and obstetric department consist of 16 physicians and 28 nurses providing care for low and high risk women during pregnancy and childbirth. The hospital contains facilities for a full range of secondary and planned tertiary patients care services for both inpatients and out patients. The administration requires that the quality of the services rendered and general operating standards of the center meet the standards of European hospitals. In addition to providing excellent care for patients, professional and technical position, there are continuing in-service education programs and specific training programs (European Gaza Hospital Records, 2003).

Nasser Hospital

Nasser Hospital was established in 1963 during the Egyptian control on GS in Khanyounis city. Nasser Hospital is considered one of two largest governmental hospitals in south of GS. Nasser Hospital includes within its large margins two main

buildings, the first building includes medical, surgical, orthopedic, pediatric surgery, operations department, emergency, intensive care unit, intensive cardiac care unite, artificial kidney unit and out patient clinics. The second building is Mubarak, which includes obstetric, gynecology, pediatric, operation room, and intensive neonatal care unit. The hospital provides services to more than 400.000 catchments population. The hospital contains facilities for a full range of secondary and tertiary patient care services for both inpatient and out patients. The hospital provides medical and surgical care as well as obstetric, neonatal and maternity care. The total number of beds is 277; with average 2500 patients per month were admitted to different hospital wards. In general, the bed occupancy rate in the hospital during 2003 was 79.5% and average length of stay was 2.3 days (Nasser Hospital Records, 2003).

The total number of physicians in the hospital was 133 physicians, 14 out of them work in labor and obstetric department and the total number of nursing staff who is working in different wards in the hospital was 231 nurses, 30 of them work in labor and obstetric departments (Nasser Hospital Records, 2003).

The standard work week is 39 hours. The number of hours in a shift varies somewhat from department to department. The standard work week is Saturday through Thursday. Support services work from 08:00 am. to 14:00 pm. depending upon their specific work areas (Nasser Hospital Records, 2003).

Shifa Hospital

Shifa Hospital is considered the biggest medical institute in PNA territories that provide secondary health services for more than 500.000 people who comprise nearly one half of the GS population and also provides tertiary health services for all Gaza population. The hospital was established in 1946 on an area of 42 Dunams and passed many stages of improvement since its establishment. In 2001 the hospital

contained 490 beds, distributed in different departments, such as internal medicine, general and special surgeries, burn unit, intensive care unit, obstetric/gynecology and neonatal departments. There are 93 day care beds in the hospital including oncology, dialysis, emergency department and other specialized clinics. The occupancy rate in the hospital reached 84.6%. The average length of stay was 3 days in general (Shifa Hospital Records, 2001).

The department of obstetrics and gynecology of Shifa Hospital offers comprehensive services and meets the needs of all problems related to women's health. Services are provided within the hospitalization unit, specialty clinics and the women's emergency room, women after normal vaginal delivery, after delivery via Cesarean Section and pregnant women in the high risk group who are hospitalized for observation. Gynecological surgeries are performed by experienced specialists include doing: hysterectomy, excision of benign and malignant tumors of the uterus and ovaries. The department of obstetric and gynecology consist of 142 beds, the staff whom working there were 65 physicians and 95 nurses (Shifa Hospital Records, 2001).

Al- Aqsa Hospital

Al Aqsa Hospital is a MOH hospital established, at the beginning of the intifada, in 2001, located in mid zone governorate of GS. The hospital provides services to 240,000 catchments population. Al Aqsa Hospital was a centre providing much needed secondary care services to the midzone area of GS. Beds Numbers of the hospital were104 beds, out of them, 8 for childbirth services. An average 10762 women per year were received maternity services, and 3784 women per year were delivered by normal vaginal delivery at the hospital. In general, the bed occupancy rate in the hospital during 2003 was 85% and the average length of stay was 2.7 days. The standard work week is 39 hours. The total number of the physicians in the

hospital was 79 physicians and the total number of the nursing staff who is working in different wards in the hospital was 85 nurses, out of them 8 work in childbirth services. The hospital contains facilities for a full range of secondary and primary patients care services for both inpatients and out patients. (Al-Aqsa Hospital Records, 2003).

Literature Review

The concepts of perceptions/perspective and satisfaction

Macran and Ross (1999) define client perspective as the following (1) a recognition that clients are individuals with their own beliefs and values who make an active contribution to the therapeutic process; (11) this recognition is translated into action by allowing the individual nature of client experiences to be expressed in a way, which is unhindered by researchers' own beliefs and values; (111) this doesn't mean having clients complete rating scales or checklists about their feelings or experiences, but to undertake a collaborative approach, which allow clients to set the agenda for what is important and meaningful for them personally in therapy (Macran and Ross, 1999).

The concept of satisfaction can be categorized into several categories. It is all one agreed that, clients' satisfaction demonstrates that satisfaction judgments are influenced by both emotional responses and cognitive disconfirmation (Oliver, 1993). Oliver (1998) defined satisfaction as "a summary of psychological state that results from the confirmation or non confirmation of expectations when compared to perceptions of a discrete episode of contact with an organization. Satisfaction is of short duration and contributes to the formation of attitude over time" (Oliver, 1981).

Another approach to define the concept of satisfaction derives from two factors; outcome and process. The former approach emphasizes the results from consuming experience. The later one extended to the nation that satisfaction involves states that not limited to mere satisfaction and can be described as a process (Oliver, 1993). For these several points of view, client satisfaction with a retail establishment may be viewed as an individual's emotional and cognitive reaction to his or her evaluation of the total set of experiences realized from patronizing the retailer. Thus, the feelings of

satisfaction arise when clients compare their perceptions of the performance of a product or service to both their desires and expectations (Kim et al, 1998).

No one standard definition of satisfaction was observed in the literature due to the fact that patient satisfaction is a multidimensional concept that is difficult to be accurately defined and measured :(Anderson Maloney and Bread, 1998; Schomer and Kucukarslan, 1997; Staniszewska and Ahmed, 1999). Staniszewska and Ahmed (1999) emphasized this saying that firstly, it is important to define and understand satisfaction and expectation, then theoretical modeling and valid instrument can be established. They added that few studies have defined and measured satisfaction within a theoretical model.

One researcher who attempted to place satisfaction in theoretical context was Pascoe (1983) who defined patient satisfaction as "a recipient reaction to salient aspects of the context, process and results of the service experience" (Pascoe, 1983). However, customer satisfaction does not only mean satisfying the needs and the reasonable expectations of customer, but also having an attitude that puts the needs of the customer first. Therefore, customer satisfaction is considered to be the heart of Total Quality Management (Evans and Lindsy, 1999).

Patients' satisfaction is influenced by patients' expectations and their perceptions of care (Anderson, Maloney and Bread, 1998). Anderson and colleagues defined expectation as "anticipation that an event will happen" (Anderson, Maloney and Bread 1998). On the other hand, perception represents a real experience and interaction of the person with the environment, and influences one's behavior (Anderson, Maloney and Bread, 1998). Faweett defined perception as "a process of organizing, interpretation and transforming information from sense, data, and memory" (Faweet, 1989).

Kasper et al 1992 observe that, the complicating reality is that the health care dynamic involves three parties; providers, policymaker and patient, unfortunately, much of debate ignores the fact that the patient is a third and coequal party in the system (Kasper et al 1992). In order to implement the patient's best interests, the health provider's role is to secure the patient's preference structure about different treatment options, the patient is not expected to make the medical decision itself, instead, the patient provides preference information (Sharp, 1998).

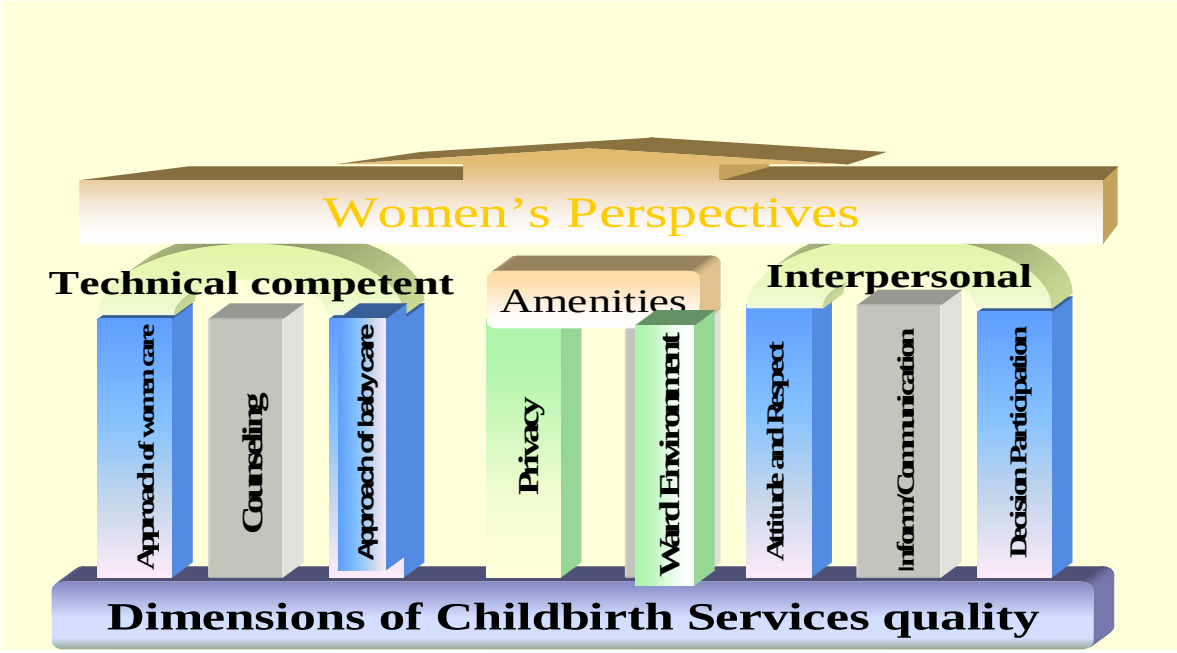
In 1975, the customer's approach to "patient hood" was introduced as a useful metaphor to describe a relationship in which the client has the right to ask for what he wants, and the focal point is the specific services that the patient would like the health professional to provide (Hanne, et al 2001). Client's requests represent preferences for particular health services and are essentially pragmatic in nature, and knowledge about client's requests is important in all help seeker-provider relationship (Hanne, et al 2001).

Humphrey 1998 said under the title of Consumer-driven health care: the world turned upside down? Consumer-driven health care" implies that consumers will have real power to make decisions that were previously made for them. It also implies that these will not be mindless decisions, that consumers will have access to, and take advantage of, useful information to make informed choices (Humphrey, 1998).

Leonie 1998 also said, health services are often provided through numerous separate programs which limit the capacity for resources to shift in response to consumer preferences and if the service system does not provide the mix of services that best meets the needs of consumers (in terms of their contribution to health and well-being), this is extremely wasteful (Leonie, 1998).

Conceptual framework

Diagram illustrate women's perception of childbirth services



An essential factor to consider when analyzing the quality of care of health facilities is the perspective of the client. For clients and communities, quality care is something that meets their perceived needs. Since a client's needs often differ, their personal satisfaction ultimately depends on the perception, attitude and expectations of each individual. Patient satisfaction is strong influencing factor in determining whether a person seeks medical advice, complies with treatments and maintains a relationship with the provider, ultimately, the dimension of quality that relates to client satisfaction affects the health and well being of the community (Brawley, 2000).

This study is concerned with the quality of care for women as delivered by health providers at governmental hospital. Donabedian's (1988) model for evaluation of care was used. Donabedian states that the process of health care has two major components including, technical competence and interpersonal relations between

Practitioner and client, both are important in providing quality care and both can be evaluated (Donabedian, 1988).

In this study the researcher adopted Donabedian models for evaluation of childbirth services at governmental hospital.

The technical competence

Technical competence refers to the skills and actual performance of health providers, this represented in this study by the following dimensions:

- Approach of women care
- Approach of baby care
- Counseling

Inter personal relationship

Inter personal relationship refers to effective listening and communication skills, this represented in this study by the following dimensions:

- Attitude and respect
- Information and communication
- Decision participation

Amenities

Amenities refer to a client's perception of the physical health care facility, this represented in this study by the following dimensions:

- Privacy
- Ward environment

Values of understanding clients' perceptions/perspective/satisfaction

Health care is increasingly consumer driven, consumers' perceptions of quality health care must be addressed. The study of consumer expectations and perceptions should be ongoing because these change over time and in response to new developments (Clark, Pokorny and Brown, 1996). However, over the last few years there has been renewed emphasis on the involvement of patients in the evaluation of health care, which has most commonly manifested itself in the measurement of satisfaction. Patient satisfaction is one measure used to assess the performance of health care programs and personnel (Dearmin, 1995).

Pasco 1983 reviewed existing health care literature and concluded that data on patients' satisfaction can serve as an indicator of service quality and as a predictor of health-related behaviors (Pascoe, 1983). The evidence that health care organizations need to identify variables affecting patient satisfaction is compelling. Satisfied patients are more likely to comply with prescribed plans of care, to have fewer complaints and to initiate fewer mal-practices. Patients' satisfaction is a key component in the evaluation of the quality of care delivered (Oliver, 1981).

Service quality is an outcome defined as "An attitude that customer develops over-time about an organization, this attitude is based on customer's perception of the organization's actual performance of particular service or group of services (Cronin et al, 1992). Health care is increasingly consumer driven. As health provider strive to provide quality health care for all consumers' perceptions of quality health care must be addressed. The study of consumer expectations and perceptions should be ongoing because these change over time and in response to new developments (Clark, Pokorny and Brown 1996).

The role of patient in assessing the quality of health care was considered as an

important issue that discussed by Kaplan and Ware (1995) who made it clear that including patients in their care can positively affect its quality, also, they mentioned that if patients better understand their care then they will be better evaluator of their care. Kaplan and Ware (1995) cited studies that endorsed their argument which clarify that informed patient do better than others regarding their care. Furthermore, they reported that traditional judgment of the quality of health care based on values, standards and expectations were made by the providers of care. But the patient assessment of health care process is a significant issue adopted by Continuous Quality Improvement that stated that both physician perceptions and assessments are valuable in evaluating of health Care services (Kaplan and Ware, 1995).

The most important change in health services the recognition that health services must respond to the preferences of the consumers, and that their opinions about care are important indicators of its quality (Surjit, 2002). Patients' views on what important in connection with the care they received may be seen as one aspect of quality of care, and patient satisfaction has increasingly come to be used as an indicators of this quality (Larsson and Larsson, 2002). With respect to evaluation criteria, the focus must be on the clients' experience, the competence of the care they received, their information levels, their satisfaction and their health status should be used as indicators of success (Leonie, et al 2004).

Leonie (1998) on his paper about the importance of patient empowerment in health system reform said" a focus on supply side issues only, without recognition of the fundamental importance of consumer empowerment will fail to promote an efficient solution to the distribution of health resources. Mechanisms to promote active consumer involvement in health care decisions are identified as a central requirement in health system reform (Leonie, 1998).

An essential factor to consider when analyzing the quality of care of health facilities is the perspective of the client. For clients and communities, quality care is something that meet their perceived needs. Since a client's needs often differ, their personal satisfaction ultimately depends on the perception, attitude and expectations of each individual. Patient satisfaction is strong influencing factor in determining whether a person seeks medical advice, complies with treatments and maintains a relationship with the provider, ultimately, the dimension of quality that relate to client satisfaction affect the health and well being of the community (Brawley, 2000).

Improving the women health services provides two benefits, it promotes women wellbeing and maximizes the services available and the efficiency with which they provided. So, achieving maternal mortality and morbidity reduction were resulting to this improvement. This improvement achieved by taking the women's view and opinion on the services they received and determine the most responsive to women desires (Revital, 2003).

Constructs of perception/satisfaction (dimensions)

Sue (1998) conduct a study to determines quality in maternity care by comparing the perception of childbearing women and midwives, the result of study were identified ten dimensions of quality which defined as, continuity of care givers, environment, information, access, care and treatment, relationship, outcome, staff attributes, choice and control (Sue, 1998). A study was conducted by Abu Dayah (2000) to assess the level of satisfaction of Palestinian people of health services provided by the MoH clinics through exit interviews of the clients who seek medical services over one week period to select the desired sample. The selected sample composed of 1555 patients distributed between GS and WB (42.8% and 57.2% of the sample size

respectively). The researcher used a questionnaire of 5 points scale to choose the suitable answer by the clients. The domains of satisfaction that studied were; patient involvement in the plan of health care, appropriateness of humanness and respect of medical staff, overall satisfaction of staff humanness and reception, overall satisfaction of diagnostic procedures, overall satisfaction of method of medical treatment, easiness of services, appropriate constellation of services, overall satisfaction of clients' privacy and staff interest.

Another study conducted by Mousa (2000) presented some results related to client's satisfaction with family planning services in Gaza Strip in Palestine concluded that domains of satisfaction among Gaza family planning recipients included attitudes and expectations, information and counseling, communication and interaction, mechanism of care and delivery of care. Also a study done in Palestine by AL Hindi (2002) explored the client satisfaction with radiology services in Gaza Strip. The researcher identified these dimensions of satisfaction, organizational culture, continuity and affordability, availability, communication and interaction, attitude and perception, comfort and privacy and approach of care (Al Hindi, 2002).

Abu Saileek (2004) conducted a study to assess clients' satisfaction with nursing care provided at selected hospital in Gaza Strip, the researcher identified these dimensions of satisfaction, information and interaction, availability/ attentiveness, comfort and environment, nurses skills and professionalism, organizational culture and lastly counseling and advising.

Factors affecting clients' perception/satisfaction

Involvement of patients in the evaluation of health care was manifested by measurement of satisfaction (Staniszwiska1 and Ahmed, 1999). Many studies tried to explore the relationships between patient satisfaction and variables that might affect

it, such as age gender, socio-economic class, income and level of education. These studies showed different results regarding the relation of client satisfaction to these variables. One study was conducted by Abd Al Kareem, Aday and Walker (1996) to provide data about patient satisfaction in government health facilities in the state of Qatar in order to improve the service delivery and the quality of primary care (Abd Al Kareem, Aday and Walker, 1996). They surveyed patients attending two major governmental out-patient health care institutes by mail and self-administered questionnaires. The analysis was performed on seven dimensions of satisfaction with medical care, including availability of services, convenience of services, facilities, humanness of doctors, quality of care, continuity of care and general satisfaction. They used the standardized Likert Scale of patient satisfaction developed by John Ware and associates. The result showed that males represented around two-thirds of respondents. The average age of respondents was 34 year. Citizens reported higher level of satisfaction in general and with each of the specific dimensions of care compared to non-citizens. Patients attending out-patient departments were more satisfied than those who went to the heal centers regarding the dimensions of satisfaction except for availability and convenience of services. Males tended to be more satisfied than females in all aspects of care, but the differences were not statistically significant. Younger patients were more satisfied with the physical environment. Income level was significantly related only to the quality of care and this was manifested by higher satisfaction with quality of care among those with lower income. Regarding the level of education of the respondent, patients with lower level of education showed higher satisfaction with the availability of services and facilities, while those with higher level of satisfaction tended to be more satisfied with the quality of care (Abd Al Kareem, Aday and Walker, 1996).

In a study to measure patient satisfaction with nursing care, Jacox and his colleagues used mailed questionnaire to survey 2892 patients after they were discharged from the hospital and completed the nursing care data that were collected on them during their hospitalization. The 1453 completed questionnaires were subjected to factor analysis and the results showed three dimensions of satisfaction of nursing care: caring about patients (interpersonal), technical skills and patient education. Age and gender were analyzed to explore their relations to the three dimensions of satisfaction with nursing care. The caring aspect was the only investigated dimension that showed the statistically significant relationship. Although men showed no difference from women with respect to their assessment of care, a weak positive relationship existed for age, and patients over 50 tended to have higher satisfaction score with nursing care than younger patients (Jacox, Bausell and Mahrenholz, 2000).

Singh, Mustapha and Haqq (1996) conducted a study on patient satisfaction at health centers in West Indies. The study aimed to identify characteristics of those health care users and their perceptions of the services provided. Therefore, 1,500 health center users were selected through multi-staged sampling process throughout the country. Data was collected using structured interviews on regular clinic days. The results showed that the majority were elderly people and represented the higher number of the low socio-economic patients. Respondents tended to be generally satisfied with the services of the health centers. When the categories of satisfied and very satisfied were combined, the results showed that 81.7% of respondents were satisfied with convenience and ease of services, 73% with the comfort of the health center, and 67.4% with the medical care received at the health centers. When doctors, nurses and pharmacists were compared with respect to "courtesy", "skills" and "advice provide", results showed that generally there are higher level of satisfaction, which was similar

in all three cases. Reducing waiting time was the greatest issue required to be improved upon the respondents' recommendation (Singh, Mustapha and Haqq, 1996).

Several researchers have taken into account the special characteristics or the users of the health care centers for future planning and improving services. For example, Gagin and Cohen (1996) noticed that there is an increase in the number of over-65 year olds among hospital patients. Also he mentioned that over 60% of the out-patient departments of urban Medical Center were elderly people. Therefore, a satisfaction survey of this population was conducted for the purpose of defining the problems in service delivery, obtaining feedback on the quality of services and setting priorities. The questionnaire was concerned with satisfaction medical and nursing treatment (Gagin and Cohen, 1996).

Another research was conducted by Freed et al (1998) to understand the determinants of adolescents' satisfaction with their health care providers and to examine the relationships among satisfaction, intention to return for follow-up, and appointment keeping behavior. A sample of 124 adolescent patients attending general adolescent clinic were surveyed prior to the visit about their attitudes regarding provider behavior. After the visit, those patients filled a questionnaire about provider behavior during the visit, satisfaction with the visit and intention to keep their follow-up appointment. Multivariate regression analysis showed that pre-visit attitudes about providers' style of behavior predicted satisfaction (beta=0.512; $p<0.01$). Visit satisfaction was associated with intention to keep schedule follow up appointments ($r = 0.327$; $p< 0.01$). However, subjects with greater intention to return were not more likely to keep their, follow-up appointments. Therefore the results revealed that provider behavior is an important determinant of adolescent satisfaction with their health care provider (Freed et al, 1998).

Another study was conducted by Clarke et al (1998) who measured satisfaction among low-income women. The researcher examined the correlation of Norplant selection and satisfaction among low-income women. Data was collected by interviewing 1152 Norplant users and 1268 non-users in four family Planning clinics in Florida, and follow-up interviews with a sub sample to 1 year later. Logistic regression models estimated the associations of socio-demographic and medical characteristics with Norplant selection and method satisfaction. Part of the results that concerned with satisfaction showed that 92% of low-income Norplant users were satisfied with the method. The overall results concluded that Norplant provides an acceptable and satisfying method of birth control for many low-income women (Clarke et al, 1998).

Domains of perceptions/satisfaction in health /maternity setting.

Loyalty

Sherbourne, et al (1992) said various health plans compete to provide care for groups of patients; much attention has been focused on patient satisfaction as a way to attract and retain patients. Studies have shown that satisfied patients tend to be more adherent to medical recommendations**.**

Creating genuine client loyalty in an increasingly competitive marketplace is one of the biggest challenges facing all professional service firms, according to Professor Melinda Muth of Mt Eliza School. While professional firms often plough large amounts of time and money into marketing and pitching for new work, they risk overlooking just how important it is to put as much energy, if not more, into building client loyalty.

Professor Muth says, "The answers lie in recognizing the close link between people and professional services," also she says "For example, why have boundaries between marketing and human resource activities? Hiring and developing people who truly understand how to build client relationships is the best way to boost client loyalty on a sustainable basis." This is a difficult issue for some professionals to come to terms with. "Yet, no amount of effort can overcome client perceptions if their experiences don't match the messages they are sent" (Muth, 2003).

Attitude and Respect

Green et al (1990) conducted a large survey in southeast England to assess expectations, experiences, and psychological outcomes of childbirth, the researcher assess positive and negative staff attitudes were reported by women, the result revealed that the women who felt in control had more positive psychological outcomes than those who felt disempowered by their caregivers. Halldorsdottir and Karlsdottir (1996) were reported similar findings in a phenomenological study in Iceland. Jacoby (1988) claims that Asian women were the most satisfied group about staff attitude in the study but Woollett and Dosanjh (1990) found that the Asian women were dissatisfied. Jacoby, attributed these differences might be to the poor response rate from Asian women to the questionnaire survey.

Chung-Hey, et al (2001) reported in their research to assess Taiwanese women's perspective about their encounters with obstetric nurses during labor, sixty percent of the participants reported having received helpful nursing behaviors; while 38 percent reported having received both helpful and unhelpful nursing behaviors. Helpful labor-coping measures that were valued by participants included performing roles of emotional support providers, comforters, and advocates. Forty percent of the

participants reported that some nurses had hindered their labor-coping ability by failing to provide emotional support and comfort measures (Chung-Hey, et al 2001).

The studies of Kempe, et al (1994) reported that nurses spent a very small percentage of their time providing supportive care for mothers in labor. Their time was mostly spent performing other activities physically separated from laboring women (Kempe, et al 1994).

Beaton (1990) was reported in his study, dimensions of nurse and patient roles in labor, that the viewing of behavior from the subject's perspective is important and he found a discrepancy in attention between laboring women and their nursing caregivers, with nurses being concerned about the management of labor care, whereas the laboring woman being more concerned about coping with the physical reality of labor (Beaton, 1990).

Sue’s study (1998) sought to identify and compare the perceptions of women and midwives concerning women's beliefs about what constitutes quality in maternity services. The two key issues were being listened to and being respected, themes that were repeated in accounts of antenatal, labor, and postnatal care (Sue, 1998).

Information and communication

For the importance of communication and the attitudes of health providers, several studies reported that a large number of women were dissatisfied with the information they received (Jacoby, 1988) and working-class women experienced the greatest difficulty in finding out what they wanted to know.

Positive and negative staff attitudes were reported by women in Green, et al's (1990) large survey in southeast England; women who felt in control had more positive psychological outcomes than those who felt disempowered by their caregivers. Halldorsdottir, (1996) were reported similar findings in a small phenomenological

study in Iceland. Seemingly conflicting views were found about staff attitudes among Asian women, who were the most satisfied group in one study (Jacoby, 1988), but were dissatisfied in another. These differences might be attributed to the poor response rate from Asian women to the questionnaire survey (Jacoby, 1988)

.Patient satisfaction surveys have also shown that patient–provider communication plays an essential role in determining patient satisfaction, if the rhetoric on listening to women's voices is to move on to action, it is important to begin to understand how women feel about existing services and what they want in terms of improved services (DiMatteo, 1994).

Eileen (1998), conducted a study to examine the development of maternal identity, the result about the information and communication revealed that lack of information was identified as a source of frustration by 20% of study population, but they did not identify the source of lack of information. Women want to know more about specific topics, such as how intense the pain would be, back pain, induction, medication and how to push to avoid episiotomy. Also 30% of study population was identified negative communication of health caregivers as a source of frustration, resulting from uncaring interactions and undesired actions by care givers.

Chung-Hey (2001), and his colleges study, to assess Taiwanese women's perspectives about their encounters with obstetric nurses during labor, which an interview for a convenience sample of 50 mothers experiencing normal childbirth in Taiwan. The study revealed that 60% 0f participants reported having received helpful nursing behaviors only; 38% reported having received both helpful and unhelpful nursing behaviors. Helpful labor-coping measures that were valued by mothers included emotional support, information/advising; 40% of participants reported that some nurses failed to provide adequate or correct information/advice (Chung-Hey, 2001).

Other authors have also shown that older consumers search for information less than younger consumers do. A review of the consumer behavior literature by Beatty and Smith (1987) found that older consumers are less likely to obtain information about services when making a brand choice decision than younger consumers. Cole and Balasubramanian (1993) found similar results. In both aided and unaided decision-making tasks, older consumers searched less for information than younger consumers did.

Anastasios (2003), in his study for Evaluation of patient satisfaction with nursing care, he reported that the patients were less satisfied with patient education and the orientation they received on admission. Emmanuel, et al (2001) conducted a study to investigate, from a service consumer perspective, mothers' needs in the immediate postpartum period, the study revealed that the women wanted specific information and education about mothering., For new mothers, early discharge made the need for rest and information a high priority.

Mngadi, et al (1999) conducted a study to generate more systematic data on maternity care provided for childbearing adolescent mothers and their new born baby in Swaziland by health professionals, the study revealed that on admission to the labor ward, verbal communication and interaction between the midwife and adolescent were minimal, being limited to instructional messages from the midwife to the adolescent. Before discharge, all of the mothers got some advice on how to take care of themselves and their newborns such as keeping the baby warm in a warm room wrapped in warm clothes to prevent child from getting cold. The mothers reported having received health education advice in post natal ward such as the importance of exclusive breastfeeding, general cleanliness, the importance of immunizations, eating good diet with plenty of fluids, the mother also got advice about different family

planning methods and immunization program and about the importance of exclusive breastfeeding and prevention of hypothermia in the newborns. Regarding care of the newborns, the mothers were generally informed to clean the umbilical cord with methylated spirit until it got dry and falls off and were informed to breastfeed the babies on demand (Mngadi, et al 1999).

Jacoby, (1988) conducted a study to assess mothers' views about information and advice in pregnancy and childbirth and the importance of good communication and the attitudes of staff. The study reported that a large number of women were dissatisfied with the information they received and working-class women experienced the greatest difficulty in finding out what they wanted to know (Jacoby, 1988).

Janssen, et al (2000) conducted a study to investigate a single room maternity care and client satisfaction, the participants were asked about information and support they received: specifically, if their opinions were sought and choices valued, if they were given adequate information for decision making. Both groups scored their care very positively (Janssen, et al 2000).

Approach of women care

Rhonda, et al (2002) examined the views of three groups of immigrant women about the care they received in hospital for the birth of their babies and compared the findings with a population-based statewide survey. The study revealed that, women's overall rating of their intrapartum care by country of birth group is described as, Vietnamese women were significantly less likely to rate their care as very good compared with the other two groups combined, No associations were found between sociodemographic factors and women's overall rating of their intrapartum care. Level of family income, level of education, maternal age, and parity all showed no relationship to women's rating of their intrapartum care (Rhonda, et al 2002)

Mngadi, et al (1999), conducted a study to generate more systematic data on maternity care provided for childbearing adolescent mothers and their new born babies in Swaziland by health professionals. The study revealed that 79% of study population were met in what they perceived as a welcoming manner, which greeting by the nurses and orientation such as being shown where to sit, where to find toilets and telephone. They felt the procedures were poorly explained to them such as finding from physical examination. 21% of mothers said "the midwives were impersonal that is they did not greet them, did not orient them and did not care". 79% of mothers were informed of the result of the first assessment and the rest did not get that information.

Sue (1998) conducted a study to identify and compare the perceptions of women and midwives concerning women's beliefs about what constitutes quality in maternity services, the result revealed that the women spoke about a range of aspects of postnatal care that were important to them, mostly related to building confidence in caring for their baby and in their ability to cope at home. With the exception of breastfeeding, midwives did not discuss other aspects of postnatal care that mattered to women. Women wanted care and advice that was effective and many wanted clear explanations of procedures, even if they were technical and highly specialized.

Privacy

The WHO Regional Office for Europe recently convened a perinatal care Workshop at which it was proposed that ten principles should underlie perinatal care in the future, one of these principles concerning mother respect; Care should respect the privacy, dignity and confidentiality of women (WHO, 1998)

Tamar, et al (2000) study about women's experiences of maternity care: satisfaction or passivity? The study revealed that women in the semi-rural villages and the remote

rural villages regarded the level of privacy they were given at the hospital as satisfactory if the staff were all female and the number did not exceed three or four nurses, and one physician. In Beirut, the majority of women delivering in large teaching hospitals complained about the vaginal examinations carried out by residents, nurses and midwives during labor:

> *"In the labor room, there were three to four residents going in and out and examining me, in addition to two nurses and the midwife. A different person was examining me every time. I was very bothered by this fact. They should have a rule in these hospitals and appoint one person for each woman. Where was my rights of privacy, this is a private thing, I did not go there to provide a show"* (Tamar, et al 2000).

Janssen, et al (2000) conducted a study to investigate a single room maternity care and client satisfaction, the study group included 205 women who were admitted to the single room maternity care unit after meeting the low-risk criteria. Their responses on a satisfaction survey were compared with those of a historical comparison group of 221 women meeting the same eligibility criteria who were identified through chart audits 3 months before the single room maternity care unit was opened. A second, concurrent comparison group comprised 104 women who also met eligibility criteria, the result revealed that the study group women were more satisfied than comparison groups in all areas evaluated, including physical environment and respect for privacy.

Approach of baby care

Tamar, et al (2000) study about women's experiences of maternity care: satisfaction or passivity? revealed that, a common need identified by women in the three areas was the chance to see their newborn baby directly after the delivery and frequently thereafter. Alternatively, they would have liked the choice of rooming-in, when the

baby stayed with them throughout. In the Bekaa, none of the women who delivered with an obstetrician in a hospital saw the newborn in the delivery room, and most had to wait several hours before having the chance to hold the baby. A 25-year-old woman having her fourth child in a hospital described the following:

> "*The first time I saw her (the newborn) was only from her back, because they took her to wash her...I would have loved to hold her...I did not ask them for that, probably if I had asked they would not give her to me anyway...this is the way I felt at least*" .

Barnett, et al (1995) and Alexy, et al (1994) studies have established that rooming-in and breastfeeding at frequent intervals after childbirth promote secretion of breastmilk and successful breastfeeding. Breastfeeding success is also affected by support from professionals, relatives, and friends. A favorable attitude on the part of the spouse can influence the mother's decision to breastfeed and its success. Support, encouragement, and a favorable attitude toward breastfeeding by health care professionals has a positive effect on first-time mothers, and intention to breastfeed is also influenced by whether or not women received information relating to breastfeeding during pregnancy and postpartum period .

Howell, (2004) conduct a study to assess obstetric patient satisfaction: Asking patients what they like. The study revealed that some women when asked about the baby care they told that "nursery was good" and "received quick competent response to needs of my baby after delivery". Mngadi, et al (1999) conducted a study to generate more systematic data on maternity care provided for childbearing adolescent mothers and their new born baby in Swaziland by health professionals. The study revealed that measurement of the length of the babies, the head circumferences and temperature check of all the newborns immediately after delivery or during the stay in the labor

ward was not done. All newborns were dried with dry towels, wrapped in blankets and placed next to their mothers in the delivery bed. 71% were encouraged to start breastfeeding their babies within 60 minutes after birth. The pediatrician was not called for consultation for any of the newborns while in the ward.

Marja-Terttu, et al (1998) conducted a study to gain information about factors that contributed to the successful establishment of breastfeeding in first-time mothers while they were still in the maternity hospital. The results revealed that mothers who had a positive experience of breastfeeding in the maternity ward and who began lactating 2 to 3 days postpartum coped better with breastfeeding than those whose experience was less positive and lactated later. Moreover, the greater the emotional and concrete support received by the mother from members of her support network, the better she coped with breastfeeding. By contrast, those mothers who were upset while in the maternity ward coped less well with breastfeeding.

WHO and UNICEF launched the international Baby Friendly hospital Initiative, which stresses the importance of breastfeeding as a means of ensuring good health and nutrition for the newborn infant (Ros, et al 2003).

Counseling

Health practices and research are paying increasing attention to what patients want, as reflected by growth of routine surveys of patients' satisfaction and more formal studies of patients' views of health care.

Abu Saileek (2003), examined client’s satisfaction with nursing care and showed the counseling domain were reported the lowest level of satisfaction 59.5% expressed by the clients. But in Mousa study (2000), who examined the client’s satisfaction with family planning services in GS, it was shown that counseling and information domain were reported the highest level of satisfaction 81%

Hanne (2001), and his colleges conducted a study to assess the patients' purpose of consultation, and they incorporated what the patient hopes to gain from consultation. It reflects the view of the patient as an active participant in the consultation process rather than a passive recipient of care.

Savage and Armstrong (1990) conducted a study involving 359 randomly selected patients consulting to compare the effect of directing and sharing styles of consultation on patient satisfaction. The authors found that patients in the directive group with self-limiting problems or chronic conditions and those receiving a prescription, reported significantly higher levels of satisfaction on several outcome measures.

Ward environment

The hospital environment, particularly the birthing room, has always been considered as an unfamiliar place by pregnant women: strange, cold, frightening and full of surprises, a place which will be the scene of a lot of pain and suffering at the time of birth. Health professionals are responsible for the undoing of this myth and should transform the environment into one associated with the image of pleasure and happiness, in which the arrival of a new and, almost always, very wanted human being, will occur. The previous familiarization of the woman with the environment makes her feel more secure and less anxious at the time of the birth (Santos and Siebert, 2001)

Misago, et al (2001) conducts a study to compare the delivery and childbirth situation in five municipalities in the State of Ceará in Brazil. Mothers were interviewed to identify health priorities, and then to collect accounts of childbirth, the results revealed that, many women reported that birthing facilities were inadequate. Delivery

and labor rooms were often noisy, unventilated and hot, and offered little or no privacy.

Anastasios, Elizabeth and Chryssoula (2003) in their study for Evaluation of patient satisfaction with nursing care; the patients express**ed** low satisfaction with the cleanliness of toilets, noise levels and the variety and temperature of meals .

Emmanuel, et al (2001) conducted a study to investigate from a service consumer perspective; mothers' needs in the immediate postpartum period. The study revealed that women wanted the creation of a restful environment .

.Sue's study (1998) sought to identify and compare the perceptions of women and midwives concerning women's beliefs about what constitutes quality in maternity services, the researcher recognized that many similarities between midwives and women related to the importance of tangible features of the services. Midwives thought that homely, familiar, and comfortable surroundings were pleasant and important to women, especially in labor. Women, however, emphasized the reassurance that homelike surroundings conveyed, namely, that their experience was normal and they were not ill. The importance of clean clinics, delivery rooms, and wards was associated with a number of beliefs. These included expectations that hospital would be "clinically clean," and provide safe areas where risk of infection was minimized.

Decision participation

The WHO Regional Office for Europe recently convened a Perinatal Care Workshop at which it was proposed that ten principles should underlie perinatal care in the future, one of these principles concerning decision participation; Care should involve women in decision making (WHO, 1998).

Hope, (1996) emphasizes that patients should be in a position to choose whether to

accept an intervention or not as part of their general right to determine their own lives. A central ethical principle behind evidence-based patient choice is that the information is being given in order to enhance choice. Patient choice goes beyond consent and involves the patient in the decision-making process. However, the move towards increasing patient involvement is not driven simply by a theoretical concern for respect for patient autonomy. Rather, it is recognition of the fact that individuals differ both in what they value and in their propensity to take risks.

The involvement of women in decision-making processes concerning their pregnancy and birth and their sense of control over the whole process is viewed as an important determinant for women's satisfaction with childbirth (Beattie, 2000).

Maternity services in the United Kingdom have responded to calls for greater user involvement, and introduced policies to support the development of women–centered maternity services. The principles of such services are that, first women are encouraged to participate in decisions about their care; and second, services providers should attempt to involve women in the planning of the services (Edwin, 2003)

Sabine, et al (2004) conducted a study to describe women's experiences of participating in decision-making related to augmentation of labour, the study revealed that the women who perceived themselves to have a good level of knowledge and expectations concerning augmentation of labour and who were also invited to participate in decision-making by supportive midwives, seemed to be more satisfied with participating than other women in this study. Most participating women, however, expressed positive experiences regarding the knowledge, interpersonal skills and abilities of the midwives. Midwives were seen as comforters (Sabine, et al, 2004).

Vande (1999) conducted a study in the USA, about how decisions were made during labour. In that study women expressed more positive reactions about the childbirth

experience when they were involved in decision making and more negative when they were not.

Sue’s study (1998) sought to identify and compare the perceptions of women and midwives concerning women's beliefs about what constitutes quality in maternity services, midwives in their comments was a perception that women either wanted active involvement or they wanted to be passive throughout the service encounter. They also believed that many younger women did not want to have to make choices about their care because they were not used to making choices. Among women, the preference for involvement and the opportunity to make significant choices varied with respect to the different phases of the service and varied between individuals regardless of age.

Methodology

Study design

The design of this study is a descriptive cross sectional one. It has been selected because this method would be useful for descriptive analysis of study constructs, namely perspectives, perceptions, experiences and satisfaction. It enables the researcher to meet the study objectives in a short time and low cost, besides that, this type of studies examines the association between cause and effect at a point of time (Coggen et al, 1993).

The study population

The study population consists of all eligible women who gave birth in the labour wards at the EGH, Naser Khan Younis Hospital, Al-Aqsa Hospital, and Shifa Hospital during the period from October 2003 to end of December 2003.

Setting of the study

The study was conducted at the EGH, Naser, Al-Aqsa, and Shifa Hospitals. Currently, these are the governmental hospitals in the GS, which provides secondary and tertiary medical and surgical services including childbirth services for the majority of the GS population. They were selected to represent the major areas in the GS since they serve the community living in camps, rural, urban and semi-urban areas.

Period of the study:

The period of collecting data for this study started from October 2003 till the end of December 2003. The study took three months from the time of conduction depending on the stability of the political situation.

Sample size

A sample size of 450 was calculated using the proportion of client satisfaction, which was about 80% in the previous study done in the area (Eid, 1996). To calculate the desired size of the study sample, the researcher estimates the prevalence of women satisfaction based on the following parameters

Prevalence=80%, a 95% level of confidence, an estimating error of 4% based on these data and calculations, the desired sample size was 384

Sample size (N) was calculated using the following equation:

$N = (Z\ 1- \alpha/2)\ 2\ P\ (1- P) / d\ 2$

Z = the standard normal deviate at confidence where level $1 - \alpha /2$

P = the proportion of women satisfaction.

d = absolute precision

Based on 95% confidence level, Z =1.96, P = 80% to maximize the sample size, and within 4% precision the sample size equals 384, the figure was rounded to 450 to compensate for any drops.

Sampling method:

The total number of deliveries in the governmental hospitals in GS annually about 23987, distributed as 11005 in Shifa Hospital, 6755 in Naser Hospital, 2443 in EGH, 3784 in Al-Aqsa Hospital. The average number of deliveries per month for each hospital of these women was used as a reference for sampling.

The participants were women from the area who had given birth between 1st October and 30th December 2003. Four hundred fifty women were randomly selected from the hospitals: 206 from the Shifa Hospital, 127 from Naser Hospital, 46 from EGH, and 71 from Shuhada Al-Aqsa Hospital. A proportional random sample of women who gave birth in the governmental hospitals at the time of the study was taken randomly

as the following:

All women who attended the governmental hospitals for delivery between 1st October and 30th December 2003 were the target population, then 15 days was selected out of whole month days during which data was collected from the hospitals (every other day).

Ethical consideration

An official letter of approval to conduct the study was obtained from the Helsinki Committee in the GS (Annex 4). Also an official letter of request was being obtained from MOH director general to conduct the study in the governmental hospitals (annex 5).

Women were given full explanation both verbally and written about the purpose of the study and assurance about the confidentiality of the information and the participation is optional and confidentiality was maintained at all times during the study. Consent forms were obtained from all participants, which were attached to each questionnaire to ensure their voluntary participation after their signing to the consent.

Questionnaire Content

Data was collected through a structured questionnaire (exit interview). The questionnaire comprised three sections and took approximately 20 minutes to complete. The sections covered details about, sociodemographic, the standard of services and the mother perception and satisfaction of services during and immediately after giving birth. The questionnaire was developed mainly using likert scale format and some open ended questions, at the end of the questionnaire for the mothers to expand on their answers and to give any additional comments. A copy of the questionnaire (Annex 6).

Pilot study

Pilot testing was done prior to the beginning of data collection to check the appropriateness of the questionnaire and to eliminate any ambiguities. Piloting was done with 20 childbirth women. After conducting the pilot interview and evaluating the suitability of questionnaire, refining of questionnaire was done according to the result of the pilot study. However, pilot subjects were excluded from the study.

Data collection team

The data collection team was the researcher himself and 8 female university students whose study was related to human sciences. Data collectors were trained in interviewing skills, filling questionnaire and clarification of the instrument item by item. Data collectors were implemented the fieldwork under the supervision of the researcher, it is notable that the instrument was implemented in Arabic (Annex 7). They underwent extensive training by the researcher in order to standerize the training, practical exercises were included and then relevant idea of the instrument was revised.

Approach of data collection

The questionnaire was administered face to face by the female data collectors after the delivery of women and ready to be discharge. The data collector explain to the woman the purpose of the study and informed her that the participation in the study is optional and not obligatory and that she had the right to refuse or participate, after agreement, a consent form was signed (annex 8).

A set of questions were prepared in the questionnaire to enable the researcher to focus on the necessary data that meet the objectives of the study. This questionnaire is a structured interviewed questionnaire. It was administered by the data collectors after the woman received childbirth services and ready to be discharged, this

questionnaire includes the following main components: sociodemographic, the mother's perception and satisfaction of services during and immediately after giving birth and open end questions.

The researcher selected using the administration of questionnaire through exit interview to ensure obtaining proper and unbiased answers by women (avoid recall bias).

Data management and statistical analysis

Data were analyzed by using the Statistical Package for Social Sciences SPSS (Windows Version 8). Descriptive statistical techniques such as frequency distribution and other inferential statistical tests such as one way ANOVA were used. A p-value of less than 0.05 was considered statistically significant. The analysis of data was conducted as:

- Over viewing the filled questionnaires
- Coding of questionnaires
- Designing data entry model
- Data entry and data cleaning
- Frequency table for the study variables
- Descriptive and advance inferential statistical analysis

Psychometrics of the instrument

Reliability

The instrument reliability test was high as 0.92. Reliability is concerned with how consistently the measurement technique measures the concept of interest (Burns and Grove, 1997). The statistical test used for internal consistency was Cronbach's Alpha Coefficient. Cronbachs' Alpha is considered the most general form of reliability

estimates and also it is concerned with the homogeneity of items compromising the scale (Polit and Hungler, 1999). A strong correlation among the items may imply strong links between the items and the latent variables. Thus, this method was chosen for this study.

Content related validity

Content related validity examines the extent to which the method of measurement includes all the major elements relevant to the construct being measured (Burns and Grove, 1997). To achieve this type of validity, the instrument was evaluated by six experts in the field, which interest in childbirth related issues. The study questionnaire and objectives were sent to them to be oriented with the objectives of the study. The researcher adopted the Content Validity Index (CVI) developed by Waltz and Bausell (1981) as instrument that determines the validity of items provided in the questionnaire, the following scale was used: (1) not relevant variable; (2) item is in need for revision to be relevant; (3) relevant but need minor modifications; (4) very relevant and succinct (Waltz and Bausell, 1981; Burns and Grove, 1997). Experts rated the content relevance of each item using a four point rating scale.

Experts comment on each item and the extent of its content relevance. After that, experts' panel discussion took place and at least four of them have agreed on each item. As a result some items were added, modified or deleted. The expert panel discussion took about 90 minutes

Constructs of perspective components

The researcher emerged the 73 items scale of the questionnaire which was used in this study into nine domains. Domains are referred to as scale which was based on a series or groups of individual questions pertaining to the same topic. The author chooses the extraction method to identify meaningful construct. These construct

labeled as loyalty, respect, information and communication, approach of women care, privacy, approach of baby care, counseling, wards environment, decision participation and overall perspectives (Table, 4).

Reliability of Constructs

The technique of measuring variables must be reliable as this reflects the extent to which an operational definition, questionnaire, test, interview schedule or other instruments is stable and consistent (Mark, 1996). This mean a measure is reliable if it gives the same result each time the situation or the factor is measured. Cronbachs' alpha coefficient was used to estimate the internal consistency of the domains of this study. It is worthnoting that the reliability coefficient for the instrument was 0.92. Cronbachs' Alpha is considered the most general form of reliability estimates and also it concerned with homogeneity of items compromising scale (Polit and Hungler, 1999).

Eligibility criteria

Inclusion criteria

All women who were admitted and stayed for at least one night at the maternity unit for delivery in one of the four hospitals during the study period and who live in GS.

Exclusion criteria

Women, who were delivered by cesarean section, had still births or neonatal deaths, along with all those women whose babies were still hospitalized.

Limitation of the study:

- The sample is hospital based rather than population based.
- For the purpose of the study, NGOs and private sector were not involved.

- Lack of relevant resources as references.
- Time limitation**.**
- The study excluded complicated cases as Cesarean Section and high risk pregnancy.

Response rate

Number of respondent women in the study was 391 women out of the sample size (450).

The response rate was 86.9% distributed as depicted in table (1)

Table (1) distribution of subjects' responses according to the hospital.

Hospital name	***Number of selected women***	***Number of respondent***	***Response rate for each hospital***
Shifa	206	177	85.9%
Al-aqsa	71	57	80.3%
Naser	127	117	92.1%
EGH	46	40	87%
Total	450	391	86.9%

Results

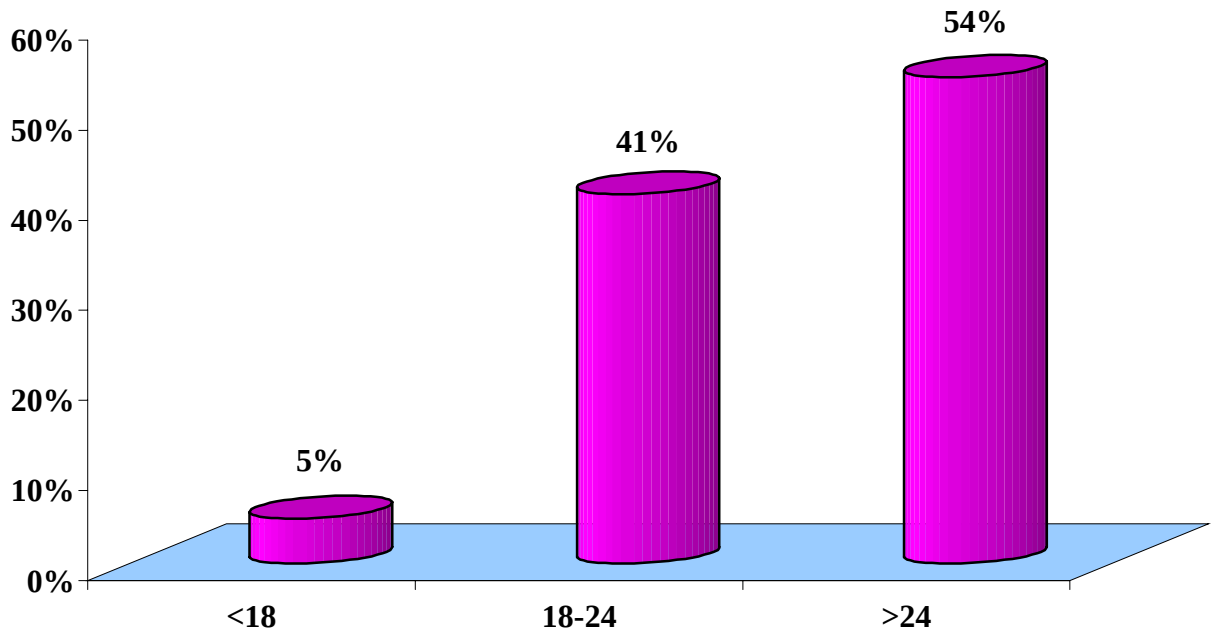
This chapter presents the results of the study questionnaire, commencing with descriptive analysis to provide summary of the sample characteristics; frequency distributions and presentation of data in tables and graph to provide a pictorial description of the sample. Univariate analysis of variance ANOVA were computed as a major component as it considered the most appropriate statistical technique to determine the relationship between the study variables.

Characteristics of study population

Table 2: Summary table of the characteristics of the study population

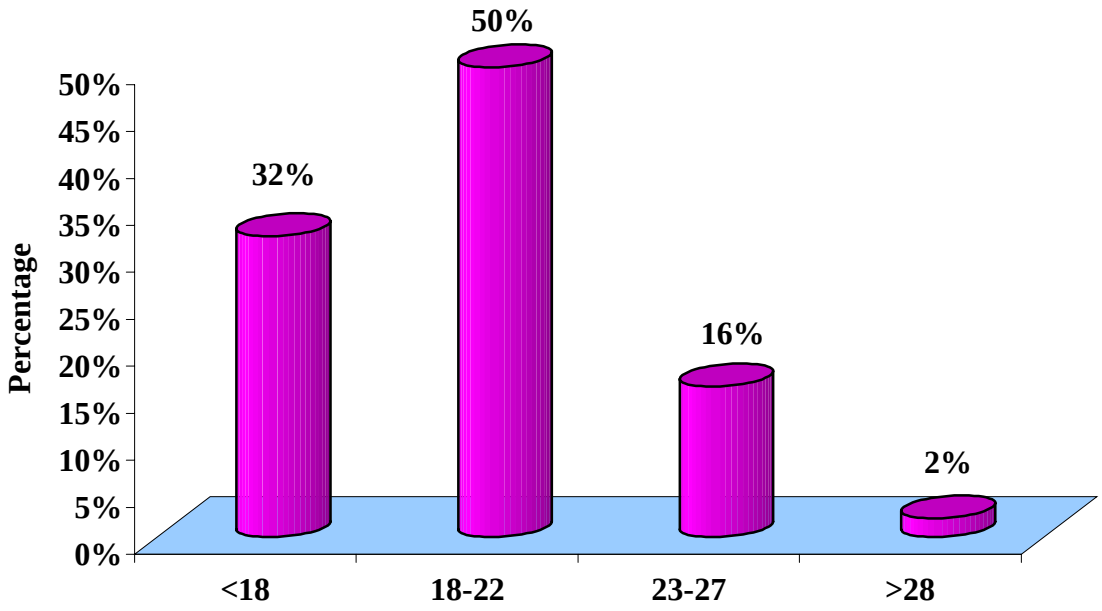
Variables	No (391)	%
Age		
• **< 18**	**19**	**5.0**
• **18-24**	**161**	**41.0**
• **>24**	**211**	**54.0**
Age at first marriage		
• **<18**	**126**	**32.2**
• **18-22**	**195**	**49.9**
• **23-27**	**63**	**16.1**
• **>27**	**7**	**1.8**
Residency		
• **City**	**158**	**40.4**
• **Village**	**89**	**22.8**
• **Camp**	**144**	**36.8**
Employment status		
• **Employed**	**27**	**6.9**
• **Not employed**	**354**	**90.5**
• **Student**	**10**	**2.6**
Women education		
• **Elementary**	**40**	**11.7**
• **Preparatory**	**96**	**24.6**
• **Secondary**	**161**	**41.2**
• **High educate**	**88**	**22.5**
Monthly income (NIS)		
• **<1000**	**214**	**54.7**
• **1000-1500**	**86**	**22.0**
• **1501-2000**	**74**	**18.9**
• **>2000**	**17**	**4.3**

Figure 1: Distribution of study population by age.



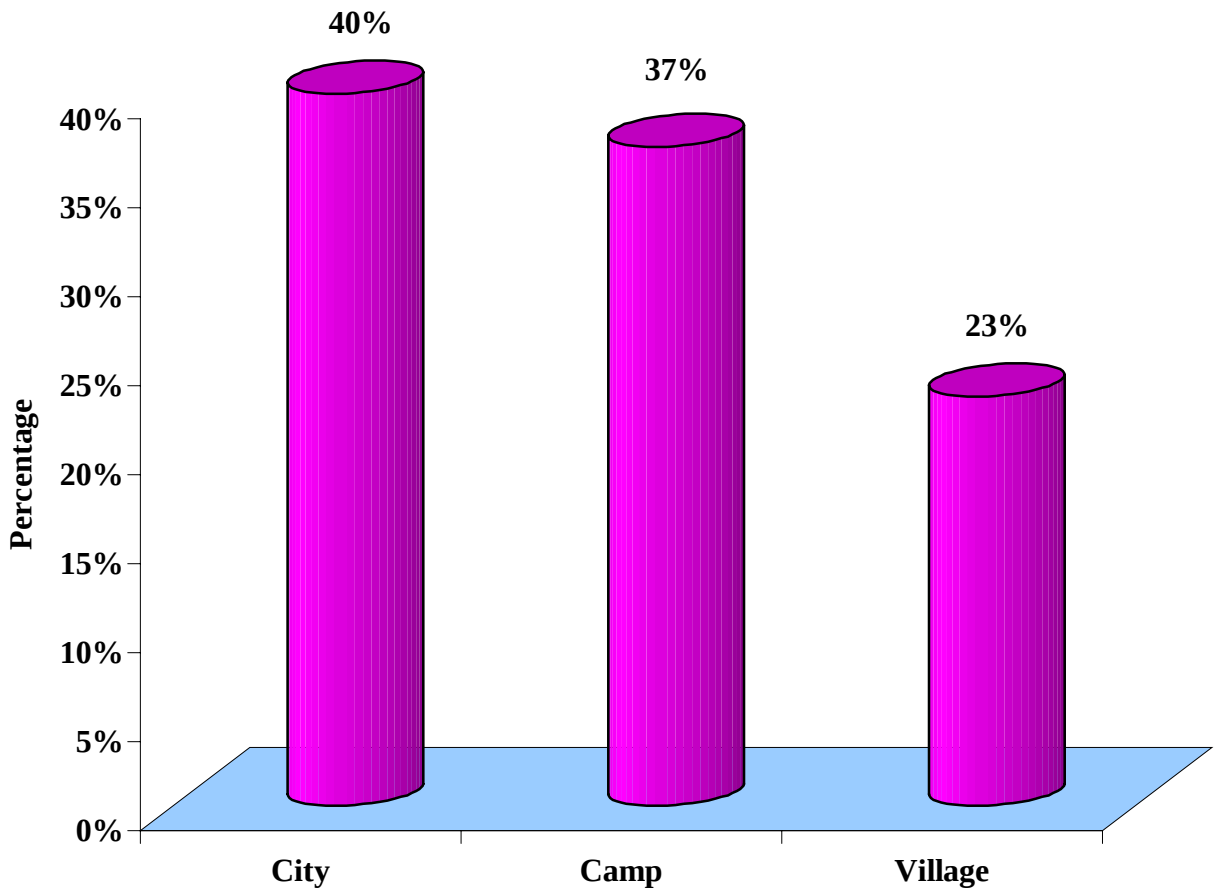
As shown in figure 1 as well as table 2, the majority of study population age were more than 24 years, which represented 54% of the study population, while the second highest age group was 18-24 years, which represented 41%. The remaining percentage was that age group less than 18 years old. The mean age was 26.7 years ± SD 6.5 years.

Figure 2: Distribution of study population by age at first marriage



As shown in figure 2 as well as table 2, the majority of study population age at first marriage were 18-22 year which represented 50%, while the second highest age at first marriage was those less than 18 year which represented 32%, the remaining proportion were depicted in figure (2). The mean age at first marriage was 19.3 ± SD 4.46 years.

Figure 3: Distribution of study population by living place



Gaza Strip has three types of residency; villages, camp and cities. Nearly 40% out of the total number of study population were living in towns, 37% were living in camps and 23% were living in villages. This distribution is shown in figure (3).

Figure 4: Distribution of study population by provinces

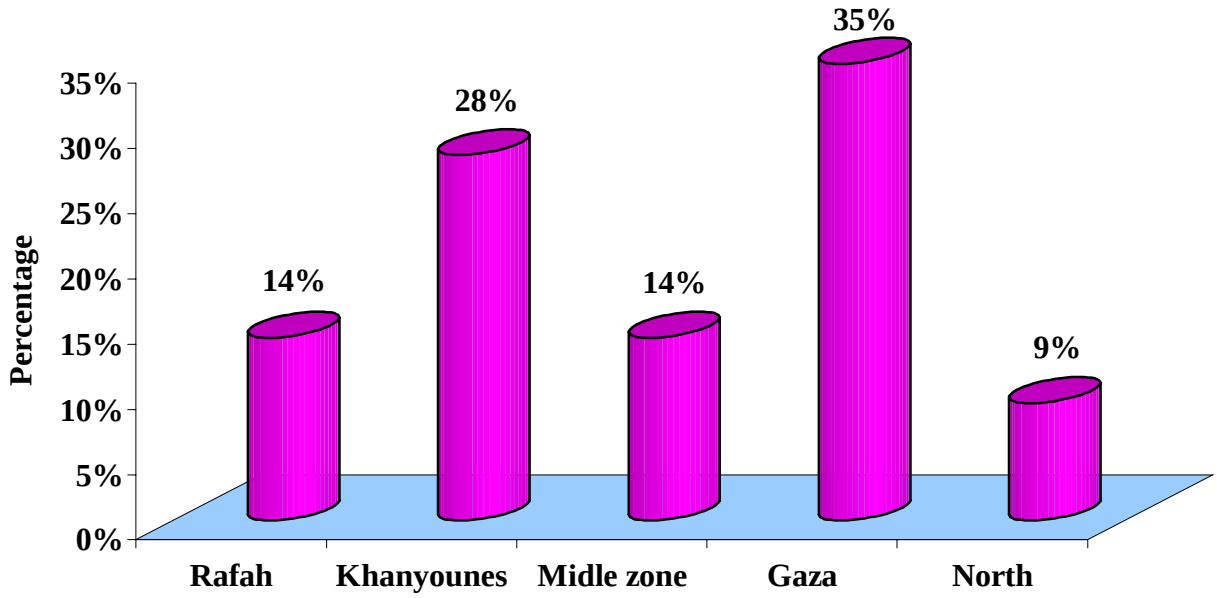
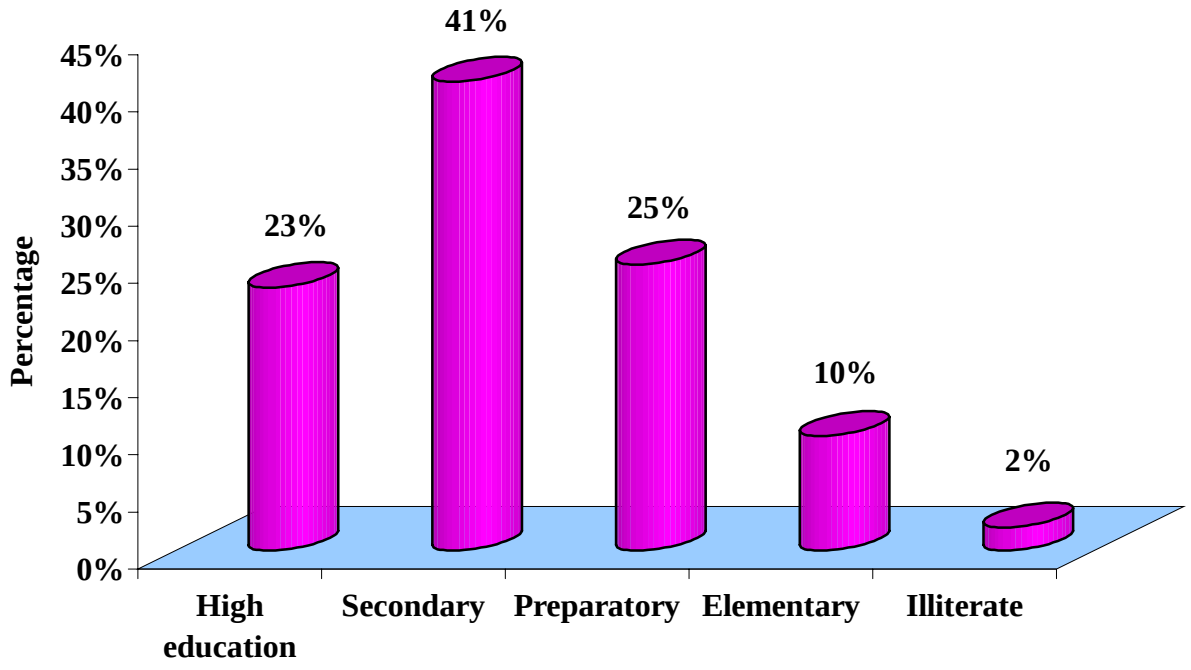


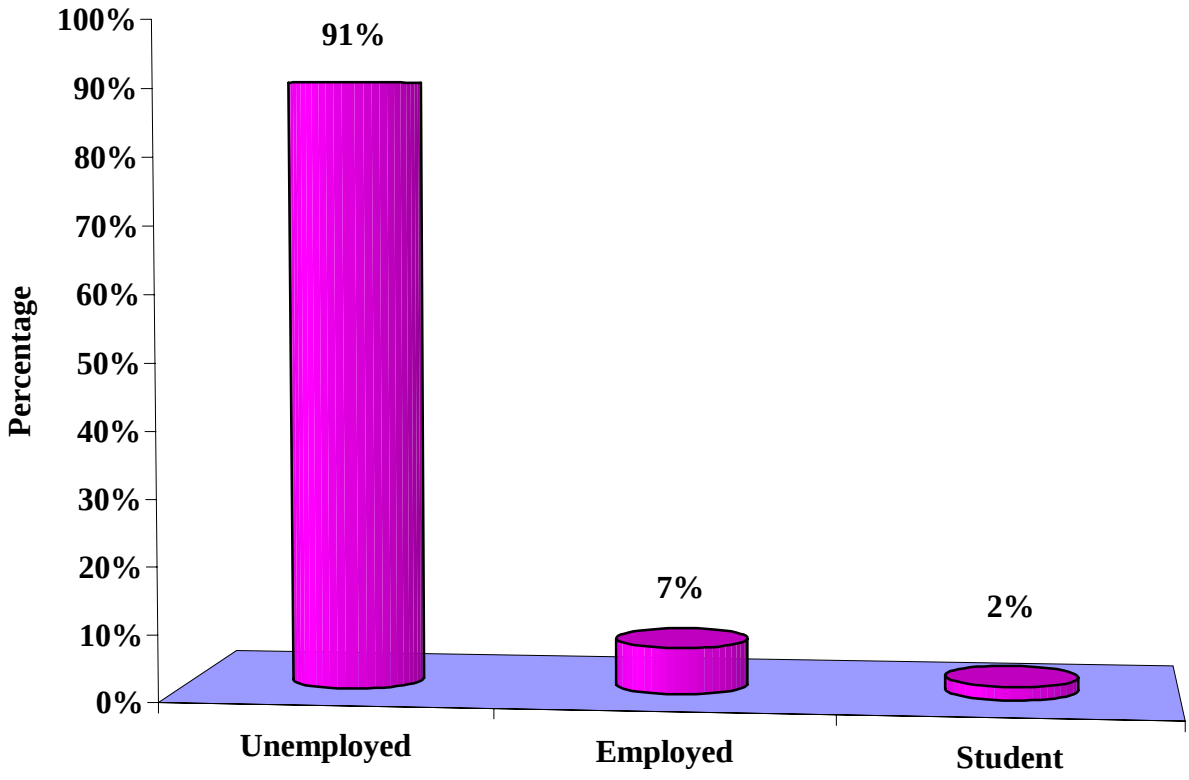
Figure 4 illustrates that, 35% of subjects were living in Gaza province, 28% were living in Khanyounes, 14% were living in Rafah, 14% were living in middle zone and 9% of population were living in north province.

Figure 5: Distribution of study population by educational level



As shown in figure 5, exactly 41% of the study population have had attained secondary education and 25% of them have received preparatory education followed by higher educational which represented 23%. Only 2% of the subjects have received no education, while 10% have received some elementary classes. The mean years of education were 10.8 ± 3.2 SD years.

Figure 6: Distribution of study population by women employment status



As shown in figure 6, about 91% of the study populations were not employed; this is a common phenomenon in Gaza Strip. However, the remaining 7% and 2% were either employed or university student, worth noting that the most common occupations among subjects were governmental or private organizational jobs.

Figure 7: Distribution of study population by household monthly income

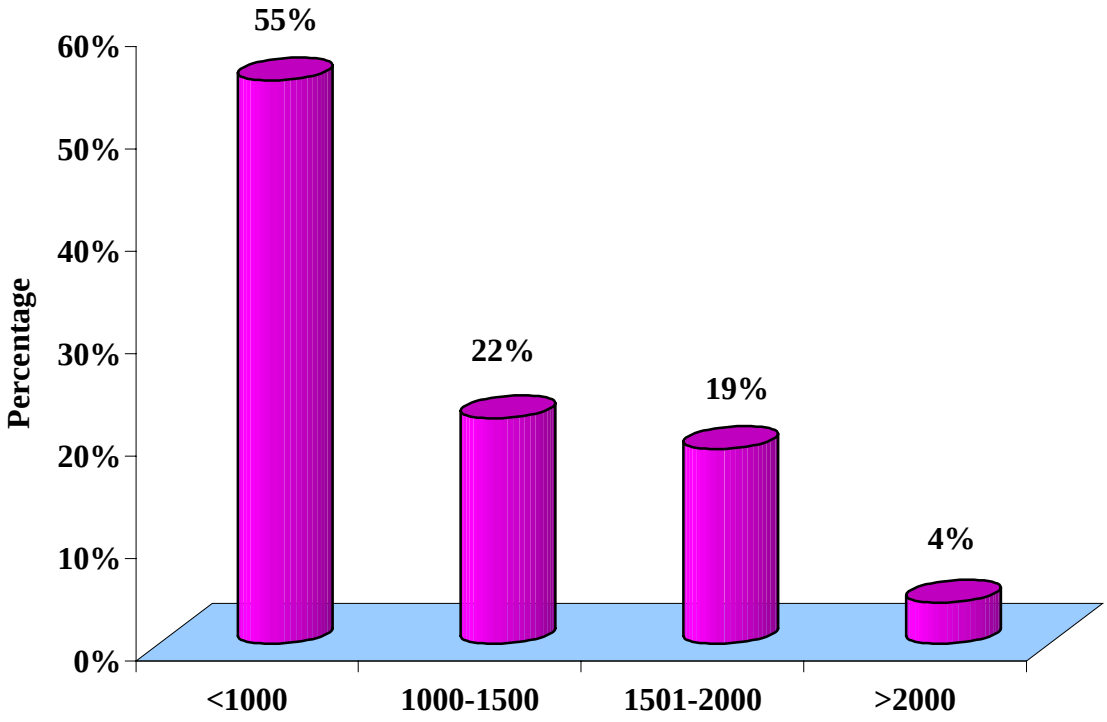


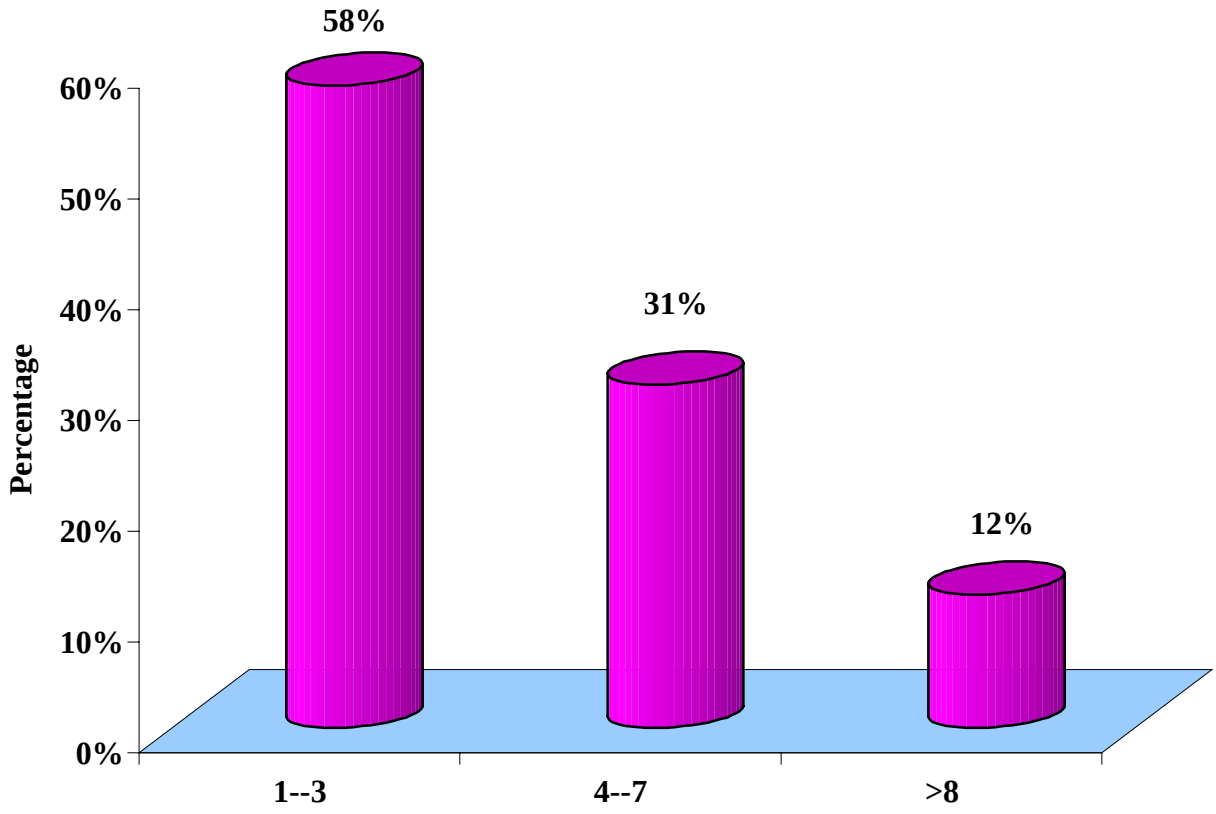
Figure 7 illustrates the average monthly income of the study population, household monthly income is categorized into four categories; the first category are those with less than 1000 NIS, which represented 55% out of the total population, the second category are those with monthly income from 1000 to 1500 NIS, which represented 22%, the third category are those with monthly income from 1501 to 2000 NIS, which represented 19%, and the forth category are those with average monthly income more than 2000 NIS which represented only 4.3% of the total study population. The average monthly income mean was 1089 $\pm$ SD 683 NIS.

Table 3: Distribution of study population by pregnancy order

No of pregnancy	N	%	Mean	Std. Deviation
1-2	**152**	**38.9%**		
3-5	**123**	**31.5%**		
>5	**116**	**29.7%**		
Total	**391**	**100.0%**	**4.0**	**3.0**

As shown in table 3, the study revealed that the majority of women (39%) have had 1-2 pregnancies, followed by those group who had 3-4 pregnancies and they represented 24%, the last group was those who had more than 5 pregnancies which represented 15%. The mean number of pregnancy was 4 $\pm$ 3 SD.

Figure 8: Distribution of study population by No of living children



As shown in figure 8, nearly 58% of subjects have had 1-3 live sons, followed by those groups who had 4-7 living sons and they represented 31%, the last group is those who had more than 8 living sons which represented 12%. The mean number of living sons was 3.8 $\pm$ 2.7 SD.

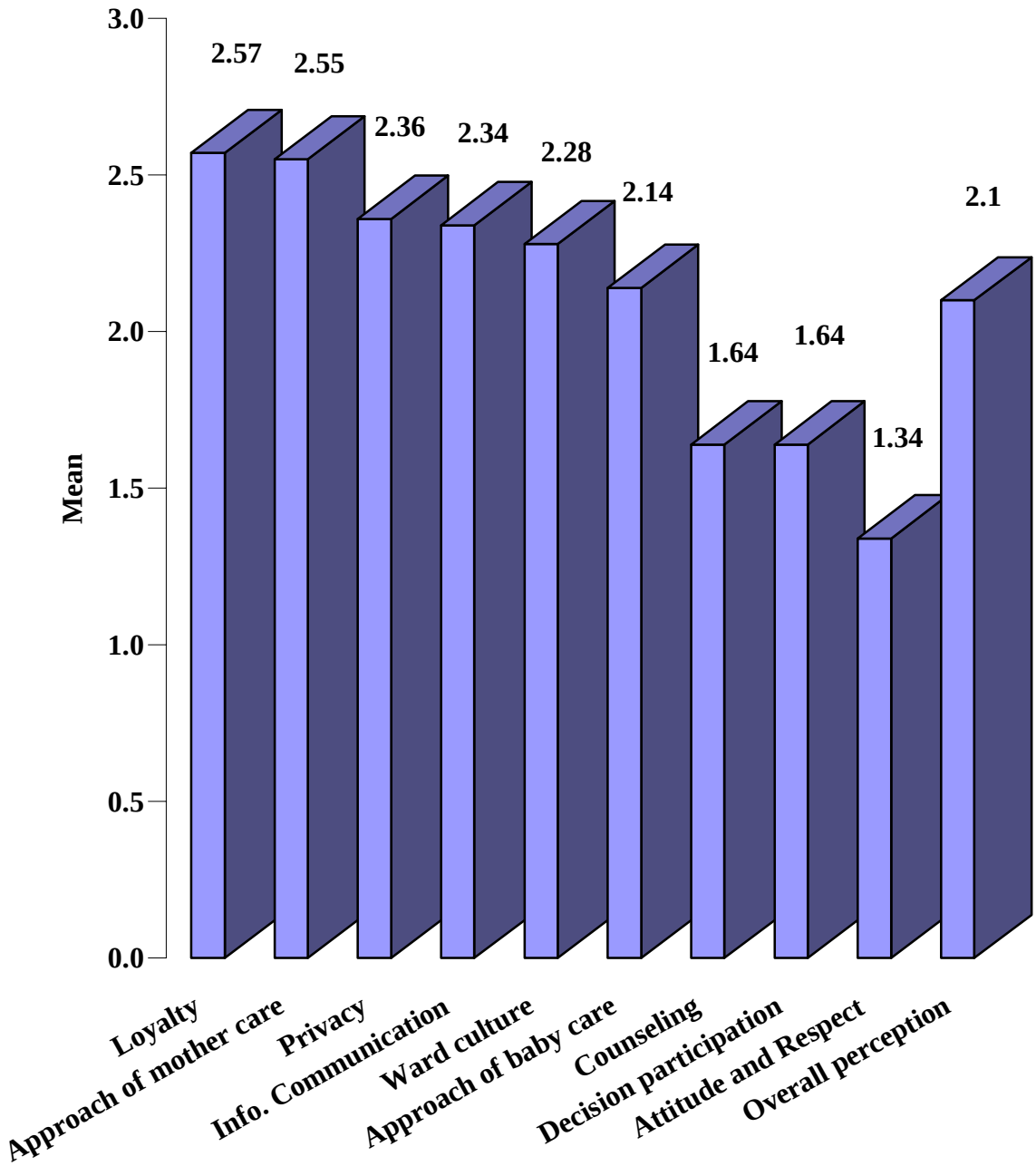
Overall perspective

The total perspective score (overall perspective) reflects the summation of all the subscales scores. Dimensions of women perspective of childbirth services were loyalty, attitude and respect, information/communication, approach of mother care, privacy, approach of baby care, counseling, ward culture and decision participation. The overall mean of perspective scores (maximum 3) was 2.1 (70%), the mean perspective scores for the subscale ranged from 1.3-2.6 (34%-86.6%), high mean scores indicate higher perspective scores.

Table 4: Construct labels, mean, standard deviation, and variance.

Construct name	Mean	Std. Deviation	Variance	Alpha
Loyalty	**2.5652**	**.6214**	**.386**	**.6754**
Attitude and Respect	**1.3343**	**.4343**	**.189**	**.7661**
Info. Communication	**2.3429**	**.4791**	**.230**	**.7663**
Approach of mother care	**2.5618**	**.3837**	**.147**	**.4108**
Privacy	**2.3591**	**.4412**	**.195**	**.4296**
Approach of baby care	**2.1402**	**.5959**	**.355**	**.7531**
Counseling	**1.6413**	**.5296**	**.280**	**.7140**
Ward environment	**2.2842**	**.5145**	**.265**	**.7679**
Decision participation	**1.6739**	**.6394**	**.409**	**.8108**

Figure 9: Distribution of women's perception by mean



Variables affecting perceptions

Sociodemographic variables

Table 5: Relationship between dimensions of women's perceptions and provinces

Dep, Variables Women perceptions	Indep, Var. " provinces"	Sum of Squares	df	Mean Square	F	P-value
Loyalty	Between Groups	4.966	4	1.241	3.291	.011*
	Within Groups	145.621	386	.377		
	Total	150.587	390			
Attitude and Respect	Between Groups	6.186	4	1.546	8.862	.001*
	Within Groups	67.360	386	.175		
	Total	73.546	390			
Information and communication	Between Groups	9.488	4	2.372	11.440	.001*
	Within Groups	80.039	386	.207		
	Total	89.527	390			
Approach of women care	Between Groups	8.048	4	2.012	15.726	.001*
	Within Groups	49.382	386	.128		
	Total	57.430	390			
Privacy	Between Groups	17.892	4	4.473	29.761	.001*
	Within Groups	58.013	386	.150		
	Total	75.905	390			
Approach of baby care	Between Groups	23.350	4	5.838	19.568	.001*
	Within Groups	115.155	386	.298		
	Total	138.505	390			
Counseling	Between Groups	6.869	4	1.717	6.465	.001*
	Within Groups	102.526	386	.266		
	Total	109.394	390			
Wards environment	Between Groups	20.180	4	5.045	23.445	.001*
	Within Groups	83.060	386	.215		
	Total	103.240	390			
Decision participation	Between Groups	17.183	4	4.296	11.655	.001*
	Within Groups	142.268	386	.369		
	Total	159.452	390			
Overall perceptions	Between Groups	3.717	4	.929	15.805	.001*
	Within Groups	22.698	386	5.880		
	Total	26.415	390			

*Statistically significant

Table 5, shows that all provinces mean were significantly different from each other. The result revealed a real significant difference between the provinces and overall perceptions as well as all dimensions of women perception (P. Value 0.001). Scheffe test indicates that the women who were living in Rafah reported the higher score of overall perceptions (mean 2.2657) and in all dimensions of women perspectives, while the women who were living in the Gaza City reported the lower score of overall perceptions (mean 1.9821) and in all

dimensions of women perspectives. That is mean, women who were living in Rafah had more positive perception than women who were living in other provinces.

Table 6: Relationship between dimensions of women perceptions and residency

Dep, Var Women perceptions	Indep. Var. "residency"	Sum of Squares	df	Mean Square	F	P-value
Loyalty	Between Groups	1.629	2	.815	2.122	.121
	Within Groups	148.958	388	.384		
	Total	150.587	390			
Attitude and Respect	Between Groups	1.965	2	.983	5.327	.005*
	Within Groups	71.581	388	.184		
	Total	73.546	390			
Information and communication	Between Groups	1.545	2	.773	3.407	.034*
	Within Groups	87.982	388	.227		
	Total	89.527	390			
Approach of women care	Between Groups	1.968	2	.984	6.885	.001*
	Within Groups	55.461	388	.143		
	Total	57.430	390			
Privacy	Between Groups	5.576	2	2.788	15.381	.001*
	Within Groups	70.329	388	.181		
	Total	75.905	390			
Approach of baby care	Between Groups	2.818	2	1.409	4.029	.019*
	Within Groups	135.687	388	.350		
	Total	138.505	390			
Counseling	Between Groups	.171	2	8.552	.304	.738
	Within Groups	109.223	388	.282		
	Total	109.394	390			
Wards culture	Between Groups	5.027	2	2.514	9.930	.001*
	Within Groups	98.213	388	.253		
	Total	103.240	390			
Decision participation	Between Groups	3.558	2	1.779	4.428	.013*
	Within Groups	155.894	388	.402		
	Total	159.452	390			
Overall perceptions	Between Groups	0.685	2	0.343	4.670	.010*
	Within Group	28.454	388	7.333		
	Total	29.139	390			

* Statistically significant

One Way ANOVA was used to estimate the differences between residency (city, camp, and village) and women perceptions. The result revealed that there is a real difference between the living places and the overall perceptions and all dimensions of women perceptions except loyalty and counseling dimensions. Scheffe test indicates that the women who were living in villages reported higher score of perception in the overall perceptions (mean 2.1645) and in all dimension of women perceptions except loyalty and counseling. Although, women who were living in cities reported the lowest score of

perceptions in all dimensions of women perceptions, all means are significantly different from each other except loyalty and counseling (Table, 6).

Table 7: Relationship between dimensions of women perceptions and ages.

Dep, Var Women perceptions	Indep. Var. "age"	Sum of Squares	df	Mean Square	F	P-value
Loyalty	Between Groups	2.794	2	1.397	3.668	.026*
	Within Groups	147.793	388	.381		
	Total	150.587	390			
Attitude and Respect	Between Groups	1.077	2	.538	2.882	.057
	Within Groups	72.470	388	.187		
	Total	73.546	390			
Information and communication	Between Groups	2.611	2	1.306	.057	.945
	Within Groups	89.501	388	.231		
	Total	89.527	390			
Approach of women care	Between Groups	.282	2	.141	.956	.385
	Within Groups	57.148	388	.147		
	Total	57.430	390			
Privacy	Between Groups	1.974	2	9.868	.005	.995
	Within Groups	75.903	388	.196		
	Total	75.905	390			
Approach of baby care	Between Groups	2.779	2	1.390	3.972	.020*
	Within Groups	135.726	388	.350		
	Total	138.505	390			
Counseling	Between Groups	.711	2	.356	1.269	.282
	Within Groups	108.683	388	.280		
	Total	109.394	390			
Wards environment	Between Groups	.877	2	.439	1.662	.191
	Within Groups	102.363	388	.264		
	Total	103.240	390			
Decision participation	Between Groups	2.332	2	1.166	2.879	.057
	Within Groups	157.120	388	.405		
	Total	159.452	390			
Overall perceptions	Between Groups	.367	2	.184	2.736	.066
	Within Groups	26.048	388	6.713		
	Total	26.415	390			

* Statistically significant

Table 7, illustrates the comparison between women's perceptions and age of study populations, which were categorized to three groups as follows, less than 18 years, 18-24 years and those more than 24 years, the result revealed a significant statistical differences between the age of women and loyalty and approach of baby care dimensions (P. value 0.026 and 0.020 respectively). Additionally the result revealed nearly significant differences between age groups and respect, decision participation as well as overall

perceptions (P.value 0.057, 0.057 and 0.066 respectively). Scheffe test showed that those women who were less than 18 year have higher score of perceptions, while the age group who were more than 24 years reported the lowest score of perceptions.

Table 8: Relationship between women perceptions and women education.

Dep, Var Women perceptions	Indep. Var. Women education	Sum of Squares	df	Mean Square	F	P-value
Loyalty	Between Groups	2.770	4	.692	1.808	.126
	Within Groups	147.817	386	.383		
	Total	150.587	390			
Attitude and Respect	Between Groups	.484	4	.121	.639	.635
	Within Groups	73.062	386	.189		
	Total	73.546	390			
Information and communication	Between Groups	.713	4	.178	.774	.542
	Within Groups	88.814	386	.230		
	Total	89.527	390			
Approach of women care	Between Groups	.822	4	.205	1.401	.233
	Within Groups	56.608	386	.147		
	Total	57.430	390			
Privacy	Between Groups	3.560	4	.890	4.748	.001*
	Within Groups	72.345	386	.187		
	Total	75.905	390			
Approach of baby care	Between Groups	1.335	4	.334	.939	.441
	Within Groups	137.170	386	.355		
	Total	138.505	390			
Counseling	Between Groups	1.681	4	.420	1.506	.200
	Within Groups	107.714	386	.279		
	Total	109.394	390			
Wards environment	Between Groups	1.223	4	.306	1.157	.330
	Within Groups	102.018	386	.264		
	Total	103.240	390			
Decision participation	Between Groups	.469	4	.117	.285	.888
	Within Groups	158.983	386	.412		
	Total	159.452	390			
Overall perceptions	Between Groups	.516	4	..129	1.923	.106
	Within Groups	25.899	386	6.710		
	Total	26.415	390			

***** Statistically significant

The educational level was categorized into five categories; illiterate, elementary, preparatory, secondary and high education. The result revealed that there is a real difference between women education level and privacy dimension (P.value 0.001). However, there was no significance difference between educational level and the other

women perceptions dimensions. Scheffe test indicates that the illiterate women reported the higher score of perceptions, while those women who had high education level reported the lowest score of perceptions (Table, 8).

Table 9: Comparison between women's perceptions and employment status.

Dep, Var "Women perspective"	Indep. Var. "employment"	Sum of Squares	df	Mean Square	F	P-value
Loyalty	Between Groups	.256	2	.128	.330	.719
	Within Groups	150.331	388	.387		
	Total	150.587	390			
Respect	Between Groups	1.071	2	.536	2.867	.058
	Within Groups	72.475	388	.187		
	Total	73.546	390			
Information and communication	Between Groups	2.409E-02	2	1.205	.052	.949
	Within Groups	89.503	388	.231		
	Total	89.527	390			
Approach of women care	Between Groups	.419	2	.210	1.426	.242
	Within Groups	57.011	388	.147		
	Total	57.430	390			
Privacy	Between Groups	9.062E-02	2	4.531	.232	.793
	Within Groups	75.815	388	.195		
	Total	75.905	390			
Approach of baby care	Between Groups	.641	2	.320	.902	.407
	Within Groups	137.864	388	.355		
	Total	138.505	390			
Counseling	Between Groups	.931	2	.465	1.665	.191
	Within Groups	108.463	388	.280		
	Total	109.394	390			
Wards culture	Between Groups	1.442	2	.721	2.748	.065
	Within Groups	101.798	388	.262		
	Total	103.240	390			
Decision participation	Between Groups	.583	2	.292	.712	.491
	Within Groups	158.869	388	.409		
	Total	159.452	390			
Overall perspectives	Between Groups	.107	2	5.357	.790	.491
	Within Groups	26.308	388	6.780		
	Total	26.415	390			

Women employment status was categories into three groups including, employed, not employed and student. The result revealed that there was no significant statistical difference between women employment status and the women perceptions of childbirth services. However, Scheffe test indicates that the unemployed women had more positive

views (mean 2.1105) than the employed women (mean 2.0386) regarding the overall perceptions (table 9)

Table 10: Comparison between women perceptions regarding monthly income.

Dep, Var "Women perspective"	Indep. Var. Monthly income	Sum of Squares	df	Mean Square	F	P-value
Loyalty	Between Groups	1.710	3	.570	1.482	.219
	Within Groups	148.877	387	.385		
	Total	150.587	390			
Respect	Between Groups	.906	3	.302	1.610	.187
	Within Groups	72.640	387	.188		
	Total	73.546	390			
Information and communication	Between Groups	1.610	3	.537	2.363	.071
	Within Groups	87.916	387	.227		
	Total	89.527	390			
Approach of women care	Between Groups	.565	3	.188	1.282	.280
	Within Groups	56.864	387	.147		
	Total	57.430	390			
Privacy	Between Groups	.763	3	.254	1.310	.271
	Within Groups	75.142	387	.194		
	Total	75.905	390			
Approach of baby care	Between Groups	1.613	3	.538	1.520	.209
	Within Groups	136.891	387	.354		
	Total	138.505	390			
Counseling	Between Groups	.792	3	.264	.941	.421
	Within Groups	108.602	387	.281		
	Total	109.394	390			
Wards culture	Between Groups	1.940	3	.647	2.470	.062
	Within Groups	101.300	387	.262		
	Total	103.240	390			
Decision participation	Between Groups	.344	3	.115	.279	.841
	Within Groups	159.108	387	.411		
	Total	159.452	390			
Overall perspectives	Between Groups	.472	3	.157	2.348	.072
	Within Groups	25.943	387	6.704		
	Total	26.415	390			

As shown in Annex 10, there was no statistical significant difference between dimensions of women perceptions of childbirth services and monthly income. However, Scheffe test revealed that family who have monthly income less than 1000 NIS reported higher positive perception with the overall perceptions (mean 2.1403), while families who have monthly income more than 2000 NIS reported lower positive perception with the overall perceptions (mean 2.0024).

Perception and hospital service provider

Table 11: Relationship between dimensions of women perception and type of hospital

Dep, var Women perceptions	Indep. Var Delivery hospital	Sum of Squares	df	Mean Square	F	P-value
Loyalty	Between Groups	6.486	3	2.162	5.806	.001*
	Within Groups	144.101	387	.372		
	Total	150.587	390			
Attitude and respect	Between Groups	6.766	3	2.255	13.070	.001*
	Within Groups	66.780	387	.173		
	Total	73.546	390			
Information and communication	Between Groups	8.051	3	2.684	12.747	.001*
	Within Groups	81.476	387	.211		
	Total	89.527	390			
Approach of women care	Between Groups	8.305	3	2.768	21.808	.001*
	Within Groups	49.125	387	.127		
	Total	57.430	390			
Privacy	Between Groups	18.777	3	6.259	42.399	.001*
	Within Groups	57.129	387	.148		
	Total	75.905	390			
Approach of baby care	Between Groups	25.980	3	8.660	29.784	.001*
	Within Groups	112.525	387	.291		
	Total	138.505	390			
Counseling	Between Groups	10.545	3	3.515	13.761	.001
	Within Groups	98.850	387	.255		
	Total	109.394	390			
Ward environment	Between Groups	21.952	3	7.317	34.837	.001*
	Within Groups	81.288	387	.210		
	Total	103.240	390			
Decision participation	Between Groups	16.237	3	5.412	14.626	.001*
	Within Groups	143.215	387	.370		
	Total	159.452	390			
Overall perception	Between Groups	3.424	3	1.141	19.209	.001*
	Within Groups	22.992	387	5.941		
	Total	26.415	390			

***** Statistically significant

Table (11), illustrates the relationship between a woman's perceptions and the hospital where the woman was delivered (EGH, Naser Hospital, Al-Aqsa Hospital and Shifa Hospital). the result revealed a significant statistical difference between all dimensions of women perception and hospitals settings. And the descriptive result of ANOVA revealed

that the EGH elicited the highest level of overall perception score (77%), Naser Hospital elicited 71%, Al-Aqsa Hospital elicited 72% and Shifa Hospital elicited 67.3%. It means that the women who were delivered at EGH were more satisfied with childbirth services than the women who were delivered at the other hospitals on GS.

Maternal and childbirth characteristics

Table 12: Relationship between dimension of woman's perception and age at first marriage.

Dep, Var Women perceptions	Indep. Var. Age at 1st marriage	Sum of Squares	df	Mean Square	F	P-value
Loyalty	Between Groups	1.010	4	.253	.652	.626
	Within Groups	149.577	386	.388		
	Total	150.587	390			
Attitude and Respect	Between Groups	.495	4	.124	.654	.624
	Within Groups	73.051	386	.189		
	Total	73.546	390			
Information and communication	Between Groups	.941	4	.235	1.025	.394
	Within Groups	88.586	386	.229		
	Total	89.527	390			
Approach of women care	Between Groups	.310	4	7.755	.524	.718
	Within Groups	57.119	386	.148		
	Total	57.430	390			
Privacy	Between Groups	1.132	4	.283	1.460	.214
	Within Groups	74.774	386	.194		
	Total	75.905	390			
Approach of baby care	Between Groups	2.801	4	.700	1.992	.095
	Within Groups	135.704	386	.352		
	Total	138.505	390			
Counseling	Between Groups	2.787	4	.697	2.523	.041*
	Within Groups	106.607	386	.276		
	Total	109.394	390			
Wards environment	Between Groups	1.393	4	.348	1.320	.262
	Within Groups	101.847	386	.264		
	Total	103.240	390			
Decision participation	Between Groups	.694	4	.174	.422	.793
	Within Groups	158.758	386	.411		
	Total	159.452	390			
Overall perceptions	Between Groups	.343	4	8.572	1.269	.282
	Within Groups	26.072	386	6.754		
	Total	26.415	390			

***** Statistically significant

Table 12, illustrates the comparison between the women perceptions and age at first marriage, the age at first marriage was categorized into four groups as follows, less than 18

years, 18-22 years, 23-27 years and those group more than 28 years, the result revealed a significant statistical differences only between the age at first marriage group and counseling dimension (P-value .041). Scheffe test showed that those women who were married at age more than 32 year has higher score perception, while the women who married at age 23-27 year reported the lower score of perception towards childbirth services.

Table 13: Relationship between women perceptions and pariaty

Dep, Var Women perceptions	Indep. Var. Pariaty	Sum of Squares	df	Mean Square	F	P-value
Loyalty	Between Groups	1.049	4	.262	.677	.608
	Within Groups	149.538	386	.387		
	Total	150.587	390			
Attitude and Respect	Between Groups	1.523	4	.381	2.040	.088
	Within Groups	72.023	386	.187		
	Total	73.546	390			
Information and communication	Between Groups	2.373	4	.593	2.628	.034*
	Within Groups	87.153	386	.226		
	Total	89.527	390			
Approach of women care	Between Groups	1.354	4	.338	2.329	.056
	Within Groups	56.076	386	.145		
	Total	57.430	390			
Privacy	Between Groups	.891	4	.223	1.146	.334
	Within Groups	75.014	386	.194		
	Total	75.905	390			
Approach of baby care	Between Groups	.344	4	8.593	.240	.916
	Within Groups	138.161	386	.358		
	Total	138.505	390			
Counseling	Between Groups	.790	4	.197	.702	.591
	Within Groups	108.605	386	.281		
	Total	109.394	390			
Wards environment	Between Groups	1.922	4	.480	1.830	.122
	Within Groups	101.319	386	.262		
	Total	103.240	390			
Decision participation	Between Groups	1.059	4	.265	.645	.631
	Within Groups	158.393	386	.410		
	Total	159.452	390			
Overall perceptions	Between Groups	7.773	2	3.887	.573	.565
	Within Groups	26.337	388	6.788		
	Total	26.415	390			

***** Statistically significant

Table 13; illustrates the comparison between the dimension of women perceptions and

pariaty. Pariaty was categorized into three groups as follows, 1-2 Para, 3-5 Para and those more than Para 5. The result revealed a significant statistical differences between number of pregnancy and the information and communication dimension (P-value .034) and marginal significant differences between pariaty and approach of women care dimensions (P-value .056). Scheffe test showed that women who had 3-5 pregnancies had higher positive score, while women who had 1-2 pregnancies had the lowest score of perceptions.

Table 14: Relationship comparison between dimensions of women perceptions and No of living children

Dep, Var Women perceptions	Indep. Var. No living children	Sum of Squares	df	Mean Square	F	P-value
Loyalty	Between Groups	2.049	2	1.025	2.676	.070
	Within Groups	148.538	388	.383		
	Total	150.587	390			
Attitude and Respect	Between Groups	1.075	2	.537	2.878	.057
	Within Groups	72.471	388	.187		
	Total	73.546	390			
Information and communication	Between Groups	.950	2	.475	2.081	.126
	Within Groups	88.577	388	.228		
	Total	89.527	390			
Approach of women care	Between Groups	.516	2	.258	1.758	.174
	Within Groups	56.914	388	.147		
	Total	57.430	390			
Privacy	Between Groups	.741	2	.370	1.911	.149
	Within Groups	75.165	388	.194		
	Total	75.905	390			
Approach of baby care	Between Groups	6.451	2	3.226	.090	.914
	Within Groups	138.440	388	.357		
	Total	138.505	390			
Counseling	Between Groups	.250	2	.125	.444	.642
	Within Groups	109.145	388	.281		
	Total	109.394	390			
Wards environment	Between Groups	.424	2	.212	.800	.450
	Within Groups	102.816	388	.265		
	Total	103.240	390			
Decision participation	Between Groups	1.938	2	.969	2.387	.093
	Within Groups	157.514	388	.406		
	Total	159.452	390			
Overall perceptions	Between Groups	.0167	2	8.350	1.118	.328
	Within Groups	28.972	388	7.467		
	Total	29.139	390			

Table 14, illustrates a comparison between women perceptions and number of living children, as depicted in the table which categorized into three groups as follow,1-3

children, 4-7 children and those of more than 7 children, the result revealed that there are nearly significant statistical differences between number of living children and attitude and respect dimension (P- value 0.057). Scheffe test indicates that the women who have living children more than 8, have higher score of perceptions while the women who have living children from 1-3 have the lowest score of perceptions.

Table 15: Relationship between dimensions of women perceptions and first experience with the hospital

Dep.Var Women perceptions	Ind.Var First delivery	No	Mean	S.D	t. test	P-value
Loyalty	yes	171	2.5439	.6705	4.951	.027*
	no	220	2.5818	.5814		
Attitude and Respect	yes	171	1.3258	.4190	1.643	.201
	no	220	1.3409	.4466		
Information/ communication	yes	171	2.3551	.4560	3.768	.050*
	no	220	2.3335	.4972		
Approach of maternity care	yes	171	2.5271	.4138	3.531	.061
	no	220	2.5888	.3573		
privacy	yes	171	2.3977	.4178	3.121	.078
	no	220	2.3291	.4572		
Approach of baby care	yes	171	2.1559	.5847	1.159	.282
	no	220	2.1280	.6056		
Counseling	yes	171	1.6184	.4887	6.549	.011*
	no	220	1.6595	.5598		
Wards culture	yes	171	2.3710	.4849	2.544	.112
	no	220	2.2167	.5276		
Decision participation	yes	171	1.6910	.6388	.048	.827
	no	220	1.6606	.6410		
Overall perceptions	yes	171	2.1096	.2554	.933	.335
	no	220	2.0932	.2643		

* Statistically significant

Table 15, shows that there is 171 women said yes when they were asked if this was the first delivery at this hospital and 220 women said no. The relationship between these two groups of women with relation to women perceptions, an independent t- test was used to compare the mean of the perceptions regarding the first delivery in this hospital, the result illustrated that the study population who were delivered for the first time in this hospital have higher positive attitude with the overall perceptions (mean 2.1096) than those whom answer were not (mean 2.0932). The result also revealed that there were a significant statistical differences between independent variable and loyalty (P- value .027), counseling

(P- value .011) and information/communication (P-value .050) of dimension of women perceptions.

Table 16: Women's perceptions and reason for choosing this hospital

Dep, Var Women perceptions	Indep. Var. Cause of choosing	Sum of Squares	df	Mean Square	F	P-value
Loyalty	Between Groups	6.606	5	1.321	3.533	.004*
	Within Groups	143.981	385	.374		
	Total	150.587	390			
Attitude and Respect	Between Groups	2.095	5	.419	2.258	.048*
	Within Groups	71.451	385	.186		
	Total	73.546	390			
Information and communication	Between Groups	2.453	5	.491	2.169	.050*
	Within Groups	87.074	385	.226		
	Total	89.527	390			
Approach of women care	Between Groups	3.744	5	.749	5.370	.001*
	Within Groups	53.686	385	.139		
	Total	57.430	390			
Privacy	Between Groups	3.620	5	.724	3.856	.002*
	Within Groups	72.285	385	.188		
	Total	75.905	390			
Approach of baby care	Between Groups	6.098	5	1.220	3.546	.004*
	Within Groups	132.406	385	.344		
	Total	138.505	390			
Counseling	Between Groups	3.274	5	.655	2.376	.038*
	Within Groups	106.120	385	.276		
	Total	109.394	390			
Wards environment	Between Groups	3.986	5	.797	3.092	.009*
	Within Groups	99.254	385	.258		
	Total	103.240	390			
Decision participation	Between Groups	1.677	5	.335	.819	.537
	Within Groups	157.774	385	.410		
	Total	159.452	390			
Overall perceptions	Between Groups	1.122	5	.224	3.416	.005*
	Within Groups	25.293	385	6.570		
	Total	26.415	390			

* Statistically significant

As shown in table 16, One Way ANOVA was used to estimate the differences between dimensions of women perceptions and the reason for choosing the hospital which categorized to; my doctor work her, nearest to my home, recommendation by others, easy previous delivery and obligatory referral. The result revealed that there was a significant statistical difference between the reason for choosing the hospital and the overall

perceptions (P-value .005) as well as all dimensions of perceptions except decision participation dimension. Scheffe test indicates that women who choose the hospital because their doctor was worked in the hospital reported the higher positive score of overall perceptions, while women whom were obligatory transferred to hospital reported the lowest score of perception towards childbirth services.

Table 17: Relationship between dimensions of women's perceptions and waiting time for examinations.

Dep, Var Women perceptions	Indep. Var. Waiting time	Sum of Squares	df	Mean Square	F	P-value
Loyalty	Between Groups	1.945	2	.973	2.539	.080
	Within Groups	148.642	388	.383		
	Total	150.587	390			
Attitude and Respect	Between Groups	2.486	2	1.243	6.787	.001*
	Within Groups	71.060	388	.183		
	Total	73.546	390			
Information and communication	Between Groups	.503	2	.252	1.097	.335
	Within Groups	89.023	388	.229		
	Total	89.527	390			
Approach of women care	Between Groups	3.632	2	1.816	13.099	.001*
	Within Groups	53.797	388	.139		
	Total	57.430	390			
Privacy	Between Groups	1.246	2	.623	3.238	.040*
	Within Groups	74.659	388	.192		
	Total	75.905	390			
Approach of baby care	Between Groups	3.834	2	1.917	5.523	.004*
	Within Groups	134.671	388	.347		
	Total	138.505	390			
Counseling	Between Groups	.523	2	.261	.932	.395
	Within Groups	108.871	388	.281		
	Total	109.394	390			
Wards environment	Between Groups	2.903	2	1.451	5.612	.004*
	Within Groups	100.338	388	.259		
	Total	103.240	390			
Decision participation	Between Groups	.439	2	.220	.536	.586
	Within Groups	159.012	388	.410		
	Total	159.452	390			
Overall perceptions	Between Groups	.602	2	.301	4.528	.011*
	Within Groups	25.813	388	6.653		
	Total	26.415	390			

* Statistically significant

Table 17, illustrates the comparison between dimension of women perceptions and waiting time from admission to examination in delivery room which were categorized to 10

minute, 30 minute and 60 minute. The result revealed a significant statistical differences between waiting time for examination and the overall perceptions (P-value .011) as well as all dimensions of women perceptions except information and communication, counseling and decision participation dimensions. Scheffe test indicates that women who were waiting shorter time for examination reported higher score of perception, while the women who waited 30 minutes or 60 minutes reported low score of perception towards childbirth services.

Table 18: Relationship between dimensions of women's perceptions and mode of delivery

Dep, Var Women perceptions	Indep. Var. Mode of delivery	Sum of Squares	df	Mean Square	F	P-value
Loyalty	Between Groups	.790	3	.263	.680	.565
	Within Groups	149.797	387	.387		
	Total	150.587	390			
Attitude and Respect	Between Groups	1.427	3	.476	2.553	.050*
	Within Groups	72.119	387	.186		
	Total	73.546	390			
Information and communication	Between Groups	.818	3	.273	1.189	.314
	Within Groups	88.709	387	.229		
	Total	89.527	390			
Approach of women care	Between Groups	.407	3	.136	.920	.431
	Within Groups	57.023	387	.147		
	Total	57.430	390			
Privacy	Between Groups	.413	3	.138	.705	.549
	Within Groups	75.492	387	.195		
	Total	75.905	390			
Approach of baby care	Between Groups	.866	3	.289	.812	.488
	Within Groups	137.639	387	.356		
	Total	138.505	390			
Counseling	Between Groups	9.760	3	3.253	.115	.951
	Within Groups	109.297	387	.282		
	Total	109.394	390			
Wards environment	Between Groups	.605	3	.202	.761	.516
	Within Groups	102.635	387	.265		
	Total	103.240	390			
Decision participation	Between Groups	.341	3	.114	.276	.843
	Within Groups	159.111	387	.411		
	Total	159.452	390			
Overall perceptions	Between Groups	9.754	3	3.251	.478	.698
	Within Groups	26.318	387	6.800		
	Total	26.415	390			

* Statistically significant

Regarding the mode of delivery (without instruments, ventose, forceps and breach) and the women perceptions, table 18, indicates that there was a real differences between mode of

delivery and attitude and respect dimension (P- value 0.05). Scheffe test indicates that women who were delivered with breach reported the higher score of perceptions, while the women who were delivered with forceps reported the lowest score of perceptions.

Table 19: Relationship between women's perceptions and number of health providers attend their childbirth.

Dep, Var Women perceptions	Indep. Var. No of staff	Sum of Squares	df	Mean Square	F	P-value
Loyalty	Between Groups	4.028	2	2.014	5.332	.005*
	Within Groups	146.559	388	.378		
	Total	150.587	390			
Attitude and Respect	Between Groups	3.064	2	1.532	8.433	.001*
	Within Groups	70.482	388	.182		
	Total	73.546	390			
Information and communication	Between Groups	1.253	2	.626	2.753	.065
	Within Groups	88.274	388	.228		
	Total	89.527	390			
Approach of women care	Between Groups	5.519	2	2.760	20.627	.001*
	Within Groups	51.910	388	.134		
	Total	57.430	390			
Privacy	Between Groups	5.094	2	2.547	13.955	.001*
	Within Groups	70.812	388	.183		
	Total	75.905	390			
Approach of baby care	Between Groups	4.857	2	2.428	7.050	.001*
	Within Groups	133.648	388	.344		
	Total	138.505	390			
Counseling	Between Groups	4.219	2	2.109	7.782	.001*
	Within Groups	105.176	388	.271		
	Total	109.394	390			
Wards environment	Between Groups	1.261	2	.630	2.399	.092
	Within Groups	101.979	388	.263		
	Total	103.240	390			
Decision participation	Between Groups	7.535	2	3.768	.092	.912
	Within Groups	159.376	388	.411		
	Total	159.452	390			
Overall perceptions	Between Groups	1.084	2	.542	8.304	.001*
	Within Groups	25.331	388	6.529		
	Total	26.415	390			

* Statistically significant

As shown in table 19, One Way ANOVA was used to estimate the difference between women perceptions and the number of health provider which categorized to three groups as; suitable, little and more than needed. The result revealed that there was a significant statistical differences between the number of health providers attended their delivery and

overall perceptions (P-value .001) as well as all dimensions except Information and communication, wards environment and decision participation dimensions (P-value .065, .092 and .912 respectively). Scheffe test indicate that the women who claimed that the number of health providers were more than needed reported the highest score of perceptions in overall perceptions (mean 2.1604) and in all dimension (except in Information and communication, wards culture and decision participation), while the women who claimed that the number of health providers were little reported the lowest perceptions' score.

Table 20: Relationship between dimensions of women's perceptions and expectations.

Dep, Var Women perceptions	Indep. Var. Services expectation	Sum of Squares	df	Mean Square	F	P-value
Loyalty	Between Groups	13.387	2	6.694	18.930	.001*
	Within Groups	137.200	388	.354		
	Total	150.587	390			
Attitude and Respect	Between Groups	7.669	2	3.834	22.584	.001*
	Within Groups	65.877	388	.170		
	Total	73.546	390			
Information and communication	Between Groups	5.119	2	2.560	11.767	.001*
	Within Groups	84.407	388	.218		
	Total	89.527	390			
Approach of women care	Between Groups	7.490	2	3.745	29.098	.001*
	Within Groups	49.939	388	.129		
	Total	57.430	390			
Privacy	Between Groups	3.889	2	1.945	10.477	.001*
	Within Groups	72.016	388	.186		
	Total	75.905	390			
Approach of baby care	Between Groups	4.627	2	2.313	6.704	.001*
	Within Groups	133.878	388	.345		
	Total	138.505	390			
Counseling	Between Groups	2.217	2	1.109	4.014	.019*
	Within Groups	107.177	388	.276		
	Total	109.394	390			
Wards environment	Between Groups	9.662	2	4.831	20.031	.001*
	Within Groups	93.578	388	.241		
	Total	103.240	390			
Decision participation	Between Groups	3.138	2	1.569	.038	.963
	Within Groups	159.420	388	.411		
	Total	159.452	390			
Overall perceptions	Between Groups	2.606	2	1.303	21.234	.001*
	Within Groups	23.809	388	6.136		
	Total	26.415	390			

* Statistically significant

As shown in table 20, women's expectation of services was categorized into three groups; between services expectation and dimensions of women perceptions. The result indicates that there was real differences between the expectation of services and the overall perceptions (P-value .001) and all dimensions (except decision participation). Scheffe test indicates that, women who had good expectation reported higher score of perceptions, while the women who had bad expectation reported low score of perceptions.

Table 21: Relationship between dimension of women's perceptions and length of stay

Dep, Var Women perceptions	Indep. Var. Length of stay	Sum of Squares	df	Mean Square	F	P-value
Loyalty	Between Groups	2.928	3	.976	2.558	.050*
	Within Groups	147.659	387	.382		
	Total	150.587	390			
Attitude and Respect	Between Groups	2.012	3	.671	3.629	.013*
	Within Groups	71.534	387	.185		
	Total	73.546	390			
Information and communication	Between Groups	.801	3	.267	1.165	.323
	Within Groups	88.725	387	.229		
	Total	89.527	390			
Approach of women care	Between Groups	1.794	3	.598	4.161	.006*
	Within Groups	55.635	387	.144		
	Total	57.430	390			
Privacy	Between Groups	7.376	3	2.459	13.885	.001*
	Within Groups	68.529	387	.177		
	Total	75.905	390			
Approach of baby care	Between Groups	.233	3	7.778	.218	.884
	Within Groups	138.271	387	.357		
	Total	138.505	390			
Counseling	Between Groups	.297	3	9.897	.351	.788
	Within Groups	109.097	387	.282		
	Total	109.394	390			
Wards environment	Between Groups	5.845	3	1.948	7.741	.001*
	Within Groups	97.395	387	.252		
	Total	103.240	390			
Decision participation	Between Groups	1.508	3	.503	1.232	.298
	Within Groups	157.944	387	.408		
	Total	159.452	390			
Overall perceptions	Between Groups	.602	3	.201	3.007	.030*
	Within Groups	25.813	387	6.670		
	Total	26.415	390			

* Statistically significant

As shown in table 21, One Way ANOVA was used to assess the relationship between the length of stay (I day, 2 days, 3 days and more) and the dimensions of women perceptions. The result showed that there were real differences between the length of stay and the overall perceptions (P-value 0.030) and five dimensions of perceptions (Loyalty, attitude and respect, Approach of women care, Privacy, environment culture). Scheffe test illustrates that women who were admitted for one day have had higher positive views regarding overall perceptions (mean 2.1277) and five of women perception's dimensions

(loyalty, attitude and respect, approach of women care, privacy and ward environment). Additionally, women who were admitted for more than 3 days reported lower positive views regarding overall perceptions (mean 2.0123) and the other dimensions. The result emerged significant differences between the number of admission days and the overall perceptions, loyalty, attitude and respect, approach of women care, privacy and ward environment (P-value 0.03, 0.05, 0.05, 0.013, 0.006, 0.001 and 0.001 respectively)

Table (20): Relationship between dimensions of women's perceptions and time period spent from delivery to discharge.

Dep, Var Women perceptions	Indep. Var. duration from delivery to discharge	Sum of Squares	df	Mean Square	F	P-value
Loyalty	Between Groups	2.113	4	.528	1.373	0.242
	Within Groups	148.474	386	.385		
	Total	150.587	390			
Attitude and Respect	Between Groups	.438	4	.109	.578	0.679
	Within Groups	73.108	386	.189		
	Total	73.546	390			
Information and communication	Between Groups	2.481	4	.620	2.750	0.028*
	Within Groups	87.046	386	.226		
	Total	89.527	390			
Approach of women care	Between Groups	1.047	4	.262	1.792	0.130
	Within Groups	56.383	386	.146		
	Total	57.430	390			
Privacy	Between Groups	1.616	4	.404	2.100	0.080
	Within Groups	74.289	386	.192		
	Total	75.905	390			
Approach of baby care	Between Groups	8.444	4	2.111	6.265	0.001*
	Within Groups	130.061	386	.337		
	Total	138.505	390			
Counseling	Between Groups	2.016	4	.504	1.811	0.126
	Within Groups	107.379	386	.278		
	Total	109.394	390			
Wards environment	Between Groups	1.120	4	.280	1.059	0.377
	Within Groups	102.120	386	.265		
	Total	103.240	390			
Decision participation	Between Groups	14.359	4	3.590	9.550	0.001*
	Within Groups	145.092	386	.376		
	Total	159.452	390			
Overall perceptions	Between Groups	.710	4	.178	2.667	0.032*
	Within Groups	25.705	386	6.659		
	Total	26.415	390			

* Statistically significant

As shown in table 20, one way ANOVA was used to estimate the differences between the periods spent from delivery till discharge and women perceptions. The time period was categorized as follows; less than 6 hours, 6- 12 hrs, 12- 24hrs and more than 24 hrs. The result showed that there were a real statistical differences between the period spent from delivery to discharge and overall perceptions (P- value 0.032) as well as information and communication, a approach of baby care and decision participation (P-value .028, .001and .001 respectively). Scheffe test revealed that the women who spent more than 24 hrs reported higher positive score of perceptions (mean 2.2001), while women who spent less than 12 hrs reported lowest score of perceptions (mean 2.0830). This means that woman who stay after delivery for one day have positive perceptions towards childbirth services more than those who stay for less than 12 hrs.

Qualitative findings

Women were asked to respond to open-ended questions, on responding to the question “what did you not like about your labor and delivery”? The women pointed and focus on:

- Health care provider’s attitudes and respect to us were not so good.
- No organization of the visiting time and the departments are crowded with visitors which lead to noisy environment.
- Shortage of health care providers especially at night.
- Inadequate numbers of beds present in the departments.
- Dirty rooms and dirty linen full of blood.
- No enough coats for newborns.
- No warm water present in the bathrooms.
- Long waiting time for examination and counseling.

- Counseling time is not long enough.
- Little response to pain by offering pain relief.
- Few female physicians.
- Shortage of information given to us before, during and after delivery.
- No attention or care given to the baby after our transfer to the obstetric department.
- We feel that there is discrimination.
- We feel that there is a lack of control.
- Physicians' rounds are not frequent enough, they occur once daily.
- Bad interaction and communication with us.

On responding to the question “What did you like about your labor and delivery?” The women pointed and focus on:

- Health care provider’s attitude and respect to us.
- More organization to the visiting time and the department’s quiet and no noisy environment.
- Clean rooms and beddings.
- Response to my pain by offering pain relief.
- Attention and good care given to me and to my baby.
- The presence of my physicians here gave me confidence and feeling control.
- Good interaction and communication offered by health providers to us.

On responding to the question “List what you would like to change in maternity services”. The women pointed and focus on:

- Admission procedures must be more effective to enhance good communication.
- Number of female physicians must be more than male physicians.

- Privacy and curtains between beds.
- Relatives must be present With me during labor to provide emotional support.
- Frequent changing of linen.
- Increasing number of health care providers to enhance positive interactions with us.
- Paying attention and responding in a short time to the woman during complaining of pain.
- Care to be just by one or two caregivers not more during childbirth process.
- They have to deal with us in a human way.
- Giving more information about specific topics, such as how intense pain would be, pain medication and how to push to avoid episiotomy.
- More time from health care providers for counseling to discuss some points of great concern to woman.
- Rooms are crowded with beds, two or three beds are present in a small room designed for one bed only.
- In order to share in decisions related to woman care, health providers have to discuss the available options of care in a way that she can make an informed choice.
- More information and advices to primigravidae about her newborn care and self care.
- Make birth experience as satisfying as possible for the mother and her family.
- Women wish to be in familiar setting in which they feel relaxed.

Discussion

This study was conducted to examine women's perceptions of childbirth services at the governmental hospitals in GS. Moreover, the study aimed to provide policymakers with up-to-date information on patient birth experiences, in order to help them improve the quality of maternity services. Furthermore, this study's aim is to highlight the areas that may help health care providers to increase the satisfaction with childbirth services at governmental hospitals.

The researcher limited his focus to women with low-risk pregnancies in order to explore their views in the absence of medical indications for specialized care. In this chapter, the researcher attempts to discus and interpret the findings of the study.

The results showed that the women's perception level for childbirth services at governmental hospitals was 70%. The result was consistent with Abu Saileek (2003) study which was conducted in two hospitals in GS to evaluate the client's satisfaction with nursing care, the result showed that the satisfaction level was 70.1% in both hospitals. Abu Saileek attributed the high level of satisfaction to the cultural and political factors, which might have an impact on their expectations and have resulted in the revealed the level of satisfaction.

Another study was conducted in GS and WB, which investigated the Palestinian's satisfaction with health services provided by MOH, the findings showed that 61.9 % of the clients' showed high level of satisfaction with health services as overall (Abu Dayya, 2000). Abu Dayya attributed the high level of satisfaction of Palestinian people to the limited expectations with regard to the difficult political and socio-economic situation of the PNA in general and MOH specifically (Abu Dayya, 2000).

Mousa (2000) conducted a study in the GS to investigate client's satisfaction with family planning services, the researcher reported that overall satisfaction as expressed

by the Palestinian women was 72% (Mousa, 2000).

Al Hindi (2002) evaluated the level of clients' satisfaction with radiology services in the Gaza Strip, the researcher reported that the overall satisfaction level 82.5% as expressed by the clients who used radiology services (Al-Hindi, 2002). Sullivan and Beeman (1982) measured the level of satisfaction with maternity care, the result demonstrates widespread satisfaction with maternity care, 93% of the respondents were satisfied or very satisfied (Sullivan and Beeman, 1982). Elizabeth A. Howell (2004), conduct a study to determine pertinent attributes of women's hospital experience related to the delivery of their children, the result revealed that the mean overall satisfaction rating for the entire sample was 92%.

In general, and in spite of the quality concerns of the health care services as Massoud reported in his situational analysis about health care in Palestine (Massoud, 1994), the findings from this study indicate that women reported relatively moderate degree of satisfaction with childbirth services (70%). This is consistent with other patient satisfaction studies discussed before. The social and cultural factors of the Palestinian society might have made the women appraise the services even they were not satisfied. This concept increases also because the women still present in the place where she received the services, furthermore, the expectation of the Palestinian women were low due to the economical and political situation and this resulted in the high level of satisfaction.

Dimension of women's perceptions

Based on what was cited in the literature, there were nine dimensions of women's perspective on childbirth services at the hospitals as perceived by the women. These nine dimensions might reflect a frame of the Palestinian women's perspective with

childbirth services at the hospitals. The level of positive perceptions about these dimensions varied as the following: loyalty (85.5%), approach of mother care (85.5%), privacy (78.6%), information/communication (78.1%), and ward culture (76.1%), approach of baby care (71.3%), decision participation (55.8%), counseling (54.7%) and staff attitude respect (44.5%). The following paragraphs present the interpretation of these dimensions and explain what behind their scores.

Loyalty

Loyalty dimension reflects the degree to which the women might have agreement of the childbirth services she received and that she will return and will recommend other women to attend the same hospital when in need for childbirth services .

Findings showed that women expressed a positive perspective for loyalty dimension (85.5%), and this could be related to some factors; low economical status of Palestinian people push women to attend childbirth services at governmental hospitals which offered these services under medical insurance. The other possible cause could be related to the fact that women in the Palestinian society are considered the corner stone in the family, so they wait at home till the last stage of delivery, therefore they went to the nearest hospital at time of birth . Also external factors as ward environment were acceptable so women were satisfied to attend the same hospital and receive the same services. Generally women express satisfaction about any services they receive. This opinion is congruent with Porter and MacIntyre (1984) who reported that women tended to say they liked whatever care they received, which is why surveys give such positive responses about childbirth. Finally women's perception about loyalty were good, and to make sure this satisfaction is maintained the researcher recommends that appraisal of services should be carried out frequently

from women views to explore the point where the mother is satisfied or dissatisfied in order to reach acceptable quality level.

Attitude and mother respect

Attitude and respect dimension reflects women's views and experience of staff behavior, this behavior as Mackey and Stepans (1994) considered praise, flexibility, acceptance encouragement, friendliness, presence and confidence, to be aspects of helpful behaviors during labor. Also the result of Sue (1998) study revealed that the two key issues which concern women's beliefs were being listened to and being respected at labor and postnatal care.

Results of this study provide clear evidence of women perspectives about attitude and respect; hence 45.5% of women had negative perception about staff attitude and respect. These findings are consistent with the women's comment in this study. For example, one woman said; *some of health providers spoke to me in an authoritative tone and I didn't seem to be able to get any feeling of reassurance*. Also another woman said; *we are humans, they have to deal with us with humanity*. Moreover another woman said; *some of them didn't speak kindly and paid little attention to me.* Consistently, the result of this study was in accordance with other studies, one study revealed that 40% of the participants reported that some nurses had hindered their labor-coping ability by failing to provide emotional support and comfort measures (Chung-Hey et al, 2001). Another study reported that nurses spent a very small percentage of their time providing supportive care for mothers in labor. Their time was mostly spent performing other activities physically separated from laboring women (Gagnon and Waghorn, 1996)

Staff attitude and respect as one important quality dimension needs a concentrating effort from decision maker to improve the level of satisfaction among women, and to

achieve this goal. Possible causes of dissatisfaction of women in this dimension include the numbers of delivered women were too many as compared to the number of health care providers present. This makes health care providers concentrate on the process of delivery more than the psychological aspects of women as emotional support, encouragement, friendliness and courtesy. So the researcher suggests covering the shortage of manpower present in the hospitals. Furthermore by concerns about in service education courses or lectures on the role of good psychological reassurance and emotional support to encourage health care providers to deal with women friendly and courtesy.

Information and Communication

The dimension of information and communication dimension reflects the women experience with the health care provider's responses, listening, answering and explanation of the needed information about some health related issues. In addition, their satisfaction with health providers concerns to keep the women and her family informed about health status of the women and her baby.

Jane (1995) said, improving communication with patients seems to be the key to improving patient satisfaction and both the amount and clarity of information patient receive are important.

The satisfaction level of information and communication dimension in this study was 78.1%. Similar findings revealed by Al-Hindi (2002) study, which investigate client's satisfaction with radiology services. The researcher reported that communication and interaction as expressed by Palestinian clients was 77.5% satisfied and 22.5% dissatisfied. Another study conducted by Abu Saileek (2004) who examined the client's satisfaction with nursing care provided at selected hospitals in Gaza Strip

showed that 67.4% of clients were satisfied with information and interaction dimension

Qualitative data reflect women's opinion with information and communication dimension, one primiparous woman said; *I hope that health providers gave me more information about specific topics, such as how intense the pain would be, pain medication and how to push to avoid episiotomy*. This means that, this woman was educated and knowledgeable about childbirth and she received services and information less than her expectations. Another woman said; *health provider instructions were difficult to follow. She asked me to keep my mouth shut without making any noise. How could I stop myself from crying out when my pain was so intense?* Some women touch the fact when said; *I see the health provider interacts with the papers and files more than the interaction with the women.*

The result was also consistent with Eileen (1998) study, when she asked woman "is there anything about your labor and delivery that is still bothering you? The result about the information and communication revealed that lack of information was identified as a source of frustration by 20% of study population. Also 30% of the study population identified negative communication with health caregivers as a source of frustration, resulting from uncaring interactions and undesired actions by care givers. Michael, 1994 said; Communication is one of the five characteristics that patients use to define health care quality, the others empathy, responsiveness, caring and reliability, are closely related to communication

In another study conducted by Emmanuel , et al (2001) to investigate from a service consumer perspective, mothers' needs in the immediate postpartum period, the study revealed that the women wanted specific information and education about mothering, For new mothers, early discharge made the need for information a high priority.

Health care providers have to empower the woman to maintain control of her self they must be labor-coping facilitators, fulfilling the roles of emotional support providers, comforters, information/interaction providers and advocates. To achieve these goals and improve the quality of childbirth services in information and communication dimension, health care providers must spend more time with the women to listen and answer her questions, give her the information she needs and encourage her to ask and explain every procedure or investigation and labor progress by simple words understood by the woman and never avoid question. Also the professionalism in hospitals, moved with time, to be routine services, no creativity and no changes. On the other hand, to enhance the relationship between the health provider and the women, health care providers have to deal with the woman as if he/she gives care only to her in order to encourage women health providers trust and avoid feeling that the mother felt the health provider interacts with files more than with her. These will help in increasing the women satisfaction to childbirth information and communication service.

Approach of Mother Care

The approach of mother care dimension is considered as one important quality dimension. It is part of the provider technical skills, this dimension reflects to which extent the health care provider knows his/her role in providing mother care during labor and delivery and their attentiveness to women's concerns, needs and preferences. It reflects also the health care provider's relationship as professional/friendly to childbearing women, health provider's ability to provide individualized care to each woman, and the health provider's competence and confidence in using clinical skills.

The result revealed that women perceived approach of mother care reported level of satisfaction as 85.5%, congruently with other studies conducted in Gaza, Mousa's (2000) study, reported similar level of satisfaction 82.4% with delivery care of family planning services. AL-Hindi's (2002) study, reported satisfaction level 80% with approach of care in radiology services.

This finding was also similar to that of Berg et al (1996) who reported that women wanted to be cared for by health provider with whom they could have a "trusting relationship," to be "seen as an individual," and to be "supported and guided" on their "own terms" during childbirth. Similar findings also identified by Wilkins' (1993) study of community midwives which reported that women wanted to feel special, to feel significant, and not just someone to be processed.

These finding were consistent with the qualitative data in this study. For example, one woman said; "some *caregivers were excellent at their job, but they didn't have a relationship with women as a person*" another women said; "*I feel the healthcare provider were trying to give me confidence, inspite of less time they adherent to me"* moreover, another woman said; *whenever I called the caregivers for help they responded but not in a shortr time, I think this occurred due to the overload they had or shortage in their number"*.

The level of satisfaction 85% to the care which mother received may be related to the nature of Palestinian culture which always looks for good rationalization to every type of services provided to them, furthermore the women in Palestinian society did not know their health rights, this could be due to knowledge deficit and low level of education. So their expectations were low and they gave high score when participate in evaluation the services they were receiving. Moreover the upgrading which

occurred in nursing, midwifery and physician education could reflect this level of satisfaction with care the mother received.

Privacy

Privacy dimension reflects to which extent the health provider preserved the privacy of mother during labour and delivery, assessment, investigation and during visiting time. In this study the findings showed that the privacy dimension scored 78.6%. This level of women experience of privacy means that the women somewhat satisfied with privacy services. Also these finding s are inconsistent with the qualitative data in this study. For example, one woman stated; *"I feel that my privacy is invaded because some time the number of care givers infront of me during examinations more than needed ".* Another woman commented *"there is a caregiver examined me without closing the curtain and other women in the room".* Another woman suggests*; "Feeling of privacy is fundamental to me, so I prefer the continuity of care to be just from one or two caregivers not more during childbirth process"*

Compared with Abu Saileek (2004) study, which included privacy, his finding showed that privacy domain reported 69.7% satisfaction level. AL-Hindi (2002) study showed that the client's reported higher level of satisfaction 90% with comfort and privacy.

From these results the researcher claims that women are in need for more respect of their privacy during childbirth services. This is because privacy is a right for women, and their satisfaction (78.6%) did not reach the clients' satisfaction in AL-Hindi study (90%). This result might be due to our Islamic/Arabic culture where the woman concerned not to expose special areas of her body to others, where she will be embarrassed and anxious and feel that she was not in privacy situation. So this feeling was difficult to postpone. For that the women will not reach a high level of

satisfaction to privacy in childbirth process, but health provider can minimize this women's feeling by achieving some factors as, provide privacy in all part of childbirth process, do assessment only when needed, use curtain during assessment and delivery, same caregiver to the same woman and concern about visiting time and visitors, this will respect women privacy, dignity and confidentiality.

Approach of baby care

Approach of baby care dimension reflects the extent of women satisfaction from the care which her newborn had received after delivery as feeding, sleeping arrangement, cleanliness and bathing, health check up. In addition, to what extent the health providers were advised the mother about this care. Approach of baby care dimension reported a relatively moderate level of satisfaction (71.3%).

Findings of this study were not consistent with Mngadi, et al (1999) study, which revealed that the pediatrician was not called for consultation for any of the newborns while in the ward. Measurement of the length of the babies, the head circumferences and temperature check for all newborns immediately after delivery or during the stay in the labor ward were not done. 71% were encouraged to initiate breastfeeding within 60 minutes after birth.

In general, this dimension reflects the role of health care provider in helping the mother to take care of her baby, and this moderate satisfaction for this service might be because every woman had a companion after delivery, and this companion provides most of the care to the baby. So she expresses this moderate level of satisfaction in this dimension. Furthermore, about 43% of woman in this study have more than three children, so she has good experience for dealing with this newborn. For that the woman might did not care for what the health provider do to her baby, and this consistent with what one women comment; "*oh, I know how to deal with my*

baby more than the health provider knows". On another hand about 58% of women in this study have less than three children, so they look for more care and advice about how to deal with their babies, and they want to hear from health providers this advice, but may be that work overload and early discharge from the hospital lead to no time to provide suitable care for baby and advising mother about her baby. This congruousness with one mother when stated;" *I am a mother for the first time, I want to know how to take care of my baby, but no one gives me full advices and information for feeding, breastfeeding, sleeping, bathing and warning*" another woman suggests;" *my request from the hospital is to give us written information to know every thing about baby health care*"

Counseling

The counseling dimension reflects that health care providers offered to women the counseling they needed through empowering their care knowledge, answering their questions, express concern, discuss her condition, advices about baby care (exclusive breast feeding, umbilical cord and immunization), instruction about exercise, suitable diet and about future use of family planning. The finding showed that women reported 54.7% of satisfaction level with counseling dimension. The result was in agreement with Abu Saileek (2004), who examined client's satisfaction with nursing care and showed the counseling domain were reported the lowest level of satisfaction 59.5% expressed by the clients. Contrary, Mousa (2000), who examined the client's satisfaction with family planning services in Gaza Strip and showed counseling and information domain were reported the highest level of satisfaction 81%.

Also in qualitative data, which gained from this study, one woman stated; "*there was no response in details to my questions during health providers round"*. Other woman suggests; "I *want just 5 minute from health provider to discuss some information of*

great concern to me". I think this request of the mother means there is no counseling in childbirth services, further more counseling is a woman's right to have a time with health provider to participate in discussion of her concern, this interaction will build trust between the health provider and the mother, thereby encouraging the women to follow his instructions and advices.

From this low level of women satisfaction with counseling dimension, decision makers should look to improve the counseling in childbirth service by the following steps, firstly, before woman discharges, give her a chance to meet a health provider for a time to discuss her concerns, secondly, training courses for health providers to enhance childbirth friendly concerns as communication, interaction, listening and problem solving skills.

Ward environment

Environment dimension reflects to what extent the woman's satisfaction with ward cleanliness, room temperature, ventilation, quietness and the comfortable measures for rest and sleeping, clean bedding and visiting hours facilitated by the providers to give the mother control over her environment. In this study, the findings showed that ward environment dimension scored 76.1% of perspectives level.

Compared with Abu Saileek (2004) study, which reported 69.7% satisfaction level with comfort and environment domain. Also Al-Hindi (2002) study, reported the highest level of satisfaction 90% with comfort and privacy. Also, Anastasios (2003) in his study for Evaluation of patient satisfaction with nursing care; the patients express low satisfaction with the cleanliness of toilets, noise levels and the variety and temperature of meals. Furthermore Emmanuel E, et al (2001) conducted a study to investigate from a service consumer perspective; mothers' needs in the immediate

postpartum period, the study revealed that the women wanted the creation of a restful environment.

This finding was consistent with the qualitative data of this study, for example, one woman stated; "*it is not acceptable to find two women in one bed as you see and the linen have blood, no one changes them*" . Another woman stated; "*what is this, I can't take a rest or sleep due to the visitor coming in and out all the time, which makes noise in the room and no one cares*". Another woman suggests; "*the number of beds in the single room are too many, I prefer to be only two or three beds in each room to avoid this crowded and noisy environment*".

The hospital environment, particularly the birthing room has always been considered as an unfamiliar place by pregnant women: strange, cold, frightening and full of surprises, a place which will be the scene of a lot of pain and suffering at the time of the birth. Health professionals are responsible for the undoing of this myth and should transform the environment into one associated with the image of pleasure and happiness, in which the arrival of a new and very important human being will occur. This environment makes woman feel more secure and less anxious at the time of birth.

Decision participation

Decision participation dimension reflects the extent of women's satisfaction with participation in decisions affecting her care by taking enough notice of her wishes and views and respect her request. In this study, the findings showed that the decision participation dimension scored 55.8% of perspectives level. This is consistent with Sabine, et al (2004) study, which revealed that the women who perceived themselves to have a good level of knowledge and expectations concerning augmentation of labour and who were also invited to participate in decision-making by supportive

midwives seemed to be more satisfied with participating than other women in the study.

To know more for decision participation dimension from the women, the qualitative data reflect consistent findings, one woman stated; "*how can I participate in my care if no one listens to me and no one listens to my views and no responses to my pain*". Another woman comments; "*during labor, I had severe back pain, I asked if I could change my position but the health provider refused my suggestion*". Another woman suggests; "*if the health provider wants me to share in decisions related to my care, he has to give enough information and options to choose from, but he never do it*"

Decision participation cached low level of women satisfaction might be because women try to be quiet and follow instruction without discussion especially when the instructions were related to medical issues This opinion is consistent with Martin, (1993) when said; "*women often very cooperative with the medical team in a hospital setting and do not express their concerns and worries*". Also it could indicate that the health provider does not invite woman to participate in decision making because woman do not perceive her self or perceived by others as antenatal caregivers to have a good knowledge concerning childbirth alternative issues to participate in choices.

Furthermore, the health care provider could not know the options or alternatives cares he/she should give the women, to make choices about their care. Moreover, in our culture the women, care not used to make choices. This is congruent with Sue's study (1998), which revealed that, many women did not want to have to make decisions about their care because they were not used to making decisions.

To improve satisfaction with participation in decision making of childbirth services, health decision maker in antenatal care should make ante natal classes to teach and to give the women information about the childbirth care and procedures of which she

has to make choices during childbirth. Furthermore they can distribute a practical guide to childbirth process with alternative care to choose from.

Demographic variables and women perceptions

This part of the discussion illustrates the relationship between dimensions of women's perspectives and demographic factors.

The provinces and residency

The results indicated that there were significant differences between dimensions of women's perspectives and provinces, the women who were living in Rafah had more positive perspective than women who were living in other provinces, while the women who were living in the Gaza province reported the lowest score. Also, there was a significant difference between women's perspectives and residency (city, camp and village), women who were living in villages reported higher score of perception with childbirth services and women who were living in cities reported the lowest score of perception.

This result attributed to the level of women's expectations to the alternative setting of childbirth services which are available in Gaza, where the women might had previous delivery, or heard from friends about the services in the setting, which enhance comparison between the services she received and her level of expectation. On the other hand, Rafah have the higher score of perspectives, this could be related to Rafah constitution which consist of multi refugee camps where most people lived, and this is consistent with Mousa (2000) findings which reported that people who lived in camps have a high level of satisfaction rather than who lived out of the camps.

Age

Findings showed that there was a significant difference with women age, loyalty and approach of baby care. The resultS showed that those women who were less than 18

year had positive attitudes towards childbirth service more than those who were more than 24 years. This result was consistent with Mousa (2000) study, which reported that the level of satisfaction with family planning decreased as age increased and he concluded that the older people in Palestine context tend to be less satisfied than younger people and this might be due to experience, exposure, perceptions and the higher level of expectations among older Palestinian women and the need to be treated with more respect and consideration. Also, Abd Alkareem, Aday and Walker (1996) found in their study that younger patients were more satisfied with physical environment. On the other hand, Al-Hindi (2002) study revealed no statistical differences between age and satisfaction level. This inconsistent relation between age and satisfaction implies that there is a need to conduct more in-depth study to investigate this relation.

This result could be attributed to the little experience of childbirth services for young women, so they were satisfied with whatever the quantity of the services provided. But women more than 24 years had previous experiences let her differentiate between the services she received before and current services and every time from delivery to delivery she looking for improvement in the services.

Educational level

The result showed that there were no significant statistical difference between educational level and overall perspectives. This finding was consistent with Abu Harbid (2004) study which revealed no significant statistical relationship between educational levels and overall satisfaction. The result was inconsistent with other studies; Al-Hindi (2002) study revealed that population of higher level of education reported a higher satisfaction level. Also Mousa (2000) study revealed that the least satisfied group is the highly educated one.

Although, the literature reveals contradictory results concerning the relationship between educational level and satisfaction, the study revealed that illiterate women reported positive experience more than educated ones. This result could be attributed to that women with high education are more knowledgeable and more educated about health issues, so their level of expectations is usually more than others. Also educated women are capable of making comparison between the services they received before and services received recently. In addition, women always look for services improvement from time to time.

Economic status

About 91%, of the study population were not employed; this is a common phenomenon in Gaza Strip. Study finding revealed that no significant statistical difference between employment with perspective's dimension regarding to the overall perspective. Al-Hindi (2002), found that occupation has no impact on level of satisfaction, and she suggested that, further studies could assess the accurate relationships. But the researcher attributes this result due to, no difference between the employed or unemployed women in their expectations to the services, because not only the employed women were educated, but from the unemployed women there were a lot of educated women but not working. This attribution was congruence with McCrea and Wright (1999) when urged that nowadays women are more informed about services and even that not-working class had the same expectations and this makes the chance of differences to be little.

Also the same finding present regarding monthly income, this means that the perspective's dimensions were not affected by economic status of the women. This is relationship consistent with Mousa (2000) study, which revealed no statistically significant between the economical status regarding to the satisfaction level. Another

study conducted by Abd Alkareem, Aday and Walker (1996) showed that income was significantly related to quality of care, but this manifested by higher satisfaction with quality of care among those with lower income. Also Al-hindi (2002) study, found that the respondents with higher financial status tend to be more satisfied than the respondents with lower financial status.

Inspite of no significant difference present, the result showed that the unemployed women and the low monthly income had more positive perspectives than the employed women and high monthly income regarding the overall perspectives. The possible explanation of this finding is that, in this political situation, the employees considering the group of people whom have good economical status and they are from the high social classes in society, so their expectation increased and as Mousa (2000) comments, they can express negative response more freely than unemployed. Also this is consistent with Hall and Dornan (1990) attempt to distinguish two possibilities; first, that independent of the actual care received, poor patients generally more accepting and more reluctant than rich patients to pass negative judgment, second that poor patients are treated in a less thorough and responsive manner.

Perceptions and maternal childbirth variables

Age at first marriage

The result of this study revealed a significant statistical difference only between the age at first marriage and counseling and in contrast analysis, the findings showed that those women who were married at age more than 32 years have higher score perspectives, while the women who married at age 23-27 years reported the lower score of perspectives. This attributed to that, the woman married at age 32 year and thinks that she is approaching the menopause looks to have a baby without looking to

the type of services, and when she is delivered normally, she will be satisfied from any type of services she received. On other hand, the women who were married at the age 23-27 years were perceived as considering that they were married at normal age of marriage in the Palestinian society, and she can evaluate the services with more realistic views.

Pregnancy order and number of living children

Findings of this study revealed a significant statistical difference between the number of pregnancies and the information and communication and the approach of women care dimensions. Women who had 3-5 pregnancies had higher mean, while women who had 1-2 pregnancies had the lowest mean regarding overall perspectives. This might be related to; the women with previous experience know how to deal with caregivers and had information about childbirth services more than those whom had only 1-2 pregnancies. While the women with 1-2 pregnancies look for more information and more level of expectations in childbirth services. The same explanation of the number of pregnancies is congruence with the number of living children.

The first delivery in the Health setting

The result of this study revealed that there were statistical significantly in loyalty, counseling and information/communication of dimension of women perspectives. The result also illustrated that the study population who delivered for the first time in this hospital have higher positive perspectives with overall perceptions than those whom who had previous delivery in this hospital. This might be due to the fact that women who received the services before are familiar with the level of services provided and they return to the same setting. This is consistent with Abu Harbid (2004) findings that the experience has direct impact on the women response. The women don't

predict changing in ANC procedure; however, they accept whatever ANC service was provided in each visit.

Reasons for choosing this hospital

The result revealed that there is a significant statistical difference between the cause of choosing the hospital and the overall perspective. The women who choose the hospital because her doctor is working there, reported the highest score of overall perspectives, while women who were obligatory transferred to hospital reported the lowest score of overall perspectives. This could be, the women who choose the hospital regarding her doctor work, considering this type of continuity of care, which the same caregiver during Ante Natal Care (ANC) will continue and provide the childbirth services for her in the hospital, so she will feel safer, secure and having felt control during labor and birth more than others. Also, she might be received the shorter waiting times and more time per counseling and the caregivers being less rushed. This is consistent with the conclusion of Ulla Waldenström (2000) study, that statistical difference in satisfaction generally were related to items where continuity of caregiver might have been the important and not to other aspects of care, continuity of care affected satisfaction with care received in a positive way.

Waiting time from admission to examination

The result of this study revealed significant statistical differences between waiting time for examination and overall perspectives. Women who were waiting the shorter time for examination reported the higher score of perceptions, while the women who waited 30 minutes or 60 minutes reported the lowest score of perceptions. Waiting time is investigated regarding patient satisfaction by several studies; Al-Hindi (2002) study revealed that the clients reported higher level of satisfaction with radiology services as they were waiting the shortest possible time. Kersink (2000) showed that

waiting in the waiting room was the item rated poorest. Another study conducted by Goupy and Gines (1996), about the outpatient care, confirmed that the lowest satisfaction was expressed toward the waiting time. Liberman and Wysenbeek (1996) study indicates that the waiting time is placed in the second order that causes dissatisfaction. From the findings and the literature review, waiting time considers from the variables which affect the satisfaction of the women regarding the childbirth services, for that, the managers and policy makers should take into consideration the waiting time should be always decreased to the lowest time to have women's satisfaction.

Mode of vaginal delivery

Findings of this study showed that there is a real difference between mode of vaginal delivery regarding women respect dimension. Women who delivered with breach reported the higher score of perspectives, while the women who delivered with forceps reported the lowest score of perspectives. This might be because woman who delivered vaginally inspite of breach presentation of her baby was saved from cesarean section and had a good birth outcome, so she would be satisfied with the services received. On the other hand, the woman who delivered by instrument, faced more manipulation during delivery and more time during childbirth process, and feel loss of control, for that she was dissatisfied.

The number of health providers during delivery

The findings revealed that there is a significant difference between the health providers number and overall perspectives. Women who reported that the number of health providers during delivery more than what is needed reported the highest score of perspective, while the women who reported that the number of health providers were little than what is needed reported the lowest score of perspectives. The

explanation for this result related to the feeling of concerning, control, trust and confidence that if emergency occurred, easy to overcome by these numbers. To reach to satisfy women with childbirth services health provider should do the best to let the woman feel control, trust, confident, and that she was being concerned, this will be achieved by good communication and supporting during delivery.

The expectation of childbirth services

The finding of this study indicates that there is a congruency between the expectation and the overall perceptions. Women who had good expectation reported higher score of perspective, while the women who had bad expectation reported lowest score of perspectives. This indicates the importance of expectation in affecting women response. The expectation of women might be from background experience for services or from informal impression gained from friends or relatives' experience. The explanation of this finding could be related to the stay period in the hospital which was shorter in delivery ward, so it is difficult to change the expectation of the mother, thus she remain with the same opinion which she had. On another hand, expectation some times depends on real level of services in the setting, so improving services are important, especially in admission procedure, which play an important role in building the first impression about the services, which will be adherent to women's expectation and views.

Length of stay

Regarding the admission days in the hospital, the result indicates that the woman who spent one day in the hospital were have higher positive perspectives with childbirth services than the women who spent more than 3 days. This result could be related to that, women expectations about childbirth process was a natural process not medical, and the woman looking for easy delivering and the return early to her home. Spending

more than one day means that childbirth became complicated, furthermore women's complaining increased by each day she stays more in the hospital, a lot of women admitted and discharged, but she still in, this causes dissatisfaction. Regarding of this result, and to improve women satisfactions with the services, health provider have to do accurate assessment for labour stages. And if women health condition needs hospital follow up; she should receive emotional support, information and good communication and interaction during length of stay.

Period from admission to delivery

Result indicate that women who delivered in period less than 6 hrs, were more satisfied than those who delivered in period more than 48 hrs from admission. The explanation of this finding might be related to waiting time, waiting is difficult in normal situation, this difficulty is increased when the women wait her baby, with times she fears from unknown about her baby and her health condition. Also, this dissatisfaction could be related to lack of reassurance, bad interactions and communication from health providers.

Time from delivery to discharge

Regarding duration from delivery to discharge, the woman who stay between 12- 24 hours were have higher positive perspectives with childbirth services than the women who stay less than 12 hrs. This is related to some factors; firstly women on this period feel more safe and confidence that she became away from complication which may occur during early postpartum, also, the women received information and health education about her self care, breastfeeding, immunization, baby care and family planning, so the women who receive this services consider that the health provider gave her complete care. This can achieved for women who spent more than 24 hours in the hospital after delivery.

Conclusions

This study was carried out for understanding the women perceptions, experiences, concerns and views to painstakingly explore factors of childbirth services at governmental hospitals that influence women's satisfaction in order to identify dimensions of childbirth's quality services. In this study women's perceptions with childbirth services is in essence considered as an indicator of women's perceived maternity quality of care in GS.

The results of the study could assist in improving the quality of hospital's childbirth services of Palestinian women in the GS by providing some indicators to start quality improving approach. They can also widen, enlarge, expand and enhance not only mankind knowledge but also awareness that can potentially trigger a wide range of factual points on this topic

To sum up, one can reach the following conclusions in:

1- The study indicated that perceptions of women towards their childbirth experiences level are relatively good (70%). Still there is a room for more improvement within this regard. Reflecting on the study findings, it could improve women perceptions positively.

2- The domains and factors extracted from the study constitute a frame for health professionals and policy makers to develop policies and procedures that improve women perceptions positively with the childbirth services.

3- The study pointed to the effects of sociodemographic characters of women (educational level, residency and age) on their perception and satisfaction about childbirth services. Attention to these points would bring more

satisfaction and would contribute to improve women positive perception about the services they received.

4- The study pointed to the impact of the maternal child variables on women satisfaction and perception which worthwhile to be consider by health providers and policy makers. More attention should be paid to women who married at age 23-27 year, primigravidae, woman with one or two para and women who have one or two children.

5- In relation to the number of health care providers do present in childbirth department, it affects the perceptions of women, which indicates that women who reported that the number of health care providers was suitable reported the highest score of positive perceptions than those who think the number of health care providers was little number.

6- The study attributed to the need for good counseling, attitude, respect, decision participation and information/ communication from health care providers will increase women perceptions about childbirth services.

7- In relation to the ward environment and comfortable measures where the childbirth services offered, the women perceived good perceptions and satisfaction for the ward where adequate comfortable measures, suitable beds number in rooms , beds' curtains and good ventilation.

However, within this overall picture of relatively moderate level of satisfaction and perceptions towards childbirth services, a number of specific issues have been identified and needed for improvement.

Recommendations

Maternity services for Palestinian women in GS should respond to calls for greater women involvement, and introduce policies and design to support as well as back up the development of woman-centered maternity services. In addition to what has been mentioned within this arena though this can be achieved if the decision and policy makers above all do consider transmitting and implementing some of the applicable research recommendations in maternity health decisions and policies to particularly gain more satisfaction and more quality of health services.

- Policy makers could do better by considering mother's bill of right such as her right for respect, counseling and privacy.
- Researcher suggests providing more concern to in-service education programs for health providers focusing on simulation techniques to allow providers to operate in a clinical context.
- Training the health personnel in interpersonal skills of communication, counseling and involvement of care are other areas need that attention. .
- Steps should be taken to increase the level of privacy which offered to all women during labour and delivery and after birth.
- Significant efforts should be paid to improve the comfortable measures of the physical environment which influences the women's satisfaction such as comfort and clean rooms, clean linens, curtains between beds and one bed for one woman.
- Pay attention to educated women, residency, age would bring more satisfaction and would contribute to improve their positive perception about the services they received.

- More attention should be paid to women who married at age 23-27 year, primigravida, woman with one or two para and women who have one or two children.

Areas for further research

- Comparing the perceptions of childbearing women and health providers about what determines quality in childbirth services?
- Study the women satisfaction in all settings of childbirth (UNRWA, Home, Private and NGOs).
- Women/providers communication research and directions for development.
- Is the information the women received enough in sharing decisions with health provider?
- Are educational materials in college, which is related to dimensions of women health care, meet, the needs of health providers and women?

Chapter (7)

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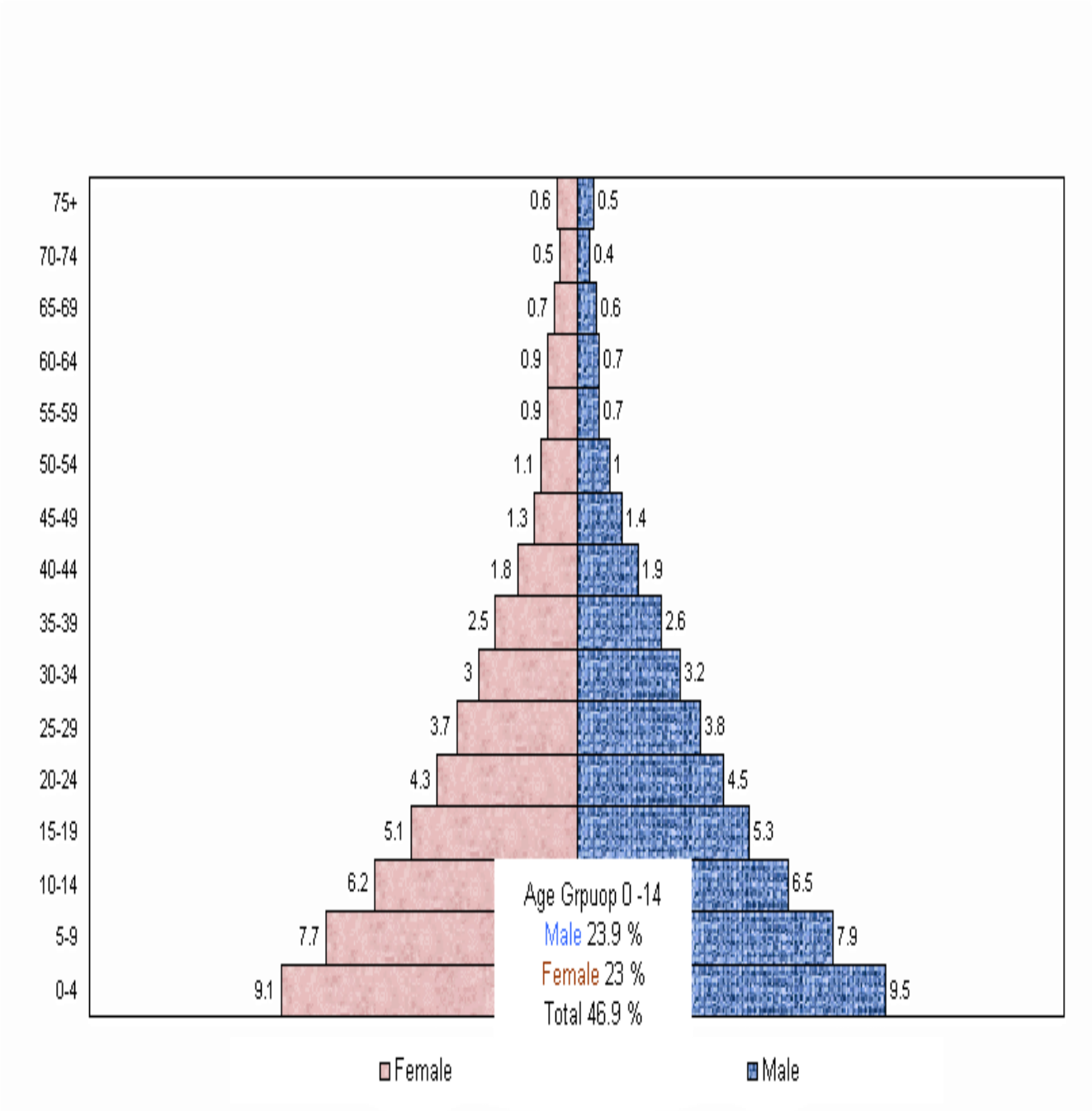
Annex (1): Palestinian West Bank and Gaza

Annex (2): Map of Gaza Strip.

Annex (3): Population Pyramid-Gaza Provinces



Annex (4): Helsinki Committee Approval Letter

بسم الله الرحمن الرحيم

Palestinian National Authority
Ministry of Health
Helsinki Committee

السلطة الوطنية الفلسطينية
وزارة الصحة
لجنة هلسنكي

Date: 28/9/2003

التاريخ: 2003/9/28

Mr./ Khalil Abo Shouib

السيد: خليل أبو شعيب

I would like to inform you that the committee has discussed your application about:

نفيدكم علماً بأن اللجنة قد ناقشت مقترح دراستكم حول:-

Women Perspective of Chilbirth Services Provided by Health Providers at Governmental Hospitals in Gaza Strip

رأي الوالدات في الخدمة المقدمة أثناء وبعد الولادة في مستشفيات وزارة الصحة بقطاع غزة

In its meeting on September 2003
and decided the Following:-

و ذلك في جلستها المنعقدة لشهر سبتمبر 2003
و قد قررت ما يلي:-

To approve the above mention research study.

الموافقة على البحث المذكور عاليه.

Ministry of Health
Helsinki Committee

Signature
توقيع

Member عضو

Member عضو

Chairperson

Conditions:-

- Valid for 2 years from the date of approval to start.
- It is necessary to notify the committee in any change in the admitted study protocol.
- The committee appreciate receiving one copy of your final research when it is completed.

Gaza Etwam – Telefax 972-7-2878166

Annex (5): Ministry of Health Permission Letter

التاريخ:

بسم الله الرحمن الرحيم

السيد/ مدير عام وزارة الصحة

الدكتور/ عبد الرحمن البرقاوى المحترم

تحية طيبة وبعد

الموضوع/ الموافقة على إجراء بحث حول تقويم الخدمات المقدمة للمرأة أثناء و بعد الولادة في مستشفيات وزارة الصحة بقطاع غزة

ضمن مشروع دراستي في كلية المهن الصحية بجامعة القدس أنوي القيام بدراسة الخدمات المقدمة للمرأة بعد الولادة في المستشفيات الحكومية في قطاع غزة

Women Perspectives of Childbirth Services Provided by Health Providers at Governmental Hospitals in Gaza Strip

ستشمل الدراسة زيارات للمستشفيات الحكومية وتعبئة استبيانات خلال الزيارة وذلك بعمل مقابلة مع النساء بعد الولادة واللواتي سيتواجدن في أقسام الولادة يوم الزيارة.

يرجى التكرم بالموافقة نحو ذلك و إصدار توجيهاتكم اللازمة

الباحث

خليل أبو شعيب

Annex (6): Exit Interview Questionnaire.

Exit Interview Questionnaire
Women's Perception of Childbirth Services at Governmental Hospital

Serial number: Date of interview: / 2003

==========

Health Facility (Name): ☐ Shifa ☐ Naser ☐EGH ☐Al-Aqsa

Date of admission: / / 2003 time of admission----------

Date of baby's birth: / / 2003 time of delivery----------

Date of discharge / / 2003 time of discharge----------

Section one: sociodemographic History

Name:……..

Address:…….

Citizenship: ☐ Refugee. ☐ Citizen.

Province ☐North. ☐GazaCity .☐Middle .☐Khanyounes. ☐ Rafah.

Residency place: ☐ City ☐Village ☐ Camp

Age: --------- Years

Years of education: ----------

Occupation: ----------

Husband's years of educational: ----------

Husband's occupation: ----------

Household average monthly income: ----------NIS

Payment for medical care:
☐ Health insurance ☐ Self pay ☐ other: (specify): ----------

Obstetric history:
Age at marriage……..Years
Number of pregnancy: ----------
Number of living children ----------

Section Two: choose the suitable alternative

1.	Was this your first time at this hospital?	☐Yes ☐No
2.	Why did you chose this hospital	☐My physician work here ☐Nearest to my home ☐ Recommendation by others ☐Easy previous delivery ☐Obligatory referral ☐Other, (specify)----------
3.	After how many minute you had been evaluated after arrival	☐10 minute ☐30 minute ☐60minute
4.	Was the birth of your baby?	☐Spontaneous vaginal ☐With forceps ☐With ventose ☐Other, (specify)----------
5.	Number of staff who surrounding you during delivery was	☐suitable ☐little ☐more than needed
6.	Did you ever fell that the health provider were too busy to spent enough time with you	☐Yes often too busy ☐Yes some time too busy ☐No not really
7.	My expectation about the childbirth services was	☐Good ☐Bad ☐Don't know
8.	Did you get the kind of services you expected?	☐Definitely yes ☐Generally yes ☐No, not really ☐No, definitely not
9.	The childbirth services which I received were	☐Good ☐Bad ☐Don't know
10.	When you need assistance, did the staff help you to meet your physical needs?	☐Yes, ☐ To some extent ☐No
11.	Did you have any difficulty in communication with hospital staff?	☐Yes, ☐ To some extent ☐No

12.	Did you feel that you have been prepared well to discharge from hospital?	☐Yes, ☐ To some extent ☐No
13.	Were you given enough information about self-care after birth?	☐Yes, ☐ To some extent ☐No
14.	Were you told the danger signs that require seeking medical attention after you went home?	☐Yes, ☐ To some extent ☐No
15.	How many days were you stayed in the hospital?	☐One day ☐Two day ☐Three days ☐More than three days
16.	Period from admission to delivery was	☐Less than 6 hours ☐From 6-12 hours ☐From 12-24 hours ☐From 24-48 hours ☐More than 48 hours
17.	How long after the birth did you returns home?	☐Less than six hours ☐Within 12 hours ☐Between 12 and 24 hours ☐Between 24 and 48 hours ☐More than 48 hours (---days)

Chick the suitable rate of satisfaction regarding to the service according to your Perspective.

No	Item	Services	Rate of satisfaction
	Patient loyalty		
18.		You will tell your friend to come to this hospital for delivery	☐Agree ☐Uncertain ☐Disagree
19.		Next time I will come back to deliver here	☐Agree ☐Uncertain ☐Disagree
	Attitude and Respect		
20.		The courtesy of the staff was satisfying	☐Agree ☐Uncertain ☐Disagree
21.		I feel that the staff was concerned about me as a person	☐Agree ☐Uncertain ☐Disagree
22.		The staff I was in contact with were friendly	☐Agree ☐Uncertain ☐Disagree
23.		Staff responds in timely manner when being called	☐Agree ☐Uncertain ☐Disagree
24.		The staff call me by name	☐Agree ☐Uncertain ☐Disagree
25.		I felt that I was being concerned	☐Agree ☐Uncertain ☐Disagree
26.		Staff consistently demonstrate willingness to listen to me	☐Agree ☐Uncertain ☐Disagree

	Information/communication		
27.		Staff telling me every thing being truthful and frank	☐Agree ☐Uncertain ☐Disagree
28.		Staff using words I can understand when explaining my situation and management	☐Agree ☐Uncertain ☐Disagree
29.		Staff encouraging me ask question, never avoiding my question	☐Agree ☐Uncertain ☐Disagree
30.		Staff explaining what I need to know about my situation	☐Agree ☐Uncertain ☐Disagree
31.		I always received a lot of support	☐Agree ☐Uncertain ☐Disagree
32.		I got enough information about the ward	☐Agree ☐Uncertain ☐Disagree
33.		Staff explain enough about what was happening?	☐Agree ☐Uncertain ☐Disagree
34.		Staff explain the examination before it was performed	☐Agree ☐Uncertain ☐Disagree
35.		Staff explain my situation after examination	☐Agree ☐Uncertain ☐Disagree
36.		Health providers telling me during examination about what they are going to do and why, telling me what they finds	☐Agree ☐Uncertain ☐Disagree
37.		Staff provide continuous information about labour progress	☐Agree ☐Uncertain ☐Disagree

	Approach of mother care		
38.		The care I received during labour and birth suited my need	☐Agree ☐Uncertain ☐Disagree
39.		I had confidence in all health professional who were providing care for me and my baby	☐Agree ☐Uncertain ☐Disagree
40.		The transfer between units handled well	☐Agree ☐Uncertain ☐Disagree
41.		I feel there was adequate communication among the staff regarding my care	☐Agree ☐Uncertain ☐Disagree
42.		The price I paid outweigh the services	☐Agree ☐Uncertain ☐Disagree
43.		I did not feel safe in the hospital	☐Agree ☐Uncertain ☐Disagree
44.		I was very bored in the hospital	☐Agree ☐Uncertain ☐Disagree
45.		I have to ask for attention	☐Agree ☐Uncertain ☐Disagree
46.		I felt ignored, no one care about me	☐Agree ☐Uncertain ☐Disagree
47.		I am satisfied with how the staff treat me at the hospital	☐Agree ☐Uncertain ☐Disagree
48.		Always there is someone when needed	☐Agree ☐Uncertain ☐Disagree

49.		I am pleased with how well my pain was controlled	☐Agree ☐Uncertain ☐Disagree
50.		When I needed help at night, there was always a nurse	☐Agree ☐Uncertain ☐Disagree
51.		I was pleased with care I received after delivery	☐Agree ☐Uncertain ☐Disagree
52.		The health provider encouraging breast feeding immediately after labor	☐Agree ☐Uncertain ☐Disagree
	Privacy		
53.		*Staff provide enough privacy during examination*	☐Agree ☐Uncertain ☐Disagree
54.		During labour and delivery I was happy with the number of staff with me.	☐Agree ☐Uncertain ☐Disagree
55.		Unit arrangement and preparation offered enough privacy.	☐Agree ☐Uncertain ☐Disagree
56.		Visitors always invade my privacy	☐Agree ☐Uncertain ☐Disagree
57.		Staff excuse before entering my unit	☐Agree ☐Uncertain ☐Disagree
	Approach of baby care		
58.		I was pleased with the standard of care my baby received	☐Agree ☐Uncertain ☐Disagree
59.		I got helpful advice about feeding baby	☐Agree ☐Uncertain ☐Disagree

60.		I got helpful advice about baby cleanliness and bathing	☐Agree ☐Uncertain ☐Disagree
61.		I got helpful advice about baby sleeping arrangements.	☐Agree ☐Uncertain ☐Disagree
62.		Check up made on baby's health and progress	☐Agree ☐Uncertain ☐Disagree
63.		I am satisfied with the care my baby received	☐Agree ☐Uncertain ☐Disagree
64.	Counseling	I was received satisfactory answers to my questions	☐Agree ☐Uncertain ☐Disagree
65.		I always had enough time to discuss my condition during my consultation	☐Agree ☐Uncertain ☐Disagree
66.		I got helpful advice about coping with a newborn	☐Agree ☐Uncertain ☐Disagree
67.		I got good advice about how to look after myself after the birth	☐Agree ☐Uncertain ☐Disagree
68.		I got helpful advice about feeding my baby from hospital staff	☐Agree ☐Uncertain ☐Disagree
69.		The staff give me instruction about breast feeding	☐Agree ☐Uncertain ☐Disagree
70.		I got instruction about importance of exclusive breast feeding	☐Agree ☐Uncertain ☐Disagree

71.		I got instruction about umbilical cord care	☐Agree ☐Uncertain ☐Disagree
72.		I got instruction about the importance of immunization	☐Agree ☐Uncertain ☐Disagree
73.		Staff advice me to do exercises	☐Agree ☐Uncertain ☐Disagree
74.		Staff gave me instruction of type and amount of good diet	☐Agree ☐Uncertain ☐Disagree
75.		Staff instruct me about family planning methods	☐Agree ☐Uncertain ☐Disagree
	Ward Environment		
76.		The maternity ward is in good condition	☐Agree ☐Uncertain ☐Disagree
77.		The toilets were clean	☐Agree ☐Uncertain ☐Disagree
78.		The temperature and ventilation of my room is suitable	☐Agree ☐Uncertain ☐Disagree
79.		The ward was clean	☐Agree ☐Uncertain ☐Disagree
80.		The ward always quiet	☐Agree ☐Uncertain ☐Disagree
81.		The bedding was clean	☐Agree ☐Uncertain ☐Disagree
82.		The ward was always comfortable to rest and sleep	☐Agree ☐Uncertain ☐Disagree

83.		Visiting hours were not long enough	☐Agree ☐Uncertain ☐Disagree
84.		The food services was good	☐Agree ☐Uncertain ☐Disagree
85.	Decision making involvement	I was adequately involved with decisions affecting my care	☐Agree ☐Uncertain ☐Disagree
86.		The staff takes enough notice of my views and wishes?	☐Agree ☐Uncertain ☐Disagree
87.		I felt I was involved with decisions that were made about my care while I was in labour	☐Agree ☐Uncertai ☐Disagree
88.		My wishes regarding pain relief were respected	☐Agree ☐Uncertain ☐Disagree
89.		I received enough pain relief as my need	☐Agree ☐Uncertain ☐Disagree
90.		The staff ask you to share in decision in care given to you	☐Agree ☐Uncertain ☐Disagree

91- What did you not like about your labor and delivery?

92- What did you like about your labor and delivery?

93- List what you would like to change in maternity services?

Thanks for your response

Annex (7): Arabic Language Questionnaire

رأي المرأة في خدمات الولادة المقدمة لها في المستشفى الحكومي

اسم المستشفى ☐ الأوروبي ☐ مبارك ☐ الأقصى ☐ الشفاء

تاريخ الدخول: / /2003 ساعة الدخول:----------

تاريخ ميلاد الطفل: / /2003 ساعة الولادة:----------

تاريخ الخروج: / /2003 ساعة الخروج:----------

الوضع الاجتماعي

الاسم----------العنوان----------

المواطنة ☐لاجئ ☐مواطن

المحافظة: ☐الشمال ☐غزة ☐الوسط ☐خان يونس ☐رفح

مكان الإقامة: ☐مدينة ☐قرية ☐معسكر

العمر:----------سنة

عدد سنوات الدراسة----------سنة

المهنة----------

عدد سنوات تعليم الزوج----------

مهنة الزوج----------

متوسط الدخل الشهري للأسرة----------

تغطية العلاج الطبي:☐ تامين صحي ☐ دفع مباشر ☐ طريقة أخري(اذكر)

الماضي الولادي للسيدة:

العمر عند الزواج----------سنة

عدد مرات الحمل----------

عدد الأبناء الأحياء----------

اختاري الإجابة المناسبة:

.1	هذه أول ولادة لك في هذه المستشفى	☐ نعم ☐ لا
.2	اخترت الولادة في هذه المستشفى بسبب	☐ طبيبي الخاص يعمل بها ☐ قربها من بيتي ☐ نصيحة من الآخرين ☐ سهولة ولادة سابقة بها ☐ تحويل إجباري ☐ أشياء أخرى
.3	بعد كم دقيقة كنت قد قيمت بعد الوصول	☐ عشرة دقائق ☐ ثلاثون دقيقة ☐ ستون دقيقة
.4	هل ولادتك الحالية	☐ طبيعية دون أدوات ☐ بالملقط ☐ بالشفط ☐ أشياء أخرى(اذكر)- - -
.5	عدد الفريق من حولى اثناء الولادة كان	☐ مناسب ☐ قليل ☐ اكثر من اللازم
.6	شعرت بأن مقدم الخدمة مشغولا جدا عن قضاء الوقت الكافي معك	☐ نعم، غالبا مشغولا ☐ نعم، أحيانا مشغولا ☐ لا، لم يكن مشغولا
.7	كانت توقعاتي عن الخدمة بأنها خدمة	☐ جيدة ☐ سيئة ☐ لا اعلم
.8	هل حصلت على نوعية الخدمات التي كنت توقّعينها	☐ بالضبط نعم ☐ نوعا ما ☐ ليس كذلك
.9	الخدمة التى تلقيتها كانت	☐ جيدة ☐ سيئة ☐ لا اعلم
.10	عندما احتجت مساعدة، هل ساعدك مقدمي الخدمة لتلبية حاجاتك الطبيعية؟	☐ نعم ☐ نوعا ما ☐ ليس كذلك
.11	هل كان عندك أي صعوبة في التعامل مع مقدمي الخدمة في المستشفى؟	☐ نعم،كثيرا ☐ نوعا ما ☐ ليس كذلك

12.	هل تم إعدادك جيدا للخروج من المستشفى؟	☐ نعم،كثيرا ☐ نوعا ما ☐ ليس كذلك
13.	أعطوني معلومات كافية حول كيفية العناية بنفسي بعد الولادة	☐ نعم،كثيرا ☐ نوعا ما ☐ ليس كذلك
14.	هل أخبرت عن إشارات الخطر التي يمكن ان تحدث في البيت والتي تستدعى طلب رعاية طبية فورية؟	☐ نعم،كثيرا ☐ نوعا ما ☐ ليس كذلك
15.	كم عدد أيام مكوثك في المستشفى	☐ يوم واحد ☐ يومان ☐ ثلاثة أيام ☐ اكثر من ثلاثة أيام
16.	المدة ما بين الوصول إلى المستشفى إلى حين ولادتك الطفل	☐ يوم واحد ☐ يومان ☐ ثلاثة أيام ☐ اكثر من ثلاثة أيام
17.	بعد كم ساعة من الولادة خرجت من المستشفى؟	☐ اقل من ست ساعات ☐ خلال 12 ساعة ☐ من12-24 ساعة ☐ من24-48 ساعة ☐ اكثر من 48 ساعة

الجزء الثالث: اختاري الدرجة المناسبة من الرضا المتعلقة بالخدمة حسب رأيك

18.	ولاء السيدة	ستخبري صديقتك للمجيء إلى هذه المستشفى للولادة	☐ موافقة ☐ غير متأكدة ☐ غير موافقة
19.		في المرة القادمة سأرجع للولادة هنا	☐ موافقة ☐ غير متأكدة ☐ غير موافقة
20.	التوجهات والاحترام	مجاملة الموظّفين كانت ترضي	☐ موافقة ☐ غير متأكدة ☐ غير موافقة
21.		شعرت بأن الفريق الصحي عاملني بإنسانية	☐ موافقة ☐ غير متأكدة ☐ غير موافقة

.22		الفريق الذي كنت باتصال معهم كانوا ودودين	موافقة غير متأكدة غير موافقة
.23		يستجيب مقدمو الخدمة عندما يطلبون مباشرة	موافقة غير متأكدة غير موافقة
.24		ناداني الفريق باسمي	موافقة غير متأكدة غير موافقة
.25		شعرت بأنّني كنت مهمة	موافقة غير متأكدة غير موافقة
.26		كان الفريق يصغون لي باستمرار	موافقة غير متأكدة غير موافقة
.27	التعامل الشخصي والمعلومات	اخبروني كلّ شيء بصدق وصراحة	موافقة غير متأكدة غير موافقة
.28		استعمل الفريق عند شرحهم حالتي وعلاجي كلمات مفهومة لي	موافقة غير متأكدة غير موافقة
.29		شجعني الفريق على الاستفسار و لم يتغاضوا عن أسئلتي	موافقة غير متأكدة غير موافقة
.30		شرح الفريق ما أحتاج لمعرفته حول حالتي الصحية	موافقة غير متأكدة غير موافقة
.31		حصلت على الكثير من الدعم دائما	موافقة غير متأكدة غير موافقة
.32		حصلت على المعلومات الكافية حول القسم	موافقة غير متأكدة غير موافقة
.33		شرح الفريق بما فيه الكفاية حول ما كان يحدث؟	موافقة غير متأكدة غير موافقة
.34		شرح لي الفريق الفحوصات قبل إجرائها	موافقة غير متأكدة غير موافقة

35.		يوضح الفريق بعد إجراء الفحص حالتي الصحية	☐ موافقة ☐ غير متأكدة ☐ غير موافقة
36.		أخبرني الفريق عما يفعلون أثناء الفحص	☐ موافقة ☐ غير متأكدة ☐ غير موافقة
37.		زودني الفريق بمعلومات مستمرة حول تقدم عملية ولادتي	☐ موافقة ☐ غير متأكدة ☐ غير موافقة
38.	رعاية الأم الصحية	العناية التي تلقيتها أثناء ولادتي ناسبت احتياجاتي	☐ موافقة ☐ غير متأكدة ☐ غير موافقة
39.		كان عندي ثقة في الفريق الذي قدم العناية لي ولطفلي	☐ موافقة ☐ غير متأكدة ☐ غير موافقة
40.		تم نقلي من كشك الولادة الى القسم بطريقة حسنة	☐ موافقة ☐ غير متأكدة ☐ غير موافقة
41.		كان هناك توافق بين الفريق بخصوص العناية بي	☐ موافقة ☐ غير متأكدة ☐ غير موافقة
42.		المبلغ الذي دفعت يساوي الخدمات التي تلقيتها	☐ موافقة ☐ غير متأكدة ☐ غير موافقة
43.		لم أشعر بالأمان في المستشفى	☐ موافقة ☐ غير متأكدة ☐ غير موافقة
44.		كنت ضجرة جدا في المستشفى	☐ موافقة ☐ غير متأكدة ☐ غير موافقة
45.		يجب أن أستجدى لكي ينتبهوا لي	☐ موافقة ☐ غير متأكدة ☐ غير موافقة
46.		شعرت بأنني مهملة، لا أحد يهتم بي	☐ موافقة ☐ غير متأكدة ☐ غير موافقة

.47		أنا راضية عن الطريقة التي يعالجونني بها في المستشفى	☐ موافقة ☐ غير متأكدة ☐ غير موافقة
.48		دائما هناك مقدم خدمة عندما احتاج إليه	☐ موافقة ☐ غير متأكدة ☐ غير موافقة
.49		أنا مسرورة مع كيفية السيطرة على الألم	☐ موافقة ☐ غير متأكدة ☐ غير موافقة
.50		عندما احتجت إلى المساعدة في الليل، كان هناك دائما مقدم خدمة	☐ موافقة ☐ غير متأكدة ☐ غير موافقة
.51		كنت مسرورة من مستوى العناية بي بعد الولادة	☐ موافقة ☐ غير متأكدة ☐ غير موافقة
.52		شجعني الفريق على إرضاع الطفل فورا بعد الولادة	☐ موافقة ☐ غير متأكدة ☐ غير موافقة
.53	الخصوصية	حافظ الفريق على خصوصية كافية أثناء إجراء الفحوصات	☐ موافقة ☐ غير متأكدة ☐ غير موافقة
.54		كنت سعيده بعدد الفريق حولي أثناء الولادة.	☐ موافقة ☐ غير متأكدة ☐ غير موافقة
.55		تجهيزات وترتيب الوحدة معدة لتوفير خصوصية كافية.	☐ موافقة ☐ غير متأكدة ☐ غير موافقة
.56		يقتحم الزوار خصوصيتي دائما	☐ موافقة ☐ غير متأكدة ☐ غير موافقة
.57		يستأذن مقدمو الخدمة قبل دخول وحدتي	☐ موافقة ☐ غير متأكدة ☐ غير موافقة
.58	رعاية الطفل الصحية	أنا كنت مسرورة من مستوى العناية بطفلي	☐ موافقة ☐ غير متأكدة ☐ غير موافقة

59.		حصلت على النصيحة حول إرضاع الطفل	موافقة غير متأكدة غير موافقة
60.		حصلت على النصيحة حول نظافة الطفل	موافقة غير متأكدة غير موافقة
61.		حصلت على النصيحة المساعدة حول ترتيبات النوم للطفل الرضيع.	موافقة غير متأكدة غير موافقة
62.		عمل فحص لصحة الطفل الرضيع ونموه	موافقة غير متأكدة غير موافقة
63.		راضية عن العناية الصحية التي تلقاها طفلي الرضيع	موافقة غير متأكدة غير موافقة
64.	الاستشارة	حصلت على أجوبة مقنعة لأسئلتي	موافقة غير متأكدة غير موافقة
65.		حصلت على وقت كافي لمناقشة حالتي أثناء الاستشارة	موافقة غير متأكدة غير موافقة
66.		حصلت على النصيحة حول كيفية التعامل مع المولود	موافقة غير متأكدة غير موافقة
67.		حصلت على نصيحة جيدة حول كيفية الاعتناء بنفسي بعد الولادة	موافقة غير متأكدة غير موافقة
68.		حصلت على النصيحة حول موضوع تغذية طفلي	موافقة غير متأكدة غير موافقة
69.		تم إعطائي توجيهات حول الرضاعة الطبيعية	موافقة غير متأكدة غير موافقة
70.		حصلت على نصائح حول الأهمية للرضاعة الطبيعية الحصرية	موافقة غير متأكدة غير موافقة
71.		حصلت على إرشادات حول عناية الحبل السري	موافقة غير متأكدة غير موافقة

.72		حصلت على إرشادات حول أهمية التطعيم	☐ موافقة ☐ غير متأكدة ☐ غير موافقة
.73		نصحني مقدم الخدمة ان اعمل تمارين رياضية بعد الولادة	☐ موافقة ☐ غير متأكدة ☐ غير موافقة
.74		أرشدني مقدم الخدمة الى نوع وكمية الغذاء الجيد	☐ موافقة ☐ غير متأكدة ☐ غير موافقة
.75		أرشدني مقدم الخدمة حول وسائل تنظيم الأسرة	☐ موافقة ☐ غير متأكدة ☐ غير موافقة
.76	بيئة القسم	إن ردهة الأمومة بحالة جيدة	☐ موافقة ☐ غير متأكدة ☐ غير موافقة
.77		المراحيض كانت نظيفة	☐ موافقة ☐ غير متأكدة ☐ غير موافقة
.78		إن درجة الحرارة وتهوية غرفتي مناسبة	☐ موافقة ☐ غير متأكدة ☐ غير موافقة
.79		كان القسم نظيفا	☐ موافقة ☐ غير متأكدة ☐ غير موافقة
.80		كان القسم هادئا دائما	☐ موافقة ☐ غير متأكدة ☐ غير موافقة
.81		الأسرة مرتبة و نظيفة	☐ موافقة ☐ غير متأكدة ☐ غير موافقة
.82		القسم دائما مهيأ للراحة والنوم	☐ موافقة ☐ غير متأكدة ☐ غير موافقة
.83		ساعات الزيارة ليست كافية	☐ موافقة ☐ غير متأكدة ☐ غير موافقة
.84		خدمات الطعام جيدة	☐ موافقة ☐ غير متأكدة ☐ غير موافقة

85.	المشاركة في القرار	شاركت بالقرارات المتعلقة بعنايتي الصحية	☐ موافقة ☐ غير متأكدة ☐ غير موافقة
86.		أخذت ملاحظاتي ووجهات نظري ورغباتي بالحسبان	☐ موافقة ☐ غير متأكدة ☐ غير موافقة
87.		شعرت بأنني شاركت بالقرارات المتعلقة بالعناية الصحية أثناء ولادتي	☐ موافقة ☐ غير متأكدة ☐ غير موافقة
88.		تم احترام طلبي المتعلق بتخفيف آلامي	☐ موافقة ☐ غير متأكدة ☐ غير موافقة
89.		حصلت على مسكن للألم حسب احتياجي	☐ موافقة ☐ غير متأكدة ☐ غير موافقة
90.		شجعت على المشاركة في اتخاذ القرار المتعلق بوضعي الصحي	☐ موافقة ☐ غير متأكدة ☐ غير موافقة

91-عددي ماذا غير جيد حول خدمات الأمومة؟

1-

2-

3-

4-

92- عددي ماذا جيد حول خدمات الأمومة؟

1-

2-

3-

4-

93-عددي ماذا تود أن يتغير في خدمات الأمومة؟

1-

2-

3-

4-

Annex (8): Consent Form

طلب موافقة

أختي العزيزة:

أرجو التكرم بالإجابة على أسئلة الاستبيان الذي تم إعداده لجمع المعلومات اللازمة لتقويم خدمات الولادة في المستشفيات الحكومية بقطاع غزة.

يتم هذا البحث بالتنسيق مع وزارة الصحة وجامعة القدس، وذلك كمتطلب تخرج لإنهاء درجة الماجستير في صحة الأم والطفل.

إن تعاونكم وموافقتكم على المشاركة والإجابة على أسئلة الاستبيان سيكون له أهمية بالغة لإنجاز هذا البحث، وكذلك للارتقاء بخدمات الولادة في المستشفيات الحكومية بقطاع غزة..

كما أن المعلومات الخاصة بكم وبنتائج البحث ستكون في سرية تامة ولكم مطلق الحرية في المشاركة أو عدم المشاركة دون أن يكون هناك أي ضرر يلحق بكم في حال عدم المشاركة أو أي عائد مادي للمشاركة.

شاكرين تعاونكم

الباحث: خليل شعيب

.....

الرقم الرمزي:_____

إقرار شهادة

أشهد بأنني سأشارك في الإجابة على أسئلة هذا الاستبيان بمحض إرادتي بعد أن علمت بأن المعلومات ستكون سرية وأنه لن يلحق بي أي ضرر ناتج عن إجراء هذا البحث.

توقيع المشاركة:.....