

**Deanship of Graduate Studies  
Al- Quds University**



**“Married Female Satisfaction with Reproductive Health  
Services in Ramallah District at the West Bank of  
Palestine”**

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‘Married Female Satisfaction with Reproductive Health  
Services in Ramallah District at the West Bank of Palestine’

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**2011/1432**

## ***Dedication***

*To my late father, to my beloved mother, wife and children, dear brothers, sisters, friends and all who gave me help and support throughout my life.*

*Ayman Abu Muhsen*

## إقرار

أنا الموقع أدناه مقدم الرسالة التي تحمل العنوان:

مستوى رضا النساء المتزوجات من خدمات الصحة الانجابيه  
والمقدمة في منطقة رام الله. فلسطين

### **Married Female Satisfaction with Reproductive Health Services in Ramallah District at the West Bank of Palestine**

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### **Declaration**

**The work provided in this thesis, unless otherwise referenced, is the  
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## *Acknowledgment*

*I would like to express my special thanks to Dr. Mohammad Shaheen for his supervision, without his kind patient and endless support this work could not be achieved.*

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*At last, all my love to my family; their encouragement was my motivation to accomplish this work.*

## **Abstract:**

Reproductive health (RH) in a community compromise the main aspect of overall community health where patient satisfaction with this aspect contributes to increase the quality of the service provided and patient participation at his/her treatment.

The main aim of this study was to assess married female level of satisfaction with reproductive health care services provided at Ramallah district- Palestine.

The population of the study consists of all married females who seek reproductive health service from a reproductive health centers in Ramallah district. A total of 300 married females were targeted for the study and interviewed while existing from the centers, 30 of them were piloted and excluded from the study, a total of 248 female were responded from the rest 270 yielding to respond rate of 91.8 %.

A pre tested Likert five scale questionnaire were used, six domains of satisfaction were studied for satisfaction (quality of service, informativeness, accessibility to the centers, waiting time, gender sensitivity and privacy).

The results revealed a relatively high satisfaction (64.2% satisfied and 29% were strongly satisfied) with reproductive health service provided at Ramallah from different providers; Governmental, United Nations Relief and Work Agency, and Non Governmental Organizations.

Despite this evidence of satisfaction, the study results show that there are some leading factors of dissatisfaction attributed to a range of factors as; long waiting time to enter the examination room, gender of the service provider and privacy tools as; shutters, and screens, some of them are harder to control than others.

In relation to the type of provider, it was found that governmental organizations had the highest level of participant's satisfaction, followed by the NGOs which was ranked secondly, while the UNRWA had the lowest level of satisfaction. In addition, results revealed that centers located in villages and nearby the participants resident area had higher level of participant's satisfaction from the centers located in cities.

This relatively high satisfaction finding could be justified to the enhancements done on reproductive health services by different providers in the past few years while taking into consideration the sensitive needs of this type of services, and due to the competition and

general development all aspects especially in terms of coverage, fund raising, well trained human resources and quality dimensions.

From the results of this research, it is highly recommend to raise the community awareness regarding the importance of their reproductive health and to increase the number of resources and logistics to ease the access to reproductive health centers,. In addition, other recommendation should take place onsite as: reducing the waiting time before entering the exam room; the health practitioner to be from the same gender while delivering a reproductive health service, it was emphasized that all health staff have to introduce themselves before starting the reproductive health examination.

Staff caring and cooperation, the availability of privacy in addition to the service quality and specialized female staff are all considered to be very important factors in directing participants to the type of provider of a reproductive health service point to get the service from.

## List of contents:

Declaration.....	i
<i>Acknowledgment</i> .....	ii
Abstract:.....	iii
List of contents: .....	v
List of Tables: .....	x
List of figures: .....	xiii
List of appendixes:.....	xiv
List of abbreviations: .....	xv
Chapter One .....	1
1. Introduction .....	1
1.1 Background .....	1
1.1.2 The significance of involving consumers in improving health care systems:.....	2
1.2. Introductions to reproductive health .....	2
1.3 Reproductive health packages .....	4
1.4 Main health services providers in Ramallah.....	4
1.5 Statement of the problem.....	4
1.6 Justification of the study .....	5
1.7 Main aim of the study .....	5
1.8 Objectives of the study.....	5
1.9 Research questions.....	6
1.10 Research Hypothesis .....	6
1.11 Definition of Terms.....	7
1.11.1. Married Female: .....	7
1.11.2 Female’s satisfaction:.....	8
1.11.3 Reproductive Health: .....	8
1.11.4 Primary Health Care Services (PHC):.....	9

1.11.5 Ramallah district:.....	9
Chapter Two.....	10
Literature review .....	10
2.1 Historical review on Reproductive Health.....	10
2.2 Client's Satisfaction as an indicator for Service Quality.....	11
2.3 The MoH policy regarding Reproductive Health .....	12
2.4 Measuring of client's satisfaction .....	14
2.5 Previous Studies .....	16
Chapter Three: .....	22
The conceptual frame work .....	22
3.1. Introduction:.....	22
3.2. Female's satisfaction .....	22
3.3 Factors that affect patient satisfaction:.....	24
3.3.1 Quality of Health Services:.....	24
3.3.2 Clinical Care: .....	25
3.3.4 Interpersonal Care:.....	25
3.3.5 Continuity and Coordination of Care:.....	26
3.3.6 Waiting time: .....	27
3.3.7 Satisfaction and Accessibility:.....	28
3.3.8 Service Privacy:.....	30
3.3.9 Informativeness of service:.....	31
3.3.10 Gender sensitivity:.....	32
3.3.11 Acceptability of the service:.....	33
3.3.12 Availability of care:.....	34
3.3.13 Finance of the service:.....	34
3.3.14 Efficacy / outcome: .....	35
3.3.15 Convenience of the service: .....	35

3.3.16 Care Coordination and Continuity: .....	35
3.2 The conceptual framework .....	36
Chapter Four .....	37
Methodology .....	37
4.1 introductions .....	37
4.2 Method of the study.....	37
4.2.1 Study design: .....	38
4.2.2 Population of the study:.....	38
4.2.3 Study settings: .....	38
4.2.4 Sample Frame .....	39
4.2.5 Sample Methodology .....	39
4.3 Demographic Characteristics of the study population.....	40
4.3.1. Sample distribution according to provider type .....	40
4.3.3 Sample distribution according to client’s age: .....	42
4.3.4 Sample distribution according to number of visits to the center:.....	42
4.3.5 Sample distributions according to the time from the last visit: .....	43
4.3.6 Sample distribution according to place of resident: .....	44
4.3.7 Sample distribution according to marital status:.....	45
4.3.8 Sample distributions according to economic condition:.....	45
4.3.9 Sample distribution according to education level: .....	46
4.3.10 sample distribution according to participants working status .....	47
4.4 Data collection instrument.....	48
4.5 The framework of the questionnaire.....	48
4.6 Validity of the instrument .....	52
4.7 Piloting .....	52
4.8 Reliability of the instrument: .....	53
4.9 Selection and training interviewers .....	53

<b>4.10 Data entry and statistical analysis .....</b>	<b>54</b>
<b>4.11 Ethical consideration .....</b>	<b>54</b>
<b>4.12 Period of the study .....</b>	<b>55</b>
<b>4.13 Limitations of the study .....</b>	<b>55</b>
<b>Chapter 5.....</b>	<b>56</b>
<b>Results and findings.....</b>	<b>56</b>
<b>5.1 Introduction .....</b>	<b>56</b>
<b>5.2 Participant’s General Reproductive Health Issues .....</b>	<b>56</b>
<b>5.3 The services provided by the centers: .....</b>	<b>60</b>
<b>4 The reasons for participants to choose specific center to get the service from .....</b>	<b>68</b>
<b>5.6 Answering Research Questions:.....</b>	<b>70</b>
<b>5.8 Testing of the study hypotheses: .....</b>	<b>81</b>
<b>5.5.1 Results of hypothesis One:.....</b>	<b>82</b>
<b>5.5.2 Results of the second hypothesis: .....</b>	<b>84</b>
<b>5.5.3 Results of the Third hypothesis: .....</b>	<b>86</b>
<b>5.5.4 Results of the fourth hypothesis:.....</b>	<b>87</b>
<b>5.5.5 Results of the fifth hypothesis: .....</b>	<b>87</b>
<b>5.5.6 Results of the sixth hypothesis: .....</b>	<b>88</b>
<b>5.5.7 Results of the Seventh hypothesis:.....</b>	<b>90</b>
<b>5.5.8 Results of the Eighth hypothesis:.....</b>	<b>90</b>
<b>6.5.9 Results of the Ninth hypothesis:.....</b>	<b>91</b>
<b>Chapter Six .....</b>	<b>93</b>
<b>Discussion and recommendations .....</b>	<b>93</b>
<b>Introduction:.....</b>	<b>93</b>
<b>6.3 discussing Satisfaction domains.....</b>	<b>96</b>
<b>6.5 Summary and conclusion .....</b>	<b>105</b>
<b>6.6 Recommendations.....</b>	<b>106</b>

<b>References:</b> .....	108
<b>List of appendix:</b> .....	113
.....	143

## List of Tables:

<b>Tables No</b>	<b>Name of the tables</b>	<b>Page</b>
Table 4.1	Sample distribution according to type of provider	41
Table 4.2	Sample distribution according to working status	47
Table 4.3	The framework of the questionnaire	48
Table 4.4	The internal reliability of study dimensions	53
Table 5. 1	Years of married	57
Table 5.2	Having children	57
Table 5.3	Number of children	57
Table 5.4	Pregnancy status	58
Table 5.5	Pregnancy month	58
Table 5.6	Contraceptive use	59
Table 5.7	Type of contraceptive device	59
Table 5.8	The previous use of a contraceptive method	59
Table 5.9	Type of contraceptive used previously	60
Table 5.10	percentages of RH services provided by the targeted centers	61
Table 5.11	Percentages of services utility and usage during the Previous visit	61
Table 5.12	Participants satisfaction from the last visit to the center	62
Table 5.13	Reasons to choose this center to get RH service:	62

<b>Tables No</b>	<b>Name of the tables</b>	<b>Page</b>
Table 5.14	Way participants knows about the services in the center	63
Table 5.15	The person who deliver the service for participants	63
Table 5.16	Respect and privacy during delivering the service	64
Table 5.17	The age of the provider	64
Table 5.18	The waiting time to enter to the examination room	65
Table 5.19	The procedure time inside the examination room	65
Table 5.20	With which participants came to the center	66
Table 5.21	The distance to the center	66
Table 5.22	The way participants came to the service point	67
Table 5.23	Time taken to access the service point	67
Table 5.24	The value and its weigh in the research questionnaire	68
Table 5.25	Weighted average according to Likert Scale	68
Table 5.26	The importance of choosing the service from this center	69
Table 5.27	Means and S.D of Quality service for the participants	70
Table 5.28	Means and S.D of Informativeness for the participants	72
Table 5.29	Means and S.D of Accessibility for the participants	74
Table 5.30	Means and S.D of Waiting time for the participants	75
Table 5.31	Means and S.D of Gender Sensitivity for the participants	76
Table 5.32	Means and S.D of privacy for the participants	77

<b>Tables No</b>	<b>Name of the tables</b>	<b>Page</b>
Table 5.33	Participants general satisfaction level with service provided	79
Table 5.34	Satisfaction level with each provider	80
Table 5.35	correlations of dependant and independent variables	81
Table 5.36	L.S.D. test according to provider type	83
Table 5.37	L.S.D. test according to provider location	85
Table 5.38	L.S.D. test according to participant's place of residency	89

**List of figures:**

<b>Figure No</b>	<b>Name of the figure</b>	<b>Page</b>
3.1	Factors affecting patient satisfaction.	23
3.2	The conceptual framework of the study	36
4.1	The percentage of participants from different providers	40
4.2	Sample distributions according to location of provider.	41
4.3	Sample distributions according to client age.	42
4.4	Sample distribution according to number of visits to the same center.	43
4.5	Sample distributions according to the time from the last visit.	44
4.6	Sample distributions according to place of residency .	45
4.7	Sample distributions according to marital status.	45
4.8	Sample distributions according to economic condition.	46
4.9	The sample distribution according to education level.	47
5.1	The overall means of all study dimensions.	79
5.2	Satisfaction levels with each provider.	80

### List of appendixes:

<b>Appendix No.</b>	<b>Name of the Appendix.</b>	<b>Page</b>
Appendix 1.	RH packages indicated by Cairo conference, 1994	113
Appendix 2	Points Delivering Reproductive Health Services at Ramallah	114
Appendix 3	The Questionnaire in Arabic	117
Appendix 4	The Questionnaire in English	126
Appendix 5	Likert scale according to the means of all answers	135
Appendix 6	Tables and Figures of Different related data percentage	136

## **List of abbreviations:**

RH	Reproductive health
SRH	Sexual Reproductive
STDs	Sexually Transmitted Diseases
FP	Family Planning
FD	Family Doctor
Gov	Government/al
UNRWA	United Nations Relief and Work Agency
UNFPA	United Nations Family Planning Association
UNICEF	the United Nations Children's Fund
NGO's	Non Governmental Organizations
PBCS	Palestinian Central Bureau of Statistics Estimation
MoH	The Ministry of Health
PHC	Primary Health Care Center
WHO	World Health Organization
IUD	Intra Uterine Devices
MDGs	Millennium Developmental Goals
PRCS	Palestinian Red Crescent Society
PMPS	The Palestinian Medical Relief Services
PFPPA	Palestinian Family Planning and Protection Association
PAPFAM	The Pan Arab Population and Family Health Project
IRRRAG	International Reproductive Rights Research Action Group
UHCW	Union of Health Working Committees

HIV	Human Immunodeficiency Virus
LSQ	Leed Satisfaction Questionnaire
OLS	Ordinary Least-Squares
DHS	Demographic & Health Surveys
EU	Europe Union
COPE	Client-Oriented Provider Efficient
SBCC	Social and behavior change communication

## **Chapter One**

### **1. Introduction**

In this chapter the researcher will give a brief about some statistics related to the Palestinian population followed by showing the importance of involving consumers in improving health care systems. An introduction to reproductive health with main providers of this services in Ramallah followed by problem statement and justification of the study with the aim, objectives and questions as well as hypothesis of this research study.

#### **1.1 Background**

The number of the Palestinian population in the occupied territories was 3.935249 of which 50.8 are males and 49.2 are females (49% of females are in reproductive age 15-49 years). The pyramid of the Palestinian population shows that 42% of the population is under the age of 15 years old, and 3.1% are over 65 years old. The natural increase of the population (Population Growth) was 2.9%; the Crude Birth Rate is 29.6%, and the total fertility rate is 4.6 (Palestinian Central Bureau of Statistics PBCS, 2009).

Reproductive health (RH) is provided to the Palestinian population through five main providers of health care services which are; the Ministry of Health (MoH) with 693 Primary Health Care Center (PHC); 159 of them providing family planning services and 25 hospitals with 2917 beds. The second provider is The UNRWA; it operates 59 PHC facilities and one

hospital with 63 beds. The third provider is the nongovernmental organizations (NGOs); it operates 194 PHC and 30 hospitals. The fourth provider is the private for profit sector with 19 hospitals and 439 beds. The fifth and last is the Military services which covers all localities and two hospitals in Gaza with 72 beds (MoH report, 2009).

### **1.1.2 The significance of involving consumers in improving health care systems:**

There is a growing evidence of the links between consumer feedback, and participation in decision-making in individual care leading to improvements in health outcomes. Provision of services in line with the wishes and needs of patients is central to a human health care system. Society has long acknowledged the importance of the views of the public in developing every service provided to them.

In the case of the health care system, patients have been found to be aware of health issues to the extent that they have been described as "expert witnesses" to the health care process, so one of the significant trends in the development of modern healthcare is the involvement of patients / clients in the management of their care and treatment. Researchers found that consumer participation in health quality management has a number of pluses for health care systems. Consumer participation provides the basis of a dialogue between health systems and consumers about improving health systems services. It provides hospitals with information about the impact of hospital services on consumers and their lives and provides hospitals with information about short and longer term outcomes of hospital treatment. This means that hospitals are made aware of significant areas of dissatisfaction with care and it gives hospital staff gain new insights into how people perceive aspects of their care. On the other hand, it is more likely to lead to fewer complaints and enables hospitals to set priorities about areas of improvement that matter to consumers (Al Sharif, 2008).

## **1.2. Introductions to reproductive health**

Reproductive health (RH) is a state of complete physical, mental and social wellbeing and not merely the absence of reproductive disease or infirmity. Reproductive health deals with the reproductive processes, functions and system at all stages of life. (RH) is a universal concern

and a crucial part of general health and a central feature of human development from childhood to life end. The health of the new born is largely a function of mother's health, nutrition status and her access to health care (The WHO Cairo Conference, 1994). Several studies in anthropology, public health, and medical anthropology (PCI, 1996; Gonzales et al, 1997) show that women tend to talk little about their sexual lives.

Although women know that fertilization occurs through the union of the man's sperm with a fluid from the woman, and that this process occurs in the uterus, the majority does not know exactly how to avoid an unwanted pregnancy. Some women have heard of pills and injections for birth control, but they do not know where to get them or how they work. Abortion is seen as a way of limiting family size; the most frequent motive for it seems to be the difficulty of supporting one more child, rather than a reaction to social sanctions against single or young mothers (Salguero et al,- 2005).

In Palestine where high related indicators about RH are reported, there will be a need to increase reproductive health services by developing and working on a strict action plan to build on previous indicators and population culture to reach effective RH service facilities (Strategic Plan of the MOH, 2008-2010). Many of pregnancy and other sexual transmitted diseases occur in Palestine especially if we knew that 53% of Palestinian females terminate their education due to early marriage (PCBS, 2006).

Emulating the marketing world, where companies are always striving to improve the quality of their products to achieve customer satisfaction by getting feedback from the customer, health research has been conducted to look at what satisfies a patient. Lari and colleagues noted that patients' satisfaction is linked to the extent to which general health care needs are met. Subsequently satisfied patients are more likely to comply with treatment, take an active role in their own health care and continue using health care services. They concluded that satisfaction surveys could help identify potential areas for service improvement and help optimize health expenditure through patient guided planning and evaluation (Lari et al, 2004).Female's health satisfaction is considered a significant factor in determining the quality of their life; the females need of quality reflects the assessment of how females perceives the health care received, and this is manifested in the measurement of satisfaction (Van Den et al, 1977).

### **1.3 Reproductive health packages**

The WHO Cairo conference in 1994 redefined the concept of RH that allows for a comprehensive package of the service provided which should include; reproductive right, sexual and RH services, safe abortion services, urgent abortion needs, post abortion services and follow up and monitoring service (Sayej, 2008).( See appendix 1).

### **1.4 Main health services providers in Ramallah**

In Ramallah district there are five main Health Care Services Providers; the first provider is the MoH which operates one secondary and tertiary hospital now called (Palestine Medical complex) with 11 beds/1000 (MoH Annual Report 2009). Also MoH operates 50 PHC clinic distributed in the central and rural areas of Ramallah district, RH services are impeded within the different services provided by these hospital and clinics. The second provider is the UNRWA with seven PHC centers and a mobile clinic. Third is The Private sector with several specialized hospitals and clinics that provides specialized and hotel health services. Then the NGO's; many NGOs are so active in providing social and health services during the past decades and from the most known in Ramallah are: Palestinian Red Crescent Society (PRCS) with one hospital, five centers and a mobile clinic; The Palestinian Medical Relief Services (PMRS) with five centers and a mobile clinic; Palestinian Family Planning and Protection Association (PFPPA) with one center; Union of Health Working Committees (UHWC) with tow centers and a mobile clinic, and Other NGOs that provide limited SRH services and consultations in Ramallah; MUFTAH, SAWA, Women Studies Center (Women's Center for Psychological and Social Counseling (2008) 2008). See (appendix 2)

### **1.5 Statement of the problem**

In order to be able to improve the quality and quantity of female health services, the researcher realized that there is lack of data about the level of satisfaction among Palestinian females with reproductive health services provided in the governmental, UNRWA and NGOs sectors in the West Bank. This type of data can enrich the existing data needed to

form policies and programs. Thus obtaining data on how females satisfied with reproductive health services can help improve the quality and coverage of such services.

## **1.6 Justification of the study**

Patient satisfaction is an individual's state of being content with the care provided in the health system (Anderson et al, 1999). It is important for reproductive health care providers to get feedback from women regarding satisfaction with reproductive health services. There is a dearth of knowledge about patient satisfaction in Palestine (Al Sharif, 2008). Reproductive health is a critical component of female's health since it helps to promote their sexual, physical, social, psychological aspects of their well being (Changole, 2010).

Therefore allowing married females to participate in the decision making process of their RH issues through assessing their satisfaction of this services will enrich national information delivered to top policy makers allowing for better feedback. Obtaining data on how female's perception of reproductive health services can help improve and promote the quality and coverage of such services.

## **1.7 Main aim of the study**

The main aim of this study was to assess married female's level of satisfaction with reproductive health care services in Ramallah district in Palestine.

## **1.8 Objectives of the study**

1. To determine the effect of “the quality of the service provided” on the level of participants satisfaction with RH services.
2. To determine the effect of “Informativeness” of the service on the level of participants satisfaction with RH services.
3. To determine the effect of “accessibility to RH clinics” on the level of participants satisfaction with RH services.

4. To determine the effect of “waiting time” on the level of participants satisfaction with RH service.
5. To examine the effect of “gender sensitivity” in providing the service with the participants satisfaction.
6. To assess the effect of “privacy” on the level of participants satisfaction with RH services.
7. To explore the level of general satisfaction among participants in relation to different providers of RH services.

### **1.9 Research questions**

1. What is the effect of quality of service on the level of female’s satisfaction with RH services?
2. What is the effect of informativeness of service on the level of female’s satisfaction with RH services?
3. What is the effect of accessibility to service clinics on the level of female’s satisfaction with RH services?
4. What is the effect of waiting time on the level of female’s satisfaction with RH services?
5. What is the effect of provider's gender on the level of female's satisfaction with RH services?
6. What is the effect of privacy on the level of female’s satisfaction with RH services.
7. What is the general level of satisfaction among married females with governmental, UNRWA and NGOs reproductive health services and packages?
8. Is there a difference in the level of satisfaction among participants in relation to type of health care providers?

### **1.10 Research Hypothesis**

1. There is no significant difference at ( $\alpha \leq 0.05$ ) with the level of satisfaction among married female in Ramallah district related to type of service provider.

2. There is no significant difference at ( $\alpha \leq 0.05$ ) with the level of satisfaction among married female in Ramallah district in relation to location of provider.
3. There is no significant difference at ( $\alpha \leq 0.05$ ) with the level of satisfaction among married female in Ramallah district in relation to age of participants.
4. There is no significant difference at ( $\alpha \leq 0.05$ ) with the level of satisfaction among married female in Ramallah district related to number of visits to the clinic.
5. There is no significant difference at ( $\alpha \leq 0.05$ ) with the level of satisfaction among married female in Ramallah district related to duration from the last visits.
6. There is no significant difference at ( $\alpha \leq 0.05$ ) with the level of satisfaction among married female in Ramallah district related to participants place of residence.
7. There is no significant difference at ( $\alpha \leq 0.05$ ) with the level of satisfaction among married female in Ramallah district related to marital status.
8. There is no significant difference at ( $\alpha \leq 0.05$ ) with the level of satisfaction among married female in Ramallah district related to economic condition.
9. There is no significant difference at ( $\alpha \leq 0.05$ ) with the level of satisfaction among married female in Ramallah district related to the level of education.

## **1.11 Definition of Terms**

### **1.11.1. Married Female:**

Female: An individual of the sex which conceives and brings forth young, or (in a wider sense) which has an ovary and produces ova. Marriage legally, is a binding contract between the two parties that joins together their possessions, income, and lives. Marriage is recognized by the state, and the dissolving of the contract can only happen through the legal process of divorce.

Marriage is also an agreement between the man and woman. Husband and wife take certain vows, to love one another, to cherish one another, and to stay together through sickness and health, for better and for worse. This agreement includes sexual faithfulness, and a promise that each person will do what they can to make the other one happy. For some people, this agreement between man and woman takes the form of a covenant between not only the

couple, but God as well. Thus, many marriages are performed within the rites of various churches and religious institutions.

The meaning of marriage should be looked at from a sociological perspective as well. A marriage is the conduit by which children are born; a marriage provides both a mother and a father for the children. The family unit, the relationship between parents and child, are all based on the marriage relationship (<http://www.the labor of love.net> 11.3.2011).

In this research study this definition will include all married females who seek a reproductive health services from one of the primary health care centers related to MoH, UNRWA or NGOs at Ramallah district in the period between Jan to the end of March 2010.

#### **1.11.2 Female's satisfaction:**

Satisfaction is an individual's state of being contented or pleased with an event. Lari and colleagues defined patient satisfaction as the extent of an individual's experience compared with his or her expectations or what patients and the population as a whole desire to receive from health care services (Lari et al, 2004). Here female's satisfaction was assessed only through the next six domains; quality of the service, informativeness, privacy, gender sensitivity, accessibility, waiting time using Likert Scale 5 points to assess the exact level of satisfaction (Anderson et al, 1999).

#### **1.11.3 Reproductive Health:**

Reproductive health is defined by the WHO "as a state of physical, mental, and social well-being in all matters relating to the reproductive system at all stages of life. Reproductive health implies that people are able to have the capability to reproduce and the freedom to decide if, when, and how often to do so. Implicit in this are the right of men and women to be informed and to have access to safe, effective, affordable, and acceptable methods of family planning of their choice, and the right to appropriate health-care services that enable women to safely go through pregnancy and childbirth (WHO, 2000). In this study all RH facilities and clinics related to UN, NGOs and the government were the place to study and measure

females' satisfaction with RH domains; quality of service, informativeness, privacy, gender sensitivity, accessibility and waiting time.

#### **1.11.4 Primary Health Care Services (PHC):**

The Alma Ata Conference defines Primary Health Care as “essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally, accessible to individuals and families in the community by means of acceptable to them, through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part of both the country’s health system, of which it is the central function and the main focus and of the overall social and economic development of the community” (WHO report 2000,p.4). The WHO also provides goals to be achieved, strategies and principles to work through (WHO, 2000 p 5).

In this research study all PHCS who provides RH services are the targeted place where married females are consulted for participation. Governmental PHCC is the governmental Institutions that provide diagnostic and preventive health care at early stages such as various health centers. The Health Center is the location where primary health services are provided. It usually has a nursing team and a general practitioner with some specialized clinics and a laboratory. It provides mother and childcare with vaccines and other services such as health education. In this research study, all PHC that provides RH services at Ramallah district were the targeted setting for participants to fill the questionnaire.

#### **1.11.5 Ramallah district:**

Ramallah is located 10 kilometers (6 miles) north of Jerusalem and currently serves as the administrative capital of the Palestinian National Authority. The district had a population of 290,401 in mid-year 2006. Its governor is Dr. Ghannam Laila. The governorate has 78 localities including four refugee camps in its jurisdiction. Thirteen localities retain the status of a municipality (The Palestinian Central Bureau of Statistics PCBS, 2008). In the governorate there were 74 PHC from different kinds of providers, all provide RH services as a part of its mission at every health facility.

## **Chapter Two**

### **Literature review**

#### **2.1 Historical review on Reproductive Health**

In 1952, the (RH) program was started in the countries of the developing countries supported and funded by the Western countries including the United States of America (Women's Center for Psychological and Social Counseling (2008) 2008). In 1973, the First International Conference for Populations and Development was held in Rumania. In 1984, the second conference held in Mexico. In 1994, the third conference held in Cairo. The aim was not only controlling the increase in the population growth but also providing special services for women during their life stages supported by men. This conference comes out with direct recommendations to improve RH services all over the world and link that with time tables and percentages to be achieved. Females in reproductive age have special recommendations from this conference regarding their RH needs; information and preventive supplies such as condoms and consultations (Women's Center for Psychological and Social Counseling (2008), 2008).

The WHO and most of the world governments start to implement strategies and programs to meet the needs related to MDGs for reproductive health and youth services. This should include special features as suggested by the United States Society for Adolescent in 1992; to deliver effective services. These features are: accessibility (including affordability, convenience, visibility / service promotion), acceptability (responsiveness - adjusting for cultural, ethnic and social diversity, culturally appropriate services and confidential), quality

of care (timing, assessment, approaches used, treatment options, safety, monitoring and evaluation), coordination and continuity of care (ensuring comprehensive services are available on site or by referral) (Senderowitz, 2003).

## **2.2 Client's Satisfaction as an indicator for Service Quality**

The client satisfaction assessment could represent a part of a multidimensional approach for conducting a quality improvement intervention. This is particularly used in the client-oriented provider efficient (COPE) method, which is a process and set of tools designed to help health-care staff at a service delivery site to continuously assess and improve their service; to review the way they perform their daily tasks and serves as a services. It is built on a framework of client rights and staff needs. The method encourages staff catalyst for analyzing the problems they identify (Letaief, 2008).

Patient satisfaction is a useful measure to provide a direct indicator of quality in healthcare, hence needs to be measured frequently so that a domesticated and localized healthcare plan could be developed (Mahfouz et al 2007). User satisfaction is a very important part of any clinical practice therefore; it is imperative to consistently undertake surveys in the community or facility to introduce better services. Thus, patient's satisfaction is an important issue for evaluation and improvement of healthcare services. User evaluations educate medical staff about their achievements as well as their failure, assisting them to be more responsive to their patients' needs (Al-Badayneh, 2009).

In related work, the International Reproductive Rights Research Action Group (IRRRAG) conducted a seven-country study to assess women's perceptions of their reproductive rights in 1995. The IRRRAG project looked at four aspects of reproductive rights: the concept of entitlement; reproductive decision-making; resistance and accommodation; and social, political, legal and economic conditions (IRRRAG, 1994). The four questions asked by the research team were: 1) According to the perceptions of women, what are the conditions, norms and beliefs that give them entitlement in the personal, health and family arena, and what do they consider they are entitled to? 2) How do women make decisions throughout their life cycles regarding childbearing, contraception, abortion, marriage, motherhood and sexuality (including sexual identity)? 3) What are the forms of resistance and accommodation in regard to reproductive health and wellness that women practice and think possible? 4)

What are the social, economic, legal and political conditions and services (e.g., health, education) that affect women's decisions over their reproductive lives and rights, according to their experience and knowledge (Adair et al, 1997).

### **2.3 The MoH policy regarding Reproductive Health**

In Palestine the MoH accept and tried to implement the recommendations for enhancing RH services from WHO, especially the recommendations from the Cairo conference by the establishment of several departments to carry out RH responsibilities. One example is the Women Health Directorate that was established in 1995 to carry out all required needs and information regarding women health. This directorate is embedded within PHC services and facilities that are considered as the backbone of the Palestinian health system . In addition, the Mother and Child Directorate and the family planning program were established in 1997, and other educational programs, workshops and publications. The MOH has emphasized the importance of the development of community – based and culturally sensitive interventions to promote RH education on its first National Strategic Plan in 1993, and until now there has been substantial work in more integrative and comprehensive manner between the MoH and other local and international organizations on activities related to RH supported by WHO, UNFPA and UNICEF. But utilization of such service packages has remained quite problematic in Palestine because of the restricted social climate, the political atmosphere, accessibility to services and other factors. For example, the gender shortage of practitioners in reproductive health care affects care provision because of limited number of female physicians (8% of total physicians) and shortage of midwives (1.4 to 10.000). Sixty two percent of Palestinian youth did not have any idea about the concept of RH (the Palestinian youth survey, 2006). However, 55% of married women use at least one method for family planning; the IUDs are the mostly used.

Fertility rate is 4.6 which is considered the highest in the region. There are high rates of maternity deaths among Palestinian women in the reproductive age which, necessitates the foundation of a 'National Committee' from all health care providers and other organizations with specific objectives directed towards reducing this indicator in Palestine according to the 5th MDGs goals(MoH report, 2007).

Locally there is a need to pay serious attention to the importance of RH due to the results of the survey held by the Palestinian Central Bureau in 2007; researchable indicators regarding RH seems to be of significant are Low percentage of the youth who know about sexually transmitted diseases.

Data show that only 8% of the 15 to 29 years old youth know about at least three sexually transmitted diseases (STDs). High rates of women's use of intrauterine devices (IUD) and pills and IUD is the most widely used family planning methods in Palestine with 29.2% of females in the West Bank; Pills rank second with. Postnatal care is still the weakness point in women reproductive health services: In spite of the increase in postnatal healthcare over the past ten years, coverage has not reached the required level.

According to recent data from PAPFAM, only 30% of Palestinian women are managing to reach hospitals to deliver their babies in a timely manner. In addition to the high rate of cesarean section where a total of 15% of births in Palestine are delivered via cesarean section with high coverage of antenatal care, however, quality of such care is questionable according to Palestinian Family Health Survey data, 98.8% of pregnant women received antenatal care services by a qualified professional, with no variations by region and governorate. In spite of the high coverage of antenatal care services, it remains unclear what deters women from seeking services at MoH facilities as only 15% of antenatal visits are done at MoH clinics compared to 65.0% in the private sector. High rate of safe professionally overseen deliveries but access to the service remains a serious challenge. Data indicate that 97.0% of deliveries occurred under safe conditions with Gaza Strip registering the highest rates with no significant variations between governorates. The improved maternal health with maternal mortality ratio was 70-80 maternal deaths per 100,000 births (PCBS. 1995).

Data released later by the MOH indicate that MMR has decreased to 37.3/100,000 in 1997 and then slightly increased in 42/100,000 in 1998. In addition there is a need to promote gender equality and empower women "When a country educates its girls, its mortality rates usually fall, fertility rates decline, and the health and education prospects of the next generation improve" (World Bank). In Palestine, gross enrolment rates in secondary education vary in favor of females especially in Tubas and Bethlehem governorates. The underweight rate indicates to a significant indicator for measuring the prevalence of severe malnutrition rates. Though a drop in underweight rates occurred between 1996 and 2000, the

rates climbed in 2004 and dropped back in 2006 reaching a national rate of 2.9%. In relation to Maternal Mortality Rate (MMR) in Palestine data shows that 104/100,000 of life delivery for mothers whose ages between 15-19 years and 66/100,000 for women aged 25-29 years. Finally low percentage of female's health workers: only 8% of all governmental physicians are female doctors, and 34% of nurses are females (PCBS, 2007).

## **2.4 Measuring of client's satisfaction**

Satisfaction is defined as a psychological state resulting when the emotion surrounding disconfirmed expectations is coupled with consumer's prior feelings about the consumption experience (Abdel Al Kareem et al, 1996).

Patient satisfaction has become an important indicator of quality of primary care and health care performance. Patient satisfaction with health care is important for several reasons. Firstly, satisfied patients are more likely to maintain consistent relationships with their care provider. Secondly, by identifying source of dissatisfaction, the primary care administration can address system weakness, thus improving their services. Thirdly, satisfied patients are more likely to develop a deeper and longer lasting relationship with their medical provider leading to improved compliance, continuity of care and ultimately better health outcomes. It is reported that low patient satisfaction is associated with lower trust in caregivers and greater chance of physician changes resulting in less continuity of care, while, high patient involvement in care has been associated with higher trust and satisfaction. Patients' satisfaction surveys have a long history in the assessment of consultation and patterns of communication and are amongst the best means of assessing the interpersonal aspect of care. Many studies measuring patient satisfaction with primary health care services have been conducted in many countries with a wide range of methods used; questionnaire with Likert scale has been accepted as the simplest method (Abdel Al Kareem et al, 1996).

The importance of satisfaction with RH services is to shade lights on this service globally due to dangerous indicators of women's reproductive health as presented by the WHO reports; 40 million undesired pregnancy cases ended into abortion. Eighty seven thousands of women die yearly due to unsafe abortion conditions; 75 million pregnant cases happen without any planning which will affect women and child health; 1600 women die per day from pregnant and maternal complications. One million cases are affected by sexual transmitted diseases per

day, of which 1600 HIV cases. RH services in developing countries are not adequate, unavailable, or have bad quality. One woman from three was raped mostly by a known person. Two millions girls are circumcised every year. By the name of Family Honor, 5000 women and girl killed yearly, 960 million persons in the world who don't read or write; two third of them were women (Women's Center for Psychological and Social Counseling (2008), 2008).

Several domains of satisfaction emerged from the literature. Informativeness, waiting time, competence, and overall quality were reported by Staniszewska as the most common studied satisfaction dimensions (Changole, 2010). Other researchers add suggested eight dimensions of satisfaction including; interpersonal manner, technical quality, finance, accessibility/ convenience of service, efficacy/ outcome, continuity, physical environment/ facilities and availability (Jacox, et al2000).

Approaches to measure satisfaction vary from short standardized questionnaire to structured and semi-structured interviews resulting in qualitative information. Questionnaire were preferred by several researchers as it saved time, helps to achieve high response rate, facilitate the process of filling the questionnaire to illiterate respondents and limits the interviews effect. Validation of the instrument is an important issue. Whenever the instruments measure what they are designed for, their reliability coefficient is supposed to be high and the result could be interrupted with the maximum level of accuracy (Fagerstrom et al, 2000).

Several studies about client's satisfaction concentrated on the methodological issues and discussed the problems and the advantages of such a methodology. Ricketts (1996) denoted the problems that had been identified by Lebow (1982) in three main areas, including the development of the instrument without any report of validation, sample selection bias, and lastly the high level of satisfaction that had been reported in many studies and were not compared with the results in the other centers in addition to having the measurements not reported over time.

Few satisfaction instruments approved their validity as Hill (1997) mentioned. He donated that the already developed instruments were used to measure satisfaction with care provided by either the physicians or by the nurse. He mentioned that it is appropriate to develop a new

specific instrument to measure patient satisfaction in nurse-led rheumatology clinics, and to be used in both the medical and nursing clinics. Therefore the Leed Satisfaction Questionnaire (LSQ) was developed to fulfill important criteria including easy completion, no too time consuming, sensitive to change, valid and reliable. The LSQ shown to be both reliable and stable (Hill, 1997).

Fitzpatrick found that there are three reasons why health professionals should take patient satisfaction seriously as a measurement: Firstly, there is convincing evidence that satisfaction is an important outcome measure. It may be a predictor of whether patients follow their recommended treatments, and is related to whether patients reattend for treatment and change their provider of health care. Evidence has also begun to emerge that satisfaction is related to improvements in health status. Secondly, patient satisfaction is an increasingly useful measure in assessing consultations and patterns of communication (such as the success of giving information, of involving the patient in decisions about care, and of reassurance). Thirdly, patient feedback can be used systematically to choose between alternative methods of organizing or providing health care (such as length of consultation or arrangements for out of hours care). Also the increasing cost of the health services and the need for better use of available resources is a concern for healthcare providers. So that there is a need to measure the efficiency of health care to determine if proper use of available resources is being made (Al Sharif, 2008).

## **2.5 Previous Studies**

### **2.5.1 Bleich et al, (2009):**

In 2009 a research paper was published and done by Bleich et al that focuses on the EU, given the similarity in health outcomes among EU member countries and the relevance of consumer satisfaction to quality of care reforms in that region. Twenty one EU countries for which data were available in the World Health Survey for 2003, the survey was conducted by face-to-face interviews in all countries except Luxembourg, where it was conducted by telephone. Survey respondents were chosen through stratified, multistage cluster sample and interviewed in the national language. Sample size varied by country. A series of additive Ordinary Least-Squares (OLS) regression models to evaluate the extent to which variables commonly associated with satisfaction with the health-care system explained observed variation in satisfaction. The study recommends more research to be done to understand the

determinants of satisfaction with the health-care system; particularly the broader societal factors that cannot be explored in this analysis. Information may be obtained by interviewing patients as they exit their health-care provider's office like the one in this study, or by visiting patients in their homes soon after they interact with the health-care system, or by conducting a survey of representative households. No single approach is ideal, but their combined results may prove most useful for advancing the knowledge base surrounding satisfaction with the health-care system. Cost and efficiency concerns and rising consumerism will probably lead to increased use of satisfaction surveys in the future.

### **2.5.2 AL-shareef, B. (2008):**

In 2008 a study conducted in Nablus, Palestine with the objectives was to measure patients' satisfaction with services provided by hospitals at Nablus city. Factors affecting patient's satisfaction including room services, staff communications skills, physicians' explanations, technical quality of health care providers, waiting time, and availability of health services. The study aims at determining the differences of satisfaction according to socio-demographic characteristics (age, gender, income, marital status, and education level). A cross sectional study was conducted at Nablus hospitals (governmental and non-governmental), from January to March, 2008, to measure patients' satisfaction with services provided at Nablus hospitals, and to determine factors affecting patients' satisfaction including room services, technical quality and interpersonal skills of health care providers, accessibility and availability of services. A total of 365 adult inpatients were chosen randomly by a stratified random sample were interviewed using a comprehensive questionnaire to rate the level of satisfaction of services received on 5- point Likert Scale. The patients in non-governmental hospitals were more satisfied than patients in governmental hospitals. About 70.2% of respondents rated their general satisfaction with governmental hospitals as good to very good. While in non-governmental hospitals, more than 90 % rated it as good to very good. The results also indicated that older patients were more satisfied than the younger ones; females were found more satisfied than males. In addition to this, patients with high income were more satisfied than others with low income. Also healthier patients were more satisfied than sicker patients. However, patients who were waiting long time (more than one hour) in the reception area to get a bed in the hospital, were less satisfied than the others; obstetric patients were found to be the most satisfied.

### **2.5.3 Nanbakhsh H. et al, (2008):**

In the Islamic Republic of Iran a study done in Urmia University of Medical Sciences with satisfaction level of reproductive health services were 92% and in rural areas of Urmia showed 94% satisfaction. In Tonkabon the majority of the study group was satisfied with the reproductive health services. Other Research carried out in rural women in Bali Indonesia showed 73.1% of respondents were satisfied with women's health services available in their area and 94.5% of ever-users of contraception were satisfied with family planning services (Nanbakhsh et al, 2008).

### **2.5.4 Gadallah et al, (2003):**

In 2003 the Eastern Mediterranean published a research study done at Egypt. The study compares patient satisfaction with primary health care services and identifies factors associated with patient satisfaction in two health districts in Egypt where a project for upgrading primary health care services had been running for three years. An exit interview was conducted for 1108 patients using a structured questionnaire. The results revealed that most clients using primary health care services were females. Patient satisfaction was high for accessibility, waiting area conditions and performance of doctors and nurses. The main complaints centered on the availability of prescribed drugs and laboratory investigations. Additionally, level of privacy in the consultation room was described as unsatisfactory by 33% of patients. There was no association between overall patient satisfaction and age, gender, education level or type of service received.

### **2.5.5 Shaheen M. et al, (2001)**

In 2001 dissemination of result of The Special Studies Program which was implemented as part of the Pilot Health Project in the West Bank and Gaza, the results of six special studies were supported under the program on a competitive basis, topics including male involvement in reproductive health, clients' satisfaction with family planning programs, the relationship between early marriage and the delivery of premature infants, factors affecting compliance for iron supplementation, and diabetes mellitus during pregnancy. Both the men and women in these studies reported that they were generally satisfied with the quality of family planning services they received at UNRWA and MoH clinics. The client satisfaction study revealed

that about one out of four women (23%) expressed dissatisfaction with the quality of family planning services provided at UNRWA and MoH clinics.

#### **2.5.6 Lodz, P(2004):**

In a study done at a health centre in Mzalawi looking at quality of care and its effects on utilization of maternity services at a primary level, a high degree of satisfaction was noted among patients with providers' attitude (97%), technical competence (86%), and working hours (91%). However, they expressed dissatisfaction with lack of privacy (Lule et al, 2000). Quality of the service considered as the central role and a main indicator of client's satisfaction with the service provided.

#### **2.5.7 Women's Center for Psychological and Social Counseling, (2008)**

A series of studies regarding RH services in Palestine were conducted with various types of results and recommendations; In 2008 "Women's Center for Psychological and Social Counseling (2008)" directory which is published by the Palestinian Women Center in Ramallah indicates that's there is shortage in providing RH services while concentrating on therapeutic services. Youth, adolescents and singles needs are neglected. There is a shortage of female's workers in the health teams. There are also shortages in maternity services. In addition, there are inadequate researches regarding women's health. Infertility issue is not on public health provider's agenda, Low levels of reproductive and psychological consultations, lack of adequate health rights knowledge between health professionals.

In 1996 a study by Abu Hwaiig indicated a discrepancy in the definition of RH amongst providers, recipients and targeted clinic region. At the same year, The Women's Coalition and Birzeit Community Health Unit disseminated the results of 1793 women interviews which reveal that 82% of them preferred to receive of the health care service from a professional of the same sex. In 1997 two studies using focus groups were carried out by The Palestinian Family and Protection Association (PFPPA); results indicates minimal understanding of reproductive and sexual health attributes in men due to lack emphasis in the media and school curricula, and lack of knowledge of laws related to sexual and RH.

In 2002 a study conducted by Al-Quds university in cooperation with the MOH recommends that counseling women and men about aspects of RH care needs and to be emphasized as an integrated component of the RH programs. Training of health care providers and further research on RH services are other recommendations.

### **2.5.8 MoH concerns about Reproductive Health**

The MoH concerns about RH were started since the first NSP in 1993 with several editing, updating and developments on the RH service management, delivery and programs. Special directorates were established in the MoH to ensure specific and quality service as women health directorate, family planning department, and mother and child health. The services were extended through 412 PHC of which 115 MoH facility that provide direct RH services distributed in the urban and rural localities in Palestine (MoH annual report 2008).

While universal access to quality reproductive health services has been articulated as the overarching goal in Palestine, certain disturbing factors continue to negatively affect achieving this goal: Existence of poverty pockets in the West Bank and Gaza with the spread of some isolated communities in remote areas of the West Bank. Closures, checkpoints and the Separation Wall resulting in physical challenge to accessibility and consequently compromising basic services such as safe institutional delivery. Duplicated healthcare systems and lack of coordination leads to severe waste of resources, Challenges related to logistics system and equitable distribution of services and resources at the level of public health services system. Data also show that 96.5% of infants in the same age group had completed their vaccination schedule according to Palestinian Unified regimen. This regimen constitutes of one dose of tuberculosis, three doses of polio, three doses of DPT and measles. The work of the Palestinian Authorities and UNRWA in creating a national immunization program that ensures universal coverage for all the under three children, expanded health education programs, and an increase in the number of maternal and healthcare centers were the key elements of this success. Ministry of Health (MoH) and UNRWA records show that respiratory tract diseases, congenital anomalies and premature birth have been the leading causes of infant and under five deaths since at least 1990-1994 (MoH annual report, 2008).

The MoH on its annual report of (2009) indicated that in Palestine there are 693 PHC centers (of which 435 MoH), and 76 hospitals (of which 24 are MoH); The Crude Death Rate was 4.4/1000, Crude Birth Rate 32.7/1000. Infant Mortality Rate was constant over the last few years with no significant change from 2000 to 2008 report and it was 25.3/1000 (UNFPA). Fertility Ratio was 4.6 per woman. The MoH reported figures shows that 22.2% of the total population is females at reproductive age. The main contraceptive method used in Palestine was Pills followed by IUDs the main reason for choosing the site to receive contraceptives was the quality of services provided (85.2%) followed by having a female provider (67.3%) (PCBS, 2004 surveys). 98%of deliveries are in health sector (of which 48% in MOH). All previous researches provides data and statistics about RH service provision and service delivery which shows high rates of morbidity and mortality related to mother, neonatal, infant and child health status(UNFPA).

This research study is the first in Ramallah that will try to introduce information about female's satisfaction of these services since married youth females considered being the most beneficiaries of RH services and constituting a high proportion of the Palestinian population and are considered the future of Palestine. Further, adult health is greatly related to the health and lifestyles during youth, such as chronic diseases and cancer. Early marriage and early pregnancy in Palestine have been consistently high and not changing (UNFPA, 2006).this research will be the first that tried to study the range and integration of females reproductive health service in Ramallah, which is an important initiative to ensure an enabling environment to females to become socially engaged and minimize the possibility of high risk behaviors. Without such services, female's ability is greatly compromised.

A new related subject have strong correlation with RH emerged from new studies; Youth Friendly Services which is generally recommended to be supportive, respectful, effective, accessible, sensitive, sufficient, convenient, ensure privacy, empowering, gender sensitive, equitable and of high quality. Services should be comprehensive enough to promote youth health and well being (physically, emotionally, psychologically, socially and spiritually), protect them from harm and address their unmet needs (UNFPA, 2008).

## **Chapter Three:**

### **The conceptual frame work**

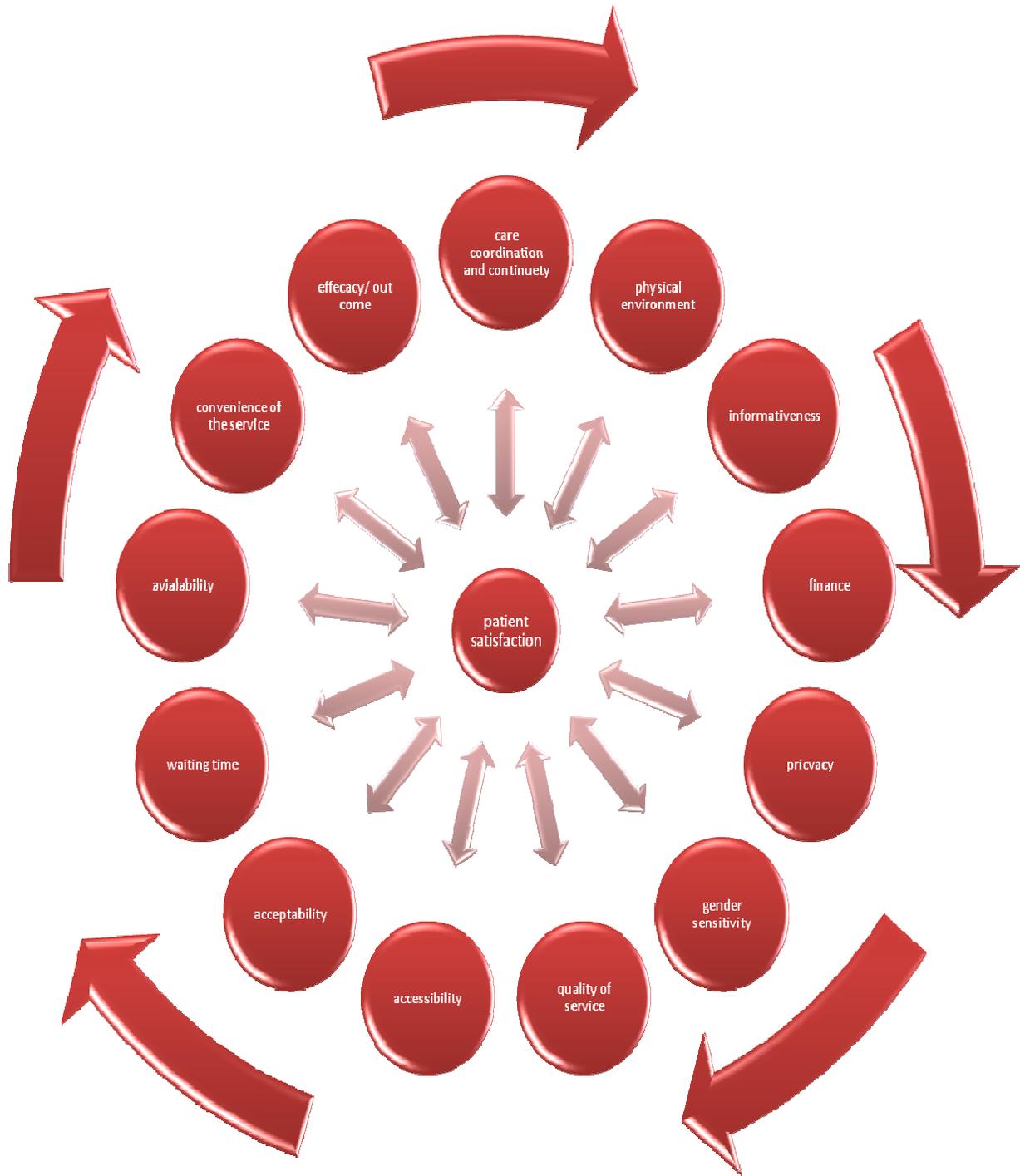
#### **3.1. Introduction:**

The main aim of this study was to assess level of satisfaction among females with RH services at Ramallah district. According to previous studies and the WHO recommendation, there are several domains of satisfaction from health care entities that were discussed in the previous chapter. In this research study only six domains of satisfaction were assessed; the quality of service, Informativeness, accessibility, privacy, waiting time and gender sensitivity while providing the service.

#### **3.2. Female's satisfaction**

Satisfaction is an individual's state of being contented or pleased with an event. Lari and colleagues defined patient satisfaction as the extent of an individual's experience compared with his or her expectations or what patients and the population as a whole desire to receive from health care services (Lari et al. 2004). Here female's satisfaction was assessed through the next six domains; quality of the service, informativeness, privacy, gender sensitivity, accessibility, waiting time using Likert Scale 5 points to assess the exact level of satisfaction (Anderson et al 1999). Female satisfaction will be measured in this study through self developed based on valid and reliable pretested national questionnaire that will contain related questions according to the local culture and the national needs of related indicators, then to be

analyzed by expert. Questionnaire with Likert scale has been accepted as the simplest method (Gadallah, 2009).



**Figure 3.1 factors affecting patient satisfaction**

### **3.3 Factors that affect patient satisfaction:**

#### **3.3.1 Quality of Health Services:**

Quality in health is about care and caring. Quality of care can be defined as “the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge”, it has also been defined as “the totality of features and characteristics of a service that bear on its ability to satisfy a given need”(Shaikh et al, 2008, 14).

The World Health Organization (WHO) emphasized the importance of quality in the delivery of health care, as defined by the criteria of effectiveness, cost and social acceptability. The impact of quality management and quality interventions emerged in several studies and had shown the central role of client's satisfaction as an indicator for the quality improvement (WHO 2000). Brown et al(2008) described nine quality dimensions of health service delivery: effectiveness, efficiency, technical competence, interpersonal relations, and access to service, safety, continuity and physical aspects of health care in addition to the physical environment and integration of the service (Hindi, 2002).

In related programs different kinds of sexual and reproductive health (SRH) and HIV services or operational programmes that can be joined together to ensure and perhaps maximize the quality of collective outcomes. This would include referrals from one service to another (UNFPA, 2009). In a study done at a health centre in Mzalawi looking at quality of care and its effects on utilization of maternity services at a primary level, a high degree of satisfaction was noted among patients with providers' attitude (97%), technical competence (86%), and working hours (91%). However, they expressed dissatisfaction with lack of privacy (Lule et al, 2000). Quality of the service considered as the central role and a main indicator of client's satisfaction with the service provided (N. Al Emadi, 2009).

Targeted females will show their level of satisfaction with quality of the service in this study in relation to their general expectations from the service and what they receive, about solutions and treatment introduced to solve their problem, clinical instructions was clear and easily understood, staff was courteous, caring and appreciating during service provision, the staff didn't keep them waiting long time, individual attention was given, staff were helping

when needed, the center had good reputation, the importance of the accreditation of the staff, the cleanliness of the clinic and instruments used.

### **3.3.2 Clinical Care:**

In the 1990s, the WHO primary programs focus was on integrating RH prevention and care with FP programs. Syndromic RH management was developed by WHO as a way of diagnosing and treating RH diseases in low-resource settings where laboratory equipment was not available. This approach is now considered inefficient for the management of other diseases in women, in terms of both clinical efficacy and cost-effectiveness (Maggwa, et al 2006). Despite advances in scientific diagnostics for RH, the focus for integrated programs has shifted to HIV prevention and care. Virtually no new data have been published on other approaches to RH care in integrated services, and those that exist give inconclusive evidence about quality of care (Odeh et al, 2005).

Despite significant attention to HIV-transmission prevention and care in recent years, evidence of quality of care following the integration of HIV services with SRH care remains weak. A study from the Dominican Republic suggests that improved counseling has positive effects on ART adherence (IPPF 2006), and two similar studies conducted in Kenya and South Africa found improvements in FP quality of care following service integration, although in both cases the intervention involved a specific training component aiming at improving quality. In light of the potential for a specialized approach to offer higher quality of care, the lack of comparisons between integrated and specialized services in terms of quality makes drawing conclusions difficult (Bérengère de Negri et al, 2007)).

### **3.3.4 Interpersonal Care:**

Effective interpersonal communication between health care provider and client is one of the most important elements for improving client's satisfaction, compliance and health outcomes. Patients who understand the nature of their illness and its treatment, and who believe the provider is concerned about their well-being, show greater satisfaction with the care received and are more likely to comply with treatment regimes (Juzoor, 2009)

Despite widespread acknowledgement of the importance of interpersonal communication, the subject is not always emphasized in medical training. Over the past 30 years, substantial investments have been made to enhance access to basic health services in developing

countries. However, there have been relatively few studies that investigate the quality of the services delivered, and fewer still that study the quality of interpersonal communication. The quality of care research that has been done shows that health counseling and provider-client communication are consistently weak across countries, regions and health services (Bérenghère de Negri et al, 2007).

Even when providers know what messages to communicate, they do not have the interpersonal skills to communicate them most effectively. They often do not know how to communicate with their patients. Despite widespread acknowledgement of the critical importance of face-to-face communication between client and provider, there are few rigorous studies of health communication in developing countries (Bérenghère de Negri et al, 2007).

Little evidence has been found that sheds light on the influence of service integration on the quality of interpersonal care or on how interpersonal care can influence the success of integrating RH care with FP services. Nevertheless, a growing body of evidence suggests a positive benefit from including sexual health counseling within RH programs and the need for intensive training and reorientation of staff to improve their skills to undertake this counseling (Abdel-Tawab et al, 2002).

### **3.3.5 Continuity and Coordination of Care:**

Fan et al (2004) found that continuity of care is strongly associated with higher patient satisfaction. This suggests that improving continuity of care may improve patient satisfaction with providers as well as with their health care organization. Dehne and his colleagues (2000) found that services rarely offered clients of RH treatment on site or provided them within the same visit or from the same provider who supplied FP services, even in settings where staff had been trained in syndromic management (Fan et al, 2004). Another South African study found that although providers reported greater continuity of care and reduced duplication of care following service integration, disjointed provision of services remained; clients in four out of eight facilities had to wait in separate lines for different services (Fan et al, 2004).

HIV-infected clients of integrated RH services in Brazil and Ethiopia reported their frustration at the poor coordination of care and the limitations of providers in addressing their holistic health needs (UNFPA 2006). Participants in this qualitative study reported that they often rely on (or would prefer) specialized HIV centers, but they also reported gaps in the provision of

comprehensive RH services in the specialized centers, which necessitate referrals to a reproductive health center. Wilson (1992) noted that continuous quality improvement insists on that "client is the king". He attributes the success of British Quality Assurance to the enrolment of the client in the quality management. The impact of quality management and quality interventions emerged in several studies and showed the central role of client's satisfaction as an indicator for the quality improvement. Marilyn (1996) argued that there are two goals of Total Quality Management, they are: the enrichment of the professionals-patients relationships, and customer satisfaction. It became consider that the indicators of client's satisfaction, professional satisfaction and quality improvement were positively interrelated (Imanaka et al, 1996).

Several studies were conducted as an evaluation and follow-up of client's satisfaction as basis for treating and improving services. A study was conducted by Eva et al (1996) to explore the role of patient's satisfaction survey in measuring health care outcomes. The socio-demographic characteristics of 960 surveyed patients were collected. In addition, the accessibility of the service, changes in patient health status and patient's opinion about the efficiency of the care were analyzed. The results showed that 72.3% of the patient's health status was improved. The majority of the patients needed home care.

### **3.3.6 Waiting time:**

Review of the literature indicates that's waiting time is considered a main factor in determining the level of satisfaction among clients of different health services (Mahfouz, et al 2007).

Several studies have identified prolonged waiting times as the main component of patient dissatisfaction, as well as the most frequent reason patients leave before medical evaluation(Hindi, F. 2002) . Many of these patients are seriously ill. Mohsin et al (2005) addressed the association between selected socioeconomic characteristics of Australian emergency patients with waiting times. Goodacre and Webster from the United Kingdom concluded that the time of presentation was the most powerful predictor of the waiting time to see a doctor (Hindi, F. 2002).

In 2008, a study conducted in Nablus, Palestine with the objectives were to measure patients' satisfaction with services provided by hospitals at Nablus city, patients who were waiting long time (more than one hour), were less satisfied than the others, while obstetric patients were found to be the most satisfied (Al-Sharif B, 2008).

In 2003, the Eastern Mediterranean published a research study done at Egypt; the study compares patient satisfaction with primary health care services and identifies factors associated with patient satisfaction in two health districts in Egypt where a project for upgrading primary health care services had been running for 3 years. Patient satisfaction was high for accessibility, waiting area conditions and performance of doctors and nurses (Mahfouz et al, 2007). However, these studies were done in areas where there were large integrated health care systems already established, unlike in Palestine where patients do not necessarily have an identifiable primary care provider. Additionally, the Palestinian population has unique cultural and linguistic features that are not present in other studies.

Reducing waiting time was the greatest issue required to be improved upon the respondent's recommendations resulting from all reviewed studies such as a study on patient's satisfaction at health centers in West India by Singh, Mustapha et al (1996). Another study conducted by Kersnik (2000) on 2160 patients with the aim of measuring their satisfaction with health care services in Slovenia, the study shows that's the poorest rating with their satisfaction was the waiting time in the waiting room (Mahfouz et al, 2007).

It is the time that the client waits inside the center starting from beginning of registration until the moment of entering the examination room (Hindi, F. 2002)?

In this research study women were asked about the following questions to assess their level of satisfaction with waiting time: Waiting time in the registration area, waiting time in the waiting area of the clinic, waiting time inside the clinic and during the procedure, the overall time during receiving the service.

### **3.3.7 Satisfaction and Accessibility:**

Accessibility is the possibility of the patient obtaining the services he/she needs at a time and place where he/she needs it, in sufficient amounts, and at a reasonable cost; Geographic,

Demographic and affordability (UNFPA, 2009). Accessibility can be viewed as the "ability to access" and possible benefit of some system or entity, accessibility have many dimension of which is the ability to access health services by minimizing the barriers of distance and cost as well as the usability of the interface. In many countries this has led to initiatives, laws and regulations that aim toward providing universal access to the health systems at reasonable cost to citizens (UNFPA, 2009).

Other Barriers to accessing services were stated by literature: Socio-demographic factors, Race/ethnicity factors, knowledge, and beliefs factors (understanding and acceptance of mental health problem, individual beliefs about help-seeking, knowledge of services, fears about losing custody, stigma), 'Life circumstance' factors (conflicting demands on parents, the presence of other stresses or difficulties), mental health factors and other factors. In addition good access to health services ensures better utilization of the service and enhances the desired health outcomes (Bryony, et al 2008).

In November 2005, a random sample of Estonian residents aged 15–74 were personally interviewed using structured questionnaires (n=1446), 29% of them reported to have a chronic illness. After the implementation of the primary health care reform in Estonia, most of chronic conditions are managed by family doctors (FD) in collaboration with specialists. Although the general population has demonstrated the increase in satisfaction with health care after the reform, it has been questioned if people with chronic diseases have been left on a more disadvantaged position in the new system with some restrictions in the access to specialists. The people with chronic conditions were less satisfied with the access to the health services. They were more satisfied with their family doctors, but less with the health insurance system and they often reported their problems in seeing the specialist. Compared to other respondents, the people with chronic conditions visited their FDs and specialists more often, but no significant differences were found between their waiting times to see the FD or a specialist (Salguero et al, 2005).

Another study held in Kenya to compare the impact of socioeconomic deprivation on risky sexual outcomes in rural and urban Kenya. Quantitative data are drawn from the Demographic & Health Surveys (DHS) and qualitative data from the Sexual Networking and

Associated Reproductive and Social Health Concerns study. Using two separate indicators of deprivation it has been reported that, although poverty is significantly associated with the examined sexual outcomes in all settings, the urban poor are significantly more likely than their rural counterparts to have an early sexual debut and a greater incidence of multiple sexual partnerships. The disadvantage of the urban poor is accentuated for married women; those in Nairobi's slums are at least three times as likely to have multiple sexual partners as their rural counterparts (Dodoo FN, 2007).

A research study was done in Egypt in 2003; the study compares patient satisfaction with primary health care services and identifies factors associated with patient satisfaction in two health districts in Egypt where a project for upgrading primary health care services had been running for 3 years. Patient satisfaction was high for accessibility, waiting area conditions and performance of doctors and nurses (Gadallah et al, 2003).

The most suitable related questions chosen from literature to ask participants about were: Availability of the service in the area of residency, reaching the service point, the time needed to reach the service point, cost of transportation, safety for them to reach the service point!

### **3.3.8 Service Privacy:**

Privacy can be divided into the following separate but related concepts: Information privacy, which involves the establishment of rules governing the collection and handling of personal data such as credit information, and medical and government records. It is also known as "data protection"; Bodily privacy, which concerns the protection of people's physical selves against invasive procedures such as genetic tests, drug testing and cavity searches; Privacy of communications, which covers the security and privacy of mail, telephones, e-mail and other forms of communication; and Territorial privacy, which concerns the setting of limits on intrusion into the domestic and other environments such as the workplace or public space. This includes searches, video surveillance and ID checks. Confidentiality between a doctor and patient means that a doctor has the express or implied duty not to disclose information received from the patient to anyone not directly involved with the patient's care.

Confidentiality is important so that healthcare providers have knowledge of all facts, regardless of how personal or embarrassing, that might have a bearing on a patient's health. Patients must feel that it is safe to communicate such information freely. Although this theory drives doctor-patient confidentiality, the reality is that many people have routine and legitimate access to a patient's records (Cedric, 2003).

In 2003 the Eastern Mediterranean published a research study done at Egypt; the study compares patient satisfaction with primary health care services and identifies factors associated with patient satisfaction in two health districts in Egypt where a project for upgrading primary health care services had been running for 3 years. Patient satisfaction was high for accessibility, waiting area conditions and performance of doctors and nurses. Additionally, level of privacy in the consultation room was described as unsatisfactory by 33% of patients, (Gadallah et al, 2003).

In a study done at a health centre in Malawi looking at quality of care and its effects on utilization of maternity services at a primary level, a high degree of satisfaction was noted among patients with providers' attitude (97%), technical competence (86%), and working hours (91%). However, they expressed dissatisfaction with lack of privacy (Lule et al, 2000). Confidentiality between a doctor and patient means that a doctor has the express or implied duty not to disclose information received from the patient to anyone not directly involved with the patient's care. Confidentiality is important so that healthcare providers have knowledge of all facts, regardless of how personal or embarrassing, that might have a bearing on a patient's health. Patients must feel that it is safe to communicate such information freely. Although this theory drives doctor-patient confidentiality, the reality is that many people have routine and legitimate access to a patient's records. (Bérengère2007)In this research study females will express their level of satisfaction with privacy in relation to the following items; Caring of privacy from the staff were clear, privacy tools are available in the examining room, the door of the exam room was closed, clean tools on couch, confidentiality of information.

### **3.3.9 Informativeness of service:**

Serving to inform; providing or disclosing information; instructive, giving information in relation to care or services provided to the patient, it means the communication and

interaction between healthcare professionals and clients and considered a priority in the quality of health care provided (<http://www.knowledgetransfer.net>. 1.8.2010 ).

In a three year analysis survey of patients' satisfaction carried out in Germany, Sweden, Switzerland, the United Kingdom and United states, it was found that patient satisfaction surveys could assist in local quality improvement efforts and facilitate the identification of poor quality care for further investigation and interventions among others. It was clear from the survey that in all the five countries surveyed; patients were commonly concerned (or dissatisfied) with information and education, coordination of care, respect for patients' preferences, emotional support, physical comfort, involvement of family and friends, and continuity and transition of care. (Fitzpatrick, R. 2002). Participants were asked the following to assess their satisfaction level: The information given from the reception desk was clear, services provided by the center was clear, welcoming from the staff, the staff introduce themselves, staff feeling and attendance about the importance of their health problem, clear preventive instructions were given, availability of sings to the center and inside the center.

### **3.3.10 Gender sensitivity:**

Gender is the wide set of characteristics that are seen to distinguish between male and female entities, extending from ones biological sex to ones social role or gender identity (Shuler et al, 1997)Experience suggests that the incorporation of gender approaches into family planning (FP) and reproductive health (RH) programs could increase their impact and sustainability. Ffurther work is needed to examine the interactions between gender norms and FP and to incorporate this understanding into social and behavior change communication (SBCC) in specific social contexts. As noted gender norms, which interact with social, political and economic factors, affect all aspects of women's lives. Mason has theorized that when assessing demographic change, it is more important to understand institutionalized gender stratification in society's allocative processes than the position of individual women on various measurable social hierarchies. She notes the need to study, at a macro-level, both gender norms and the processes by which valued goods are distributed among individuals, including access to and control over material resources; decision-making autonomy and freedom of movement; sexual norms and women's sexual freedom; legal rights; and public roles (Schuler et al 19977).

Gender inequality can affect reproductive decisions made at the household level, as well as the nature of services that are provided and the individual who decides how services are provided. For example, family planning programs have traditionally targeted women for contraceptive use. Recently, the need for male responsibility has been articulated around the world, but thus far, with little change in service provision (Adair et al, 1997). From the literature review, there was sensitivity between males and females during provision of the services which affects the desired outcomes of the services, so targeted population will express their level of gender sensitivity through the questionnaire. Gender inequality can affect reproductive decisions made at the household level, as well as the nature of services that are provided and the individual who decides how services are provided (Schuler and Hashemi, 1997).

In this study females will be asked about their level of satisfaction from the gender of the providers in terms of: Examination by a male practitioner, discussing her RH issues and status, the provider to be from the same gender may be better for her.

### **3.3.11 Acceptability of the service:**

Satisfactoriness by virtue of conforming to approved standards, the act of a person to whom something is offered or tendered by another, whereby he receives that which is offered with the intention of retaining it. A contract is not valid without the acceptance of an offer by the party to whom the offer is made, either expressly or by conduct:

(<http://www.knowledgetransfer.net>. 1.9.2010).

The terms ‘access to’ and ‘acceptability of’ services are commonly used within research and practice communities. However, there is relatively little theoretical writing about the two concepts and a number of different definitions or models exist (for example, Pechansky and Thomas, (1981); Aday and Anderson, (1981); Maxwell, (1984); Gulliford et al, (2001); Rosen et al, (2001). As stated in the protocol the research team chose not to align themselves to a particular model or concepts of access and acceptability at the outset of the review though they noted the potential usefulness of the scoping review on access to health care conducted by Gulliford et al (2001) and the further work leading from that review carried out by Rosen et al (2001) and (Bryony et al, 2008).

### **3.3.12 Availability of care:**

High availability is a system design approach and associated service implementation that ensures a prearranged level of operational performance will be met during a contractual measurement period. Users want their health system to be ready to serve them at all times. Availability refers to the ability of the user community to access the health system, whether to submit new service, update or alter existing service, or collect the results of previous one. If a user cannot access the health system, it is said to be unavailable. Generally, the term downtime is used to refer to periods when any system is unavailable, (Blazevska, et al2004).

It is an umbrella term that includes reliability (including resilience), maintainability, serviceability, and security. A common definition of availability is "the ability of a component or a health service (under combined aspects of its reliability, maintainability and security) to perform its required function at a stated instant or over a stated period of time". Service availability is sometimes expressed as an availability percentage, i.e., the proportion of time that the service is actually available for use by the customers within the agreed service time. However, this definition of service availability is generally considered to be archaic and immeasurable to any party's real satisfaction in a modern health environment. Current best practice suggests that availability should be expressed in business centric terms, focusing on the impact of unavailability on business processes, (<http://www.knowledgetransfer.net>. 1.10.2010).

### **3.3.13 Finance of the service:**

It refers to who funds on the service to mobilize the system, one are the general expenditure on health which means the sum of outlays on health maintenance, restoration or enhancement paid for in cash or supplied in kind by government entities. Includes transfer payments to households to offset medical care costs and extra budgetary funds to finance health services and goods, the revenue base of these entities may comprise multiple sources, including external funds. Second is the NGO's expenditure on health which is not prominently financed and controlled by governments but considered as supplementary fund by local, national or international organizations (WHO. 2002 p 4).

### **3.3.14 Efficacy / outcome:**

Integration of the service with Different kinds of sexual reproductive health (SRH) and HIV services or operational programmes that can be joined together to ensure and perhaps maximize collective outcomes, this would include referrals from one service to another (UNFPA. 2009).

Total number of cases attending and treated at the centre during period of time and number of cases referred to the district hospital in the same period (Mahfouz. 2007).

### **3.3.15 Convenience of the service:**

This dimension contributes to service quality and considers a main factor in assessing the level of satisfaction (Jacox et al. 2000).

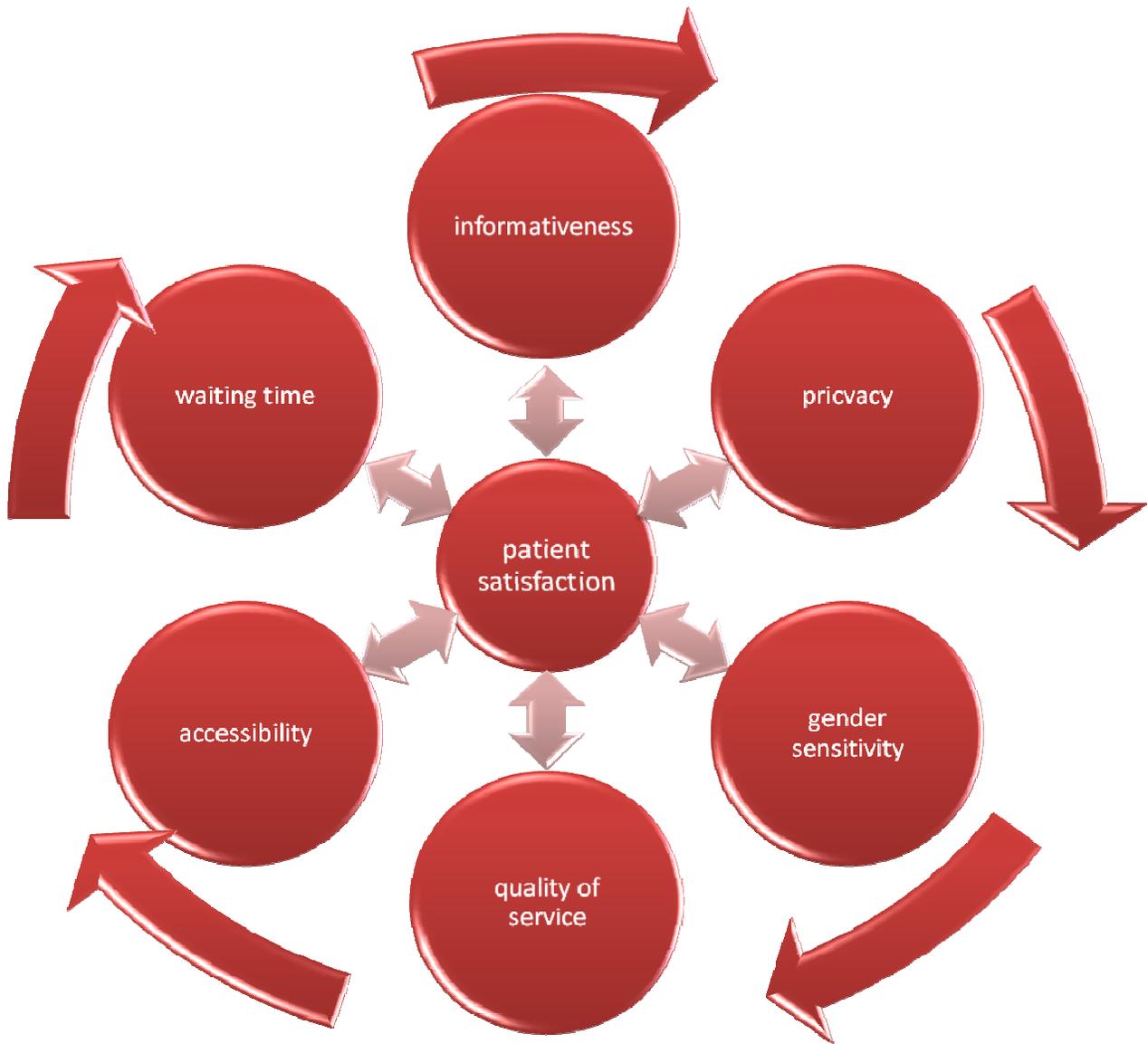
The quality of being suitable to one's comfort, purposes, or needs. It is personal comfort or advantage; something that increases comfort or saves work.

(<http://www.knowledgetransfer.net>. 1.7.2010).

### **3.3.16 Care Coordination and Continuity:**

It is the relationship between past and present care in conformity with the therapeutic needs of the patient with the extent to which the patient receives complete care and services, Dehne and his colleagues (2000) found that services rarely offered clients RH treatment on site or provided to them within the same visit or from the same provider who supplied FP services, even in settings where staff had been trained in syndromic management. Another South African study found that although providers reported greater continuity of care and reduced duplication of care following service integration, disjointed provision of services remained; clients in four out of eight facilities had to wait in separate lines for different services (Maharaj and Cleland. 2005).

### 3.2 The conceptual framework



**Figure 3.2 the conceptual framework of the study**

## **Chapter Four**

### **Methodology**

#### **4.1 introductions**

This chapter describes the population of the study, its sample method, methods and tests used for validity and reliability of the instrument of the study, the statistical methods used to deal with data, results and interpretations. So In this chapter the researcher describes the methodology used during the research, the study design, setting and frame, the study population and sample size, data collection instrument, data analysis, and piloting.

#### **4.2 Method of the study**

In order to obtain solid and objective data, a purposive sample technique is used to ensure representation of different strata. A quantitative standardized structure questionnaire was used. It is known that's this type of research methods gives in details the quality of the study and the quantity which is expressed by statistical numbers that illustrates the size, extent and level of the study and its relation with other variables, while the quality aspect depends on the description and illustration of these features. This research study will depends on the questionnaire as the main tool for collection of the data in relation to aim and objectives of the study.

The study is conducted as a part the requirements for the degree of master of health policies and management from the school of public health, Al-Quds University. Data was collected from different service points that represent governmental UNRWA and NGOs clinics in Ramallah district that provides reproductive health services. Discussions were held with

targeted organizations representatives, service providers and professionals before the study to make implementation of the study are more feasible.

#### **4.2.1 Study design:**

Purposive Cross- sectional study (is recommended by Burns and Grove, 1997) to assess the level of client's satisfaction with RH services provided: data required cross sectional sample to reduce cost and time.

Samples represent married females existing from institutions that deliver RH services in Ramallah district where asked and participated in filling the self administered questionnaire about their level of satisfaction with the RH services that they receive from this center. This considered the first study that measures the satisfaction level with RH services in Ramallah District.

#### **4.2.2 Population of the study:**

Those married females who attend one of the following centers that provide RH services at Ramallah district (see appendix 2).

#### **4.2.3 Study settings:**

The Governmental, UNRWA and NGOs health centers that provide RH services in Ramallah district, the geographical area were divided into two localities urban, rural, and data were collected from both areas.

Urban Area: Is the area that is characterized by higher population density and vast human features in comparison to areas surrounding it? Urban areas may be cities, towns or conurbations, but the term is not commonly extended to rural settlements such as villages and hamlets, targeted population well express their level of satisfaction with urban health centers that provides RH services by asking a representative sample from different service points using the study tool.

Rural Areas: Referred to as 'countryside' is a large and isolated area of a country, often with low population density. A trained staff visits some points at rural areas that deliver RH

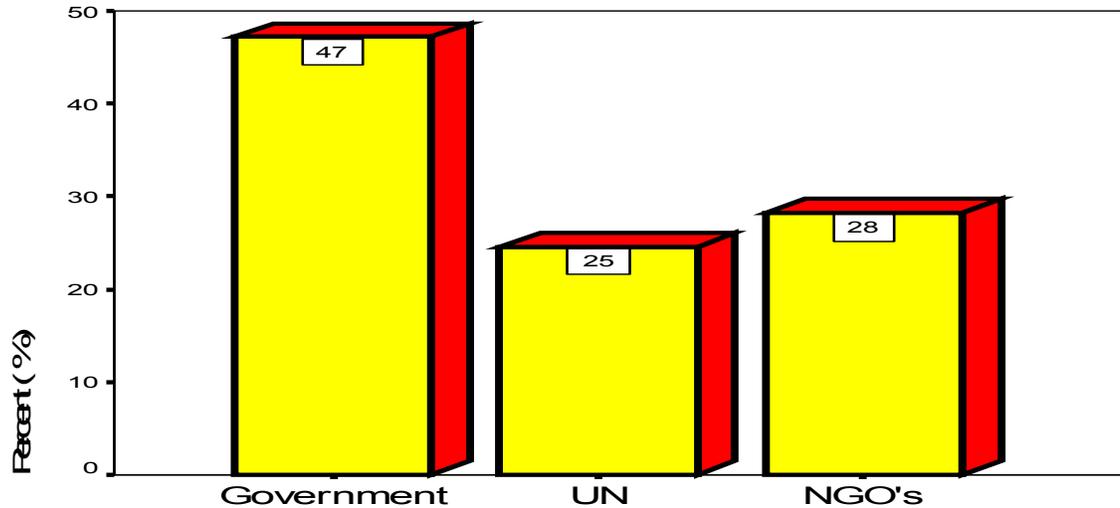
services to Measure the level of female satisfaction with this service through predetermined schedule and having a sample that met the requirements criterion of the study.

#### **4.2.4 Sample Frame**

Every married female who met the study criterion; married, in the reproductive age, and who attend a governmental, UNRWA or NGOs RH facility at Ramallah district in the first 1-3 months of 2010, was the targeted population of this study.

#### **4.2.5 Sample Methodology**

From the data obtained from the MoH, there was 74 points from different providers that deliver RH services, from which 12 registered center (16% from the total as recommended by the statistician) were mostly Randomly chosen to interview participants, This ratio is considered to be representative for the total centers to ensure representation of different strata. It was recommended that representation of participants to be according to population size, so ratios of samples was 43% from the city, 32% from villages and 25% from camps. Then the researcher distribute the questionnaire to the three types of providers( MoH, UNRWA, NGO's) to ensure high level of representation were all providers shows high level of cooperation. A sample of 300 married females was selected for participation in the study, 30 females was piloted and excluded, while 248 female were responded yielding respond rate of 92%. The next Figure shows the percentage of participants of different providers (Table 4.2)



**Figure 4.1 the percentage of participants from different providers:**

### **4.3 Demographic Characteristics of the study population**

The total number of the sample that represented the study population was (300), the researcher piloted the questionnaire for (30) females attend RH point and then exclude them from the study to avoid bias, the responding females were (248), providing a response rate of (92%), from different providers in different district localities, table (4.2) illustrate the sample distribution according to demographic profiles as:

#### **4.3.1. Sample distribution according to provider type**

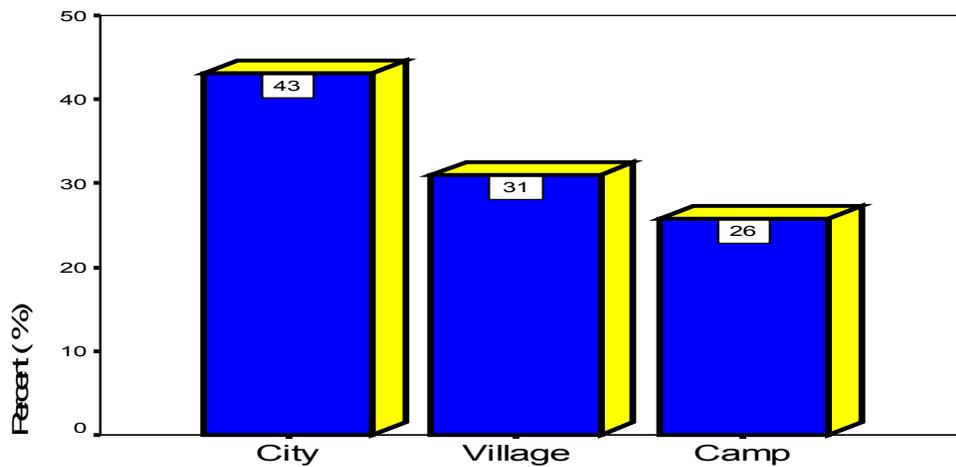
Table (4.1) it can be noticed that's the MoH have the highest level of representation with 117 participants (47% of all providers) followed by the NGO's with 70(28%) participant and finally the UNRWA with 61(25%) participant. This distribution are consistence with the number of center for each provider type indicating that MoH have higher number of clinics leading to a higher number of clients than other providers.

**Table 4.1 sample distribution according to type of provider**

<b>Provider</b>	<b>Frequency</b>	<b>Percentage %</b>
MoH	117	47.2
NGO's	70	28.2
UNRWA	61	24.6
<b>Total</b>	<b>248</b>	<b>%100.0</b>

**4.3.2. Sample distribution according to location of provider:**

Figure (4.2) shows that the participants who attend a RH center located in a city have the highest level of representation with 107 participants (43% of total) followed by centers located in villages with 77 participants (31%) while the centers located in camps have the lowest level of representation with 64 (26%). Also see (Table 4.3.2)



**Figure 4.2 sample distributions according to location of provider.**

### 4.3.3 Sample distribution according to client's age:

Figure (4.3) shows that's the participants whose ages were between 20-24 years have the highest level of representation with (33%) from the total, followed by females aged between 25-30 years with (30%), then the participants aged between 31-35 years (17%) followed by participants aged between 15-19 years with (10%) while the lowest level of representation was for participants whose ages were 36 years and more with a ratio of (9%) (See Table 4.3).

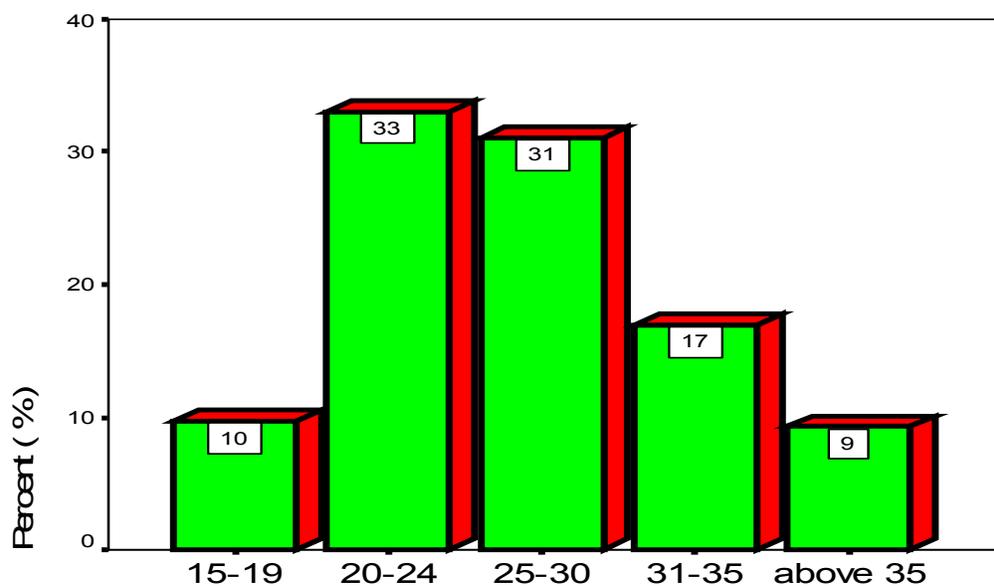
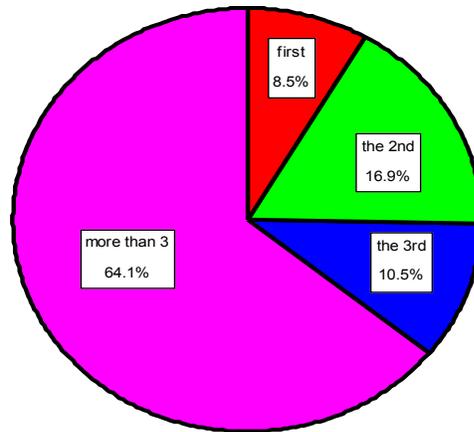


Figure 4.3 Sample distributions according to client age.

### 4.3.4 Sample distribution according to number of visits to the center:

Regarding the number of visits to the center, it can be seen that's the highest ratio of representation was for females who visits the center four times or more with (64%) from all of them, followed by participants who visited the center for the 2nd time with participants (% 16.9) and then participants of the 3rd visit with (%10.5) and finally participants with the first visit to the service point had the lowest number of participants (% 8.5). This representation is very important and very representative to

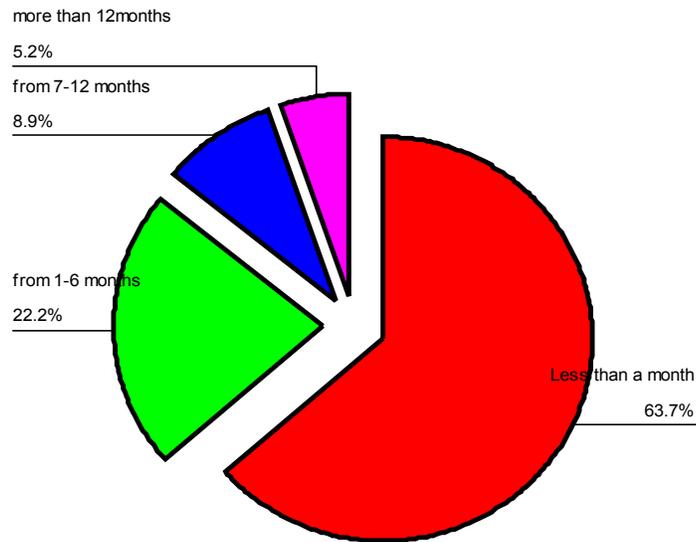
the Palestinian adult population since the Palestinian Authority ministries consider the adult stage up to the age of 39 years. (Also see table 4.4)



**Figure 4.4 sample distribution according to number of visits to the same center.**

#### **4.3.5 Sample distributions according to the time from the last visit:**

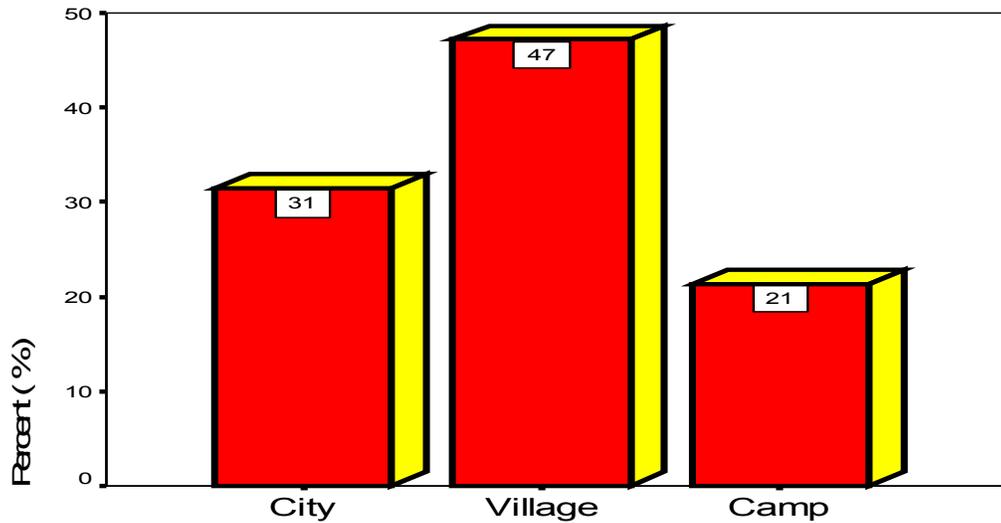
Figure (4.5) shows that participants who visited the center since from less than a month had the highest number of representation (64%) from all participants followed by participants who visited the center since more than a month and less than 6 months with (22%), followed by from 6 to 12 months with (9%) while the lowest rank was for those who visited the center since more than a year with (5 %) from all participant which could reflect the real satisfaction from services provided in this service center or may be due to the good access to this center. (table 4.5).



**Figure 4.5 Sample distributions according to the time from the last visit.**

#### **4.3.6 Sample distribution according to place of resident:**

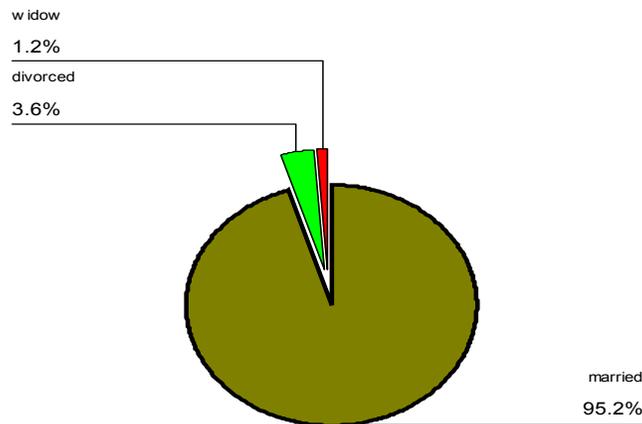
From table (4.6) we can conclude that participants who live in a village have the highest level of representation with (47%) of all participants followed by those who live in cities with (32%) while participants who live in a camp had the lowest level of representation of (21%). Those results may indicate that part of the participants have to visit a service center located in cities seeking special clinical care services in urban areas.



**Figure 4.6 Sample distributions according to place of resident.**

#### **4.3.7 Sample distribution according to marital status:**

Figure (4.7), shows that married participants had 95.2% of representation from the total sample followed by divorced females with (3.6%) then widows with (1.2%). (See Table 4.7)

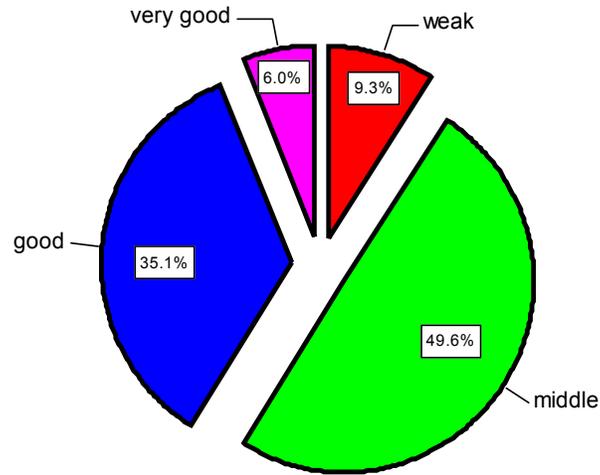


**Figure 4.7 Sample distributions according to marital status.**

#### **4.3.8 Sample distributions according to economic condition:**

According to participants description of their economic condition, the next figure (4.8) shows that participants with middle economic condition have the highest level of representation with (49.6%) followed by participants with good economic condition with (35.1%) and weak

condition with (9.3), while the lowest rate was for those with very good condition with 15 participant (6%). (See Table 4.8)



**Figure 4.8 Sample distributions according to economic condition.**

#### **4.3.9 Sample distribution according to education level:**

According to the level of education figure (4.9) show that the participants with a university degree had the highest level of representation with (38.3%) followed by those with high school with (36.7%) then primary degree with (18.5%) followed by elementary degree with (4.8%) while those who had more than university degree have the lowest level of representation with (1.7%). This means that the majority of the participants considered to be educated and had the ability to read and write very well.

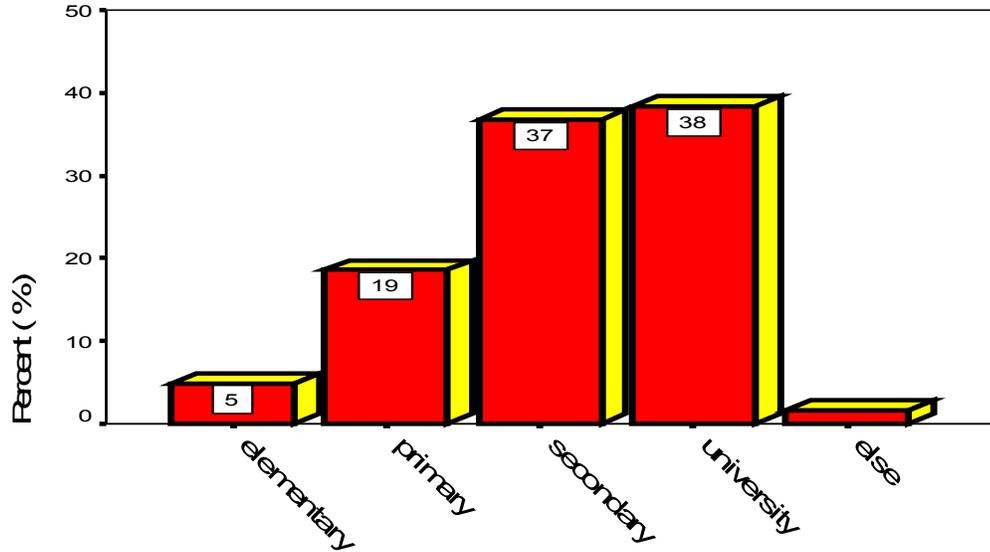


Figure 4.9 the sample distribution according to education level

#### 4.3.10 sample distribution according to participants working status

Table (4.2) working status

Working status	Frequency	Percentage
Worker	5	2.0
student	20	8.1
Employee	57	23.0
At house	164	66.1
farmer	1	0.4
Else	1	0.4
<b>Total</b>	<b>248</b>	<b>% 100.0</b>

Table (4.2) indicates that most of the participants were not employed for paid jobs during the period of participation with a ratio of 66.1%; 23% were employed, 8.1% were students while the lowest representation was for those who were farmers or not mentioned here, which means that the majority of them had enough time and capability to benefit from services had provided to them in the health care centers,

#### 4.4 Data collection instrument

The instrument used in this study was a structured questionnaire (exit interview) as shown in appendix 4.1. This constructed questionnaire was based on a pretested WHO (2007), PAPFAM(2000), PAFPP(2003) questionnaires, reviews of the literature and the investigators own observations and consultations from experienced persons.

Part of the items of the questionnaire were written in the Arabic language while most of the items were written in the English language, the investigator translate it to the Arabic language and consult the supervisor before conducting the interviews with participants to make sure that's no change on the meaning after translation.

#### 4.5 The framework of the questionnaire

After signing the consent form from all participants, the questionnaire was filled by participants. This questionnaire as will be shown next was taken from other pretested questionnaires some were translated to Arabic language and consulted by an editor, the questionnaire had several parts as illustrated in table (4.3):

**Table (4.3) the framework of the questionnaire**

<b>Part No</b>	<b>Part title</b>	<b>Questions</b>
<b>Part one</b>	Participant demographic data	9
<b>Part two</b>	<b>study dimensions</b>	
	The 1st dimension: quality of the service	16
	The 2nd dimension: the Informativeness	9
	The 3rd dimension: accessibility to the service	7
	The 4th dimension: the waiting time	5
	The 5th dimension: gender sensitivity	5
	The 6th dimension: the privacy	5
<b>Part three</b>	<b>Organizational Profiles</b>	
	Services that are provided by the center	11

	The service from the previous visit	12
	The services in general	6
<b>Part four</b>	<b>Choosing from different variables</b>	12
<b>Part five</b>	<b>Reasons for choosing this center</b>	7
<b>Part six</b>	<b>Open questions</b>	2
	<b>Level of general satisfaction</b>	1

- Part one includes participants' demographic data as age, residency, occupation, financial status, and level of education.
- Part two includes information related to the satisfaction dimensions (quality, Informativeness, accessibility, waiting time, privacy, and gender sensitivity) using Likert Scale type. Females expressed their level of satisfaction by rating 5 points:
  - (1: strongly agreed, 2: agreed, 3: no comment 4: not agreed, 5: strongly disagreed).
- Part three discusses the service and organizational profile as place, number of visits, human resources and equipment, waiting time and procedures time, level privacy and other information related to the delivery of the RH service.
- Part four presents data related to choosing from different variables of services provided.
- Part five explored why the participants choose this center.
- Part six consists of two open ended questions which allow for exploration of important problems that the females encounter and recommendations for RH services to be listed. In addition, there was a separate question about the general level of satisfaction from the service provided.

Questions were directed towards the married females after they received RH service and before leaving from the service center. In order to assess participants satisfaction with the study six domains (the quality of service provided, informativeness, accessibility, waiting time, gender sensitivity and privacy), participants have to express their level of satisfaction

with the following items which were based on previous tested questionnaires that has the following elements:

**Quality of service provided:**

Their general expectations from the service they receive.

Solutions and treatment introduced to solve their problem.

Getting the needed treatment of the problem.

The health professional was caring about your problem.

Appreciated by the staff.

Clinical instructions were clear and easily understood.

Staff was courteous.

Caring and appreciating during service provision.

The staff didn't keep them waiting long time.

The staff was calling the patient by his name.

Individual attention was given.

Staff was helping when needed.

The center had good reputation.

The importance of the accreditation of the staff.

The cleanliness of the clinic.

The instruments used were clean.

**Informativeness:**

The information given from the reception desk was clear.

Information about the Services provided by the center was clear.

Welcoming from the staff was noted.

The examiner introduces his self before the examination.

Staff feeling and attendance about the importance of the health problem.

Health instructions were clear.

Clear precautions and preventive instructions were given.

Availability of sings to the center, and inside the center.

**Accessibility:**

Availability of the service in the area of residency.

Reaching the service point easily.

Availability of transportations.

The time needed to reach the service point.

Cost of transportation was reasonable.

Safety for them to reach the service point.

Availability of car parking.

**Waiting Time:**

Waiting time in the registration area.

Appointment time reasonable.

Waiting time in the waiting area of the clinic.

Waiting time inside the clinic and during the procedure.

The overall time during receiving the service.

**Gender Sensitivity:**

The examiner introduces his self before beginning the examination.

Examination by a male practitioner was accepted.

Explaining the procedure before starting.

The courteous and respect from the staff.

Discussing her RH issues and status.

The provider to be from the same gender may be better for her.

#### **Service Privacy:**

Caring of privacy from the staff was clear.

Privacy tools are available in the examining room.

The staff pays attention to the door of the exam room.

Clean towel on couch.

The staff maintain confidentiality of information.

### **4.6 Validity of the instrument**

The questionnaire was valid "the extent to which a measuring instrument measures what is supposed to measure", so the instrument used in this study was a structured questionnaire (exit interview) as shown in the annex. This questionnaire was based on a pretested WHO (2007), PAPFAM (2000), PAFPP (2003) questionnaires and reviews of the literature and the investigator observations and consultations from a panel of experts under the supervision of the investigator's supervisor of the study to introduce the necessary amendments accordingly.

### **4.7 Piloting**

The piloting is useful in the time consumptions of the questionnaire and adequacy of the responses. Thirty of married clients to RH facility were used as pilot study (10% of the total sample) to determine the need for rephrasing or weaknesses in construction of the questionnaire to insure that it will meet the purpose of the study. All participants in the pilot

study were excluded to reduce selection bias. The result of internal reliability was 94% which is considered to be high and no changes were introduced on the questionnaire.

#### 4.8 Reliability of the instrument:

Internal Reliability of the instrument was tested through Cronbach Alpha coefficients which indicate to the following results:

**N of Cases = 248, Reliability Coefficients = 95 Items, Alpha = 0.944**

so from the value of Alpha=0.944, were its value should be from 0 to 10 to represent the range of a multi- point formatted questionnaire, a 0.7 is considered to be acceptable value for this test. So from the 0.944 result we can conclude that's this is an excellent result to indicate to the reliability of the instrument's paragraphs. In addition the researcher calculates the reliability of each dimension of the tool separately as follows:

**Table (4.4) the internal reliability of study dimensions**

No	Dimension	Cronbach Alpha value
1-	Quality of the service	0.974
2-	Informativeness	0.928
3-	Accessibility	0.912
4-	Waiting time	0.889
5-	Gender Sensitivity	0.758
6-	Privacy	0.944
	<b>Total value</b>	0.944

So we can notice from the table (4.13) that's the value of the reliability test that was examined through Cronbach Alpha test for each dimension were high and ranges between 0.974 to 0.758 were the total value was 0.944 which is a very high value that indicates to the ability of data to reflect the sample results on the population of the study.

#### 4.9 Selection and training interviewers

A group of 6 female students from the School of Nursing of Al-Quds University were chosen to meet and ask females for participation and filling the questionnaire. The interviewers had

rigorous training on the questionnaire itself, interviewing skills and research ethics. The original English questionnaire was translated and administered in Arabic, three sessions of training were held and all of them was attending the training sessions in the library of the university for one hour for each session, they trained on how to interact with females, study related concepts, questionnaire concepts and research requirements, how to access service points, which one and which day, and then supervised by the researcher and clinics seniors to interview the selected women to participate in the study. Two hundred and forty eight Of 300 women (92%) responded and fill the questionnaire.

#### **4.10 Data entry and statistical analysis**

After collecting questionnaires and due to the researcher limited experience in statistics and the use of SPSS (statistical packages of social sciences) data was sent to a specialized statistician with Master Degree of Biostatistics SPSS software was used for data entry and analysis based on response codes in the questionnaire Analytical tests (Spearman correlation and chi-squared tests) were used to study the relationship between variables.. Data was reviewed, labeled with numbers to allow for all data to be analyzed and extraction of results and answering research questions and hypothesis. The following statistical methods were used by him:

- Descriptive statistical methods like frequencies, ratio, means and standard deviations.
- Measuring of reliability using Cronbach Alpha Coefficient.
- A series of statistical tests were applied to the study as, the mean, standard deviation, One Way ANOVAs, Least Significant Difference (LSD), Spearman correlation and Chi-Squared Tests.
- Tables and tabulations were used to perform different presentations and comparisons.

#### **4.11 Ethical consideration**

An official letter of approval was obtained from General Directorate of PHC at MOH, administrative departments of UNRWA, NGOs. Informed Consent (appendix 4.1) was provided for every respondent before participation the research. Every participant had the right to refuse participation and to withdraw. Completed questionnaires were treated with high confidentiality.

#### **4.12 Period of the study**

The total time taken to accomplish this research study was conducted between (September 2009) to (December 2010). While the time of collecting the data was between the beginnings of January to the end of March of 2010.

#### **4.13 Limitations of the study**

The following are some main limitations of the study:

1-Due to time and cost constrains, this study was limited to the area of Ramallah district and can't be generalized to other Palestinian districts.

2- And because of the sensitivity of the reproductive health issues, questions and discussions, females were asked to fill the questionnaire by themselves in the same center under the interviewers or the senior nurse supervision; this may cause them to be affected from the public situation of the center.

## **Chapter 5**

### **Results and findings**

#### **5.1 Introduction**

The main purpose of this study was to assess level of married female's satisfaction with reproductive health services in Ramallah district. In this chapter the researcher introduces the main results from the study according to the participant's answers in relation to the questionnaire items. Answers to the research questions and results of the study hypothesis are presented. But before that, the researcher will introduce some characteristic of participants and services provided by the centers and how those participants evaluate those services from their point of view in relation to the items presented in the questionnaire.

#### **5.2 Participant's General Reproductive Health Issues**

The following tables illustrate some important data about the reproductive health and related issues of participants of the study:

The results of table (5.1) shows that 55.5% of participants were married for more than four years which may add a point to the quality of their answers; 12.5% were married since 4 years, 12.1% since 3 years, while the lowest ratio 8.5% were for participants married since two years.

**Table (5.1) years of marriage**

<b>Number of years for marriage</b>	<b>Frequency</b>	<b>Percentage</b>
One year	28	11.3
Two years	21	8.5
3 years	30	12.1
4 years	31	12.5
More than 4 years	138	55.6
<b>Total</b>	<b>248</b>	<b>% 100.0</b>

**Table (5.2) do you have children.**

<b>The answer</b>	<b>Frequency</b>	<b>Percentage</b>
Yes	208	83.5
No	41	16.5
<b>Total</b>	<b>248</b>	<b>% 100.0</b>

The result of the question (do you have children) shows that the majority of participants 83.5% had children.

**Table (5.3) number of children**

<b>The answer</b>	<b>Frequency</b>	<b>Percentage</b>
One child	48	23.1
Two children	52	25.0
Three children	40	19.2
Four children or more	68	32.7
<b>Total</b>	<b>208</b>	<b>% 100.0</b>

Table (5.3) shows that among the participants who had children, 32.7% had four children or more, then comes those who had two children with 25%, and 23.1% had one child; the lowest ratio was for those who had three children with 19.2% of total indicating to a good experience of the majority of those participants in their life style as married with children

**Table (5.4) Are you pregnant now.**

<b>The answer</b>	<b>Frequency</b>	<b>Percentage</b>
Yes	121	48.8
No	127	51.2
<b>Total</b>	<b>248</b>	<b>% 100.0</b>

Table (5.4) indicates that almost half (51.2%) of the participants were pregnant during participation in this study where the remaining were not.

**Table (5.5) pregnancy month**

<b>Pregnancy stage</b>	<b>Frequency</b>	<b>Percentage</b>
1st trimester	41	33.9
2nd trimester	31	25.6
3rd trimester	49	40.5
<b>Total</b>	<b>121</b>	<b>% 100.0</b>

This table (5.5) shows that almost of pregnant participants were at the last stage of pregnancy with a percent of 40.5%, while participants in the first stage compromise 33.9% of pregnant while participants at the 1st stage compromise 25.6%.

Table (5.6) shows that most of the non pregnant participants were using a contraceptive method at the time of participation of this study with 81.1% percent while 19.5% were not using any method indicating to a good knowledge about family planning methods among the participants.

**Table (5.6) contraceptive use**

<b>contraceptive use</b>	<b>Frequency</b>	<b>Percentage %</b>
Yes	103	81.1
No	24	18.9
<b>Total</b>	<b>127</b>	<b>% 100.0</b>

**Table (5.7) type of contraceptive method**

<b>Contraceptive type</b>	<b>Frequency</b>	<b>Percentage</b>
Normal	18	17.4
Tablets	22	21.4
Device	45	43.7
Condom	11	10.7
Else	7	6.8
<b>Total</b>	<b>103</b>	<b>% 100.0</b>

Table (5.7) represents the answers on the question about the type of contraceptive method used by participants'. The table shows that 43.7% of those women uses a contraceptive device, 21.4% uses tablets and 17.4% use normal method; while the lowest rank 6.8% was for those who use a type that is not mentioned in this study.

**Table (5.8) did you use a contraceptive method previously.**

<b>Previously used a contraceptive</b>	<b>Frequency</b>	<b>Percentage</b>
Yes	97	39.1
No	151	60.9
<b>Total</b>	<b>248</b>	<b>% 100.0</b>

Table (5.8) shows that 60.9% of all participants didn't use any method of contraceptive type previously while 39.1% of them used a contraceptive type in the past.

**Table (5.9) type of contraceptive method used in the past**

<b>type of past used contraceptive</b>	<b>Frequency</b>	<b>Percentage</b>
Normal	35	23.2
Tablets	31	20.5
Device	61	40.4
Condom	22	14.6
Else	2	1.3
<b>Total</b>	<b>151</b>	<b>% 100.0</b>

Results of table (5.9) shows that 40.4% of the participants used a contraceptive device to prevent pregnancy occurrence, 23.2% used normal way, 20.5% used tablets while the lowest rank was for those who used a different type with 1.3%.

### **5.3 The services provided by the centers:**

This part of the chapter discusses some ratios of different reproductive health services provided by the centers such as type of services participants receive, the way participants know about the services provided by the center, previous visits to the center, satisfaction from the last visit, the distance to the center, availability of privacy in the centers and others illustrated in the following tables and gives an idea about participants perspectives on the RH services provided in those centers:

Table (5.10) shows a high percentage of women (87%) know about antenatal care service that is provided by the center, while 47% of all participants know about the family planning and contraceptive devices services. The Postnatal care services are known by 45.2% of the participants while Mammography services were known only by 2.4% which was the lowest ratio.

**Table (5.10) percentages of RH services provided by the targeted centers:**

No	Services provided:	Percentage
1	antenatal care service:	87.5
2	Postnatal care services.	45.2
3	Obstetric services.	12.5
4	Menopausal services	19.4
5	Sexual transmitted diseases services	8.9
6	Pap smear test.	32.3
7	Mammography.	2.4
8	Education and consultation.	37.9
9	Family planning and contraceptive devices.	47.2
10	Post abortion services and consultations.	8.5
11	Referral to hospitals services.	42.3

**Table (5.11) percentages of services utility and usage during the previous visit:**

No	Services provided:	Percentage
1	antenatal care service:	64.1
2	Postnatal care services.	13.3
3	Obstetric services.	1.2
4	Menopausal services	1.2
5	Sexual transmitted diseases services	0.0
6	Pap smear test.	6.5
7	Mammography.	0.0
8	Education and consultation.	6.9
9	Family planning and contraceptive devices.	27.0
10	Post abortion services and consultations.	2.0
11	Referral to hospitals services.	6.9

Table (5.11) shows that 64% of participants visits the RH centers was for antenatal care services. Twenty seven percent of participants visit the center for Family planning and contraceptive devices and 13.3% of participants visited the centers for postnatal care services. The results showed that there were no respondents who had visited the targeted centers neither for sexual transmitted diseases nor for mammography.

**Table (5.12) Participants satisfaction from the last visit:**

<b>Satisfaction level</b>	<b>Frequency</b>	<b>Percentage</b>
<b>Strongly Satisfied</b>	98	39.5
<b>Satisfied</b>	124	50.0
<b>No Comments</b>	17	6.9
<b>Not Satisfied</b>	8	3.2
<b>Strongly Not Satisfied</b>	1	0.4
<b>Total</b>	<b>248</b>	<b>% 100.0</b>

Table (5.12) about the satisfaction from the previous visit to the center, its concluded that half of participants are satisfied of the last visit with 50% ratio, while 39.5% were strongly satisfied, 7% had no comments about the service they received. The lowest ratio of participants was for those who were not satisfied from the service with 0.4% ratio.

**Table (5.13) the reasons to choose a specific center to get RH service:**

<b>The reason</b>	<b>Frequency</b>	<b>Percentage</b>
Good Access	123	49.6
Special service provision	66	26.6
Reputation	35	14.1
Else	24	9.7
<b>Total</b>	<b>248</b>	<b>% 100.0</b>

Table (5.13) shows the main reason that the participants gave for choosing a specific RH service was good access to the center with a rate of 49.6%. Twenty six point six percent came due to good reputation of the center, while the lowest ratio 9.7% was for those who came to get special services that are provided by the center.

**Table 5.14 the way participants know about the services provided by the center:**

<b>The source</b>	<b>Frequency</b>	<b>Percentage</b>
Friend	43	17.3
Neighbor	32	12.9
Mother	46	18.5
Mother in low	46	18.5
Husband	27	9.10
Radio	0	0.0
T.V.	1	0.4
Newspaper	2	0.8
Other sources	51	20.6
<b>Total</b>	<b>248</b>	<b>% 100.0</b>

The answers of the question about the way participants know about the services provided by the center indicates that 20.6% of the participants knew about the center and the services provided from other sources of information which is not mentioned here. However, the 2<sup>nd</sup> source was the mother and the mother- in- low with equal ratio of 18.5%; the 3<sup>rd</sup> source was friends with 17.3% of the total sample.

**Table (5.15) the person who delivers the service for the participants:**

<b>The provider</b>	<b>Frequency</b>	<b>Percentage</b>
Male nurse	17	6.9
Male doctor	46	18.5
Female nurse	92	37.1
Female doctor	74	29.8
Health practitioner	8	3.2
Don't know	3	1.2
Else	8	3.2
<b>Total</b>	<b>248</b>	<b>% 100.0</b>

the results of table (5.15) shows that 37.1% of the participants received the service from a female nurse, 28.9% recieved the service from a female doctor, 18.5% from a male doctor

while 1.2% didn't know the position of the person who served them, which indicates that there is a need for introducing the practitioner to the client. This indicates a very good understanding and cooperation from providers to the females' special needs which reduces the gender sensitivity effect while delivering reproductive health services which contributes to and explains the high satisfaction level among participants in this study.

**Table (5.16) respect and privacy during delivering the service:**

<b>Agreement level</b>	<b>Frequency</b>	<b>Percentage</b>
Strongly agreed	112	45.2
Agreed	112	45.2
No comments	18	7.3
Not agreed	4	1.6
Strongly not agreed	2	0.8
<b>Total</b>	<b>248</b>	<b>% 100.0</b>

Table (5.16) shows that the answers of the participants about the presence of respect and privacy during delivering the service was positive indicating to a high degree of privacy and respect at the majority of centers. More than 90% of the participants strongly agreed or agreed about the presence of privacy and respect, while the rest of the participants had no comments or who didn't feel that there is privacy and respect during the service received.

**Table (5.17) the age of the provider**

<b>Provider age</b>	<b>Frequency</b>	<b>Percentage</b>
20 – 30 years	61	24.6
31 – 40 years	127	51.2
41 – 50 years	57	23.0
More than 50 years	3	1.2
<b>Total</b>	<b>248</b>	<b>% 100.0</b>

Table (5.17) shows that 51.2% of the participants think the age of the provider was between 31 – 40 years, were 24.6% considered the age was between 20 -30 years, 23% considered the age was 41 – 50 years, while the lowest ratio (1.2%) for those who considered the age was above 50 years.

**Table (5.18) participants waiting time to enter to the examination room**

<b>Waiting time</b>	<b>Frequency</b>	<b>Percentage</b>
Up to 10 minutes	48	19.4
From 11-20 minutes	55	22.2
From 21- 30 minutes	79	31.8
From 31- 60 minutes	28	11.3
More than an hour	38	15.3
<b>Total</b>	<b>248</b>	<b>% 100.0</b>

The results of the question about the waiting time to enter the examination room presented in table (5.18) and indicate that 31.8% of the participants had to wait between 21-30 minutes before entering the examination clinic. However, 22.2% waited between 11-20 minutes, 19.4% waited less than 10 minutes while the lowest rate was (11.3%) for those who waited between 31- 60 minutes.

**Table (5.19) the procedure time inside the examination room**

<b>procedure time</b>	<b>Frequency</b>	<b>Percentage</b>
Up to 10 minutes	57	23.0
From 11-20 minutes	107	43.1
From 21- 30 minutes	66	26.6
From 31- 60 minutes	17	6.9
More than an hour	1	0.4
<b>Total</b>	<b>248</b>	<b>% 100.0</b>

The results of the question about the procedure time inside the examination room from table (5.19) shows that 43.1% of the participants spent between 11-20 minutes inside the examination room, 26.6% spent from 21-30 minutes, 23% spent up to 10 minutes while 0.4 spent more than an hour inside the examination room.

**Table (5.20) with which participants came to the center**

<b>The person</b>	<b>Frequency</b>	<b>Percentage</b>
Alone	136	54.8
With your husband	43	17.3
Friend	21	8.5
Mom in low	23	9.3
Mother	16	6.5
Else	9	3.6
<b>Total</b>	<b>248</b>	<b>% 100.0</b>

Table (5.20) shows that most of the participants (54.8%) came to the center alone; 17.3% came with their husband; 9.3% came with their mother in low; 3.6% came with other person.

**Table (5. 21) the distance to the center was**

<b>The Distance</b>	<b>Frequency</b>	<b>Percentage</b>
Less than 1 Km	70	28.2
From 1 to 2 Km	63	25.4
From 3 to 4 Km	40	16.1
From 5 to 6 Km	27	10.9
From 7 to 8 Km	22	8.9
More than 8 Km	26	10.5
<b>Total</b>	<b>248</b>	<b>% 100.0</b>

Table (5.21) shows that 28.2% of the participants had travelled less than 1 Km distance to access the service center, 25.4% travelled between 1-2 Km, 16.1% travelled between 3-4 Km while (19,8%) percent of participants traveled for more than 7 Km to access the service center. This indicate to a good coverage in general primary health care centers (within the

catchment area of residency) with an understandable need to travel for special services in urban areas.

**Table (5.22) the way participants came to the service center**

<b>The way of Transportation</b>	<b>Frequency</b>	<b>Percentage</b>
On feet	99	39.9
by car	104	41.9
By bus	26	10.5
By taxi	19	7.7
<b>Total</b>	<b>248</b>	<b>% 100.0</b>

Table (5.22) shows that the most frequent way to reach the service point was by using their private cars with a ratio of (41.9%); (39.9%) reaches the service point on feet which indicates the closeness of the service centers to their residence, 10.5% came by bus while 7.7% came by taxi.

**Table (5.23) time taken to arrive to the service center**

<b>Procedure Time</b>	<b>Frequency</b>	<b>Percentage</b>
Up to 10 minutes	57	23.0
From 11-20 minutes	107	43.1
From 21- 30 minutes	66	26.6
From 31- 60 minutes	17	6.9
More than an hour	1	0.4
<b>Total</b>	<b>248</b>	<b>% 100.0</b>

Table (5.23) shows that it took 11-20 minutes for 43.1% of the participants to reach the service center, 21-30 minutes for 26.6% of the participants to reach the service center; 31-60 minutes for 23%; the lowest ratio 0.4% was for those who needs more than one hour to reach the service center indicating to a good accessibility for participants to reach the centers on a reasonable time waking on feet.

#### 4 The reasons for participants to choose specific center to get the service from

The participants in the study were asked about the main reasons for choosing a particular center to obtain the RH service. Options of answers included availability of privacy, good accessibility, staff care and cooperation, short waiting time, reasonable appointments, presence of female provider, and service quality. In order to analyze the answers, the weighted average was calculated for participant's answers using Likert three levels scale according to the following table: criteria:

**Table (5.24) the value and its weigh in the research questionnaire:**

<b>The weight</b>	<b>The value</b>
1	Not important
2	Important
3	Very important

Then, the weighted average was calculated as follows:

**Table (5.25) weighted average according to Likert Scale**

<b>Agreement level</b>	<b>The weighted average</b>
Weak	From 1 to 1.66
Moderate	from1.67 to 2.33
High	from2.34 to 3.00

The results of table (5.26) show that:

1- The total mean for all factors was 2.69, indicating a 'High Degree of Agreement' from the participants to all factors, the means were ranged from 2.5-2.77 indicating to a homogenous agreement levels for the importance of all factors in the table in choosing the service point, and they consider all factors as important. The staff care and cooperation ranked firstly as the main reason for choosing the center while the short waiting time was the weakest factor.

2- The participants consider the 3rd item related to the care and cooperation of the staff as the strongest one with a mean of 2.77 and of the participants consider this factor as the main one among other mentioned factors.

3- The availability of privacy in addition to the service quality and specialized female staff are all considered to be very important factors in determining the service point by participants; means were 2.75, 2.74, 2.73 in sequence t

The participants agreed about the accessibility in addition to appropriate appointments ranked thirdly in the importance with a mean score of 2.67 and 2.65 in sequence indicating to a good coverage policy by different providers specially the public sector in providing the reproductive health care services.

4- The 4th paragraph ‘short waiting time’ is the weakest among all others with 2.5 mean and high agreements level.

**Table (5.26) the importance of the following factors to participants for choosing the RH service from specific center**

<b>No</b>	<b>Factors</b>	<b>S.D.</b>	<b>Mean</b>
1	Availability of privacy	0.480	2.75
2	Good accessibility	0.520	2.67
3	Staff care and cooperation	0.434	2.77
4	Short waiting time	0.630	2.50
5	Reasonable appointments	0.534	2.65
6	Specialized female providers	0.503	2.73
7	Service quality	0.448	2.74
	<b>TOTAL</b>	<b>0.370</b>	<b>2.69</b>

## 5.6 Answering Research Questions:

In order to answer research questions, the six dimensions of satisfaction in the study tool were presented separately according to participant's answers and analyzed using the means and standard deviations in reference to Rinsis Likert Scale as shown in appendix 5).

### **Answer to research question one: What is the effect of quality of service on the level of female's satisfaction with RH services?**

Respondents answers were homogenous regarding the effect of quality of service indicating to a very good satisfaction level with most domain items while the item 'the clinic was clean' ranked firstly and has the highest agreement level among all participants indicating to special attention among all providers to the clean lines of the clinic as a quality indicator. The item 'staff gives individual attention' has the least score indicating to a special attention that has to be made from different providers to enhance this item.

So the quality of RH services provided in Ramallah district has positive effect on the level of female's satisfaction with this services. The effect of each item is manifested in table (5.26) with related interpretation.

**Table 5.27 Means and S.D of Quality of service provided for all participants:**

No	Paragraph	Mean	S.D.
14	The clinic was clean	3.87	0.512
15	The staff uses standard clean instruments	3.84	0.500
4	The health professional was caring about your problem.	3.84	0.483
16	The clinical instructions was easy to understand	3.81	0.348
11	Experience and accreditation of the staff makes you feel better.	3.79	0.592
10	You trust this center due to The good reputation.	3.78	0.394
3	You got the needed treatment of this problem.	3.76	0.646
12	The staff was calling you by your name	3.76	0.229

5	The staff was welcoming you	3.75	0.312
13	The staff was courteous	3.74	0.501
2	Your health problem is solved	3.73	0.588
9	The staff were helping when needed	3.71	0.692
6	The staff in general was caring about you	3.69	0.136
1	Generally the service was according to expectations.	3.64	0.580
7	The staff didn't keep you waiting	3.47	0.102
8	Staff gives individual attention	3.46	0.513
	<b>Quality Of Services</b>	<b>3.73</b>	<b>0.548</b>

The results of this dimension (Quality of service provided) show the following (see table 5.27):

- The total mean of this dimension was (3.73) shows that there were a moderate degree of agreement among the participants on all paragraphs. The range of means was (3.46 – 3.87) which indicates a homogenous readings and responses from the participants; were all means are close to each other indicating to high degree of agreement among the participants about the quality of service provided. The results shows that the “cleanliness of the doctor’s office” had the highest score with a mean of 3.87 were ‘Staff gives individual attention’ had the lowest items score with a mean of 3.46.
- ‘The health professional was caring about your problem’ in addition to ‘The staff uses standard clean instruments’ occupy the 2<sup>nd</sup> degree among providers to indicate to the quality standards applied at those clinics by having (3.84) mean, 5<sup>th</sup> level.
- Most participants agreed that ‘the clinical instructions was easy to understand’ are true and occupy the 3<sup>rd</sup> degree of ranking with a mean of (3.81) indicating to the importance of this item for providers as a quality indicator from the fifth level.

**Answer to the second question: What is the effect of Informativeness of service on the level of female’s satisfaction with RH services?**

Respondents answers were heterogeneous and differ for most of the items., The item ‘the health instruction was clear’ had the highest agreement level for all providers with a mean score of 3.74 indicating to a good explaining of the instructions from the professionals, while the item ‘The provider introduces himself before the examination’ had the lowest agreement level with a mean of 2,93 indicating the need for the health professionals to introduce themselves at the beginning of any RH procedure.

Generally participants were satisfied with most of this domain items from different providers. Table (5.28) followed by the interpretation explains each item separately

**Table (5.28) Means and S.D of Informativeness for all participants:**

<b>No</b>	<b>Paragraph</b>	<b>S.D</b>	<b>Mean</b>
23	The health instructions was clear	0.651	3.74
25	clear road signs to the center	0.312	3.73
22	There were clear explanation about your health status	0.383	3.73
17	Receiving clear information at the reception desk	0.562	3.71
21	The health professional was attending to your concerns.	0.578	3.68
24	Clear precautions ,preventive procedures were given	0.520	3.67
19	Generally you feel that the staff was welcoming you.	0.312	3.67
18	Information about the services provided by the center is clear.	0.541	3.61
20	The provider introduces his/her self before the exam	0.183	2.93
	<b>Informativeness total</b>	<b>0.391</b>	<b>3.61</b>

The results of this dimension (informativeness) show that:

- The total mean of this dimension was (3.61) for all paragraphs with moderate level of agreement. The means ranged between (2.93 – 3.74) indicating to heterogeneous degrees of agreement ranged from weak to moderate. ‘The health instructions was clear’ had the first rank with a mean of 3.74 indicating a good way used by providers for Informativeness, where “The provider introduces himself or herself before the examination’ had the lowest rank among all paragraphs with a mean score of 2.93 of this dimension.
- The items ‘There were clear explanation about your health status’ and ‘clear road signs to the center’ had the 2<sup>nd</sup> ranking for Informativeness with the same mean (3.73) . ‘Receiving clear information at the reception desk’ had the 3<sup>rd</sup> rank with a mean of (3.71) for Informativeness. (Figure 5.3 at list of appendix)

**Answer to the third question: What is the effect of accessibility on the level of female’s satisfaction with RH services?**

Respondent’s answers were homogenous regarding items for accessibility to the service. The item “It was safe to come to the center’ had the highest score with a mean of (3.80) among all items related to accessibility to the center, while ‘availability of parking encourages you to come to this center’ had the lowest score with a mean score of (3.38) indicating to the need for taking this item into consideration from the providers.

Generally, respondents were satisfied about access to reproductive health care services provided at Ramallah district and this domain had no negative effect on satisfaction. Table (5.29) and its interpretation explain each item separately as follows.

- The total mean of all paragraphs (3.61) shows a moderate level of agreement 4th grade from all participants at this dimension where the means was ranged from( 3.38-3.80) indicating to a homogenous respond and readings from all participants. ‘It was safe to come to the center’ was the strongest paragraph related to accessibility to the center while ‘Availability of Parking encourages you to come to this center’ had the lowest paragraph.
- The 6<sup>th</sup> paragraph ‘It was safe to come to the center’ shows that females gave this paragraph their highest rank among other paragraphs of the 3<sup>rd</sup> dimension as an indicator of accessibility with a mean of (3.8) with a moderate level of agreement.

- ‘The centre at the same resident area’ ‘It was easy to reach the center’ ‘Transporting time to and from the center was reasonable’ were also considered to be a positive points to the providers occupying the 2<sup>nd</sup> rank among all paragraphs from participants in relation to accessibility with (3.7), (3.64), (3.63) means from the 4<sup>th</sup> grade
- ‘Cost of transportation was reasonable’ ranked 3rdly with ( 3.58) mean from the 3<sup>rd</sup> level
- ‘Availability of Parking encourages you to come to this center’ had the lowest ranking grade from the 2<sup>nd</sup> level with (3.83) mean indicting to the need to enhance this indicator to increase the accessibility aspects to the service centers.

**Table (5.29) Means and S.D of Accessibility for the participants:**

No	Paragraph	Mean	S.D.
27	It was safe to come to the center	3.80	0.590
30	The centre at the same resident area	3.70	0.226
32	It was easy to reach the center	3.64	0.174
29	Transporting time to and from the center was reasonable	3.63	0.346
31	Cost of transportation was reasonable	3.58	0.284
28	Transportations was available	3.56	0.158
33	Availability of Parking encourage you to come to this center	3.38	0.125
	<b>Accessibility Total</b>	<b>0.268</b>	<b>3.61</b>

**Answer to the fourth question: What is the effect of waiting time on the level of female’s satisfaction with RH services?**

Respondent’s answers on the items of this domain show relatively homogenous readings and answers. The item ‘Procedure time inside the clinic was reasonable’ had the highest score indicating to high satisfaction with this item. However, the item “waiting time to enter the clinic was short” had the lowest score among all items indicating to a long waiting time for respondents to inter the examination room.

It should be distinguished between the effect of waiting time to enter the clinic which was long and could affect the satisfaction level negatively from the respondent’s point of view. This is explained in Table (5.30).

**Table (5.30) Means and S.D of waiting time for the participants**

<b>No</b>	<b>Paragraph</b>	<b>Mean</b>	<b>S.D</b>
37	Procedure time inside the clinic was reasonable	3.65	0.327
35	The appointment was reasonable	3.56	0.224
38	The total time of receiving the service was acceptable.	3.54	0.389
34	Registration procedures takes short time	3.46	0.112
37	waiting time to enter the clinic was short	3.29	0.182
<b>Waiting time</b>		<b>3.5</b>	<b>0.274</b>

Results of table (5.30) about waiting time dimension shows:

- The total mean of all paragraphs (3.5) indicates a moderate degree of agreement of the 3<sup>rd</sup> level from all participants. The means ranged between (3.29-3.65). This is considered to be close and homogenous response for waiting time items. The item “Procedure time inside the clinic was reasonable” had the highest score of agreement from all participants, while the ‘waiting time to enter the clinic was short’ had the lowest score.
- ‘Procedure time inside the clinic was reasonable’ had the highest score of agreement in the 4<sup>th</sup> dimension from all participants and considered to the most positive aspect of waiting time for the different providers. Its mean was (3.65) with 4<sup>th</sup> level agreement. ‘The appointment was reasonable’ ‘The total time of receiving the service was accepted’ are also consider to be a positive points for all providers having the 2<sup>nd</sup> rank of waiting time paragraphs with (3.56), (3.54) means and moderate agreement level from the 3<sup>rd</sup> grade. ‘Registration procedures takes short time’ had the 2<sup>nd</sup> rank with mean of (3.46) and moderate agreement.
- The item ‘waiting time to enter the clinic was short’ had the lowest score with a mean of (3.29) and a moderate agreement level, so it should not be ignored and have to be enhanced.

**Answer to the Fifth question: What is the effect of provider's gender on the level of female's satisfaction with RH services?**

Respondent's answers were not homogenous and differ according to the wide range of all items means. The item with the highest score was 'You feel with staff respect and courteous' indicating to a respectful relation between staff and respondents, however, the item 'The staff introduce themselves before the procedure' had the lowest score indicating to the need for health professionals to introduce themselves before the RH examination.

Respondents were relatively satisfied with this domain in spite of the negative effect of some items of this domain. Table (5.31) explains the effect of each item:

**Table (5.31) Means and S.D of Gender Sensitivity for the participants**

<b>No</b>	<b>Paragraph</b>	<b>Mean</b>	<b>S.D</b>
42	You feel with staff respect and courteous	3.72	0.539
41	The staff explain the procedure before starting	3.60	0.668
43	It was normal to discus sexual and reproductive health issue	3.52	0.222
40	It was accepted to be examined by male health practitioner	2.90	0.240
39	The staff introduce themselves before the procedure	2.83	0.174
	<b>Gender Sensitivity total</b>	<b>3.32</b>	<b>0.298</b>

Results of this dimension (gender sensitivity) show:

- The total average of means (3.32) shows a moderate degree of agreement which gives this dimension the 2<sup>nd</sup> level of agreement. The range of means was between (3.72 – 2.83) indicating to a heterogeneous answers with different levels all was weak or moderate.
- From the participants point of view; The 4<sup>th</sup> paragraph 'You feel staff respect and courteous with you' was ranked the first position as a good indicator for accepting the gender sensitivity dimension with a mean of (3.72) and 4<sup>th</sup> level of agreement to be ranked firstly among all other paragraphs. 'The staff explains the procedure before starting' are also a positive point for providers from the participants view and ranked at the 2<sup>nd</sup> position

with a mean of (3.6). The participants were not ashamed to discuss reproductive or sexual problem, which can be concluded from their answers on the paragraph, ‘It was normal to discuss sexual and reproductive health issue’ and it is considered a positive point for providers with a mean of (3.52) and it come in the third level.

- The 1<sup>st</sup> paragraph ‘‘The staff introduces themselves before the procedure’ had the lowest ranking with a mean of (2.83) and first level of agreement, so it should be enhanced and developed.( see Figure 5.5 at list of appendix)

**Answer to the sixth question: What is the effect of privacy on the level of female’s satisfaction with RH services?**

Respondent’s answers show homogeneous results and readings for all items of the domain, the item ‘‘confidentially of information are clear’ had the highest score among all items while the item ‘The staff care for your privacy is clear’ had the lowest score.

The respondents were satisfied with this domain in general from all providers but there was a need for more attention and care from the health professionals to the participants’ privacy. Table (5.32) explains each item separately.

**Table (5.32) Means and S.D of privacy for all participants**

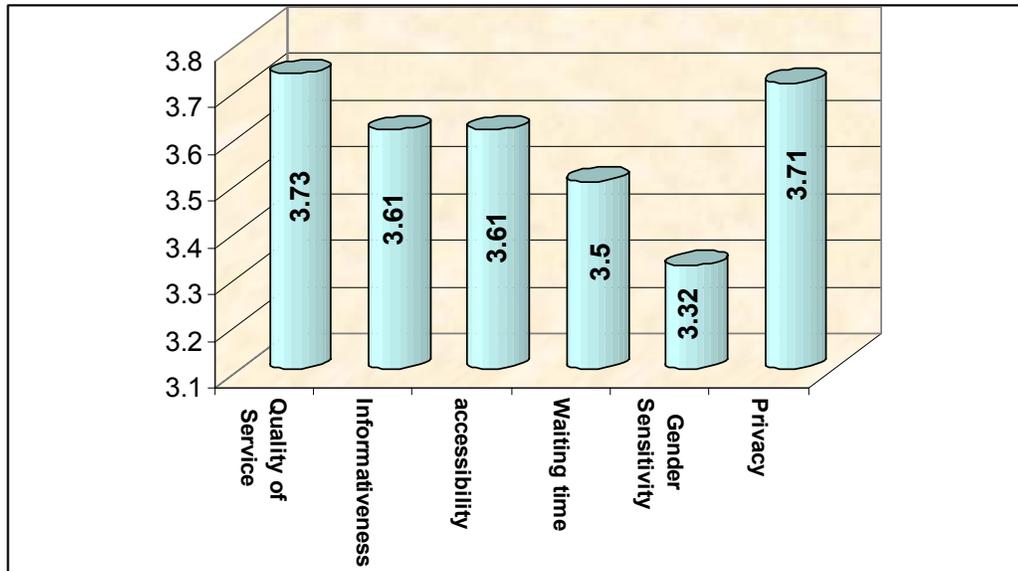
<b>No</b>	<b>Paragraph</b>	<b>Mean</b>	<b>S.D</b>
48	Confidentially of information are clear	3.78	0.478
46	The door was closed during your visit	3.74	0.322
47	Clean couch with clean towel	3.74	0.322
44	Exam room is equipped with privacy tools	3.69	0.398
45	The staff care for your privacy is clear	3.64	0.305
	<b>Privacy total</b>	<b>3.71</b>	<b>0.401</b>

### **Results of this dimension (privacy) show:**

- The total average of means (3.71) shows a moderate degree of agreement which gives this dimension the 4<sup>th</sup> level of agreement. The range of means was between (3.78 – 3.64) indicating to a homogenous readings, responding and answers with similar levels all was moderate.
- Participants indicates to the 5<sup>th</sup> paragraph ‘‘confidentially of information are clear’ to had the highest score to be considered the strongest point among all other paragraphs indicating good privacy, the mean was (3.78) moderate grade 4<sup>th</sup> level. ‘The door was closed during your visit’ ‘Clean couch with clean towel’ are also good indicators for privacy were participants gives those paragraphs a mean of (3.74) 4<sup>th</sup> grade of agreement. ‘Exam room is equipped with privacy tools’ this paragraph is agreed upon from participants to have the 3<sup>rd</sup> ranking in privacy with a mean of (3.69) 4<sup>th</sup> level. The 1<sup>st</sup> paragraph ‘‘the staff care for your privacy is clear’ had the lowest ranking with a mean of (3.64) and 4<sup>th</sup> level of agreement, so it should be enhanced and developed. (See Figure 5.6).

### **Summary for total means of all study dimensions**

From this important figure (5.1) which is seemed to be summary for all dimensions means, we can notice that the total mean for all dimensions is (3.58) which indicates a moderate degree of agreement from the 3<sup>rd</sup> level among all participants in the study. The means ranged between (3.73 – 3.32) indicating to a homogenous response and answers on the questionnaire generally. Results show that the 1<sup>st</sup> dimension; Quality of service is the strongest among all other paragraphs with a mean of (3.73) and 4<sup>th</sup> grade level of agreement while Gender Sensitivity dimension had the weakest level of agreement with a mean of (3.32) and moderate agreement from the 2<sup>nd</sup> level (also see table 5.40).



**Figure (5.1) the overall means of all study dimensions.**

**Answer to the Seventh question: What is the general level of satisfaction among married females with governmental, UNRWA and NGOs RH services and packages?**

Respondents answers show a relatively high level of general satisfaction; 64% of respondents were satisfied from the RH services provided in Ramallah district, 29% was very satisfied with those services. However, the remaining were either had no comments or were not satisfied with the services. This is explained in e table (5.33) and its interpretations:

**Table (5.33) participant's general satisfaction level with service provided**

The answer	Percentage	Frequency
Very satisfied	29.0	72
Satisfied	64.2	159
No comments	4.0	10
Not satisfied	1.6	4
Strongly not satisfied	1.2	3
<b>Total</b>	<b>% 100.0</b>	<b>248</b>

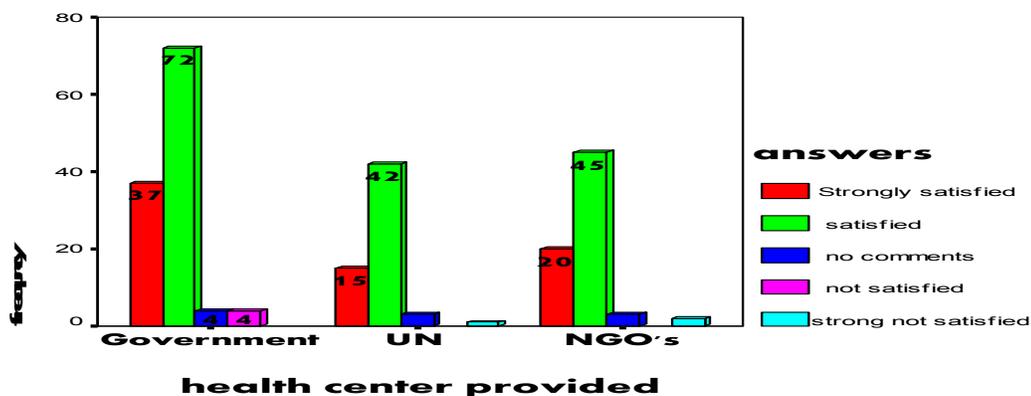
The justification of this results may be due to the continuous development of the Palestinian health care system during the past years through introducing a comprehensive health care services through a variety of approaches and tools to all people, and expanding the services in both quantitative and qualitative dimensions to ensure maximum coverage of quality health services, the vision of many providers was to introduce a comprehensive health care system contributes to continuous enhancing and developing of health care services in Palestine(MoH, 2010) .

**Answer to the eighth question:** Is there a difference in the level of satisfaction among participants in relation to type of health care providers?

In relation to the provider type, (43.9%) of the respondents were either strongly satisfied or satisfied from the governmental health. On the other hand, 26.2% of the respondents were either satisfied or strongly satisfied by the NGOs services; while 22.9% of the respondents were either satisfied or strongly satisfied by the UNRWA health services.

**Table (5.34) satisfaction level with each provider**

health center provided	Strongly satisfied	satisfied	no comments	not satisfied	strongly not satisfied
Government (%)	14.9	29.0	1.6	1.6	0.0
UNRWA (%)	6.0	16.9	1.2	0.0	0.4
NGO's (%)	8.1	18.1	1.2	0.0	0.8



**Figure (5.2) satisfaction levels with each provider.**

## 5.7 Testing of the study hypotheses:

To answer the research hypotheses, the researcher used L.S.D and Pearson correlation, One- Way Anova. Table (5.36) shows the results:

Table (5.35) correlations of dependant and independent variables

المحور	المتغير																	
	المؤسسة التي يتبع لها مركز الصحة الإيجابية		موقع عيادة الصحة الإيجابية		الفئة العمرية		عدد الزيارات		آخر زيارة		مكان السكن		الحالة الاجتماعية		الوضع المادي		المستوى التعليمي	
	F	Sig.	F	Sig.	F	Sig.	F	Sig.	F	Sig.	F	Sig.	F	Sig.	F	Sig.	F	Sig.
Quality Of Services	5.583	<b>0.004</b>	3.266	<b>0.040</b>	1.594	<b>0.176</b>	1.785	<b>0.151</b>	0.277	<b>0.842</b>	6.765	<b>0.001</b>	0.767	<b>0.465</b>	0.728	<b>0.536</b>	0.788	<b>0.534</b>
Informativeness	5.633	<b>0.004</b>	4.561	<b>0.011</b>	1.289	<b>0.275</b>	2.092	<b>0.102</b>	0.609	<b>0.610</b>	5.949	<b>0.003</b>	0.477	<b>0.621</b>	1.097	<b>0.351</b>	1.138	<b>0.339</b>
Accessibility	2.962	<b>0.054</b>	5.233	<b>0.006</b>	0.625	<b>0.645</b>	1.308	<b>0.272</b>	2.212	<b>0.087</b>	1.322	<b>0.268</b>	1.166	<b>0.313</b>	1.571	<b>0.197</b>	0.646	<b>0.630</b>
Waiting time	3.852	<b>0.023</b>	3.934	<b>0.021</b>	0.953	<b>0.434</b>	1.406	<b>0.242</b>	0.458	<b>0.693</b>	8.161	<b>0.000</b>	0.666	<b>0.515</b>	1.101	<b>0.349</b>	1.932	<b>0.106</b>
Gender Sensitivity	1.807	<b>0.166</b>	1.373	<b>0.255</b>	0.499	<b>0.737</b>	0.977	<b>0.404</b>	1.202	<b>0.310</b>	3.369	<b>0.036</b>	1.077	<b>0.342</b>	1.050	<b>0.371</b>	3.018	<b>0.019</b>
Privacy	4.870	<b>0.008</b>	5.403	<b>0.005</b>	1.404	<b>0.233</b>	2.186	<b>0.090</b>	0.850	<b>0.468</b>	6.816	<b>0.001</b>	0.989	<b>0.374</b>	0.954	<b>0.415</b>	0.706	<b>0.589</b>
<b>TOTAL</b>	<b>5.007</b>	<b>0.007</b>	<b>4.947</b>	<b>0.008</b>	<b>0.907</b>	<b>0.460</b>	<b>1.856</b>	<b>0.138</b>	<b>0.893</b>	<b>0.445</b>	<b>6.437</b>	<b>0.002</b>	<b>0.920</b>	<b>0.400</b>	<b>1.234</b>	<b>0.298</b>	<b>1.238</b>	<b>0.295</b>

\*The significant level is at  $\alpha \leq 0.05$ .

### 5.7.1 Results of hypothesis One:

The first hypothesis: **‘There is no significant difference at  $\alpha \leq 0.05$  with the level of satisfaction among married female in Ramallah district related to type of provider variable’.**

This Hypothesis was tested using One Way ANOVA test and the correlation results were presented in table (5.36) which indicates to the following.

There is a significant difference at  $\alpha \leq 0.05$  in four factors in relation to the type of provider (GOV, UNRWA, NGO's) which means that the answers of all participants were differ according to the provider type. This difference is clear in the following dimensions;

Quality of service Provided; the F value was (5.583) with significant level of (0.004), which considered significant at  $\alpha \leq 0.05$ . This means that the type of provider affects participant's level of satisfaction.

Informativeness; the F value was (5.633) with significant level of (0.004), which is considered significant at  $\alpha \leq 0.05$ . This means that the type of provider affects participant's level of satisfaction.

Waiting time; the F value was (3.852) with significant level of (0.023), which is considered significant at  $\alpha \leq 0.05$ . This means that the type of provider affects participant's level of satisfaction.

The Privacy; the F value was (4.870) with significant level of (0.008), which is considered significant at  $\alpha \leq 0.05$ . This means that the type of provider affects participant's level of satisfaction.

There is No significant difference at  $\alpha \leq 0.05$  in the other two factors in relation to the type of provider (GOV, UNRWA, NGO's). This means that the answers of all participants were

homogenous even if the provider is changed. This is manifested in the accessibility and Gender Sensitivity dimensions.

Following the total of all study dimensions in relation to the provider type at  $\alpha \leq 0.05$ , were the F values was (5.007), and significant level of (0.007), there was a significant level at  $\alpha \leq 0.05$  because the P value = 0.007 > 0.05 which means that answers of respondents are affected by the type of provider of the RH services (GOV, UNRWA, NGO's) which let us reject the hypothesis. 'Post hoc' tests are recommended to know why participant's answers were different in relation to provider type so (L.S.D.) test were used as follow:

**Table (5.36) L.S.D. test according to provider type**

<b>Provider A</b>	<b>Provider B</b>	<b>Mean Difference</b>	<b>Sig</b>
GOV	UNRWA	0.3375 *	0.002
	NGO's	0.0499	0.663
UNRWA	GOV	0.3375 *-	0.002
	NGO's	- 0.2876 *	0.024
NGO's	GOV	0.0499 -	0.663
	UNRWA	0.2876 *	0.024
*The mean difference is significant at the 0.05 level			

From table (5.37) we can notice significant differences among participants answers who receive the RH service from GOV, and others from UNRWA in the four dimensions mentioned above were the mean of participants from the GOV has 0.3375 difference and the level of significant was 0.002 which is less than 0.05 so this is considered as a significant difference indicating to difference in the participants answers.

From table (5.37) we can notice significant differences among participants answers who receive the RH service from NGO's and others from UNRWA in the four dimensions mentioned above were the mean of participants from the NGO's has 0.2876 difference and

the level of significant was 0.024 which is less than 0.05 so this consider as a significant difference indicating to difference in their answers.

The differences indicates to a significant difference level at  $\alpha = 0.05$  related to type of RH provider at Ramallah district were we noticed that clients of UNRWA were less satisfied with RH services than GOV clients or NGO's so the hypothesis was rejected.

### **5.7.2 Results of the second hypothesis:**

The second hypothesis was **'There are no significant difference at  $\alpha \leq 0.05$  with the level of satisfaction among married female in Ramallah district related location of service point variable'**.

This hypothesis was tested using One Way ANOVA which shows:

There is a significant difference at  $\alpha \leq 0.05$  in five factors in relation to the location of service center (CITY, VILLAGE, CAMP). This means that the answers of all participants were different according to the provider location, this difference is clear in the following five dimensions;

Quality of service Provided; the F value was (3.266) with significant level of (0.040) which is considered significant at  $\alpha \leq 0.05$ . This means that the location of provider affects participant's satisfaction level with the quality of service provider.

Informativeness; the F value was (4.561) with significant level of (0.011) which is considered significant at  $\alpha \leq 0.05$ . This means that the location of the provider affects participant's answers about Informativeness of service.

Accessibility; the F value was (5.233) with significant level of (0.006), which is considered significant at  $\alpha \leq 0.05$ . This means that the location of the provider affects participants' answers about accessibility to the center.

Waiting time; the F value was (3.934) with significant level of (0.021), which is considered significant at  $\alpha \leq 0.05$ . This means that the location of the provider affects participants level of satisfaction related to their waiting time.

The Privacy; the F value was (5.403) with significant level of (0.005) which is considered significant at  $\alpha \leq 0.05$ . This means that the location of provider affects participants' level of satisfaction with the privacy.

There is No significant difference in the last domain (Gender Sensitivity) in relation to the location of the provider (city, village, camp). This means that the answers of all participants were homogenous regardless of the provider location; this manifested in the Gender Sensitivity dimensions.

Following the total means of all the study dimensions in relation to location of provider there were significant difference at  $\alpha \leq 0.05$ , the F value was (4.947), and significant level of (0.008) because P value = 0.008 > 0.05. This means that answers of respondents are affected by the location of the provider of the RH services (city, village, camp) (so the hypothesis was rejected).

'Post hoc' tests are recommended to know why participants' answers were different in relation to provider type so (L.S.D.) test was used as follow:

**Table (5.37) L.S.D. test according to provider location**

Location a	Location B	Mean Difference	Sig
City	Village	0.3155 *-	0.004
	Camp	0.0073 -	0.949
Village	City	0.3155 *	0.004
	Camp	0.3082 *	0.013
Camp	City	0.0073	0.949
	Village	0.3082 *	0.013
*The mean difference is significant at the 0.05 level			

From this table we can notice a significant differences among participants answers who receive the RH service in a City and others in the Village in the most five dimensions mentioned above were the mean of participants from the village has 0.3155 difference and significant level of 0.004 which is less than 0.05 so this is considered as a significant difference indicating to difference in the participants answers.

From table (5.38) it is noticed a significant differences among the participants answers who receive the RH service from camps and others from villages in the five dimensions mentioned above were the mean of participants from the villages has 0.3072 difference and significant level of (0.013) which is less than 0.05 so this is considered as a significant difference indicating to difference in the participants answers.

Those differences indicates to a significant difference level at  $\alpha = 0.05$  related to location of RH provider at Ramallah district where it can be noticed that the clients from villages were more satisfied with RH services located in Ramallah city or camp so the hypothesis was rejected.

### **5.7.3 Results of the Third hypothesis:**

The 3<sup>rd</sup> hypothesis “**There are no significant difference at  $\alpha \leq 0.05$  with the level of satisfaction among married female in Ramallah district related to age variable.**”

This hypothesis was tested using One Way ANOVA test which shows:

There was No significant difference at  $\alpha \leq 0.05$  in all dimensions in relation to the age variable which means that's the answers of all participants were homogenous regardless of their age. Following the total means of all study dimensions in relation to the participants' age, there was no significant difference at  $\alpha \leq 0.05$  since the F value was (0.907), and significant level of (0.460), and because the P value =  $0.05 < 0.460$ . This means that the answers of respondents are not affected by the participant's age variable, so the hypothesis was accepted.

#### **5.7.4 Results of the fourth hypothesis:**

The fourth hypothesis was **‘There are no significant difference at  $\alpha \leq 0.05$  with the level of satisfaction among married female in Ramallah district related number of previous visits to the center.**

This hypothesis was tested using One Way ANOVA test which shows:

There was no significant difference at  $\alpha \leq 0.05$  in all dimensions in relation to the number of previous visits variable which means that’s the answers of all participants were homogenous regardless of their previous visits to the center.

There was No significant difference in all dimensions in relation to the number of previous visits variable which means that’s the answers of all participants were homogenous regardless of number of visits. Following the total means of all study dimensions in relation to the previous visits, there were no significant difference at  $\alpha \leq 0.05$  since the F value was (1.856), and sig level (0.138) and because the P value =  $0.05 < 0.138$ , this means that the answers of respondents are not affected by the number of previous visits to the center variable so the hypothesis was accepted.

#### **5.7.5 Results of the fifth hypothesis:**

The 5<sup>th</sup> hypothesis was **‘There are no significant difference at  $\alpha \leq 0.05$  with the level of satisfaction among married female in Ramallah district related to the period from the last visits to the center.**

This hypothesis was tested using One Way ANOVA test which shows:

There was no significant difference at  $\alpha \leq 0.05$  in all dimensions in relation to the duration from the previous visit variable, means that the answers of all participants were homogenous regardless of the duration from the previous visits to the center.

There was No significant difference in all dimensions in relation to the duration from the previous visit to the center variable which means that the answers of all participants were homogenous regardless of the period since the last visit. Following the total means of all study dimensions in relation to the previous visits, there were no significant difference at  $\alpha \leq 0.05$  since the F value was (0.893), and the level of significant was (0.445) and because

the P value =  $0.05 < 0.445$  this means that the answers of respondents were not affected by the period from the previous visits to the center variable, so the hypothesis was accepted.

#### **5.5.6 Results of the sixth hypothesis:**

The 6<sup>th</sup> hypothesis was **'There are no significant difference at  $\alpha \leq 0.05$  with the level of satisfaction among married female in Ramallah district related to place of residency variable'**.

This hypothesis was tested using One Way ANOVA test which shows:

There is a significant difference at  $\alpha \leq 0.05$  in 5 dimensions in relation to the place of residency variable (city, village, camp) which means that's the answers of all participants differed according to the participants location of residence. This difference is clear in the following five dimensions;

Quality of service Provided; the F value was (6.765) with significant level of (0.001), which is considered significant at  $\alpha \leq 0.05$ . This means the place of residence affects participants' level of satisfaction with the quality of service provided.

Informativeness; the F value was (5.949) with significant level of (0.003), which is considered significant at  $\alpha \leq 0.05$ . This means that the place of residence affects participants level of satisfaction with Informativeness of service.

Waiting time; the F value was (8.161) with significant level of (0.000), which is considered significant at  $\alpha \leq 0.05$ . This means the place of residence affects participants answers related to waiting time.

Gender Sensitivity; the F value was (3.369) with significant level of (0.036), which is considered significant at  $\alpha \leq 0.05$ . This means that the place of residence affects participants' level of satisfaction with Gender Sensitivity variable.

The Privacy; the F value was (6.816) with significant level of (0.001), which is considered significant at  $\alpha \leq 0.05$ . This means that the place of residency affects participants' level of satisfaction with the privacy.

There is No significant difference in last factor (accessibility) in relation to the participant’s place of residence (city, village, camp). This means that the answers of all participants were homogenous regardless their residency place, this manifested in the Accessibility dimension.

Following the total means of all study dimensions in relation to participants place of residency, there were a significant difference at  $\alpha \leq 0.05$  since the F value was (6.473), and the level of significant was (0.002), and because the P value = 0.002 < 0.005 this means that answers of the respondents are affected by their place of residence variable to get the RH services (city, village, camp) so the hypothesis was rejected.

‘Post hoc’ tests were recommended to know why participants answers were differ in relation to participants place of residency, so (L.S.D.) test were used as follow:

**Table (5.38) L.S.D. test according to participant’s place of residence**

<b>Location A</b>	<b>Location B</b>	<b>Mean Difference</b>	<b>Sig</b>
City	Village	0.3757 *-	0.000
	Camp	0.2679 *-	0.038
Village	City	0.3757 *	0.000
	Camp	0.1087	0.367
Camp	City	0.2679 *	0.038
	Village	- 0.1087	0.367
*The mean difference is significant at the 0.05 level			

From table (5.38) it can be noticed a significant differences among participants answers who live in a City and others who live in the village in the most five dimensions mentioned above were the mean of participants from the village was (0.3757) difference and the significant level was (0.000) which is less than 0.05 so this considered as a significant difference indicating to difference in their answers.

It also can be noticed significant differences among participants answers who live in a Camps and others who live in the city in the five dimensions mentioned above were the mean of participants who live in the Camps was (0.2679) difference and the significant

level was (0.038) which is less than 0.05 so this is considered as a significant difference indicating to difference in their answers.

Those differences indicates to a significant difference level at  $\alpha = 0.05$  related to participants place of residency at Ramallah district were it was noticed that the participants' who live in Ramallah city were less satisfied with RH services than participants who live in villages or a camp so the hypothesis was rejected.

#### **5.7.7 Results of the Seventh hypothesis:**

The seventh hypothesis was **‘There are no significant difference at  $\alpha \leq 0.05$  with the level of satisfaction among married female in Ramallah district related to duration of their marital status from the visit to the center.**

This hypothesis was tested using One Way ANOVA test which shows:

There was no significant difference at  $\alpha \leq 0.05$  in all dimensions in relation to the duration from the marital status variable which means that the answers of all participants were homogenous regardless of their marital status duration from the visits to the center.

There was No significant difference in all dimensions in relation to their marital status duration variable which means that the answers of all participants were homogenous regardless of their marital status duration. Following the total means of all study dimensions in relation to their marital status duration variable, there were no significant difference at  $\alpha \leq 0.05$  since the F value was (0.920), and significant level of (0.400), and because the P value =  $0.05 < 0.400$  this means that the answers of the participants were not affected by the duration of the participants marital status variable, so the hypothesis was accepted.

#### **5.7.8 Results of the Eighth hypothesis:**

The Eighth hypothesis was **‘There are no significant difference at  $\alpha \leq 0.05$  with the level of satisfaction among married female in Ramallah district related to their economic condition during their visit to the center.**

This hypothesis was tested using One Way ANOVA test which shows:

There was no significant difference at  $\alpha \leq 0.05$  in all study dimensions in relation to the participants economic condition variable, the answers of all participants were homogenous regardless of their economic condition during the visits to the center.

Following the total means of all study dimensions in relation to their economic condition variable, there was no significant difference at  $\alpha \leq 0.05$  since the F value was (1.234) with significant level of (0.298) and because the P value =  $0.05 < 0.298$  which means that the answers of respondents are not affected by the participant's economic condition during their visits to the center variable, so the hypothesis was accepted.

#### **5.7.9 Results of the Ninth hypothesis:**

The Ninth hypothesis was 'There **was no significant difference at  $\alpha \leq 0.05$  with the level of satisfaction among married female in Ramallah district related to their education level variable**'.

This hypothesis was tested using One Way ANOVA test which shows:

There is a significant difference at  $\alpha \leq 0.05$  in Gender Sensitivity dimensions in relation to the participants education level variable, that's the answers of all participants were different in this dimension according to the participants level of education, as follows:

Gender Sensitivity dimension; the F value was (3.018) with significant level of (0.019), which is considered significant at  $\alpha \leq 0.05$ , this means that the education level of the participants affects their satisfaction level with the gender sensitivity variable.

There was No significant difference in all other factor (Quality of service, Informativeness, waiting time, accessibility and privacy) in relation to the participant's educational level; means that the answers of the participants were homogenous in all those dimensions regardless to their educational level.

Following the total means of all study dimensions in relation to their educational level variable there was a significant difference at  $\alpha \leq 0.05$  the F value was (1.238) with significant level of (0.295). Because the P Value = 0.295 > 0.05, which means that the answers of the participants were affected by their educational level. , Therefore since the answers considered to be homogenous about their satisfaction with RH services provided at Ramallah district regardless of their level of education so the 9<sup>th</sup> hypothesis was accepted.

## **Chapter Six**

### **Discussion and recommendations**

#### **6.1 Introduction:**

In this chapter the researcher will discuss the main findings and results as the investigator's main aim was to assess the level of married female's satisfaction with reproductive health services in Ramallah district and factors affecting their satisfaction. This research study used a pretested questionnaire on 248 female's participants who attend a RH center to benefit from related services during the first three months of 2010.

The participants were selected from 12 centers of all those centers that provide RH services at Ramallah district. The results revealed relatively high level of general satisfaction with the service provided from different providers; 93.2% were satisfied or strongly satisfied with reproductive health services in Ramallah district from different kinds of providers while only 2.8% were not satisfied or strongly not satisfied with this service.

This level of high satisfaction should be justified. Many factors could be attributed to such level of satisfaction from which the incredible increase on the number of Primary Health Care Centers in the Palestine from 454 in 1994 to 693 in 2009 (MOH Annual Report 2010) which enhance the coverage and access and contributes to clients satisfaction in the area where the participants live. In addition, the competition policy among providers through fund raising, better coverage, and quality of services by all providers enhanced the quality

and quantity of services and may contributed to the increase in the satisfaction level among all clients.

These results are consistent and agree with other studies that have been conducted in several local and worldwide areas that have high level of satisfaction with RH service. for example a study done in Alexandria, Egypt in (1994), 69% of the nearly 600 women interviewed said they were satisfied with their most recent FP methods (Gadallah et al, 2003). Also this results are consistent with the conclusion of a study conducted at Malawi in 2009 were most women who delivered at the hospital were satisfied with the care offered. This satisfaction is mainly due to the frequent reviews of patients by nurses and doctors in the unit (Changole et al, 2010). As well, a study done in 2009 by Bleich et al in 21 European countries reported relatively high level of satisfaction with reproductive health care services (Bleich et al, 2009).

In addition, in the Islamic Republic of Iran a study done in Urmia University of Medical Sciences, reported 92% level of satisfaction with reproductive health services among women in urban areas compared to 94% level of satisfaction among women living in rural areas.. Another research carried out among rural women in Bali, Indonesia showed that 73.1% of the respondents were satisfied with women's health services available in their area and 94.5% of those who used contraception were satisfied with family planning services (Nanbakhsh et al, 2008).

A cross sectional study which was conducted in 2008 at Nablus hospital with the aim was to measure satisfaction with the services provided in Nablus Hospitals and to compare levels of satisfaction among governmental and nongovernmental hospitals. The results revealed a relatively high level of satisfaction more in nongovernmental hospitals with a rate of more than 90% with very good or good satisfaction level (Al Sharif, 2008).

In a cross-sectional study of patient satisfaction with care which was conducted over a period of 1 year from March 2004 to March 2005 in a secondary-level hospital in Karachi, Pakistan. Using the SERVQUAL tool and exit interviews, data were collected quarterly from a total of 1533 patients. Results show that the level of satisfaction of the patients with the outpatient health services provided (including RH services) were increased from 34.4% to 82.0% over the past year period (Iftekhar et al, 2010).

In 2002 a study was conducted by Hindi, F. to measure clients satisfaction with radiology services in Gaza Strip revealed that overall satisfaction exceeds 82%, lowest degree of satisfaction were reported toward communication/interaction, and continuity/affordability. Across sectional survey was conducted between January and August 2003 in primary health care centers at Capital Health Region, Kuwait, using a questionnaire included socio-demographic characteristics as well as the overall and differential satisfaction with the different aspects of services. Subjects aged above 50 years showed the highest overall and differential satisfaction. Male subjects and those who completed primary school showed the highest overall satisfaction. Other socio- demographic characteristics were not significantly related to overall satisfaction scores (Hindi, 2002).

In relation to the general satisfaction level and the researcher hypothesis, it was noted that there was a significant difference in relation to provider type were the governmental centers had the highest level of satisfaction, while the centers related to the NGOs ranked secondly and the UNRWA centers occupy the last rank. This could be related to the effort done by the governmental sector on the quality and coverage of the health services provided specially those for mother and child health. Several policies, procedures and directorates were added or modified in the past decade to meet the requirements of the quality of health service depending on the international and WHO recommendations. This include the following services; women health directorate, mother and child directorate, quality Department; family planning department, Palestinian Health Information Center (MoH report, 2008), and expanding the primary health care services to reach people in rural areas to become 693 center at the end of 2008( MoH report 2009).

- The location of the provider: the participant's answers showed a significant difference of (0.008) in their view of the importance of the location of provider. The results show that the participants were more satisfied with RH centers located in villages followed by centers located in cities while the centers located in camps had the lowest level of satisfaction. Those results could be due to the following factors; good accessibility as the geographical areas are smaller than cities and the centers in villages located within the catchment area of the participants and a lot of them can reach the center on foot as reported by 40% of study participants which lower the cost and increase satisfaction. In addition, due to small population

number, the waiting time in centers located villages should be less than others in cities or crowded camps which also allow for the informativeness and privacy dimensions to have higher level of satisfaction.

- Participants' place of residence: the participant's answers show a significant difference of (0.002) in relation to their area of resident. The results show that the participants who live in villages were more satisfied with RH services than those who live in Ramallah city or a camp. The previous interpretation on the location of the RH center is valid and explains this level of significant.

It seems that the satisfaction level of the participants was the highest among those who receive the RH services from a governmental center located in villages close to the participants' residence.

## **6.2 discussing Satisfaction domains**

Respondents in this research study express their satisfaction level with six important satisfaction factors from which was indicated in the literature review, those factors were: the Quality of Service provided, Informativeness from the service provider, waiting time, accessibility to the service center, Privacy during providing the service, and gender sensitivity.

**In the first domain "Quality of the service provided"** the participants show satisfaction from the 4<sup>th</sup> level with the quality of the services provided. The average mean of quality items were (3.73 degree). The highest item that's the participants were satisfied with was (the clinic was clean) with a mean of 3.9 degree while the lowest item participants were satisfied was 'staff gives individual attention'.

From those results it could be concluded that the cleanliness of the centers affects participants' level of satisfaction and they consider it the main aspect of the quality of the services provided to them. In spite of the lower level of participants' satisfaction with the item 'staff gives individual attention', it was clear that the mains of all items were very close to each other with no significant difference (0.04) between the highest and lowest items mean.

This closeness of results in the items gives the governmental sector higher level of satisfaction than the other two providers, could be due factors such as the center was built

recently and it still clean from inside since the governmental sector expands the number of PHCS in the past few years from 470 centre to 693 center while data show slow increase in the number of PHCS related to NGOs in addition now new centers reported for the UNRWA at the same period. Other factor could be that the center is the only one on the village (area) and the participants options were limited to make comparisons. Other factor could be the governmental insurance coverage to the participants in the study which decrease the cost of getting the service since they have to pay fees in the NGOs sector.

The crowdedness of clients in the UNRWA centers, the presents of the center in the catchment area of the participants, the availability of free of charge services (IUDs, Pills, Condoms), all are other factors that could explains this satisfaction level specially from the governmental sector in Ramallah district.

In relation to the participants variables mentioned in the researcher hypothesis, answers of participants show a significant difference in the following variables: type of provider, location of RH center and participant resident. It seems that the governmental centers provide higher quality services than the UNRWA or NGO's

This relatively high level of satisfaction with the quality of services provided at Ramallah district could be due to the implementation of the primary health care principles and needs made by different providers of the Palestinian health care sector in cooperation with international agencies and the WHO, were there was an increase of 52.9% on the number of PHCS in 2009 compared to 1994 in the public sector (5746 person/ center in 2000 to 5679/center in 2009 in spite of the population increase) (MoH, 2009).

The policy of quality improvement and quality assurance of the health services which was adopted by different providers in the past decade was reflected on the enhancements done on the main indicators of the Palestinian population as seen in MoH annual reports and lead to control over many diseases. In addition, the policies of fund raising and investment in the human resources as training and educating locally or internationally were all contributed to the quality of services provided. The number of health practitioners increased in the public sector from 7458 in 2000 to 14526 in 2009.

In related work; there was focusing on special programs by those providers to add to the quality of services provided as; School Health and education Program, Mother Health Handbook, dental health, mammography test, Family planning services and methods, antenatal and post natal care services, Pap smear test, community health officers, mental

health services and others. All those were considering being a corn stone in the quality of the services provided which will add to the level of satisfaction.

Comparing with related studies, in the study done at 2009 by Sara Bleich et al in 21 European countries were relatively high level of satisfaction was reported with reproductive health care services, quality of service was part of the recommendations from the study that contributes to increase patient's satisfaction (Bleich, et al, 2009). Another study done at a health centre in Malawi looking at quality of reproductive health care and its effects on utilization of maternity services at a primary level, a high degree of satisfaction was noted among patients with providers' attitude (97%), technical competence (86%), and working hours (91%). However, they expressed dissatisfaction with lack of privacy (Lule et al. 2000).

**In the second domain “Informativeness”** female's shows satisfaction from the 4th level with (middle level) with Informativeness. The average mean of Informativeness items was (3.61) degree. The highest item participants were satisfied with was “the health instructions were clear” while the lowest item the participants were satisfied with was “the health practitioner introduces himself/herself before the procedure”. These results could be explained by the effort made by different providers on the health instructions to be simple and easily understood through enough and well trained staff, or by giving pressures or other materials to the clients about RH services they seek. However, the lowest level of satisfaction was that the health practitioner didn't introduce himself/herself before the exam which is considered as a wrong practice that has to be enhanced.

In relation to research hypothesis, the participants were satisfied with this domain, answers show a significant difference in the provider type, provider location and participant place of resident. This could be explained by the enhancements made by different providers; especially the governmental provider, on the general aspects of the service quality and coverage as managing to reach people in rural areas, trained and motivated staff, knowledge of personnel and establishing new related departments by some of providers as the Palestinian health information center in MoH in 2003 in the MoH which contributes to increase the education and communication with clients and society in the catchment area.

For provider location, the participants were more informed about the RH service they seek in villages; this could be due to the small number of clients in centers in villages compared to crowded centers in cities and camps, which allows for the health practitioners to spend more time with RH services seekers and to give more detailed information.

For participants' place of residence, those who live in villages were more satisfied with informativeness domain than those who live in cities or camps. This could be due to a range of factors such as the center is the only one in the village that provides health care services. The second factor could be the number of the population in villages are generally less than number of population in cities and camps which means the number of clients seen by a RH practitioner in villages may be less than those in cities and camps which allow for the participants who lived in villages to spend more time and to get more information about the service they seek than those who live in cities and camps.

Compared with a study published in 2008 that assessed women's satisfaction with the reproductive health services in the population laboratory of Urmia University of Medical Sciences in 2003, a random sample of 600 married women aged 15–49 years completed a satisfaction questionnaire based on Bruce's criteria. Overall 76.2% of women were satisfied and 15.8% were completely satisfied with the total reproductive health service; however 34.0% of women were unsatisfied or completely unsatisfied with their health care provider. Factors that needed be improved were: providing all modern contraception methods in the health centers; using educational materials (e.g. pamphlets and brochures) at reproductive health consultations; and improving information given to clients to ensure informed choice of family planning method(Nanbakhsh et al, 2008).

**In the third domain 'accessibility'** the participants show satisfaction at the 4th level with accessibility. The average mean of accessibility items was (3.61) degree. The highest item that the participants were satisfied with was "you feel with safety while coming to the service point", while the lowest item was the "availability of car parking encourages you to visit this center".

These results could be explained by the fact that the centers were in the participant's area of residency and they didn't go long distance to access the center. It worth saying that this study was conducted at the same district (Ramallah) from the participants who seeks RH services inside the same geographical area which lowers the possibilities of being unsafe to access the centers of different providers.

However, they were less satisfied with the item related to the availability of parking because the providers didn't pay attention to provide enough parking area or that the parking area was small and crowded.

In relation to research hypothesis, answers show a significant difference in relation to level of satisfaction with the location of the provider. Since the access to RH centers was reasonable and most of the participants (93%) manage to reach the center with less than half an hour as shown in table (5.23) indicating to success of increasing the coverage policy made by different providers. In relation to the provider location, participants were more satisfied from centers located in villages since they pay less time, and cost (generally no internal transportations fees) to access those centers in this small geographical area in addition to lower number of clients compared with centers located in cities and camps. Comparing with a study published in 2008 and done at Nablus district to study the satisfaction with accessibility domain, a total of 80% of respondents rated accessibility of services in hospital to be in range of good to very good indicating to high satisfaction level (Al Sharif et al, 2008).

In 2003 by the Eastern Mediterranean done at Egypt that compares patient satisfaction with primary health care services and identifies factors associated with patient satisfaction in two health districts in Egypt where a project for upgrading primary health care services had been running for 3 years, Patient satisfaction was high for accessibility, waiting area conditions and performance of doctors and nurses. The main complaints centered on the availability of prescribed drugs and laboratory investigations (Gadallah et al, 2003).

**The fourth domain was 'waiting time'**: the participants show satisfaction from the 3<sup>rd</sup> level with waiting time. The average mean of waiting time items was (3.5) degree. The highest item participants were satisfied with was the time inside the examination room was reasonable while the lowest item were satisfied with was the waiting time to enter the examination room. This indicates to the need to reduce the waiting time for patients to

enter the examination room as long waiting time will affect the level of patients satisfaction.

This could be explained that, from the participants point of view, it is better to spend more time with the health practitioner and they consider it a positive point for different provider; the time inside the examination room was satisfactory to the participants since this gives them enough time to talk and discuss their needs with the health care provider.

However, the participants expressed their lower level of satisfaction with the waiting time before entering the examination room. This indicates the need to reduce this time through increasing the RH staff and number of clinics especially in cities, increase the working days for MCH services.

In relation to research hypothesis of this domain, answers show a significant difference in the provider type variable, provider location and participant place of resident. Those results indicate that the provider type variable affects the waiting time, and as shown before, the public sector had the highest level of satisfaction which could be due to the vast increase in the number of PHCS leading to better distribution of health services and reduces the number clients to the same center and reduces the waiting time. Or, in small localities and villages, the governmental centers could be the only in this rural area so the small number of clients had no other option to compare the services with.

In addition, the location of the center were close to the participants place of residence, that have been discussed before, had an important effect since centers in villages had less number of clients than crowded centers in cities or camps leading to reduction in waiting time and increasing in the level of satisfaction.

This agreed with a study conducted **In 2008** in Nablus city, Palestine with the objectives were to measure patients' satisfaction with services provided by hospitals at Nablus city, patients who were waiting long time (more than one hour), were less satisfied than the others, while obstetric patients were found to be the most (Al Sharif et al, 2008).

**The fifth domain was 'Gender Sensitivity'**: the participant's level of satisfaction came on the 2<sup>rd</sup> level with this domain. The average mean of Gender Sensitivity items was (3.32) degree. The highest item participants were satisfied with was 'the feeling of

welcoming and respect from the staff' while the lowest item was satisfied with was 'the health practitioner introduces himself'.

The findings could be explained by importance of the public relations and communication with patients that the staff was well trained. In addition, the culture of our population generally is courteous and people tend to respect and help clients since the community is small and the people know each other. However, participants show lower satisfaction level with the item 'the health practitioner introduces himself' which could be for the same reasons mentioned in the Informativeness domain. One reason for low satisfaction on this domain is that there are male doctors who still provide MCH services to women in the clinics which is not well accepted culturally in the Palestinian society. Therefore, there is a need to hire more female physicians at the RH clinics.

In relation to research hypothesis for this domain, the participants' answers show a significant difference in the participants' educational level and place of resident in relation to gender sensitivity. The sensitivity of this domain was reflected on the answers of the participants due to the religious, cultural habits and knowledge of the participant, and it was concluded the more the educational level the more the satisfaction from RH services in relation to gender sensitivity domain.

In addition, the participants who live in villages were more satisfied with the services from those who live in camps or cities. This could be due to the presents of a female health practitioner in centers located in villages. However, it seems that the providers of RH services manage to overcome this problem by assigning female health practitioners in spite of the shortage of females in the Palestinian health care sector (ref.). This manifested in table (5.15) were more than 70% of participants received the RH service from a female health practitioner.

In 2004 dissemination of the results of the survey held by the Palestinian Central Bureau of Statistics revealed that's the main reason for choosing the site to receive contraceptives was the quality of services provided (85.2%) followed by having a female health practitioner from the provider (67.3%), the followed survey in 2007 indicates to low percentage of female's health workers; only 8% of all governmental physicians are female doctors, and 34% of nurses are females (PCBS, 2004 surveys)

In 1996 a local research study conducted by The Women's Coalition and Birzeit Community Health Unit, Palestine disseminated the results of 1793 women interviews which reveal that 82% of them preferred provision of the health service from a health professional of the same sex (Women's Center for Psychological and Social Counseling, 2008).

**The 6<sup>th</sup> domain was 'Privacy':** female's shows satisfaction from the 4th level with Privacy. The average mean of Privacy items was (3.71) degree. The highest item was "the staff maintained confidentiality" which means the staff has good ethical practice, there is privacy in examination rooms, and there is confidentiality in interpersonal communication, documentation and archiving system. .

In relation to research hypothesis, answers show a significant difference in the provider type variable, provider location and participant place of resident in relation to privacy domain. Since patient privacy in health care settings is a universal concern, patient must feel that it is safe to communicate such information freely (Cedric, 2003). In addition, in our community it is so important to deal with privacy carefully taking into consideration the cultural, religious and lifestyle aspects. In this research study most of participants show a relatively high level of satisfaction with this domain indicating to the care provided by different health care providers to the privacy domain and its requirements and tools.

From the results of this study, it is noted that the participants were satisfied with privacy from governmental centers which could be due to the availability of privacy measures, and the high training of staff on privacy maintenance. In relation to provider location, participants were more satisfied with privacy in centers located in villages followed by camps and cities. This could be due to the special precautions taken by managers and staff of those centers while dealing with the conservative population living in villages.

This satisfaction is consistent with other studies such as the study which was implemented by the partners for Health Reform Plus Project in Jordan during August 2005 at the Ministry of Health (MoH) adult hospitals. Overall, MoH hospitals in Jordan appear to be doing a relatively good job at providing services to their patients. Patients were generally satisfied with the admissions process, safety and privacy issues, and the cleanliness of their

rooms, and they were very impressed with the technical knowledge of physicians and nurses. On the other hand, significant gaps in communication exist among MoH physicians, nurses, and patients (Al -Badayneh. 2006).

When comparing the current study with a study done in Egypt that investigated the factors which influenced client's satisfaction with primary health care services, it was found that the level of privacy in the consultation room was described as unsatisfactory by 33% of Egyptian clients (Gadallah, 2003). This indicates that the participants of this study were more satisfied with the level of privacy than the Egyptian participants.

Another study done at a health centre in Malawi looking at quality of care and its effects on utilization of maternity services at a primary level, participants expressed dissatisfaction with lack of privacy (Lule et al,2000), which means that in the Palestinian MCH clinics there is more satisfaction of clients with privacy domain.

### **6.3 Summary and conclusion**

In this research study, 248 married females were participating in this research study as a prerequisite for the master degree in health policies and management program with the main aim was to assess their satisfaction level with RH services provided in Ramallah district.

Participants show a relatively very high level of satisfaction. There was a 3rd level of overall agreement among participant's answers on all the 6 domains studied in this research. The means ranged from 3.32 to 3.73. The "quality of service provided" was the dimension that had the highest satisfaction level. On the other hand, gender sensitivity domain was the lowest in level of satisfaction for the participants.

In relation to the factors which played major roles in influencing the participant's satisfaction with MCH services, the type of provider was significantly correlated. It is concluded that that the governmental centers ranked firstly among the care provided. The second factor was the place of residence where those living in villages were more satisfied with the service provided. As well, those participants who received health care from a center that is close to their area of living were more satisfied than the others.

Waiting time before entering the examination room is questionable and attention should be paid to such a domain from all providers since participants show low satisfaction level with this item. In addition, there is a need to hire female health care providers to take care of the MCH needs of the women in all health sectors, which can increase female clients satisfaction with the care provided.

This level of satisfaction is consistence with other research studies locally and internationally and could be justified with the competition among providers in terms of coverage, funding, and quality of services while providing RH services.

## **6.4 Recommendations**

**From this study, the researcher came up with the following recommendations that are classified into three levels, as follows:**

### **Recommendations for the policy makers level:**

- The importance of reproductive health services in communities indicates to the need for making those services available in terms of coverage and quality in the majority of primary health care centers.
- There is a need for community mobilization and education about the importance of reproductive health issues and how to benefit from the related services.
- There is a need for training for different types of providers and staff members at the national level, to enhance the quality of the services provided according to the international standards.
- Increase the number and distribution of MCH services to ease accessibility and decrease costs of services and time of seeking health care.
- Increase funding and financial support for centers that provide MCH services, in order to improve their quality of care, the general environment, and the infrastructure of clinics.
  - It is highly recommended that waiting time before entering the examination room had to be reduced through increasing the days of services provided.

### **For future research studies:**

**At the level of future research, it is highly recommended to:**

- There is a need to study other variables that could influence the level of satisfaction of clients with MCH services.

- This study is limited to Ramallah district; therefore there is a need to conduct other studies at other districts to make comparisons between the services. To use other tools to measure the level of satisfaction of the women who receive MCH services, in order to see if there will be differences of findings.

**For Health Care Providers:**

- It is highly recommended for a RH practitioner to be from the same gender, or that a female nurse attends during examination of the woman.
- It is highly recommended that all health practitioners have to introduce themselves to the clients whether orally or by holding a tag name before initializing the health examination.
- Examination rooms should be equipped with privacy measures such as shutters, screens and towels.
- Staff care and cooperation is an important item that increases client's satisfaction with health services, thus this should be emphasized by all health care providers. Onsite training should be done to staff of clinics in regards to interpersonal skills and communication.

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**List of appendix:**

**(Appendix 1) RH packages indicated by Cairo conference, 1994**

1-	Reproductive Wright	Reproductive education, support and counseling
2-	Sexual and RH services	Providing the related services of: Consulting, family planning, providing of contraceptives, pregnancy, pre and postnatal care, fertility, monopole, STD, mammography, uterine swapping, laboratory and Psychological support.
3-	unsafe Abortion services	Education and consultations
4-	Urgent Abortion needs	Medical evolution, operations, follow-up, transferring, urgent abortion contraceptives
5-	Post abortion services	Antibiotics, pain killer, hospitalization and Psychological support.
6-	Follow-up and monitoring	Availability for standard protocols for delivering SRH services, information system and indicators for quality services, abortion statistics.

**(Appendix 2) MoH centers delivering reproductive health services at Ramallah district**

<b>Number</b>	<b>Provider</b>	<b>Location</b>
1	MOH	Neileen
2		Biet Reema
3		Qibia
4		Dier Abu Mish'al
5		Silwad
6		Turmus'aya
7		Singil
8		Mazraa Sharqeya
9		Kufur Ni'meh
10		EL Taybeh
12		Shuqba
11		Abood
13		Bani Hareth
14		Rantees
15		Alluban Algharbi
16		Ras Karkar
17		AL Mughayer
18		Aaroura
19		Ubueen
20		Diar Dubwan
21		Ein Yabroud
22		Kufur Malik
23		Kouber
24		Doura El Qaryi
25		Shibteen
26		Diar Ammar
27		Bani Ziad
28		Kharbatha Musbah
29		Saffa
30		Biet Ellu
31		Bietunia

<b>Number</b>	<b>Provider</b>	<b>Location</b>
32		Abu Fallah
33		Bil'een
34		AL Mazraa Gharbeyeh
35		Atara
36		Dier Bzeei
37		Burqa
38		Bitteen
39		Bie 'Uor Tahta
40		Dier Qiddees
41		Dier Jareer
42		Biet Liqya
43		Biet seera
44		Al Tereh
45		Bier Ziet
46		Ramallah Tahta
47		Umumet El Biereh
48		Diar Essudan
49		Mazarei Ennoubani
50		Dier Nizam
51	UNRWA	Amaari
52		Jalazoun
53		Qalandya
54		Biet Sureek
55		Dier Ammar
56		biet 'our Tahta
57		Aien Areek
58		Moblie Clinic
59	HWC	Kufur Neimeh
60		Mazraa Sharqeyeh
61		Mobile Clinic
62	PHC	Mughayer
63		Turmusayya
64		Sinjil

<b>Number</b>	<b>Provider</b>	<b>Location</b>
65		Dier Ghasaneh
66		Aboud
67		Mobile Clinic
68	PRCS	Ramallah
69		Biereh
70		Silwad
71		Dier Abu Mishaal
72		Biddu
73		Qatanna
74	PFPPA	Ramallah

Appendix 3: The questionnaire in Arabic:



بسم الله الرحمن الرحيم

جامعة القدس

كلية الصحة العامة

برنامج السياسات والتخطيط الصحي

## إستمارة

أختي المراجعة :

يقوم الباحث بإجراء دراسة بعنوان

**" رضى الشباب المتزوجات من خدمات الصحة الإنجابية المقدمة فى منطقة رام الله "**

وذلك ضمن متطلبات الدراسات العليا في برنامج ..... - جامعة القدس .

الرجاء الإجابة على أسئلة الاستمارة بكل صدق وموضوعية، علما بأن المعلومات التي سيتم جمعها سوف تستخدم فقط لأغراض البحث العلمي ، وستعامل بسرية تامة .

وشكرا لتعاونكم

بإشراف : د . محمد شاهين

الطالب : أيمن أبو محسن

## القسم الأول : خلفية المبحوث

1. عيادة/ مركز الصحة الإيجابية التابعة ل:  
 وزارة الصحة  للوكالة  جمعية غير حكومية  خاصة

2. عيادة/ مركز الصحة الإيجابية الواقع في :  
 المدينة  البلدة  القرية  المخيم

3. الفئة العمرية:  
 (من 15 الى 19 O) (من 20 الى 24 O) (من 25 الى 30 O)  
 (من 31 الى 35 O) (36 سنة فأكثر O).

4. هذه هي الزيارة :  
 الأولى  الثانية  الثالثة  أربعة فأكثر

5. متى كانت آخر زيارة للمركز:

قبل اقل من شهر  من شهر إلى ستة أشهر

من ستة أشهر الى سنة  أكثر من سنة

6. مكان السكن: مدينة  قرية  مخيم

7. الحالة الاجتماعية: متزوجة  منفصلة  أرملة

8. كيف تصفين وضعك المادي :

ضعيف  متوسط  جيد  جيد جدا

9. المستوى التعليمي:

ابتدائي O اعدادي O ثانوي O جامعي O أكثر من ذلك O

القسم الثاني: محاور الدراسة

الرجاء اختيار مدى موافقتك على العبارات التالية بدقة:

1- غير موافقة مطلقا 2- غير موافقة 3- لا اراي لي 4- موافقة 5- موافقة بشدة

الرقم	السؤال	غير موافقة مطلقا	غير موافقة	محايدة لا رأي لي	موافقة	موافقة بشكل مطلق
	المحور الأول : جودة الخدمة	1	2	3	4	5
1	الخدمات اجمالا كانت ممتازة كما كان متوقعا اصلا	1	2	3	4	5
2	ان المشكلة الصحية التي اتيت من اجلها قد عولجت	1	2	3	4	5
3	انك حصلت على العلاج / الوصفة المناسبة لهذه المشكلة	1	2	3	4	5
4	كان واضحا اهتمام مقدم الخدمة الكبير بمشكلاتك الصحية	1	2	3	4	5
5	شعرت بانك مرحب بك من الموظفين بشكل عام	1	2	3	4	5
6	اجمالا شعرت باهتمام الموظفين طوال مراحل الخدمة في المركز	1	2	3	4	5
7	الموظفين حافظو ان يكون وقت الانتظار مناسباً في المركز	1	2	3	4	5
8	شعرت باهتمام خاص من كل موظف طوال مراحل الخدمة في المركز	1	2	3	4	5
9	موظفو المركز كانوا يقدمون العون كلما اقتضى الامر	1	2	3	4	5
10	انت تثقين بهذا المركز لان سمعته جيدة بتقديم الخدمات الصحية	1	2	3	4	5
11	انت تشعرين بالراحة لان الاطباء والعاملين مؤهلين ولديهم خبرة في تقديم هذه الخدمة	1	2	3	4	5
12	الاطباء والموظفين كانوا ينادونك باسمك الشخصي	1	2	3	4	5
13	شعرت ان الموظفين كانوا لطيفين معك	1	2	3	4	5

الرقم	السؤال	غير موافقة مطلقا	غير موافقة	محايدة لا رأي لي	موافقة	موافقة بشكل مطلق
14	مكتب الطبيب نظيفا	1	2	3	4	5
15	العاملون الصحيون يستخدمون ادوات مخصصة نظيفة	1	2	3	4	5
16	التعليمات الطبية عن الوصفة سهلة الفهم	1	2	3	4	5
	<b>المحور الثاني : التعليمات والمعلومات</b>					
17	المعلومات من موظف الاستقبال كانت واضحة و مفهومة	1	2	3	4	5
18	المعلومات عن الخدمات التي يقدمها المركز كانت معروفة لك	1	2	3	4	5
19	شعرت بانك مرحب بك من الموظفين بشكل عام	1	2	3	4	5
20	الطبيب او مقدم الخدمة عرف على نفسه قبل الفحص	1	2	3	4	5
21	كان واضحا اهتمام الطبيب الكبير بمشكلاتك الصحية	1	2	3	4	5
22	كان هنالك شرح مفسر ومفهوم عن وضعك الصحي	1	2	3	4	5
23	كان هنالك ارشادات طبية واضحة عن طرق معالجة المشكلة التي اتيت من اجلها	1	2	3	4	5
24	كان هنالك نصائح طبية واضحة عن طرق الوقاية من هذه المشكلة في المستقبل	1	2	3	4	5
25	اللافتات والارمات التي تدل على المركز وبداخل المركز متوفرة بشكل مفهوم	1	2	3	4	5
	<b>المحور الثالث : الوصول للمركز</b>					
26	الوصول للمركز كان سهلا	1	2	3	4	5
27	المواصلات كانت متوفرة	1	2	3	4	5
	الوقت المطلوب أثناء الذهاب والإياب للمركز كان معقولا	1	2	3	4	5

الرقم	السؤال	غير موافقة مطلقا	غير موافقة	محايدة لا رأي لي	موافقة	بشكل مطلق موافقة
28						
29	المركز ضمن مسافة معقولة (نفس القرية المخيم أو المدينة)	1	2	3	4	5
30	كانت تكلفة الوصول للمركز المادية معقولة	1	2	3	4	5
31	قدومك للمركز كان أمانا	1	2	3	4	5
32	وجود موقف للسيارات تابع للمركز يشجعك للحضور اليه لاخذ الخدمة	1	2	3	4	5
<b>المحور الرابع : وقت الانتظار</b>						
33	انجاز اجراءات التسجيل كان سريعا	1	2	3	4	5
34	الموعد لاخذ الخدمة كان مناسباً	1	2	3	4	5
35	وقت الانتظار قبل الدخول لغرفة الفحص كان مناسباً لك	1	2	3	4	5
36	الوقت الذي قضيتيه اثناء الفحص مع الموظف كان مناسباً لك	1	2	3	4	5
37	إجمالي الوقت المستغرق لأخذ الخدمة جميعها كان مناسباً لك	1	2	3	4	5
<b>المحور الخامس : اختلاف جنس مقدم الخدمة</b>						
38	قام العاملون بتقديم أنفسهم لك قبل الفحص	1	2	3	4	5
39	لقد تم الفحص بواسطة موظف ذكر وكان الامر مقبول لك	1	2	3	4	5
40	تم التوضيح لك عن الفحص الذي سيجرى لك بشكل مفهوم	1	2	3	4	5
41	شعرت بالاحترام والتعاطف من الموظفين	1	2	3	4	5
42	لم تشعرين بحرج شديد من النقاش عن موضوع الصحة الجنسية أو الإنجابية	1	2	3	4	5
<b>Privacy المحور السادس : الخصوصية</b>						
43	اهتمام العاملون بخصوصيتك أثناء الفحص كان ملحوظا	1	2	3	4	5
44	غرفة الفحص مجهزة بوسائل الحفاظ على الخصوصية	1	2	3	4	5
45	الموظف اغلق باب الغرفة حفاظا على خصوصيتك	1	2	3	4	5
46	تزود سرير الفحص باغطية نظيفة كان ملاحظا	1	2	3	4	5

الرقم	السؤال	غير موافقة مطلقا	غير موافقة	محايدة لا رأي لي	موافقة	موافقة بشكل مطلق
47	الطاقم يحافظ على سرية المعلومات بشكل مناسب	1	2	3	4	5

### القسم الثالث : الخدمات

#### الخدمات التي يقدمها المركز :

يرجى وضع إشارة دائرة حول الإجابة المناسبة :

يقدم المركز خدمة	الإجابات
A.1 : رعاية الحامل	نعم لا
A.2 : خدمات رعاية واضعات	نعم لا
A.3 : خدمات عقم	نعم لا
A.4 : خدمات سن الأمان	نعم لا
A.5 : معالجة الأمراض المنقولة جنسيا	نعم لا
A.6 : مسحة عنق الرحم	نعم لا
A.7 : تصوير الماموغرافي للتثدي	نعم لا
A.8 : تثقيف واستشارة صحية	نعم لا
A.9 : خدمات تنظيم الأسرة واعطاء وسائل منع الحمل	نعم لا
A.10 : خدمات الاجهاض ومعالجة مضاعفاته	نعم لا
A.11 : خدمة التحويل للمستشفى للولادة	نعم لا

#### الخدمة التي حصلت عليها في الزيارة الأخيرة :

يرجى وضع إشارة دائرة حول الإجابة المناسبة :

حصلت على خدمة	الإجابات
B.1 : رعاية الحامل	نعم لا
B.2 : خدمات رعاية واضعات	نعم لا
B.3 : خدمات عقم	نعم لا
B.4 : خدمات سن الأمان	نعم لا
B.5 : معالجة الأمراض المنقولة جنسيا	نعم لا

لا	نعم	B.6 : مسحة عنق الرحم
لا	نعم	B.7 : تصوير الماموغرافي للثدي
لا	نعم	B.8 : تثقيف واستشارة صحية
لا	نعم	B.9 : خدمات تنظيم الاسرة واعطاء وسائل منع الحمل
لا	نعم	B.10:خدمات الاجهاض ومعالجة مضاعفاته
لا	نعم	B.11 : خدمة التحويل للمستشفى للولادة
B.12 : خدمات أخرى ( حدي ) :		

. الخدمات بشكل عام :

1. ما مدى رضاك من الخدمة خلال الزيارة السابقة للمركز:  
 راضية جدا  راضية  لا اراي لي  غير راضية  غير راضية جدا
2. لقد اخترت هذا المكان لتلقي خدمات الصحة الإنجابية لأنه:  
 اقرب مكان  بسبب وجود خدمة خاصة بالمكان  سمعة المكان  سبب آخر
3. لقد علمت عن المركز والخدمات التي يقدمه من:  
 صديقة  جاره  امك  حماتك  زوجك  الراديو  التلفاز  الجريدة  غير ذلك
4. الشخص الذي قدم لك الخدمة التي اتيت من اجلها:  
 الممرض  الطبيب  الممرضة  الطبيبة  العامل الصحي  لا اعلم  غير ذلك
5. الاحترام والخصوصية اثناء تقديم الخدمة ( الفحص ) كانت كبيرة وملموسة:  
 موافقة بشدة  موافقة  لا اراي لي  غير موافقة  غير موافقة بشدة
6. كان عمر الشخص الذي قدم لك خدمة الصحة الانجابية:  
 من 20-30 عاما  من 31-40  من 41-50  اكثر من 50 عاما

القسم الرابع : الاختيار من متعدد :

يرجى وضع دائرة حول الحالة المناسبة في كل مما يلي :

1. مضي على زواجك:  
 سنه  سنتين  ثلاث سنوات  أربع سنوات  غير ذلك .
  2. لديك أولاد : لا  نعم
- إذا كانت الإجابة نعم ، كم عدد الأولاد :

واحد  اثنان  ثلاثة  اكثر من ذلك .

3. انت حامل الآن: لا  نعم .

إذا كانت الإجابة نعم ، في أي مرحلة :

في الثلاثة أشهر الأولى من الحمل  الثانية  الثالثة .

4. انت تستعملين الآن وسيلة منع الحمل: لا  نعم

إذا كانت الإجابة نعم ، ما نوع الوسيلة :

طبيعي  حبوب  لولب  واقي ذكري  غير ذلك

5. في السابق هل استعملت إحدى وسائل المنع هذه: لا  نعم

إذا كانت الإجابة نعم ، ما نوع الوسيلة :

طبيعي  حبوب  لولب  واقي ذكري  غير ذلك

6. المهنة المعتادة:

عامله  طالبه  موظفه  ربة بيت  مزارعه  غيره .

7. انتظرت حتى سمح لك بالدخول للغرفة الطبيب او الفحص:

حتى 10 دقائق  من 10-20 دقيقة  من 20-30 دقيقة

من 30-60 دقيقة  أكثر من ساعة

8. استغرق وقت الفحص داخل الغرفة:

حتى 5 دقائق  من 5-10 دقيقة  من 10-15 دقيقة

من 15-20 دقيقة  اكثر من ساعة

9. حضرت الى المركز :

لوحدهك  مع زوجك  مع سلفتك  مع حماتك  مع امك  غير ذلك

10. المسافة التي قطعتها للوصول للمركز كانت حوالي :

اقل من 1 كم  من 1-2 كم  من 3-4 كم

من 5-6 كم  من 7-8 كم  اكثر من 8 كم

11. وصلت للمركز:

مشيا على الاقدام  بواسطة سيارة  بواسطة باص  بواسطة تكسي

12. استغرق وصولك للمركز (مشيا أو بالسيارة) :

حتى 10 دقائق  من 10-20 دقيقة  من 20-30 دقيقة

من 30-60  دقيقة أكثر من ساعة

القسم الخامس : ما أهمية العوامل التالية لاختيارك هذه العيادة لتلقى الخدمة:

غير مهمة	مهمة نسبيًا	مهمة جدًا	
			1. توفر الحفاظ على الخصوصية
			2. سهولة الوصول للعيادة
			3. سهولة التعامل مع الطاقم الموجود بالعيادة
			4. لان وقت الانتظار قليلا
			5. لان مواعيد الحصول على الخدمة مناسبة
			6. لانك تتلقي الخدمة من طاقم نسائي متخصص
			7. لان الخدمات ذات جودة ومميزة

### القسم السادس :

#### A . الأسئلة المفتوحة :

A.1 : الرجاء ذكرنا لنواقص أو المشاكل المهمة التي واجهتك داخل المركز:

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A.2 : الرجاء ذكر بعض الاشياء التي رغبتك باخذ الخدمة من هذه العيادة :

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ما مدى شعورك بالرضا العام عن الخدمة المقدمة في هذه العيادة:

راضية جد  راضية  لا اري لي  غير راضية  غير راضية جدا

انتهت الاستبانة

مع الشكر

الباحث

ايمن ابو محسن

#### Appendix (4) : The questionnaire in English

**Part one: Participant demographic data**

**date of visit:**

**1- Reproductive health center service that provided by:**

Government  UN  NGO's.

**2- Reproductive health center service that's located in:**

City  town  Village  Camp.

**3- Age Group between:**

(15-19)  (20-24)  (25-30)  (31-35)  above 35.

**4- This is:**  the first visit  the 2nd  the 3rd  more than 3.

**5- The last visit was before:**

Less than a month  from 1-6 months  from 7-12 months  
 more than 12months.

**6- Residency place:**  city  village  camp

**7- Marital status:**  married  divorced  widow

**8- Your economic conditions are:**  weak  middle  good  very good

**9- Your educational level:**  elementary  primary  secondary   
 university  else.

**Part Two:**

Please select your agreement range for the following sentences according to the following scale:

**Don't agree absolutely    2- Don't Agree        3- No Comments        4- Agree**  
**5-Agree absolutely.**

No	The question	Don't agree absolutely	Don't agree	No Comments	Agree	Agree absolutely.
	<b>Quality Of Services :</b>					
1	Generally the service was according to expectations.	1	2	3	4	5
2	Your health problem is solved	1	2	3	4	5
3	You got the needed treatment of this problem.	1	2	3	4	5
4	The health professional was caring about your problem.	1	2	3	4	5
5	You were appreciated by the staff	1	2	3	4	5
6	The staff in general was caring about u during the whole service	1	2	3	4	5
7	The staff didn't keep you waiting	1	2	3	4	5
8	Staff gives individual attention	1	2	3	4	5
9	The staff were helping when needed	1	2	3	4	5
10	You trust this center due to The good reputation.	1	2	3	4	5
11	Experience and accreditation of the staff makes you feel better.	1	2	3	4	5
12	The staff was calling you by your name	1	2	3	4	5
13	The staff was courteous	1	2	3	4	5
14	The clinic was clean	1	2	3	4	5
15	The staff uses standard clean instruments	1	2	3	4	5

No	The question	Don't agree absolutely	Don't agree	No Comments	Agree	Agree absolutely.
16	The clinical instructions was easy to understand	1	2	3	4	5
	<b>Informativeness</b>					
17	Receiving clear information at the reception desk	1	2	3	4	5
18	Information about the services provided by the center was clear.	1	2	3	4	5
19	Generally you feel that the staff was welcoming you.	1	2	3	4	5
20	The examiner introduces his self before the examination.	1	2	3	4	5
21	The health professional was attending to your concerns.	1	2	3	4	5
22	There were clear explanation about your health status	1	2	3	4	5
23	The health instructions was clear	1	2	3	4	5
24	Clear precautions and preventive procedures were given	1	2	3	4	5
25	clear road signs to the center	1	2	3	4	5
<b>Accessibility</b>						
27	It was easy to reach the center	1	2	3	4	5
28	Transportations was available	1	2	3	4	5
29	Transporting time to and from the center was reasonable	1	2	3	4	5
30	The centre at the same resident area	1	2	3	4	5
31	Cost of transportation was reasonable	1	2	3	4	5
32	It was safe to come to the center	1	2	3	4	5

No	The question	Don't agree absolutely	Don't agree	No Comments	Agree	Agree absolutely.
33	Availability of Parking encourage you to come to this center	1	2	3	4	5
<b>Waiting time</b>						
34	Registration procedures takes short time	1	2	3	4	5
35	The appointment was reasonable	1	2	3	4	5
36	waiting time to enter the clinic was short	1	2	3	4	5
37	Procedure time inside the clinic was reasonable	1	2	3	4	5
38	The total time of receiving the service was accepted.	1	2	3	4	5
<b>Gender Sensitivity</b>						
39	The staff introduce themselves before the procedure	1	2	3	4	5
40	It was accepted to be examined by male health practitioner	1	2	3	4	5
41	The staff explain the procedure before starting	1	2	3	4	5
42	You feel staff respect and courteous with you	1	2	3	4	5
43	It was normal to discuss sexual and reproductive health issue	1	2	3	4	5
<b>Privacy</b>						
44	The examination room are equipped with privacy tools and instruments(as shutters)	1	2	3	4	5
45	The staff care for your privacy is clear	1	2	3	4	5
46	The door was closed during your visit	1	2	3	4	5
47	Clean couch with clean towel	1	2	3	4	5

No	The question	Don't agree absolutely	Don't agree	No Comments	Agree	Agree absolutely.
48	Secretly of your information are clear	1	2	3	4	5

**Part three:**

**A: The center provides the following services, Please circle the correct answer:**

Services provided:	The answers	
Pregnant care service:	No	Yes
Postnatal care services.	No	Yes
Obstetric services.	No	Yes
Menopausal services	No	Yes
Sexual transmitted services	No	Yes
Pap smear test.	NO	Yes
Mammography.	NO	Yes
Education and consultation.	NO	Yes
Family planning and contraceptive devices.	NO	Yes
Post abortion services and consultations.	NO	Yes
Referral to hospitals services.	NO	Yes
Other service please specify:		

**B: you receive the following service**

<b>Services provided:</b>	<b>The answers</b>	
Pregnant care service:	<b>No</b>	<b>Yes</b>
Postnatal care services.	<b>No</b>	<b>Yes</b>
Obstetric services.	<b>No</b>	<b>Yes</b>
Menopausal services	<b>No</b>	<b>Yes</b>
Sexual transmitted services	<b>No</b>	<b>Yes</b>
Pap smear test.	<b>NO</b>	<b>Yes</b>
Mammography.	<b>No</b>	<b>Yes</b>
Education and consultation.	<b>No</b>	<b>Yes</b>
Family planning and contraceptive devices.	<b>No</b>	<b>Yes</b>
Post abortion services and consultations.	<b>No</b>	<b>Yes</b>
Referral to hospitals services.	<b>No</b>	<b>Yes</b>
Other service please specify:		

**C: general features of the service provided:**

**1- Your satisfaction from the last visit was:**

- Very satisfied     satisfied     no comments     unsatisfied  
 Strongly unsatisfied :

**2- You choose this place because of:**

- Good access     special service provision     reputation     else

**3- You know about the center and services provided from your:**

- Friend     neighbor     Mother     mom in low     husband     radio     TV      
Newspaper     else .

**4- The person who deliver the service for you was:**

- Male nurse     male physician     female nurse     female physician     health practitioner  
 don't know     else

**5- There was a lot of privacy and respect during the procedure:**

- Strongly agree     Agree     no comments     don't agree     strongly don't agree

**6- The age of the person who deliver the service for you was between:**

- 20-30     31-40     41-50     more than 50.

**Part 4: please circle on the appropriate answer**

- 1- **Married since:**  one year     2 yrs     3yrs     4 yrs     more

- 2- **Do you have children:**  No    Yes ( one     tow     three     more).

- 3- **Are you pregnant now:**  No    Yes( 1st trimester     2nd     3rd).

**4- Now you are using a contraceptive method:**

No  Yes( normal  tablets  IUD  condom  else )

**5- Previously you used contraceptive method:**

No  Yes( normal  tablets  IUD  condom  else ).

**6- You are now:**  worker  student  employee  unemployed. farmer  else.

**7- The waiting time to enter the clinic was up to:**

10  11- 20  21- 30  31-40  more than 40min

**8- The service inside the room takes up to:**

10  11- 20  21-30  31-40  more than 40min.

**9- You came to the center:**

alone  with your husband  friend  mum in law  mother  else:

**10- The distance to the center was about:**

Up to 1 Km  1-2Km  3-4Km  5-6Km  7-8Km  More than 8Km.

**11- You came to the center:**

walking  by car  by bus  by taxi

**It takes you to the center in minutes up to:**

10  11-20  21-30  31-40  more than 40min

**Part 5:**

What is the importance of the following factors on choosing this center to get the service from?

	<b>Very important</b>	<b>Important</b>	<b>Not important</b>
Availability of privacy			
Good access to the center			
Good relations and information from the staff			
Waiting time is short			
Appropriate appointments			
Female specialized staff			
High quality service			

**Part 6: open questions:**

**1- Please list the most important problems you face during your visit:**

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**2- Please list the most important things that makes you visit this center:**

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**3- How do you describe your level of satisfaction with the service provided by the center:**

Strongly satisfied  
 strongly unsatisfied

satisfied

no comments

unsatisfied

The end of questionnaire

**The researcher**

**Ayman Abu Muhsen**

**Appendix 5: Likert scale according to the means of all answers: (Rinsis Likert 2010)**

Don't agree absolutely ↑ ↑ ↑ ↑	Level 5	1.19- 1.00
	Level 4	1.39-1.20
	Level 3	1.59-1.40
	Level 2	1.79-1.60
	Level 1	1.99-1.80
Don't Agree		2.00
Low degree ↑ ↑ ↑ ↑	Level 5	2.19-2.01
	Level 4	2.39-2.20
	Level 3	2.59-2.40
	Level 2	2.79-2.60
	Level 1	2.99-2.80
Agree mild degree		3.00
↓ ↓ ↓ ↓ ↓ mild Degree	Level 1	3.19-3.01
	Level 2	3.39-3.20
	Level 3	3.59-3.40
	Level 4	3.79-3.60
	Level 5	3.99-3.80
Strongly Agree		4.00
↓ ↓ ↓ ↓ ↓	Level 1	4.19-4.01
	Level 2	4.39-4.20
	Level 3	4.59-4.40
	Level 4	4.79-4.60
	Level 5	5.00-4.80

Strongly Agree		
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**Appendix 6: Tables and Figures of Different related data percentage**

**Table (4.1) the frequent and percentage of participants from different providers**

<b>Provider</b>	<b>Frequency</b>	<b>Percentage %</b>
MOH	117	47.2
UNRWA	70	28.2
NGO's	61	24.6
<b>Total</b>	<b>248</b>	<b>%100.0</b>

**Table 4.2 sample distributions according to location of provider (N 248):**

<b>Location</b>	<b>Frequency</b>	<b>Percentage</b>
City	107	43.1
Village	77	31.0
Camp	64	25.9
Total	248	% 100.0

**Table 4.3 sample distribution according to client age (N 248)**

<b>Age Group</b>	<b>Frequency</b>	<b>Percentage</b>
19 – 15	24	9.7
24 – 20	82	33.1
30 – 25	77	31.0
35 – 31	42	16.9
36 and more	23	9.3
<b>Total</b>	<b>248</b>	<b>% 100.0</b>

**Table 4.4 sample distribution according to number of visits (N 248)**

<b>Visit number</b>	<b>Frequency</b>	<b>Percentage</b>
First visit	21	8.5%
Second visit	42	16.9%
Third visit	26	10.5%
Fourth visit or more	159	64.1
<b>Total</b>	<b>248</b>	<b>100%</b>

**Table 4.6 Sample distributions according to the time from the last visit (N 248)**

<b>The last visit was before</b>	<b>Frequency</b>	<b>Percentage</b>
Less than one month	158	63.7
From 1 to 6 months	55	22.2
From 6 to 12 months	22	8.9
More than a year	13	5.2
<b>Total</b>	<b>248</b>	<b>% 100.0</b>

**Table 4.7 Sample distributions according to place of residency (N 248)**

<b>Place of Residency</b>	<b>Frequency</b>	<b>Percentage</b>
City	78	31.5
Village	117	47.1
Camp	53	21.4
Total	248	% 100.0

**Table 4.8 Sample distributions according to marital status (N 248)**

<b>marital status</b>	<b>Frequency</b>	<b>Percentage</b>
Married	236	95.2
Widow	3	1.2
Divorced	9	3.6
Total	248	100%

**Table 4.9 Sample distribution according to economic condition (N 248)**

<b>Economic Condition</b>	<b>Frequency</b>	<b>Percentage</b>
Weak	23	9.3
Middle	123	49.6
Good	87	35.1
Very Good	15	6.0
Total	248	%100.0

**Table 4.10 the sample distribution according to education level (N 248)**

Educational Level	Frequency	Percentage
Elementary	12	4.8
Primary	46	18.5
Secondary	91	36.7
University	95	38.3
Else	4	1.7
Total	248	100%

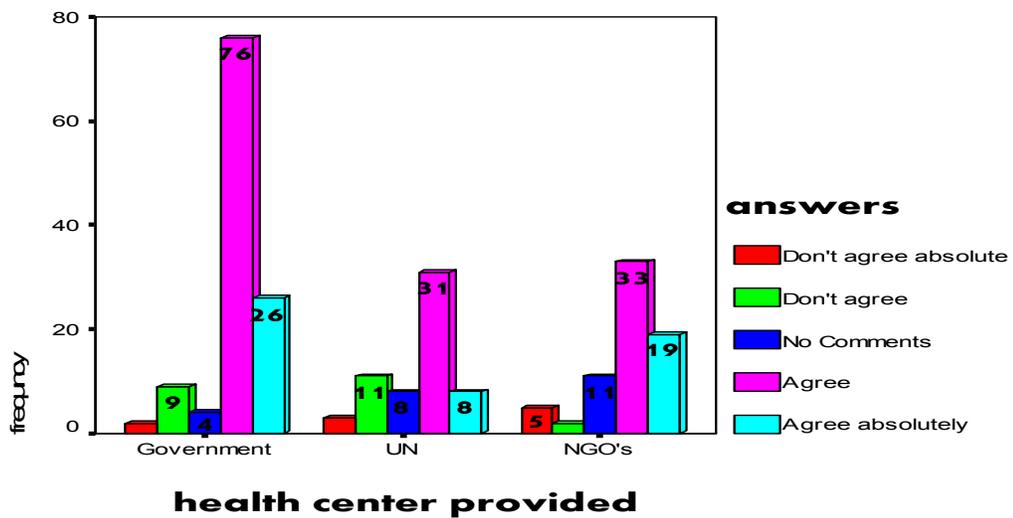


Figure 5.3 Means and S.D of quality for all participants N=248

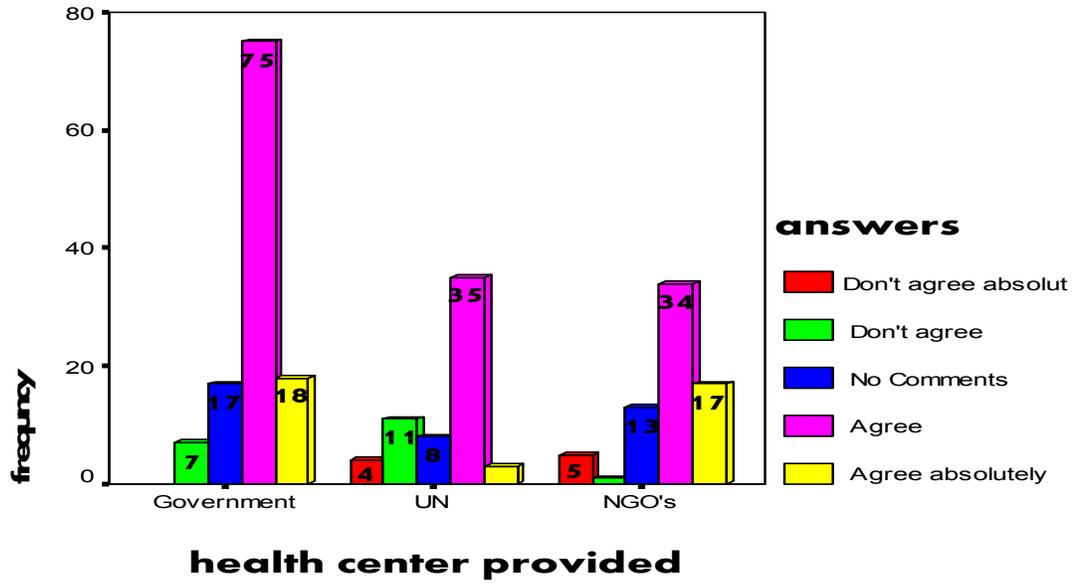


Figure 5.4 Means and S.D of Informativeness for all participants N=248

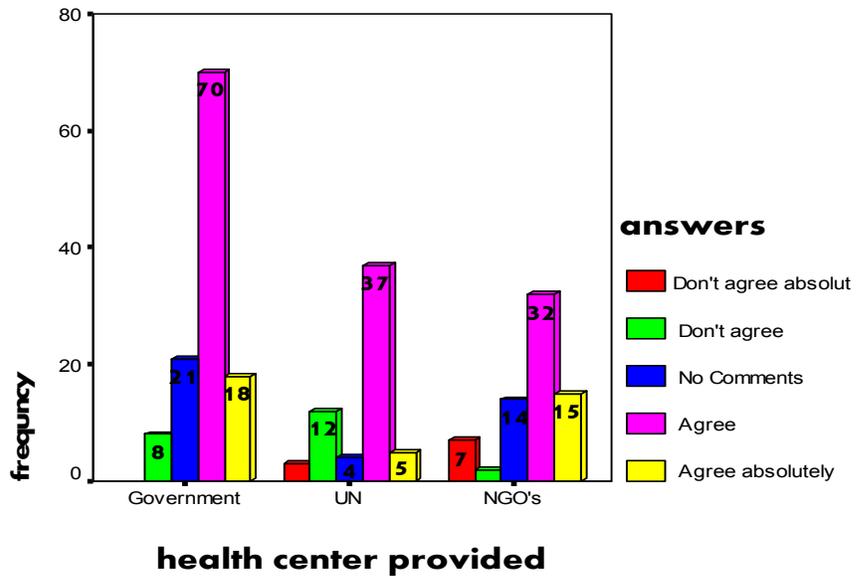


Figure 5.5 Means and S.D of accessibility for all participants N=248

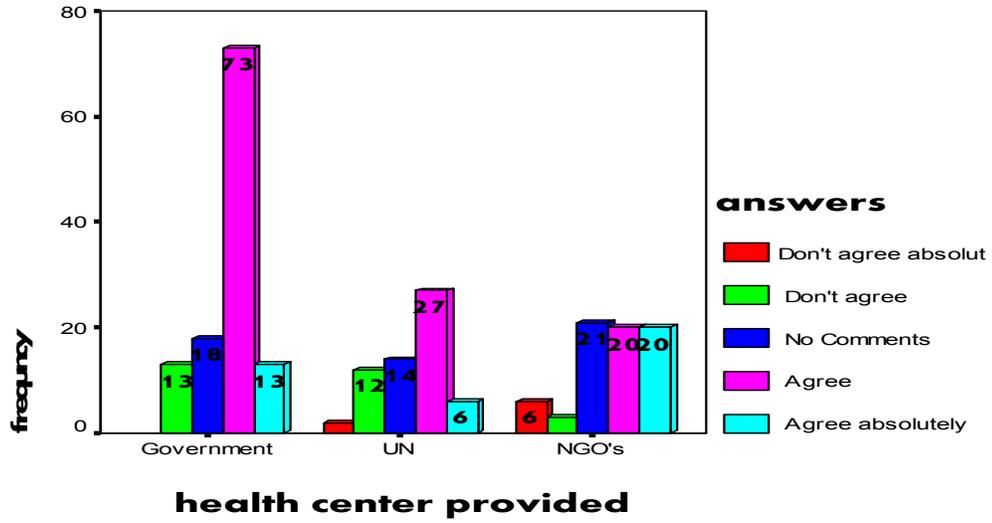


Figure 5.6 Means and S.D of Waiting time for all participants N=248

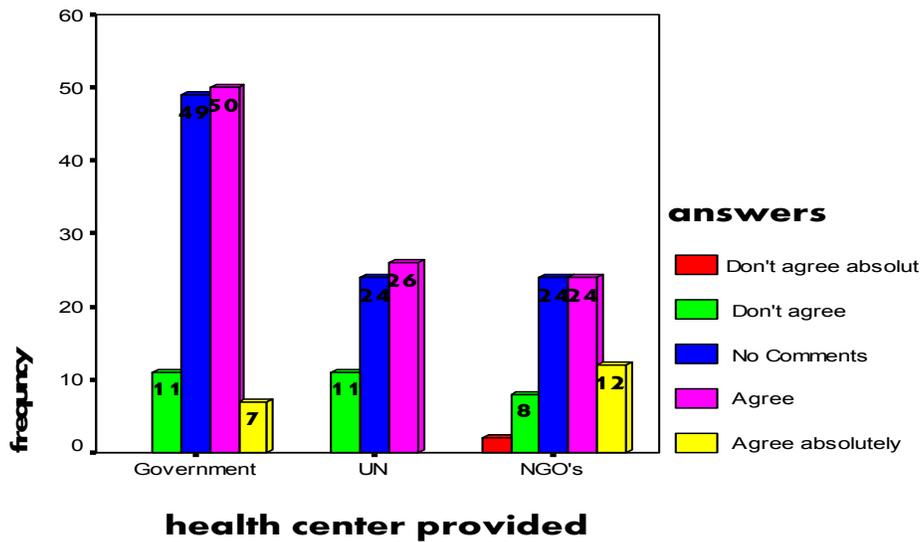


Figure 5.7 Means and S.D of Gender sensitivity for all participants N=248

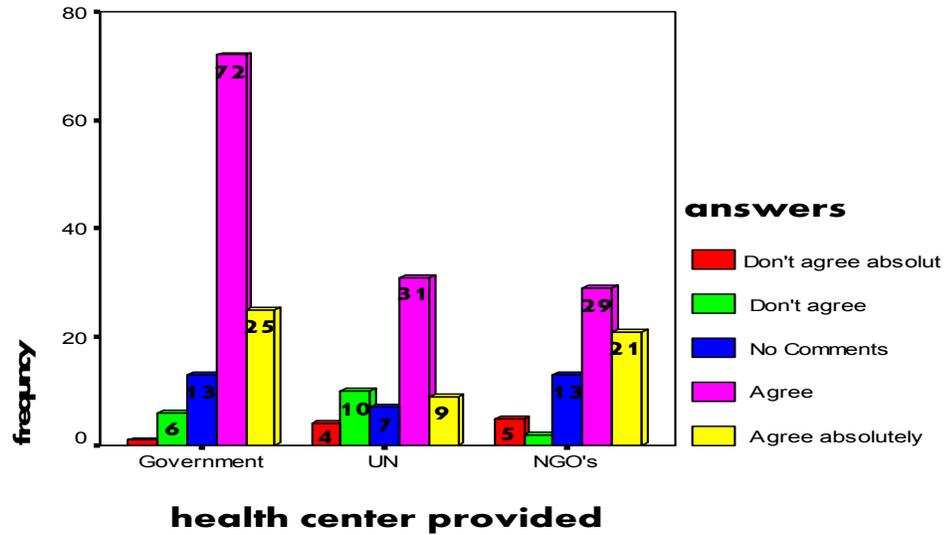


Figure 5.8 Means and S.D of privacy for all participants N=248

Table 5.40 the overall means of all study dimensions

NO	Dimension	S.D.	Mean
1-	The 1 <sup>st</sup> dimension: Quality of Service	0.548	3.73
2-	The 2 <sup>nd</sup> dimension: Informativeness	0.391	3.61
3-	The 3 <sup>rd</sup> dimension: accessibility	0.268	3.61
4-	The 4 <sup>th</sup> dimension: Waiting time	0.274	3.50
5-	The 5 <sup>th</sup> dimension: Gender Sensitivity	0.298	3.32
6-	The 6 <sup>th</sup> dimension: Privacy	0.401	3.71
	<b>Total</b>	<b>0.736</b>	<b>3.58</b>

مستوى رضا النساء المتزوجات من خدمات الصحة الانجابيه  
والمقدمة في منطقة رام الله. فلسطين

300

30

.%92

270

248

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(

%64.2)

(

%29

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